Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00071-158

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

March 31, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	West Palm Beach VA Medical Center
FY	fiscal year
ICU	intensive care unit
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 26, 2015.

Review Results: The review covered eight activities. The facility's reported accomplishments were veteran treatment courts, kiosk deployment, and scheduled patient room refurbishment.

Recommendations: We made recommendations in all eight of the following activities:

Quality Management: Ensure that emergency airway management privileges granted are appropriate for the practitioners' skills and training. Require that the Cardiopulmonary Resuscitation Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. Include all required elements in the quality control policy for scanning.

Environment of Care: Require that Environment of Care Committee minutes include all required elements and that infection prevention and control meeting minutes consistently reflect discussion of identified high-risk priority areas. Ensure that patient care areas and public restrooms are clean and that toilet paper dispensers are in good repair. Store clean and dirty items separately. Secure medication carts when not in use.

Medication Management: Complete monthly medication storage area inspections. Revise the policy for safe use of automated dispensing machines to include minimum competency requirements for users. Require that oral syringes are available for liquid medications and that they are stored separately from parenteral syringes.

Coordination of Care: Ensure requestors consistently select the proper consult title. Update the local consult policy for policy changes, and review the policy at least every 3 years.

Magnetic Resonance Imaging Safety: Conduct contrast reaction and fire emergency drills in magnetic resonance imaging. Conduct initial patient safety screenings. Require radiologists and/or Level 2 magnetic resonance imaging personnel to document resolution of all identified contraindications prior to completing the scan.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake. Report all required data elements to the Veterans Health Administration.

Surgical Complexity: Ensure all nursing employees who perform 12-lead electrocardiograms have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and have competency assessment and validation completed and documented. Require that post-anesthesia care competency assessment and validation is included in competency checklists and completed for nursing employees on the intensive care unit.

Emergency Airway Management: Revise the emergency airway management policy to include a specific plan to manage difficult airways. Ensure clinician reassessment for continued emergency airway management competency includes all required elements.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–39, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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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 quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2014 and FY 2015 through January 26, 2015, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the West Palm Beach VA Medical Center, West Palm Beach, Florida,* Report No. 11-03669-97, February 21, 2012).

During this review, we presented crime awareness briefings for 165 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 321 responded. We shared summarized results 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.

Reported Accomplishments

Veteran Treatment Courts

The facility was instrumental in the recent establishment of veteran treatment courts in St. Lucie and Martin counties in Florida. The purpose of the program is to avoid unnecessary criminalization of veterans with mental illness, which can lead to extended incarceration. Thirty-eight veterans successfully completed the program this year.

Kiosk Deployment

The facility installed 28 kiosks throughout the main campus and the community based outpatient clinics to streamline the check-in process and allow veterans quick access to update their demographic information. This system has helped the medical support staff spend more time assisting veterans and providing administrative support to providers.

Coordination of Patient Room Refurbishment and Repair

Repairing and refurbishing the walls, floors, and equipment in a patient's room can be difficult because the rooms are usually occupied and such efforts are disruptive to patients. The facility implemented an innovative method for repairing and refurbishing patient rooms on a regular basis. Through coordination and planning between Nursing, Facilities Management, and Environmental Management Services, a patient room is closed for 6–8 hours on a rotating basis for needed repairs and maintenance. This approach ensures minimal disruption for patients and is highly successful.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 20 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Of the 20 licensed independent practitioners' folders reviewed, 19 practitioners' privileges for EAM were not appropriate for their skills and training at the time of renewal.	**1.** We recommended that facility managers ensure that emergency airway management privileges granted are appropriate for the practitioners' skills and training.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.	Twelve months of Cardiopulmonary Resuscitation Committee meeting minutes reviewed: • Committee minutes did not reflect a review of each episode. • Code reviews did not include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.	**2.** We recommended that the Cardiopulmonary Resuscitation Committee review each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	• The scanning policy did not include an alternative means of capturing data when the quality of the source documents did not meet image quality controls and a correction process if scanned items have errors.	**3.** We recommended that the quality control policy for scanning include an alternative means of capturing data when the quality of the source document did not meet image quality controls and a correction process if scanned items have errors.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

We inspected the 6A-medical, 7A-surgical/oncology, and 3C-inpatient MH units; the CLC-N and CLC-S units; the 2B-ICU; the Blind Rehabilitation Center; the Emergency Department; and the 9A-primary care clinic. We also performed a perimeter inspection of the 3C dining room construction site. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 30 employee training records (10 critical care and 20 CLC) and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	Six months of EOC Committee meeting minutes reviewed: • Five sets of meeting minutes did not contain discussion of EOC rounds deficiencies, so there was no consistent identification of trends and actions or tracking of actions to closure.	**4.** We recommended that Environment of Care Committee minutes include consistent discussion of rounds deficiencies, trends, and actions and tracking of actions to closure.
	The facility conducted an infection prevention risk assessment.		
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.	Six months of infection prevention and control meeting minutes reviewed: • Some high-risk priority areas identified in the infection prevention risk assessment were not consistently discussed, and others were not presented for discussion at all.	**5.** We recommended that infection prevention and control meeting minutes consistently reflect discussion of identified high-risk priority areas.
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Two of six patient care areas had dirty floors. • Public restrooms adjacent to five of six patient care areas had trash on the floor, dirty commodes, issues with toilet paper dispensers (such as missing parts and dispensers not properly closed), and/or sticky strips on walls. • One of six patient care areas had dirty bases on tray tables and rolling equipment items.	**6.** We recommended that facility managers ensure patient care areas and public restrooms are clean and toilet paper dispensers are in good repair and monitor compliance.
X	The facility met infection prevention requirements.	• One of six patient care areas had clean and dirty items stored together.	**7.** We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.
X	The facility met medication safety and security requirements.	• Two of six patient care areas had medication carts that were unlocked and unattended.	**8.** We recommended that the facility secure medication carts when not in use and that facility managers monitor compliance.
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
	Designated critical care employees received blood borne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
X	The facility met environmental safety requirements in critical care.	• The 2B-ICU had dirty bases on tray tables and rolling equipment items. • Public restrooms adjacent to the 2B-ICU had sticky strips on walls.	See recommendation 6.
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received blood borne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements in the CLC.	• Both CLC units had dirty resident room floors, restrooms, and hallways. • Public restrooms adjacent to the CLC units had trash on the floor, a dirty commode, a damaged toilet paper dispenser, and/or sticky strips on walls.	See recommendation 6.
X	The facility met infection prevention requirements in the CLC.	• Both CLC units had clean and dirty items stored together.	See recommendation 7.
X	The facility met medication safety and security requirements in the CLC.	• On the CLC-N unit, two medication carts were unlocked and unattended.	See recommendation 8.
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the 2B-ICU, 6B-medicine telemetry unit, 3C-inpatient MH unit, and Emergency Department and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
X	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.	• The 2B-ICU, 6B-medicine telemetry unit, and Emergency Department had one or more missed monthly medication storage area inspection.	**9.** We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include minimum competency requirements for users.	**10.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include minimum competency requirements for users and that facility managers monitor compliance.
X	The facility employed practices to prevent wrong-route drug errors.	• On the 2B-ICU, 6B-medicine telemetry unit, and 3C-inpatient MH unit and in the Emergency Department, oral syringes were not available for staff to administer liquid medications when dose amounts differed from the unit dose packages supplied, and employees reported they were using parenteral syringes instead.	**11.** We recommended that facility managers ensure that oral syringes are available for liquid medications on all nursing units and in the Emergency Department and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 41 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Nine consult requests (22 percent) did not include "inpatient" in the title.	**12.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
X	The facility met any additional elements required by VHA or local policy.	Facility policy on governing local policies required that local policies be updated as needed for policy changes and reviewed at least every 3 years. • The facility did not update the local consult policy in response to policy changes and did not review it at least every 3 years.	**13.** We recommended that the facility update the local consult policy for policy changes and review the policy at least every 3 years and that facility managers monitor compliance.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) employee safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 46 employees (30 randomly selected Level 1 ancillary staff and 16 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.	• The facility did not conduct contrast reaction and fire emergency drills in the MRI areas.	**14.** We recommended that the facility conduct contrast reaction and fire emergency drills in magnetic resonance imaging and that the facility managers monitor compliance.
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	• None of the 35 EHRs contained initial patient safety screenings.	**15.** We recommended that the facility conduct initial patient safety screenings and that the facility managers monitor compliance.
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Nineteen of the 21 applicable EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**16.** We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that the facility managers monitor compliance.
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[f]

We reviewed relevant documents, the EHRs of 31 patients who experienced stroke symptoms, and 10 Emergency Department employee training records, and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, 2B-ICU, and 6A-medical and 3C-inpatient MH units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Thirty of the 31 EHRs (97 percent) did not contain documented evidence of completed stroke scales.	**17.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Nineteen of the 29 applicable EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.	**18.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
	Clinicians provided printed stroke education to patients upon discharge.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	• The facility did not report the following data to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**19.** We recommended that the facility report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Six of 10 employees on the 2B-ICU, 6B-medical telemetry, 7A-surgical/oncology, 6A-medical, and 3C-inpatient MH units did not have 12-lead electrocardiogram competency assessment and validation included in their competency checklists. • Nine of 10 employees on the 2B-ICU, 6B-medical telemetry, 7A-surgical/oncology, 6A-medical, and 3C-inpatient MH units did not have 12-lead electrocardiogram competency assessment and validation documentation completed for FY 2014. • Seven of 10 employees on the 2B-ICU did not have post-anesthesia care competency assessment and validation included in their competency checklists. • Nine of 10 employees of the 2B-ICU did not have post-anesthesia care competency assessment and validation documentation completed for FY 2014.	**20.** We recommended that facility managers ensure that all nursing employees who perform 12-lead electrocardiograms have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and have 12-lead electrocardiogram competency assessment and validation completed and documented. **21.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the 2B-ICU.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the Veterans Integrated Service Network Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 20 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

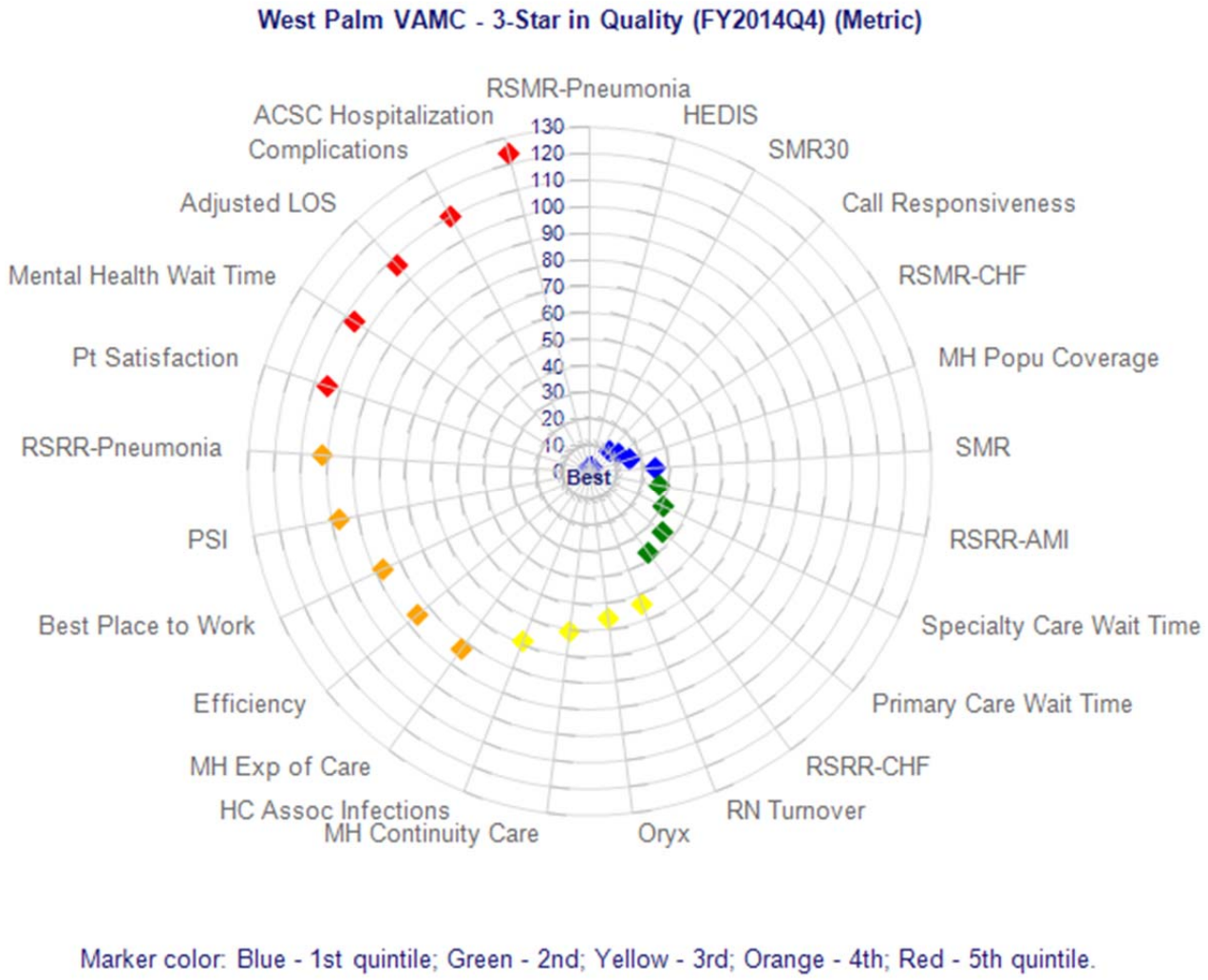
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
X	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway	• Facility policy did not address a plan for managing difficult airways.	**22.** We recommended that the facility revise the emergency airway management policy to include a specific plan to manage difficult airways.
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• Fourteen of 20 clinicians did not have documentation of all required subject matter content elements. • Seventeen of 20 clinicians did not have evidence of successful demonstration of all required procedural skills on airway simulators or mannequins. • Four of 20 clinicians did not have evidence of successful airway management and intubation of at least one patient in the preceding 2 years, written certification of airway management competency from the evaluating superior at the non-VA facility, or successful demonstration of airway management and intubation skills to the facility subject matter expert.	**23.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements, including a written test, and that facility managers monitor compliance. **24.** We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance. **25.** We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes one of the three required components and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (West Palm Beach/548) FY 2015 through January 2015[1]	
Type of Organization	Primary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$372.4
Number (as of February 13, 2015) of:	
• **Unique Patients**	45,839
• **Outpatient Visits**	260,802
• **Unique Employees**[2]	2,043
Type and Number of Operating Beds:	
• **Hospital**	155
• **CLC**	120
• **MH**	25
Average Daily Census:	
• **Hospital**	124
• **CLC**	86
• **MH**	19.1
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Fort Pierce/548GA Delray Beach/548GB Stuart/548GC Boca Raton/548GD Vero Beach/548GE Okeechobee/548GF St. Lucie/548QA
Veterans Integrated Service Network Number	8

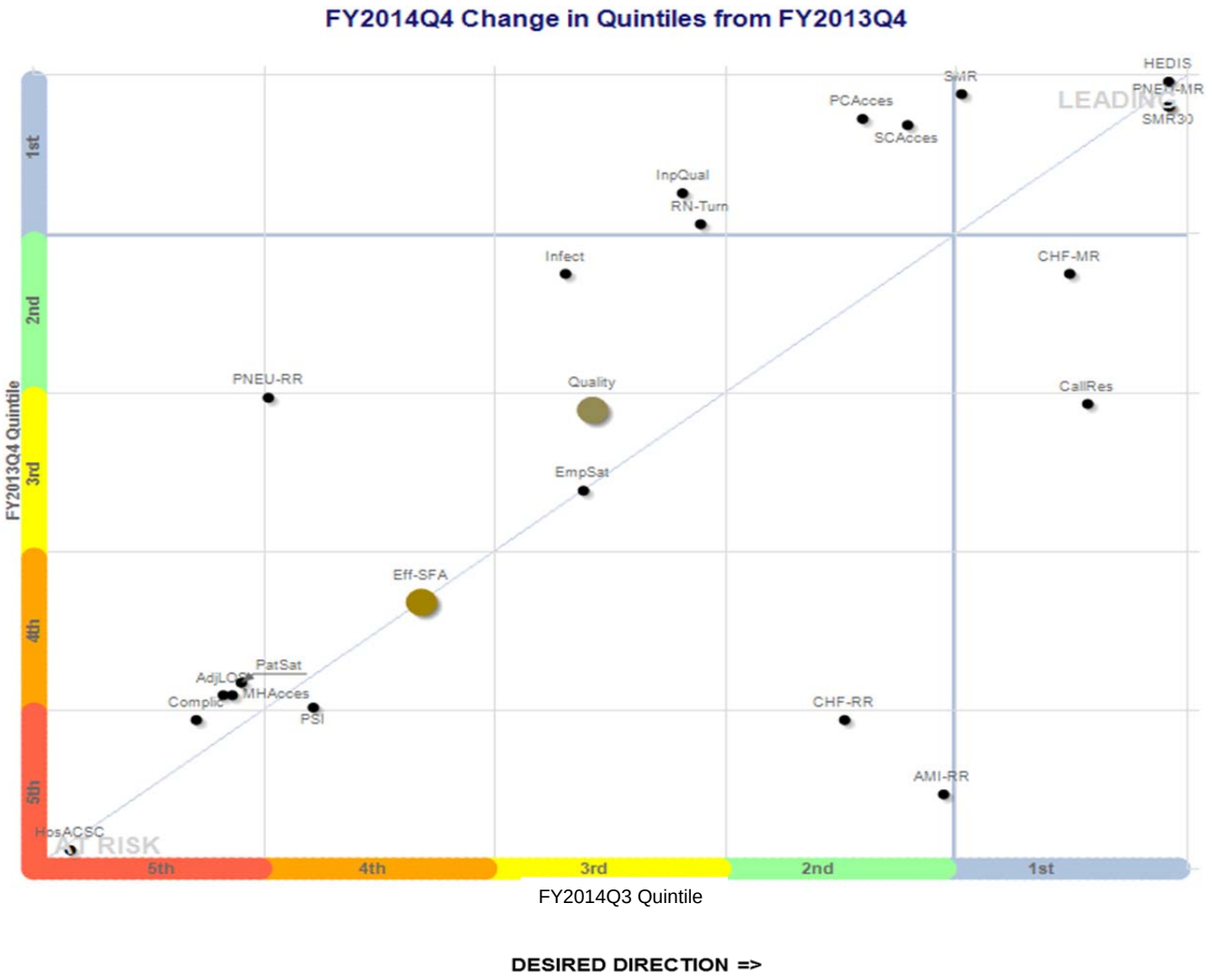
[1] All data is for FY 2015 through January 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 6, 2015

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 Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed and concur with CAP Review conducted at the West Palm Beach VA Medical Center the week of January 26, 2015.

2. Appropriate action has been initiated and/or completed as detailed in the attached response. Thank you!

(original signed by:)
Paul Bockelman

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 25, 2015

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

Subject: **CAP Review of the West Palm Beach VA Medical Center, West Palm, 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 Combined Assessment Program (CAP) site visit conducted January 26–30, 2015. We concur with the findings and are implementing the corrective actions identified to improve processes.

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 facility managers ensure that emergency airway management privileges granted are appropriate for the practitioners' skills and training.

Concur

Target date for completion: April 15, 2015

Facility response: All providers will complete the Out of Operating Room Airway Management (OOORAM) credentialing competency checklist which identifies current skills and training requirements (Refer to MCM 548-111-157 entitled Out of OR Airway Management). 100 percent of the ED and ICU physicians have completed the checklist to date and the inpatient RRTs will have this completed by 4/15/2015. The future privileging of all providers will be dependent on remaining current with requirements outlined in MCM 548-111-157. Documentation will be maintained by the respective services and the Medical Staff Office (credentialing) and the Minutes for the Professional Standards Board will support completion of OOORAM credentialing and re-credentialing activities. The future privileging of all providers will be dependent on remaining current with requirements outlined in MCM 548-111-157. Documentation will be maintained by the respective services and the Medical Staff Office (credentialing) and the Minutes for the Professional Standards Board will support completion of OOORAM credentialing and re-credentialing activities.

Recommendation 2. We recommended that the Cardiopulmonary Resuscitation Committee review each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: July 31, 2015

Facility response: A Cardiopulmonary Resuscitation (CPR) Monitoring template has been designed to ensure consistent review and discussion of code elements at the committee. A review of Code Blue events monthly by the committee members will be a standing agenda item for the CPR Committee and the minutes will provide supporting documentation for tracking purposes. Additionally, six month (February, March, April, May, June, and July) review of CPR Committee Minutes will support consistent monthly review of Code Blue events.

Recommendation 3. We recommended that the quality control policy for scanning include an alternative means of capturing data when the quality of the source document did not meet image quality controls and a correction process if scanned items have errors.

Concur

Target date for completion: May 1, 2015

Facility response: The Document Scanning Policy MCM 548-136H-416 has been updated to include both elements cited. Updated changes were highlighted and will be sent out for collaboration on or before 3/2/15. The Document Scanning Policy MCM 548-136H-416 posting after signage will be completed by 4/30/15 and all staff will be notified of the posting in the Director's Daily Bulletin.

Services are reminded at 90-60-30 days prior to expiration that the MCM is due for review and revision. As a standing agenda item a deficiency report is submitted and discussed at the monthly Performance Improvement Board attended by leadership. Minutes will support tracking of MCM revision deficiencies.

Recommendation 4. We recommended that Environment of Care Committee minutes include consistent discussion of rounds deficiencies, trends, and actions and tracking of actions to closure.

Concur

Target date for completion: July 31, 2015

Facility response: Environment of Care (EOC) rounds are reported to the Environment of Care Committee (EOCC) quarterly. To avoid deferral of the report due to time constraints, FY15 Quarter 1 results of Rounds will be reported to the Rounds Team and their assessment forwarded to the EOCC out of Committee and will then be formally submitted to the EOCC in March. The EOC Rounds Deficiencies Report will be reported quarterly as a standing EOCC agenda item starting in April with tracking and trending analysis with actions identified and tracked through to completion. Two quarterly reports will be submitted and discussed which will be reflected in EOC Committee Minutes by 7/31/15.

Recommendation 5. We recommended that infection prevention and control meeting minutes consistently reflect discussion of identified high-risk priority areas.

Concur

Target date for completion: August 1, 2015

Facility response: Infection Prevention Risk Assessment high risk priority areas will be added as a bi-monthly standing agenda item at the General Infection Prevention and Control Committee (IPCC) meetings beginning with the 3/27/15 meeting. By 8/1/15,

three consecutive bi-monthly IPCC Minutes will support consistent reporting and discussion of the high-risk priority areas.

Recommendation 6. We recommended that facility managers ensure patient care areas and public restrooms are clean and toilet paper dispensers are in good repair and monitor compliance.

Concur

Target date for completion: May 30, 2015

Facility response: Sticky strips on the walls in the restrooms were used to affix hand hygiene signage. All hand hygiene signs will be replaced with a more permanent solution in all locations by 6/1/15.

The housekeeping staff were retrained on daily general cleaning to including care for rolling equipment. Teaching was reinforced to ensure staff report items requiring repair or replacement to the supervisor immediately to ensure a work order is placed timely. Environmental Management Service has also increased the cleaning frequency of the public restrooms from three to six times daily to ensure cleanliness is maintained in high traffic areas. Supervisors have also increased the number of Quality Assurance/Quality Control (QA/QC) inspections performed per day to identify discrepancies and make on the spot corrections. In addition to clinical and inpatient areas, QA/QC's have been expanded to all public forum areas, i.e., public restrooms and family waiting areas. Discrepancy/work order feedback will be provided to Housekeeping Staff that work in the areas so they are made aware of what should be reported. The EMS Chief will ensure deficiencies with corrective actions will be tracked and trended by unit and will be added as a standing agenda item at Environmental Management Service staff meetings. Three consecutive months (March, April and May) of meeting Minutes will support the report was submitted and discussed.

Recommendation 7. We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Storage room signage with clear guidance was revised and posted as to what equipment is appropriately stored in which storage room. Staff were provided re-education regarding appropriate storage room use and this will be captured in Staff Meeting Minutes.

Nurse Managers that provide supervision for areas that have clean and dirty utility rooms will perform daily rounds before 12 noon during normal business hours to ensure clean/dirty items are in the correct location and not comingled. Clinical Nurse Leaders will perform weekly random rounds and provide feedback to the Nurse Managers for corrective actions as needed. Additionally, weekly environment of care rounds

performed by Infection Control staff will include documentation that clean and dirty storage rooms were checked with compliance noted. Deficiencies will be cited in the weekly report and tracking and trending will be identified in the EOC Rounds Deficiencies Report reported quarterly as a standing EOCC agenda item starting in April, 2015 with tracking and trending analysis with actions identified and tracked through to completion. Two quarterly report submissions and applicable discussion will be documented in the EOCC Minutes by 9/30/15.

Recommendation 8. We recommended that the facility secure medication carts when not in use and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: All Flow Carts on the six patient areas were physically checked and all security components were functional. Staff on both units cited were trained and sign in sheets support re-education outlining cart security was provided. Nurse Managers that provide supervision for areas that use Flow Carts will perform daily rounds before 12 noon during normal business hours to ensure Flow Carts are secure when not in use. Clinical Nurse Leaders will perform weekly random rounds and provide feedback to the Nurse Managers for corrective actions as needed. Formal facility-wide weekly environment of care rounds will include documentation that Flow Carts were checked with compliance by nursing representation on the team. Deficiencies will be cited in the weekly report and tracking and trending will be identified in the EOC Rounds Deficiencies Report. This will be reported quarterly as a standing EOCC agenda item starting in April including tracking and trending analysis with actions identified and tracked through to completion.

Recommendation 9. We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Pharmacy will inspect all wards to ensure 100% compliance with required monthly inspections. If the inspection is not completed by the 25th of the month, it must be reported to the current Supervisor for reassignment. A monthly standing agenda item of Ward Inspection Reports will be submitted, discussed, and documented in the Minutes for Medication Use Committee (MUC). A six month review will support that an aggregated report was submitted and documented in the MUC Minutes.

Recommendation 10. We recommended that the facility revise the policy for safe use of automated dispensing machines to include minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: May 1, 2015

Facility response: Pharmacy and Nursing will collaboratively identify guidelines and competency requirements which will be outlined in a policy (MCM) identifying expectations for staff regarding the use of automated dispensing machines (Pyxis). The MCM will be completed and will be sent out for collaboration by 4/30/15. The MCM posting after signage will be completed by 5/30/15 and all staff will be notified in the Director's Daily Bulletin. Services are reminded at 90-60-30 days prior to expiration that the MCM is due for review and revision. As a standing agenda item a deficiency report is submitted and discussed at the monthly Performance Improvement Board attended by leadership. Minutes will support tracking of MCM revision deficiencies.

Recommendation 11. We recommended that facility managers ensure that oral syringes are available for liquid medications on all nursing units and in the Emergency Department and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

Concur

Target date for completion: April 2, 2015

Facility response: Logistics has placed an order for 20ml oral syringes with a delivery expectation of 2/25/15. Par levels for oral syringes will be established and will be bar-coded for ED, medical, surgical, psychiatric acute care and the community living center distribution. Distribution of oral syringes will be implemented with par levels maintained by 4/1/15.

Recommendation 12. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: May 1, 2015

Facility response: On 2/19/15, the list for all consult titles was reviewed at the Medical Record Committee to identify all titles that should have outpatient and inpatient in the title name option. It was determined that some titles were identified to have only one or the other option. All consult titles that have a single option will be reviewed and all those not restricted by business rules will have both options available. Changes to the consult titles will be communicated to provider staff with an emphasis on providers use the correct title when ordering the consult. Inpatient consults that are to be completed in the inpatient setting prior to discharge should be entered as an inpatient consult.

Education tracking will be supported in Staff Meeting Minutes for Services that have provider staff by 4/30/15.

Recommendation 13. We recommended that the facility update the local consult policy for policy changes and review the policy at least every 3 years and that facility managers monitor compliance.

Concur

Target date for completion: May 1, 2015

Facility response: MCM 548-11-359 Consultations has gone out for collaboration multiple times due to VHA consult management changes. The revision is in the final stage and will complete the collaboration process by 3/31/15. The MCM posting after signage will be completed by 4/30/15 and all staff will be notified of the posting in the Director's Daily Bulletin. Services are reminded at 90-60-30 days prior to expiration that the MCM is due for review and revision. As a standing agenda item a deficiency report is submitted and discussed at the monthly Performance Improvement Board attended by leadership. Minutes will support tracking of MCM revision deficiencies.

Recommendation 14. We recommended that the facility conduct contrast reaction and fire emergency drills in magnetic resonance imaging and that the facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Medical Center Fire Safety coordinator conducted an MRI emergency drill on Jan 30, 2015. A Contrast reaction drill will be conducted on 2/27/15 by the MRI Safety Coordinator. Both drill outcomes will be documented in MRI Safety Committee Minutes by 3/31/15. MRI and Contrast Reaction Drills will be conducted quarterly and will be reported as a standing agenda item in the MRI Safety Committee Minutes. Two quarterly reports will be submitted, discussed and documented in MRI Safety Committee Minutes.

Recommendation 15. We recommended that the facility conduct initial patient safety screenings and that the facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: All Veterans requiring MRI exams will be screened by the requesting provider at the time of order placement. All second level screening will be completed by Level 2 MRI Staff. Random Review of 30 patient records monthly will be verified by the MRI Safety Officer with evidence that first level screening was completed by the ordering provider supporting 90% compliance in the documentation. Pertinence review

with actions when the target is not met will be reported to the MRI Safety Committee quarterly as a standing agenda item. Two quarterly reports will be submitted, discussed, and documented in MRI Safety Committee Minutes.

Recommendation 16. We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that the facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Magnetic Resonance Imaging contraindications will be documented in the electronic medical record by the radiologist or the Level 2 MRI staff prior to the exam. Random Review of 30 patient records monthly will be verified by the MRI Safety Officer with evidence that contraindications were supported in the documentation with 90% compliance. Pertinence review with actions when the target is not met will be reported to the MRI Safety Committee quarterly as a standing agenda item. Three quarterly reports will be submitted, discussed, and documented in MRI Safety Committee Minutes by 12/31/15.

Recommendation 17. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: July 30, 2015

Facility response: The Stroke Committee will provide oversight to ensure guidelines are established and education is provided for all providers as appropriate. Three consecutive months (April, May and June) of random review of 100% or 30 (whichever is less) suspected acute ischemic stroke patient records will be reported to the Stroke Committee as a standing agenda item with 90% compliance supporting NIH Stroke Scale documentation. Corrective actions will be identified if the target is not met.

Recommendation 18. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: At the time of admission, an initial screening is conducted and documented in the Nursing Admission Note. Additionally, if the screen is positive speech pathology and nutrition and food services receive referrals. ED staff were provided comprehensive education outlining screening process expectations that all

outpatients that present will have a dysphagia screen performed if the Veteran presents to the ED with r/o stroke and for all Veterans in the ED prior to providing any oral intake. This will be documented in the note entitled Nursing ER Assessment Note. ED comprehensive education will be rolled out to all inpatient units and will be captured in Staff Meeting Minutes. For three consecutive months (March, April, and May) the Nurse Managers will verify that 30 random pertinence reviews of the electronic medical record were conducted to ensure the dysphagia screening was performed and documented in the Nursing Admission Note and the Nursing ER Assessment Note as appropriate. Additionally 90% compliance with actions for improvement will be reported. This will be reflected in the June Medical Record Committee Minutes. Units not meeting the target for all three months will be required to report monthly on this screen until the target is met for three consecutive months. Once the target is met for three consecutive months dysphagia screening will be added to the units Quarterly Pertinence Review Form to ensure sustainability.

Recommendation 19. We recommended that the facility report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: December 31, 2015

Facility response: All VHA expectations for reporting will be identified for Acute Ischemic Stroke to include those outlined that are to be self-reported in IPEC. Medicine Service will collect the data and self-report IPEC data as required. Minutes for three consecutive quarters will support IPEC data was reported to the Stroke Committee as a standing agenda item.

Recommendation 20. We recommended that facility managers ensure that all nursing employees who perform 12-lead electrocardiograms have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and have 12-lead electrocardiogram competency assessment and validation completed and documented.

Concur

Target date for completion: June 30, 2015

Facility response: Nursing will review the 12-lead EKG competency checklist to identify a single tool to consistently use to capture competency assessments. All staff will be required to complete the accepted 12-lead EKG competency checklist to validate competency or opportunities for improvement. All Nurse Managers with staff that perform EKGs will verify that all competency folders were reviewed and the accepted tool is complete and posted in the folder. Nurse Managers will be assigned to report EKG competency checklist completion compliance at 100% at the Nurse Executive

Board. All reporting will be completed by 6/30/15. To ensure sustainability, Nursing will determine a method to report annual reporting of EKG competency to the NEB.

Recommendation 21. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the 2B-ICU.

Concur

Target date for completion: June 30, 2015

Facility response: Nursing will review the Post Anesthesia Care Unit (PACU) competency checklist to identify a single tool to consistently use to capture the competency assessment. All staff will be required to complete the accepted PACU competency checklist to validate competency or opportunities for improvement. All Nurse Managers with staff that perform PACU will verify that all competency folders were reviewed and the accepted tool is complete and posted in the folder. Nurse Managers will be assigned to report PACU competency checklist completion compliance at 100% at the Nurse Executive Board. All reporting will be completed by 6/30/15. To ensure sustainability, Nursing will determine a method to report annual reporting of PACU competency to the NEB.

Recommendation 22. We recommended that the facility revise the emergency airway management policy to include a specific plan to manage difficult airways.

Concur

Target date for completion: April 30, 2015

Facility response: The policy MCM 548-111-157 Out of Operating Room Airway Management was reviewed and revised to include specific guidelines to be followed when managing a difficult airway. The MCM was sent out for concurrence with expected finalization by 4/1/15. The MCM posting after signage will be completed by 4/30/15 and all staff will be notified of the posting in the Director's Daily Bulletin. Services are reminded at 90-60-30 days prior to expiration that the MCM is due for review and revision. As a standing agenda item a deficiency report is submitted and discussed at the monthly Performance Improvement Board attended by leadership. Minutes will document tracking of MCM revision deficiencies.

Recommendation 23. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements, including a written test, and that facility managers monitor compliance.

Concur

Target date for completion: April 15, 2015

Facility response: All providers will have completed the Out of Operating Room Airway Management (OOORAM) credentialing competency checklist which identifies current skills and training requirements (Refer to MCM 548-111-157 entitled Out of OR Airway Management) and all required subject matter content elements including a written test will be included. 100% of the ED and ICU physicians have completed the checklist and the inpatient RRTs will have this completed by 4/15/2015. The future privileging of all providers will be dependent on remaining current with requirements outlined in MCM 548-111-157. Documentation will be maintained by the respective services and the Medical Staff Office (credentialing) and the Minutes for the Professional Standards Board will support completion of OOORAM credentialing and re-credentialing activities. Services are reminded at 90-60-30 days prior to expiration that the MCM is due for review and revision. As a standing agenda item a deficiency report is submitted and discussed at the monthly Performance Improvement Board attended by leadership. Minutes will support tracking of MCM revision deficiencies.

Recommendation 24. We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.

Concur

Target date for completion: April 15, 2015

Facility response: All providers will have completed the Out of Operating Room Airway Management (OOORAM) credentialing competency checklist which identifies current skills and training requirements (Refer to MCM 548-111-157 entitled Out of OR Airway Management) including the evidence of successful demonstration of all required procedural skills on airway management simulations. 100% of the ED and ICU physicians have completed the checklist and the inpatient RRTs will have this completed by 4/15/2015. The future privileging of all providers will be dependent on remaining current with requirements outlined in MCM 548-111-157. Documentation will be maintained by the respective services and the Medical Staff Office (credentialing) and the Minutes for the Professional Standards Board will support completion of OOORAM credentialing and re-credentialing activities.

Recommendation 25. We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes one of the three required components and that facility managers monitor compliance.

Concur

Target date for completion: April 15, 2015

Facility response: All providers will have completed the Out of Operating Room Airway Management (OOORAM) credentialing competency checklist which identifies current skills and training requirements (Refer to MCM 548-111-157 entitled Out of OR Airway Management) including the reassessment for continued emergency airway

management competency. 100% of the ED and ICU physicians have completed the checklist and the inpatient RRTs will have this completed by 4/15/2015. The future privileging of all providers will be dependent on remaining current with requirements outlined in MCM 548-111-157. Documentation will be maintained by the respective services and the Medical Staff Office (credentialing) and the minutes for the Professional Standards Board will support completion of OOORAM credentialing and re-credentialing activities.

Office of Inspector General
Contact and Staff Acknowledgments

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This report is available at **www.va.gov/oig.**

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] The references used for this topic were:
- VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke*, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.