Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00601-376

Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System Gainesville, Florida

June 25, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CLC	community living center
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	North Florida/South Georgia Veterans Health System
FY	fiscal year
ICU	intensive care unit
IPCS	interactive patient care system
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
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 April 20, 2015.

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

- Coordination of Care
- Computed Tomography Radiation Monitoring
- Surgical Complexity

The facility's reported accomplishments were systems redesign and patient centered care.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that licensed independent practitioners who perform emergency airway management have the appropriate privileges granted to match their skills and training. Reduce credentialing and privileging folders to the two-part format. Require that the Operating Room Committee includes the Chief of Staff as a member and that committee minutes reflect review of National Surgical Office reports. Establish a committee to provide oversight of the safe patient handling program.

Environment of Care: Require that Infection Control Committee meeting minutes consistently reflect discussion of all identified high-risk areas, that fire drills are conducted once per shift per quarter at the Lake City campus, and that negative air pressure systems in the Gainesville campus surgical intensive care unit are functional. At the Gainesville campus, ensure locked mental health unit stationary panic alarm testing includes documentation of VA Police response time, and ensure testing of portable panic alarms. Require that designated employees at both campuses complete competency assessment on the use of emergency evacuation devices and that construction workers at the Gainesville campus wear VA-issued identification badges.

Medication Management: Ensure that oral syringes are available for liquid medications in all units/areas at both campuses and that they are stored separately from parenteral syringes.

Advance Directives: Screen inpatients to determine whether they want to have a discussion about advance directives, and document the screening.

Emergency Airway Management: Revise the emergency airway management policy to include a plan for managing a difficult airway. Require that initial clinician emergency

airway management competency assessment includes evidence of a completed written test. Report provider specific emergency airway management data to the Operative and Invasive Procedures Committee.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–31, for the full text of the Directors' comments). We consider recommendation 14 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

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
- CT Radiation Monitoring
- ADs
- 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 April 24, 2015, and inspectors conducted the review 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 North Florida/South Georgia Veterans Health System, Gainesville, Florida,* Report No. 12-04190-89, January 17, 2013).

During this review, we presented crime awareness briefings for 456 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. We distributed an electronic survey to all facility employees and received 704 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Systems Redesign and Improvements in Access for Sleep Studies

As of January 2014, the facility had more than 2,000 patients waiting for a sleep study. Through systems redesign efforts, increased clinic access, use of non-VA care, and contact with patients to remind them of their scheduled studies, as of April 2015, only 38 patients were waiting for a sleep study. This improvement in access is being maintained even though the average number of new sleep study requests made each week is 75.

Patient Centered Care Initiatives

The Get Well Network IPCS is an innovative computerized care delivery model aimed at improving patient outcomes. The system has 450 operational monitoring units (217 in Gainesville and 233 in Lake City). The IPCS is used by veterans for entertainment and education and by employees for education and communication with patients. In addition to patient education, the IPCS champion team developed and deployed quick patient order sets for falls, diabetes, and heart failure and used the system for hand hygiene, falls, pain, and discharge planning information. Because of these efforts, in June 2014, the facility received a prestigious IPCS award at a national IPCS meeting.

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, 25 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.	• Six of the 25 providers had completed EAM training requirements but did not have EAM privileges approved. • None of the 25 credentialing and privileging folders had been converted to the required two-part design.	**1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate privileges granted to match their skills and training. **2.** We recommended that the facility reduce credentialing and privileging folders to the two-part format.
	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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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.	Twelve months of Operating Room Committee meeting minutes reviewed: • The Chief of Staff was not a member. • Committee minutes did not reflect review of National Surgical Office reports.	**3.** We recommended that the Operating Room Committee include the Chief of Staff as a member and that committee minutes reflect review of National Surgical Office reports.
	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The facility did not have a committee that provided oversight of the newly initiated safe patient handling program.	**4.** We recommended that the facility establish a committee to provide oversight of the safe patient handling program.
	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.		
	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.		

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 emergency management.[b]

At the Gainesville campus, we inspected the 2W-medical/surgical/step-down and 5E-5W-locked MH units; the surgical, medical, and cardio thoracic ICUs; the CLC unit; Emergency Department areas 1 and 2; and the infusion clinic. At the Lake City campus, we inspected the 2N- and 3N-medical/surgical units; the CLC-2, CLC-3, and CLC-4 units; the Emergency Department; the medical ICU; and the infusion clinic. We also performed perimeter inspections of the Gainesville campus crisis stabilization unit and radiology construction sites. Additionally, we reviewed relevant documents, including 20 employee training and competency records (10 from each campus), 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
	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.		
	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.	Four quarters of Infection Control Committee meeting minutes reviewed: • Minutes did not consistently include discussion of all the facility's high-risk areas identified in the infection prevention risk assessment.	**5.** We recommended that Infection Control Committee meeting minutes consistently reflect discussion of all identified high-risk areas.
	The facility had established a process for cleaning equipment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Past 2 quarters of fire drill documentation for health care occupancy buildings reviewed: • The Lake City campus did not consistently conduct fire drills once per shift per quarter in each building designated for health care occupancy.	**6.** We recommended that facility managers ensure all buildings designated for health care occupancy at the Lake City campus have fire drills conducted once per shift per quarter and monitor compliance.
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• At the Gainesville campus, none of the three negative air pressure systems in the surgical ICU airborne infection isolation rooms were functional.	**7.** We recommended that facility managers ensure negative air pressure systems in the Gainesville campus surgical intensive care unit are functional and monitor compliance.
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	The VA National Center for Patient Safety MH EOC Checklist requires testing of panic alarms, including VA Police response time, on a periodic basis at a frequency determined by the facility. • For the Gainesville campus locked MH units, stationary panic alarm testing for July–September 2014 did not include documentation of VA Police response time, and there was no documentation of portable panic alarm testing.	**8.** We recommended that facility managers ensure Gainesville campus locked mental health unit stationary panic alarm testing includes documentation of VA Police response time and ensure testing of portable panic alarms and monitor compliance.
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
X	Employees received training and competency assessment on use of emergency evacuation devices.	• At the Gainesville campus, two of 10 designated employees did not complete competency assessment on the use of emergency evacuation devices. • At the Lake City campus, four of 10 designated employees did not complete competency assessment on the use of emergency evacuation devices.	**9.** We recommended that facility managers ensure designated employees complete competency assessment on the use of emergency evacuation devices and monitor compliance.

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
X	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.	• At the Gainesville campus crisis stabilization unit and radiology construction sites, four of five construction workers were not wearing a VA-issued identification badge.	**10.** We recommended that engineering managers ensure all Gainesville campus construction workers wear VA-issued identification badges and that facility managers monitor compliance.
	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 40 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. At the Lake City campus, we inspected the Emergency Department, the post-anesthesia care unit, the ICU, and CLC-2. At the Gainesville campus, we inspected the Emergency Department, the medical ICU, and the 2E and 4W medical/surgical units. Additionally, for these areas, we 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 area 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.		
NA	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.		
	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 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.		
X	The facility employed practices to prevent wrong-route drug errors.	• None of the units/areas inspected at both the Lake City and Gainesville campuses had oral syringes available for employees to administer liquid medications when dose amounts differed from the unit dose packages supplied.	**11.** We recommended that facility managers ensure that oral syringes are available for liquid medications in all units/areas at the Lake City and Gainesville campuses 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 40 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. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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		
	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.		
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 15 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist, technologist expert in CT, and medical physicist reviewed all CT protocols revised during the past 12 months, and a medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review, and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether VHA facilities complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 49 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area 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 an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	When inpatients requested a discussion about ADs (create, change, and/or revoke), employees: • Documented the discussion • Used the required AD note titles	• Twenty-eight of the 49 EHRs (57 percent) did not contain documentation that employees offered patients discussions regarding changing and/or revoking existing ADs.	**12.** We recommended that employees screen inpatients to determine whether they want to have a discussion about advance directives and document the screening and that facility managers monitor compliance.
	The facility met 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. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	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 34 clinicians applicable for the review period January 1 through 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.

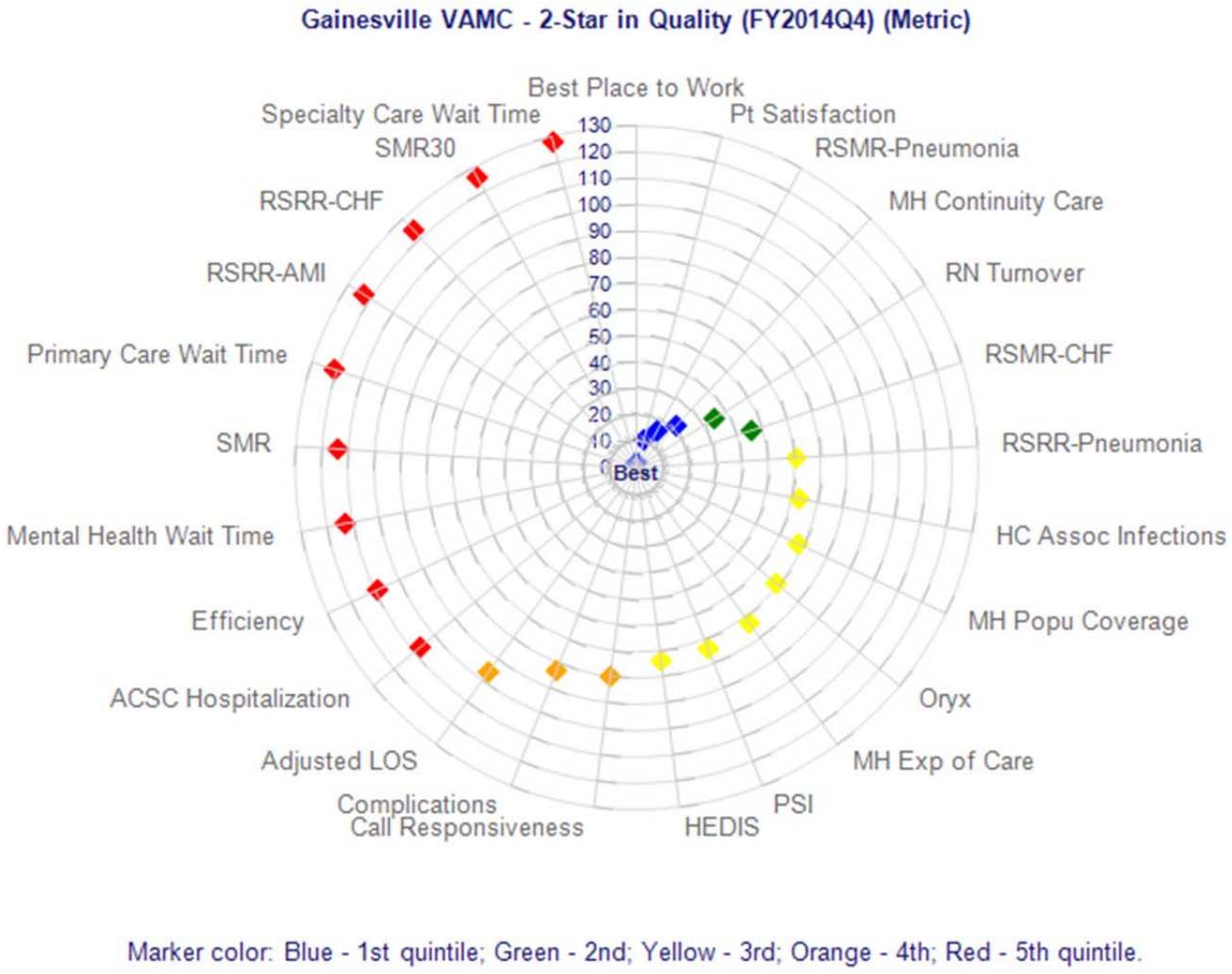
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated 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 a difficult airway.	**13.** We recommended that the facility revise the emergency airway management policy to include a plan for managing a difficult airway.
X	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	• None of the applicable five clinicians with initial EAM competency assessment had documented evidence of a completed written test.	**14.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of a completed written test and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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		
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on out of operating room EAM reviewed: • The facility did not report any provider specific EAM data to the oversight committee as required.	**15.** We recommended that the facility report provider specific emergency airway management data to the Operative and Invasive Procedures Committee.

Facility Profile (Gainesville/573) FY 2015 through April 2015[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$850.1
Number (as of March) of:	
• **Unique Patients**	114,466
• **Outpatient Visits**	777,692
• **Unique Employees**[2]	4,707
Type and Number of Operating Beds:	
• **Hospital**	291
• **CLC**	221
• **MH**	74
Average Daily Census:	
• **Hospital**	204
• **CLC**	117
• **MH**	67
Number of Community Based Outpatient Clinics	11
Location(s)/Station Number(s)	Jacksonville/573BY Valdosta/573GA Ocala/573GD St. Augustine/573GE Tallahassee/573GF Lecanto/573GG The Villages/573GI Saint Marys/573GJ Marianna/573GK Palatka/573GL Waycross/573GM
Veterans Integrated Service Network Number	8

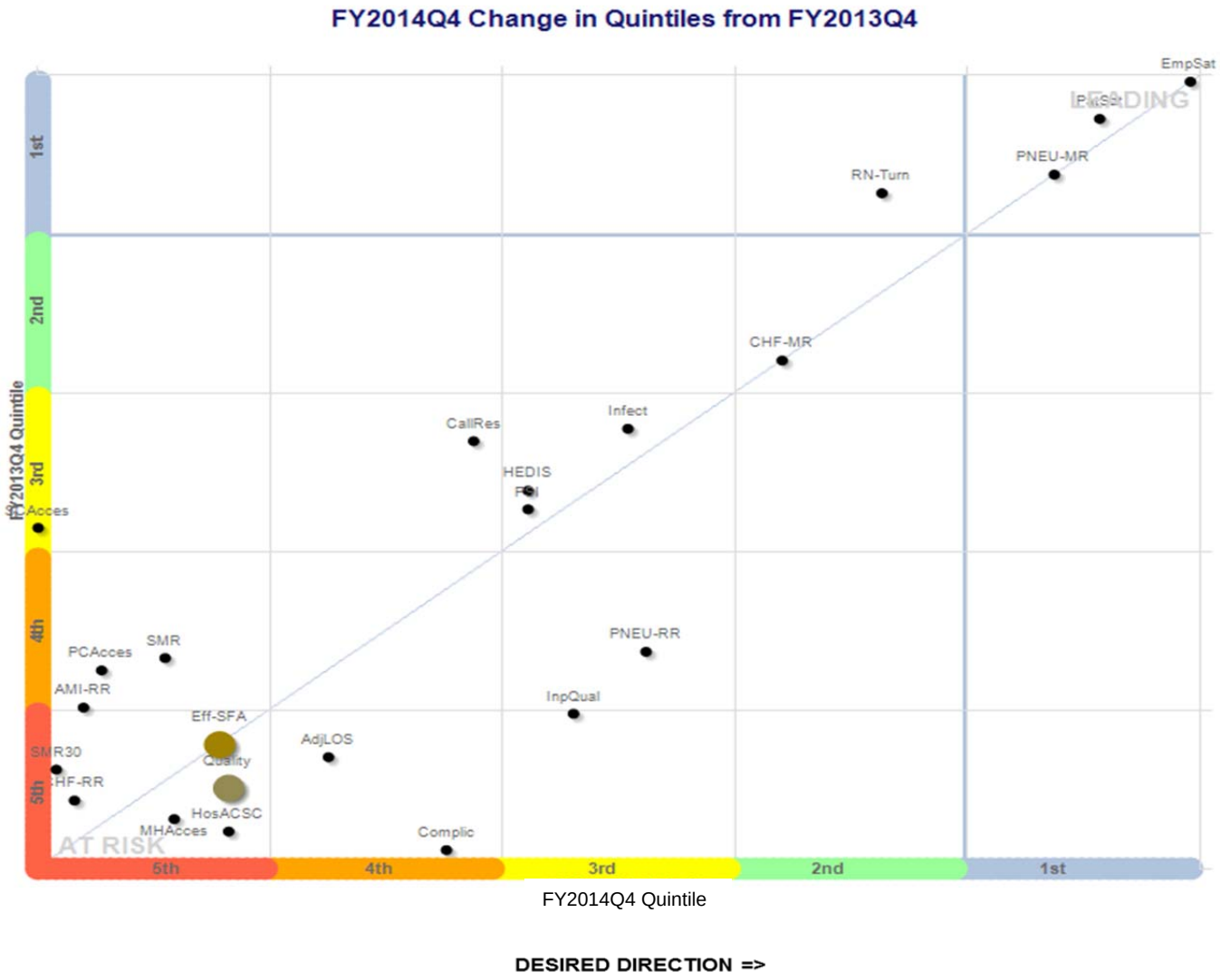
[1] All data is for FY 2015 through April 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 21, 2015

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

Subject: **CAP Review of the North Florida/South Georgia Veterans Health System, Gainesville, 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 North Florida/South Georgia Veterans Health System, Gainesville, Florida, conducted the week of April 20, 2015.

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

Dave Whitmere/for
Paul Bockelman, MBA, FACHE

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 21, 2015

From: Director, North Florida/South Georgia Veterans Health System (573/00)

Subject: **CAP Review of the North Florida/South Georgia Veterans Health System, Gainesville, FL**

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

1. I have reviewed and concur with the findings and recommendations in the report of the CAP Review.

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

Thomas Wisnieski, MPA, FACHE

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 licensed independent practitioners who perform emergency airway management have the appropriate privileges granted to match their skills and training.

Concur

Target date for completion: June 30, 2015

Facility response: Five of the seven provider privileges for EAM will be presented for approval at the May 2015 MEC meeting. The other two provider privileges for EAM will be presented for approval at the June 2015 MEC meeting once they have completed the biannual EAM training successfully.

Recommendation 2. We recommended that the facility reduce credentialing and privileging folders to the two-part format.

Concur

Target date for completion: December 31, 2015

Facility response: The Chief of Staff's office has implemented the plan to complete a minimum of 10 conversion/audits per month with expected completion in December.

Recommendation 3. We recommended that the Operating Room Committee include the Chief of Staff as a member and that committee minutes reflect review of National Surgical Office reports.

Concur

Target date for completion: May 15, 2015 – Completed

Facility response: COS added to committee membership as of April 2015. OR Committee Agenda amended to include NSO reports as of May 2015.

Recommendation 4. We recommended that the facility establish a committee to provide oversight of the safe patient handling program.

Concur

Target date for completion: July 1, 2015

Facility response: The Accident Review Board has been remodeled to include oversight of the Safe Patient Handling Program. This committee will track and trend injury data, as well as oversee the Safe Patient Handling Program.

Recommendation 5. We recommended that Infection Control Committee meeting minutes consistently reflect discussion of all identified high-risk areas.

Concur

Target date for completion: July 31, 2015

Facility response: All identified high-risk areas will be added to the Infection Control Committee meeting for appropriate evaluation and follow-up at the next quarterly meeting in July 2015.

Recommendation 6. We recommended that facility managers ensure all buildings designated for health care occupancy at the Lake City campus have fire drills conducted once per shift per quarter and monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: A monthly inventory was developed and is discussed at Environment of Care (EOC) Committee to maintain compliance. Current status (2015 Q1) indicates all required fire drills have been conducted in health care occupancies. Monthly reporting to the EOC will demonstrate sustainment.

Recommendation 7. We recommended that facility managers ensure negative air pressure systems in the Gainesville campus surgical intensive care unit are functional and monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: Identified rooms are not currently in use as negative air pressure rooms. A new exhaust system is being installed with HEPA filters to replace outdated exhaust. Once installed rooms will be re-designated as negative air pressure and will be tested according to facility policy.

Recommendation 8. We recommended that facility managers ensure Gainesville campus locked mental health unit stationary panic alarm testing includes documentation of VA Police response time and ensure testing of portable panic alarms and monitor compliance.

Concur

Target date for completion: May 18, 2015 – Completed

Facility response: When conducting duress/panic alarm drills Officer(s) will advise dispatch upon arrival to the location of the Duress/Panic Alarm via standard radio communication. The Daily Operations Journal was modified to require the time the alarm came into dispatch and the actual time the officer(s) responded to the unit location.

All staff have been issued and are in possession of working personal alarms. SOP was modified to add monthly function testing. Nurse Manager will ensure monthly checks are completed and documented, verifying personal alarms are operational.

Recommendation 9. We recommended that facility managers ensure designated employees complete competency assessment on the use of emergency evacuation devices and monitor compliance.

Concur

Target date for completion: August 31, 2015

Facility response: All new employees in nursing are trained during orientation. Skills fairs on the Evacusled were conducted in both LC and GV during quarter 2 and 3. Managers and educators will be instructed on the importance of maintaining annual competencies. A 100% review of nursing staff competency documentation will be completed for FY 15 Evacusled training. Additional opportunities for staff to complete the competency will be provided as needed.

Recommendation 10. We recommended that engineering managers ensure all Gainesville campus construction workers wear VA-issued identification badges and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2015

Facility response: Random spot checks will be conducted to ensure VA-issued ID badges are worn as well as reviewed during weekly construction rounds monitoring general contractor employees (to include all subcontractors) entering/exiting project sites without an appropriate NF/SGVHS identification badge. Compliance will be monitored at the Construction Committee.

Recommendation 11. We recommended that facility managers ensure that oral syringes are available for liquid medications in all units/areas at the Lake City and Gainesville campuses and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

Concur

Target date for completion: August 31, 2015

Facility response: Syringes were ordered and will be available for issue to wards and clinics for use once received. Usage will be monitored monthly by Item Managers to determine if current par level is acceptable. Nursing will educate staff as these become available on the units.

Recommendation 12. We recommended that employees screen inpatients to determine whether they want to have a discussion about advance directives and document the screening and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: The "RN Admission Database Screening/Orientation/Education" template will be modified to include Advance Directive screening opportunity for discussion to all patients admitted to the hospital. All positive screens requesting a discussion will trigger an automatic consult to Social Work. Social Work Service will provide discussion as needed.

Recommendation 13. We recommended that the facility revise the emergency airway management policy to include a plan for managing a difficult airway.

Concur

Target date for completion: June 30, 2015

Facility response: Policy is being revised to include plan for managing a difficult airway.

Recommendation 14. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of a completed written test and that facility managers monitor compliance.

Concur

Target date for completion: May 1, 2015 – Completed

Facility response: All emergency airway management training documents are now retained by the Simulation Center, including written tests. Electronic records are maintained by the Simulation Center and Anesthesia.

Recommendation 15. We recommended that the facility report provider specific emergency airway management data to the Operative and Invasive Procedures Committee.

Concur

Target date for completion: June 30, 2015

Facility response: Provider specific EAM data will be sent to Operative & Invasive Committee on quarterly basis and included in meeting minutes.

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 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[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 Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[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.