



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

Office of Healthcare Inspections

Report No.10-02992-83

**Combined Assessment Program
Review of the
Bay Pines VA Healthcare System
Bay Pines, Florida**

February 8, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

AD	advance directive
AED	automated external defibrillator
BCLS	Basic Cardiac Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CPRS	computerized patient record system
EOC	environment of care
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
LMS	Learning Management System
MDRO	multidrug-resistant organisms
MSDS	material safety data sheets
MSEB	Medical Staff Executive Board
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PR	peer review
QM	quality management
SOPs	standard operating procedures
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

	Page
Executive Summary	i
Objectives and Scope	1
Objectives	1
Scope	1
Reported Accomplishment	2
Results	2
Review Activities With Recommendations	2
QM.....	2
EOC.....	4
COC	5
Management of Test Results.....	5
Review Activities Without Recommendations	6
Management of MDRO.....	6
Medication Management	6
Physician C&P.....	6
Comments	7
Appendixes	
A. Facility Profile	8
B. Follow-Up on Previous Recommendations.....	9
C. VHA Satisfaction Surveys and Hospital Outcome of Care Measures.....	12
D. VISN Director Comments	14
E. Facility Director Comments	15
F. OIG Contact and Staff Acknowledgments	20
G. Report Distribution	21

Executive Summary: Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, FL

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of November 15, 2010.

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

- Management of Multidrug-Resistant Organisms
- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishment was the culture change in the community living center to an environment that encourages respect, relationships, and a sense of belonging.

Recommendations: We made recommendations in the following four activities:

Quality Management: Evaluate resuscitation events for errors, and analyze data for trends and opportunities to improve care. Document that all peer review corrective actions have been completed, and provide a summary of completed actions to the oversight committee. Aggregate and analyze service-specific data related to unexpected events in conjunction with moderate sedation. Strengthen medical record review processes to ensure that all required

components are monitored, and report results to the oversight committee.

Environment of Care: Provide training to staff regarding access to material safety data sheet information. Ensure that designated staff complete annual respirator fit testing. Require radiology department staff to have documented annual radiation safety training.

Coordination of Care: Update the local policy, and require designated staff to document advance directive notification and screening for all patients.

Management of Test Results: Communicate normal test results to patients within the specified timeframe.

Comments

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

(original signed by:)

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

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through November 19, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, Florida*, Report No. 07-01248-13, October 24, 2007). The

facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 245 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Reported Accomplishment

CLC Culture Change

The Bay View CLC has worked to develop relationships with residents to demonstrate respect and encourage a sense of belonging. Residents share in decision making through neighborhood meetings and participation in the IC Committee. Examples of resident driven projects include the garden club, the renovation of surroundings to a beach décor, participation in computer games to develop relationships, and the transformation of a traditional food service to a select menu prepared by chefs.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Review of Resuscitation and Its Outcomes. VHA and The JC require that facilities evaluate each resuscitation event for opportunities to evaluate and implement desired changes.¹ The CPR Committee had started to compile data on each event, but we did not find evidence that they discussed the results and made recommendations to improve processes.

¹ VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

For example, data revealed potential problems with timeliness of intubation, epinephrine administration, and defibrillation, but meeting minutes did not document discussion or actions taken.

PR. Facility policy requires service chiefs to discuss PR findings with individual providers and to implement any actions recommended by the PR Committee. Service chiefs are then required to provide written feedback to the PR Committee that recommended actions were completed. We found that service chiefs were not providing the PR Committee with written feedback of completed actions. In addition, the PR Committee's quarterly report to the MSEB did not include the facility required summary of actions completed by service.

Moderate Sedation. VHA requires facilities to monitor and analyze moderate sedation, including the use of reversal agents.² We did not find evidence that the Operative and Invasive Procedure Committee critically analyzed data related to the use of reversal agents and other unexpected events in conjunction with moderate sedation. The facility needs to aggregate service-specific data to identify possible organization-wide trends.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific areas of review and to monitor the copy and paste functions.³ While services had completed medical record quality reviews, we found that they did not include all of the required components. For example, we found that only one service monitored the copy and paste functions in the electronic medical record. In addition, results of service-specific quality reviews were not reported to the Medical Record Committee for trending, analysis, and identification of opportunities for improvement.

Recommendations

1. We recommended that the CPR Committee evaluate each resuscitation event for errors or deficiencies in technique and critically analyze that data to identify trends and opportunities to improve care.
2. We recommended that service chiefs provide the PR Committee with written documentation that all corrective actions have been completed and that the PR Committee

² VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

³ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

include a summary of completed actions in quarterly reports to the MSEB.

3. We recommended that service-specific data related to unexpected events, including the use of reversal agents, in conjunction with moderate sedation be aggregated and analyzed.

4. We recommended that medical record review processes be strengthened to ensure that each service monitors all required components, including the copy and paste functions, and that results be reported to the Medical Record Committee.

EOC

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

We inspected inpatient units (locked behavioral health, medical, surgical, CLC, and medical intensive care), the emergency department, radiology, and outpatient clinics. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

MSDS. OSHA requires that MSDS information be available in each clinical area. Staff on three of six units could not locate paper MSDS copies and were not aware of the electronic MSDS program, so they could not access the information.

IC. OSHA requires that designated employees be fit tested annually if the facility uses N95 respirators. We reviewed annual training records for employees designated to use the respirators and found that 14 (56 percent) of the 25 records did not have documentation of the required annual fit testing.

Radiation Safety. The Nuclear Regulatory Commission requires annual radiation safety training for radiology department employees. We reviewed training records for five radiology registered nurses and five technologists. None of the records had complete documentation of radiation safety training.

Recommendations

5. We recommended that managers provide training to staff regarding access to MSDS information.

6. We recommended that designated staff complete annual N95 respirator fit testing.

7. We recommended that radiology department staff have documented annual radiation safety training.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, ADs, and discharges in accordance with applicable requirements.

We reviewed medical records for documentation of advance care planning, ADs, and discharge instructions. We identified the following area that needed improvement.

Documentation of AD Notification and Screening. VHA requires that facility directors identify staff responsible for conducting AD notification and screening and that AD notification and screening are documented in each patient's medical record.⁴ We reviewed the medical records of 12 patients. We found no documentation of AD notifications, and 11 (92 percent) of the records did not have evidence of AD screening. In addition, facility policy did not assign designated staff to complete AD notification and screening.

Recommendation

8. We recommended that managers update facility policy and require that designated staff document AD notification and screening for all patients.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.⁵

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following area that needed improvement.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that results were available to the ordering provider.⁶ We reviewed the medical records of 20 patients who had normal results and found that

⁴ VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

⁵ *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*; Report No. 01-01965-24; November 25, 2002.

⁶ VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

6 (30 percent) records did not contain documented evidence that facility staff communicated results to the patients.

Recommendation

9. We recommended that staff communicate normal test results to patients within the specified timeframe.

Review Activities Without Recommendations

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We reviewed the facility's IC risk assessment, employee training records, and medical records. We inspected an inpatient medical/surgical unit and a CLC unit and interviewed employees. We determined that the facility had an effective program in place. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transportation, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the pharmacy and the chemotherapy clinic. We also interviewed staff. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 14–19, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile⁷		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	8	
CBOCs	Bradenton, FL Fort Myers, FL Naples, FL Palm Harbor, FL Port Charlotte, FL Sarasota, FL Sebring, FL St. Petersburg, FL	
Veteran Population in Catchment Area	320,648	
Type and Number of Total Operating Beds:	226	
• Hospital, including Psychosocial Residential Rehabilitation Treatment Program		
• CLC/Nursing Home Care Unit	112	
• Other	66 domiciliary	
Medical School Affiliation(s)	University of South Florida Nova Southeastern University	
• Number of Residents	41.9	
	<u>FY 2010</u>	<u>Prior FY</u>
Resources (in millions):		
• Total Medical Care Budget	\$607	\$556
• Medical Care Expenditures	\$606	\$556
Total Medical Care FTE	3,235	3,256
Workload:		
• Number of Station Level Unique Patients	97,375	95,010
• Inpatient Days of Care:		
○ Acute Care	63,790	54,888
○ CLC/Nursing Home Care Unit	31,499	30,453
Hospital Discharges	12,956	12,069
Total Average Daily Census (including all bed types)	353	324
Cumulative Occupancy Rate	87.6	77.4
Outpatient Visits	1,263,477	1,207,967

⁷ All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
1. Protect health information from unauthorized disclosure.	(Nursing Service Monitoring Program) Question #1: Unattended computers in your work area are secure = 97.8 percent compliance. Question #2: Sensitive paper documents secure or transmitted/discarded securely = 98.6 percent compliance.	Y	N
2. Properly place ceiling tiles in tracks, and replace damaged and stained ceiling tiles.	All ceiling tiles identified in the report were immediately replaced, and those not properly aligned were placed into the correct position. Environmental Management Services has staff to systematically assess each building for damaged, stained, or improperly placed ceiling tiles. Supervisors conduct monthly inspections to identify discrepancies and take corrective action if needed.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
<p>3. Address residue on walls near sinks, compromised surfaces on patient furniture and equipment, and stained privacy curtains.</p>	<p>All soiled surfaces were cleaned, and any adhesive residue was removed. Unsafe furniture was removed from use, and replacements were ordered. The torn seat cushion in the patient shower and the stained privacy curtains in the patient care area were immediately replaced. Fifty patient bed trays were ordered and have been installed. All patient bedside night stands identified for replacement have been replaced. Privacy curtains are routinely changed. Monitoring the condition of furniture and privacy curtains in patient care areas is done by Environmental Management Services supervisors during monthly inspections.</p>	<p>Y</p>	<p>N</p>
CPRS Business Rules			
<p>4. Ensure CPRS business rules comply with VHA policy related to altering signed notes in the medical record.</p>	<p>This issue was addressed and resolved prior to the OIG exit. Health Information Management Systems staff removed this business rule and restricted the ability to retract, amend, or delete signed medical records to the Privacy Officer and the Chief of Health Information Management Systems.</p>	<p>Y</p>	<p>N</p>

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
CBOC			
<p>5. Ensure clinical staff performing direct patient care comply with VHA policy related to maintenance of CPR certification.</p>	<p>Facility policy and medical staff bylaws and rules were amended to ensure compliance with VHA policy. CPR competence is a requirement for all physicians. Newly hired physicians receive CPR and AED education. All physicians must maintain current active BCLS certification.</p> <p>Service chiefs and supervisors ensure designated staff are trained and maintain current certification in BCLS. Employees must ensure BCLS cards are current. Basic Life Support training uses American Heart Association guidelines and covers AED use.</p>	Y	N

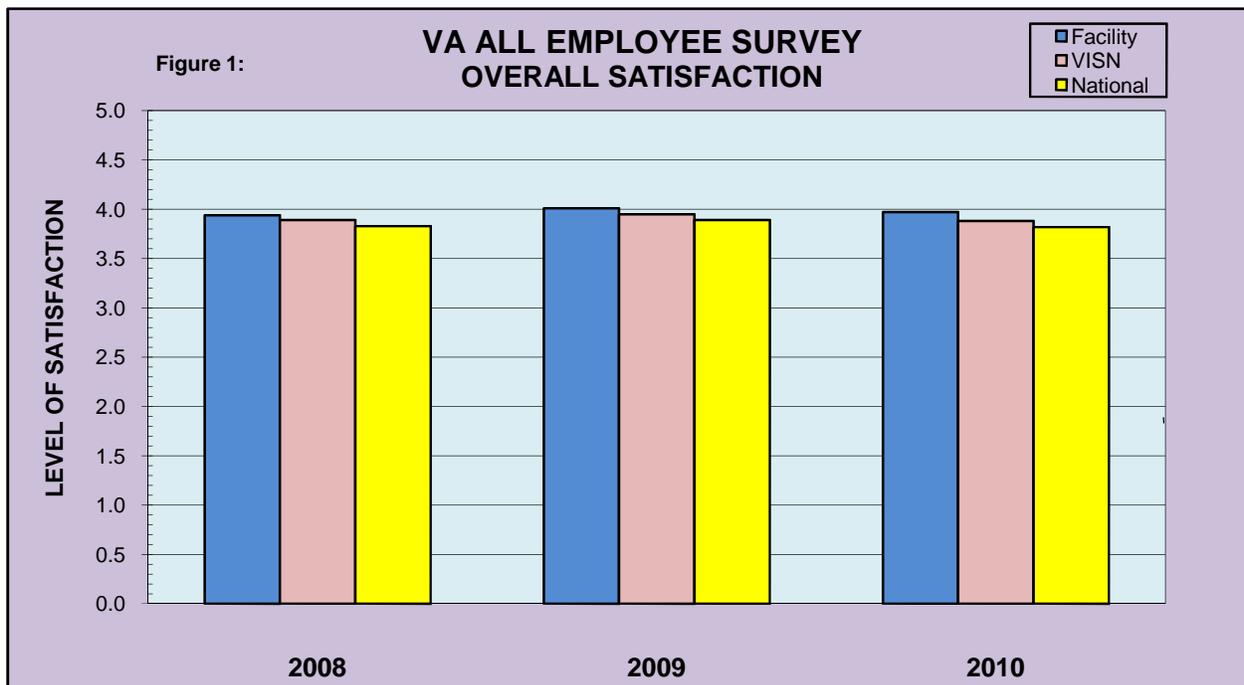
VHA Satisfaction Surveys

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

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	63.2	67.4	64.2	58.9	58.5	58.8
VISN	65.8	68.3	64.3	58.1	56.8	56.5
VHA	63.3	63.9	64.5	54.7	55.2	54.8

Employees are surveyed annually. Figure 1 below shows the facility’s overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.⁸ The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are “adjusted” to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility’s Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	14.76	10.3	16.52	19.96	22.2	15.26
VHA	13.31	9.73	15.08	20.57	21.71	15.85

⁸ CHF is a weakening of the heart’s pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: January 20, 2011

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

Subject: **CAP Review of the Bay Pines VA Healthcare System,
Bay Pines, FL**

To: Director, Kansas City Healthcare Inspections Division
(54KC)

Director, Management Review Service (VHA CO 10B5 Staff)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, Florida.
2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.



Nevin M. Weaver, FACHE
Network Director, VISN 8

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 19, 2011
From: Director, Bay Pines VA Healthcare System (516/00)
Subject: **CAP Review of the Bay Pines VA Healthcare System,
Bay Pines, FL**
To: **Director, VISN 8 (10N8)**

1. The recommendations made during the Office of Inspector General (OIG) Combined Assessment Program (CAP) Review conducted November 15–November 19, 2010, have been reviewed and our comments and implementation plan are noted below.
2. I would like to thank the OIG CAP Review Team for their professionalism and consultative feedback to our employees during our review. This review provides us with the opportunity to continue improving care to our veterans.
3. If you have questions or require additional information, please contact Joanna Eastman-Gaudreau, Risk Manager, at 727-398-9317.



WALLACE M. HOPKINS, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the CPR Committee evaluate each resuscitation event for errors or deficiencies in technique and critically analyze that data to identify trends and opportunities to improve care.

Concur

Target Completion Date: March 31, 2011

We had previously identified opportunities for improvement of code events such as documentation and additional training. We have revised the code data collection "code" sheet and implemented the use of an electronic pocket personal computer based system which records data entered at a code and allows for synchronization with defibrillator data which creates a more accurate event report. To facilitate tracking of all code events, we have also developed an electronic incident report tool to report these events. All code events are reviewed at the monthly CPR Committee. Each committee member is assigned a code event to review prior to the meeting and to present an overall summary of the code at the meeting. In collaboration with the primary area the opportunity to improve care will be initiated and tracked to completion. This new process allows the CPR Committee to evaluate each resuscitation event for errors or deficiencies in technique and critically analyze data to identify trends and opportunities to improve care. Summary reports containing performance improvement activities are prepared and presented to the Critical Care Committee quarterly.

Recommendation 2. We recommended that service chiefs provide the PR Committee with written documentation that all corrective actions have been completed and that the PR Committee include a summary of completed actions in quarterly reports to the MSEB.

Concur

Target Completion Date: May 31, 2011

A new process for documenting and monitoring PR Committee recommendations/corrective actions was developed and approved at the December 2010 PR Committee. The PR Committee/Chairman will send a memorandum to the Service Chief notifying them that their respective service provider was issued a Final Level 2 or Level 3 Rating which may contain recommendations/corrective actions for improvement in clinical care or services, as applicable. The Service Chief will confirm review and completion of the recommendations/corrective actions with the provider by returning written

documentation (certification of completion) to the PR Committee. The PR Committee will monitor completion of these recommendations/corrective actions on a quarterly basis. The PR Committee will then provide a summary report to the MSEB verifying completion of the recommended corrective actions each quarter. The MSEB will document their review of this information in the MSEB minutes. This new process was initiated following the January 2011 PR Committee meeting. The first quarterly summary report to the MSEB will be for Quarter 2 and is scheduled for presentation at the regularly scheduled MSEB meeting in May 2011.

Recommendation 3. We recommended that service-specific data related to unexpected events, including the use of reversal agents, in conjunction with moderate sedation be aggregated and analyzed.

Concur

Target Completion Date: February 28, 2011

We have developed a dashboard for Operative and Other Invasive Procedures Committee that includes aggregate data from all clinical sections that use moderate sedation. Each section performing moderate sedation is expected to report the total number of cases and any adverse or unexpected events, including the use of reversal agents. This data will be aggregated, trended and analyzed by the section/service levels for discussion at the quarterly Operative and Other Invasive Procedures Committee. Our critical analysis of this data will be stratified at the section/service and overall healthcare system levels. Services have been educated on the revised process and full implementation is expected at the next quarterly Operative and Other Invasive Procedures Committee meeting in February 2011.

Recommendation 4. We recommended that medical record review processes be strengthened to ensure that each service monitors all required components, including the copy and paste functions, and that results be reported to the Medical Record Committee.

Concur

Target Completion Date: March 31, 2011

We have developed a new medical record review tool with all the required components, including the copy and paste functions, as identified in VHA Handbook 1907.01. Staff have been educated on the use of the tool and data is currently being retrieved from the medical record. Service specific data will be collected, aggregated, trended and analyzed by the Medical Records Subcommittee monthly, shared with service leadership, and reported to the Management of Information Committee for further actions/recommendations at the MSEB, as appropriate.

Recommendation 5. We recommended that managers provide training to staff regarding access to MSDS information.

Concur

Target Completion Date: February 14, 2011

Leadership has provided a myriad of educational opportunities to inform staff where to locate the MSDS reference material. Staff training was provided via an electronic postmaster message sent out to all staff on January 14, 2011, and at the Quarterly Fire and Safety Educational sessions conducted on January 7, 10, and 11, 2011. Future quarterly fire and safety educational sessions and bi-monthly New Employee Orientation will contain updated training elements on access to MSDS. Also, MSDS access information has been added to the inventory of screen savers that rotate over each employee's computer work station at periodic intervals. Staff knowledge will be monitored during weekly Leadership/EOC Rounds.

Recommendation 6. We recommended that designated staff complete annual N95 respirator fit testing.

Concur

Target Completion Date: March 31, 2011

The respirator used at the Bay Pines VA Healthcare System is the Half-mask dual cartridge respirator (N100) equipped with HEPA filters which provides additional protection in lieu of the N95. The supervisors of the employees who were identified as not compliant with annual fit testing during the OIG visit have been contacted to require the employees to obtain their medical clearance form and make an appointment with the Safety Office to have the fit testing activity completed no later than March 31, 2011.

The IC Committee will charter a workgroup to conduct a risk assessment of the effectiveness of the current fit testing program and to identify the designated staff who requires annual fit testing.

Recommendation 7. We recommended that radiology department staff have documented annual radiation safety training.

Concur

Target Completion Date: Completed

Radiation Safety Training had been completed by all appropriate staff (radiation workers). However it was reported during the OIG visit, documentation of the completed training was not easily retrievable. To facilitate tracking completion of the training, radiation protection training has been added to the VA LMS for all appropriate staff. The employee, supervisor, and radiation safety officer are able to monitor

radiation protection education through the LMS and LMS Administrator completion report.

Recommendation 8. We recommended that managers update facility policy and require that designated staff document AD notification and screening for all patients.

Concur

Target Completion Date: Completed

On Wednesday, November 17, 2010, all Social Work staff members received education regarding AD notification and screening. Additional information was added to the Advance Directive Discussion Note template to ensure the components of the note are in compliance with VHA Handbook 1004.02. In addition, the Bay Pines VA Health Care System Memorandum 516-10-16-013, Advance Directives, has also been updated to ensure compliance that designated staff document AD notification and screening for all patients. The Social Work Supervisor is monitoring a random sample daily for compliance which shows satisfactory results.

Recommendation 9. We recommended that staff communicate normal test results to patients within the specified timeframe.

Concur

Target Completion Date: April 29, 2011

Some services are currently reporting normal test results to patients within the 14-day time frame. However, several services are still in the process of collaborating with clinical application coordinators to create a CPRS Template that generates an Auto Letter to patients regarding their normal test results. This mechanism will also provide documentation in CPRS in the form of a progress note. Bay Pines VA Healthcare System Memorandum 516-10-11-069, Ordering and Reporting of Test Results, will be updated to reflect normal test results to be communicated to the patient within the 14-day time frame.

OIG Contact and Staff Acknowledgments

Contact	Dorothy Duncan, Director Kansas City Office of Healthcare Inspections
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