



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

**Office of Healthcare Inspections**

**Report No. 14-00689-142**

**Combined Assessment Program  
Review of the  
Orlando VA Medical Center  
Orlando, Florida**

**May 6, 2014**

**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
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Orlando VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 March 24, 2014.

**Review Results:** The review covered nine activities. We made no recommendations in the following five activities:

- Nurse Staffing
- Community Living Center Resident Independence and Dignity
- Management of Test Results
- Suicide Prevention Program
- Management of Workplace Violence

The facility's reported accomplishments were the increased use of mobile technologies in patient care and participation in a project to automate reusable medical equipment processing.

**Recommendations:** We made recommendations in the following four activities:

*Quality Management:* Complete Focused Professional Practice Evaluations for newly hired licensed independent practitioners within the timeframe required by facility bylaws.

*Environment of Care:* Ensure Environment of Care Committee and Administrative Executive Committee minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure. Secure medication/supply carts at all times. Ensure Nursing Service is represented at Radiation Safety Committee meetings.

*Medication Management – Controlled Substances Inspection Program:* Initiate timely actions to address deficiencies identified during annual physical security surveys. Consistently complete pharmacy inspections on the same day initiated.

*Mental Health Residential Rehabilitation Treatment Program:* Complete and document monthly Mental Health Residential Rehabilitation Treatment Program self-inspections, daily public area inspections and bed checks, and weekly contraband inspections. Ensure medications in resident rooms are secured, and document daily inspections for this. Document written agreements acknowledging resident responsibility for medication security.

## 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 23–29, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.  
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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 nine activities:

- QM
- EOC
- Medication Management – CS Inspection Program
- Nurse Staffing
- CLC Resident Independence and Dignity
- Management of Test Results
- Suicide Prevention Program
- Management of Workplace Violence
- MH RRTP

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 2013 and FY 2014 through March 21, 2014, 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 Orlando VA Medical Center, Orlando, Florida, Report No. 11-02084-01, October 17, 2011*). We made a repeat recommendation in MH RRTP.

During this review, we presented crime awareness briefings for 331 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 534 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**

### **Mobile Health Application Pilot**

Orlando is one of three VHA medical centers participating in the Mobile Health Application Pilot Program for the use of iPads<sup>®</sup> in the clinical setting. The goal of this project is to increase efficiency, convenience, and accessibility for patients, clinicians, and caregivers through use of mobile and web-based technologies.

### **Reusable Medical Equipment Project**

The facility is participating in a pilot project with General Electric to automate sterilization of reusable medical equipment. The project purpose is to validate proper automation of surgical instrument sterilization, packaging, and delivery to the operating room, possibly reducing the risk of exposure to unsanitary instruments while simultaneously improving efficiency.

## 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.<sup>1</sup>

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. 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
	<p>There was a senior-level committee/group responsible for QM/performance improvement that met regularly.</p> <ul style="list-style-type: none"> <li>• There was evidence that outlier data was acted upon.</li> <li>• There was evidence that QM, patient safety, and systems redesign were integrated.</li> </ul>	
	<p>The protected peer review process met selected requirements:</p> <ul style="list-style-type: none"> <li>• The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs.</li> <li>• Actions from individual peer reviews were completed and reported to the PRC.</li> <li>• The PRC submitted quarterly summary reports to the MEC.</li> <li>• Unusual findings or patterns were discussed at the MEC.</li> </ul>	
	<p>FPPEs for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.</p>	
NA	<p>Specific telemedicine services met selected requirements:</p> <ul style="list-style-type: none"> <li>• Services were properly approved.</li> <li>• Services were provided and/or received by appropriately privileged staff.</li> <li>• Professional practice evaluation information was available for review.</li> </ul>	

<b>NM</b>	<b>Areas Reviewed (continued)</b>	<b>Findings</b>
NA	<p>Observation bed use met selected requirements:</p> <ul style="list-style-type: none"> <li>• Local policy included necessary elements.</li> <li>• Data regarding appropriateness of observation bed usage was gathered.</li> <li>• If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.</li> </ul>	
NA	<p>Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.</p>	
NA	<p>The process to review resuscitation events met selected requirements:</p> <ul style="list-style-type: none"> <li>• An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted.</li> <li>• Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code.</li> <li>• Data were collected that measured performance in responding to events.</li> </ul>	
	<p>The surgical review process met selected requirements:</p> <ul style="list-style-type: none"> <li>• An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes.</li> <li>• All surgical deaths were reviewed.</li> <li>• Additional data elements were routinely reviewed.</li> </ul>	
	<p>Critical incidents reporting processes were appropriate.</p>	
	<p>The process to review the quality of entries in the EHR met selected requirements:</p> <ul style="list-style-type: none"> <li>• A committee was responsible to review EHR quality.</li> <li>• Data were collected and analyzed at least quarterly.</li> <li>• Reviews included data from most services and program areas.</li> </ul>	
	<p>The policy for scanning non-VA care documents met selected requirements.</p>	

<b>NM</b>	<b>Areas Reviewed (continued)</b>	<b>Findings</b>
NA	The process to review blood/transfusions usage met selected requirements: <ul style="list-style-type: none"> <li>• A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage.</li> <li>• Additional data elements were routinely reviewed.</li> </ul>	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
X	The facility met any additional elements required by VHA or local policy.	Facility bylaws require that FPPEs be completed by the service chief within 90 days. We reviewed 25 FPPEs of providers hired in FY 2012. <ul style="list-style-type: none"> <li>• Ten FPPEs were not completed by the service chief until more than 12 months after initiation.</li> </ul>

**Recommendation**

1. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are completed within the timeframe required by facility bylaws.

## 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 and whether selected requirements in radiology and acute MH were met.<sup>2</sup>

At the Lake Baldwin campus, we inspected the ambulatory surgery, post-anesthesia, endoscopy, radiology, physical medicine and rehabilitation, and laboratory areas. We also inspected the podiatry, dermatology, general surgery, wound care, infectious disease, pulmonary, cardiology, urology, outpatient MH, infusion/oncology/hematology, dental, spinal cord injury, and women's health clinics. At the Lake Nona campus, we inspected four CLC units. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 10 radiology employee training records. 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
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee and Administrative Executive Committee meeting minutes reviewed: <ul style="list-style-type: none"> <li>Minutes did not reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.</li> </ul>
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	<ul style="list-style-type: none"> <li>Three of 23 patient care areas had unlocked and unattended medication/supply carts.</li> </ul>
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	<b>Areas Reviewed for Radiology</b>	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended the meetings.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policies, Radiation Safety Manual, and Radiation Safety Committee documents reviewed: <ul style="list-style-type: none"> <li>• Nursing Service was not represented at Radiation Safety Committee meetings for the past 4 quarters.</li> </ul>
<b>Areas Reviewed for Acute MH</b>		
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	

<b>NM</b>	<b>Areas Reviewed for Acute MH (continued)</b>	<b>Findings</b>
NA	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist and VA's National Center for Patient Safety study of suicide on psychiatric units.	
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

### Recommendations

2. We recommended that processes be strengthened to ensure that EOC Committee and Administrative Executive Committee minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.
3. We recommended that processes be strengthened to ensure that medication/supply carts are secured at all times and that compliance be monitored.
4. We recommended that processes be strengthened to ensure that Nursing Service is represented at Radiation Safety Committee meetings.

## Medication Management – CS Inspection Program

The purpose of this review was to determine whether VHA facilities complied with requirements related to CS security and inspections.<sup>3</sup>

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from 8 CS areas and the inpatient and outpatient pharmacies. 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
	Facility policy was consistent with VHA requirements.	
X	VA police conducted annual physical security surveys of the pharmacies, and any identified deficiencies were corrected.	Annual physical security surveys for past 2 years reviewed: <ul style="list-style-type: none"> <li>Pharmacy did not take action to correct deficiencies identified in the annual physical security survey completed in October 2013 within the 30-day timeframe set by VA Police.</li> </ul>
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Documentation of pharmacy CS inspections conducted during the past 6 months reviewed: <ul style="list-style-type: none"> <li>For 2 months, documentation did not reflect that inspections were consistently completed on the same day they were initiated.</li> </ul>
	The facility complied with any additional elements required by VHA or local policy.	

## **Recommendations**

5. We recommended that managers initiate timely actions to address deficiencies identified during annual physical security surveys.
6. We recommended that processes be strengthened to ensure that pharmacy inspections are consistently completed on the same day they were initiated and that compliance be monitored.

## Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on a CLC unit.<sup>4</sup>

We reviewed facility and unit-based expert panel documents and 15 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 1 randomly selected CLC unit for 50 randomly selected days between October 1, 2012, and September 30, 2013. 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
NA	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

## CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.<sup>5</sup>

We reviewed 20 EHRs of residents (10 residents receiving restorative nursing services and 10 residents not receiving restorative nursing services but candidates for services). We also observed 10 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key 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
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	<b>Areas Reviewed for Assistive Eating Devices and Dining Service</b>	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

## Management of Test Results

The purpose of this review was to evaluate whether VHA facilities complied with selected requirements for managing test results.<sup>6</sup>

We reviewed relevant policies and procedures and the EHRs of 30 patients who had critical laboratory, abnormal radiology, or abnormal cytology test results/values in FY 2014 (10 for laboratory, 10 for radiology, and 10 for cytology). In addition, we reviewed the EHRs of 30 patients who had normal laboratory, radiology, or Pap smear results/values. We also conversed with key 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
	The facility had a written policy or guideline that addressed the management of critical/abnormal test results/values, and compliance was monitored.	
	Providers were notified of critical/abnormal test results/values by appropriate staff within the expected timeframe.	
	Patients were notified of critical/abnormal test results/values within the expected timeframe and by the approved method of communication.	
	Follow-up actions were taken in response to critical/abnormal test results/values.	
	Patients were notified of normal test results/values within the expected timeframe.	
	The facility complied with any additional elements required by VHA or local policy.	

## Suicide Prevention Program

The purpose of this review was to evaluate the extent VHA MH providers consistently complied with selected suicide prevention program requirements.<sup>7</sup>

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 30 patients assessed to be at high risk for suicide. 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
	The facility had a full-time Suicide Prevention Coordinator and a plan for back-up.	
	The facility had a process for responding to referrals from the Veteran Crisis Line and for identifying and tracking patients who are at high risk for suicide.	
	The facility issued required reports regarding any patients who attempted or completed suicide within the past 12 months.	
	The facility had a process to follow-up on patients who missed MH appointments.	
	Patients had documented safety plans that specifically addressed suicidality.	
	Patients and/or their families participated in plan development.	
	Safety plans contained all required elements.	
	There was documented evidence that the patients and/or their families received a copy of the plan.	
	Patient Record Flags were placed for high-risk patients.	
	The facility complied with any additional elements required by VHA or local policy.	

## Management of Workplace Violence

The purpose of this review was to determine the extent to which VHA facilities managed violent incidents.<sup>8</sup>

We reviewed relevant documents, 3 Reports of Contact from disruptive patient incidents that occurred during the period March 2013–March 2014, and 16 training records of employees who worked in areas considered at high risk for violence. Additionally, we conversed with key 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
	The facility had policies, procedures, or guidelines on preventing and managing violent behavior.	
	The facility conducted a Workplace Behavioral Risk Assessment to designate high-risk areas.	
	The facility had an Employee Threat Assessment Team, a Disruptive Behavior Committee/Board, and a prevention and management of disruptive behavior program disruptive behavior reporting and tracking system.	
	The facility used and tested appropriate physical security precautions and equipment in accordance with the local risk assessment.	
	The facility had an employee training plan that addressed the security issues of awareness, preparedness, precautions, and police assistance, and employees received the training defined in the plan.	
	Selected incidents were managed appropriately according to the facility's policies.	
	The facility complied with any additional elements required by VHA or local policy.	

## MH RRTP

The purpose of this review was to determine whether the facility's MH RRTPs complied with selected EOC requirements.<sup>9</sup>

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans RRTP and the Substance Abuse RRTP, 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	Findings
	The residential environment was clean and in good repair.	
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
X	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	Seven months of self-inspection documentation reviewed: <ul style="list-style-type: none"> <li>• There was inconsistent documentation of monthly self-inspections.</li> </ul>
X	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	Two months of inspection documentation reviewed: <ul style="list-style-type: none"> <li>• Daily inspections of public areas and bed checks were not consistently documented.</li> <li>• Weekly contraband inspections were not consistently documented.</li> <li>• Daily inspections of resident rooms for unsecured medications were not consistently documented. This was a repeat finding from the previous CAP review.</li> </ul>
X	Written agreements acknowledging resident responsibility for medication security were in place.	Ten EHRs reviewed: <ul style="list-style-type: none"> <li>• None of the EHRs contained a medication security agreement signed by the resident.</li> </ul>
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	

NM	Areas Reviewed (continued)	Findings
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process.	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	
X	Medications in resident rooms were secured.	Five resident rooms inspected: <ul style="list-style-type: none"> <li>• We found an unsecured and unattended medication cabinet in one of the rooms.</li> </ul>
	The facility complied with any additional elements required by VHA or local policy.	

### Recommendations

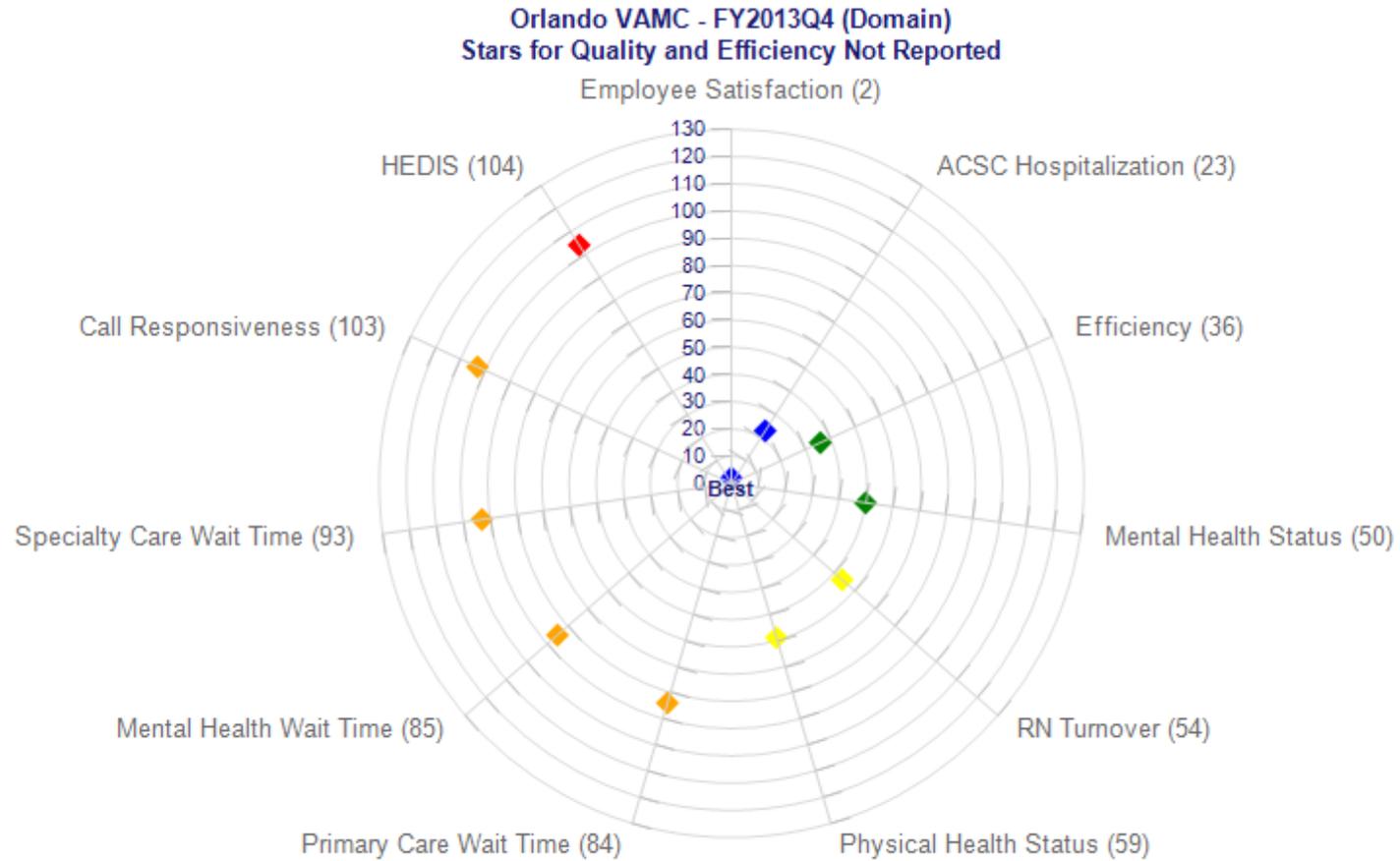
7. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections, daily public area inspections and bed checks, and weekly contraband inspections are completed and documented and that compliance be monitored.
8. We recommended that processes be strengthened to ensure that medications in resident rooms on the MH RRTP units are secured and daily inspections for this are documented and that compliance be monitored.
9. We recommended that processes be strengthened to ensure that written agreements acknowledging MH RRTP resident responsibility for medication security are documented and that compliance be monitored.

<b>Facility Profile (Orlando/675) FY 2014 through March 2014<sup>a</sup></b>	
<b>Type of Organization</b>	Excluded
<b>Complexity Level</b>	2-Medium complexity
<b>Affiliated/Non-Affiliated</b>	Affiliated
<b>Total Medical Care Budget in Millions</b>	\$534.5
<b>Number of:</b>	
• <b>Unique Patients</b>	84,306
• <b>Outpatient Visits</b>	631,043
• <b>Unique Employees<sup>b</sup></b>	2,085
<b>Type and Number of Operating Beds (February 2014):</b>	
• <b>Hospital</b>	0
• <b>CLC</b>	118
• <b>MH</b>	60
<b>Average Daily Census:</b>	
• <b>Hospital</b>	NA
• <b>CLC</b>	98
• <b>MH</b>	53
<b>Number of Community Based Outpatient Clinics</b>	7
<b>Location(s)/Station Number(s)</b>	Viera/675GA Daytona Beach/675GB Kissimee/675GC Orange City/675GD Leesburg/675GE Clermont/675GF Lake Baldwin/675GG
<b>VISN Number</b>	8

<sup>a</sup> All data is for FY 2014 through March 2014 except where noted.

<sup>b</sup> Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

### Strategic Analytics for Improvement and Learning (SAIL)<sup>c</sup>

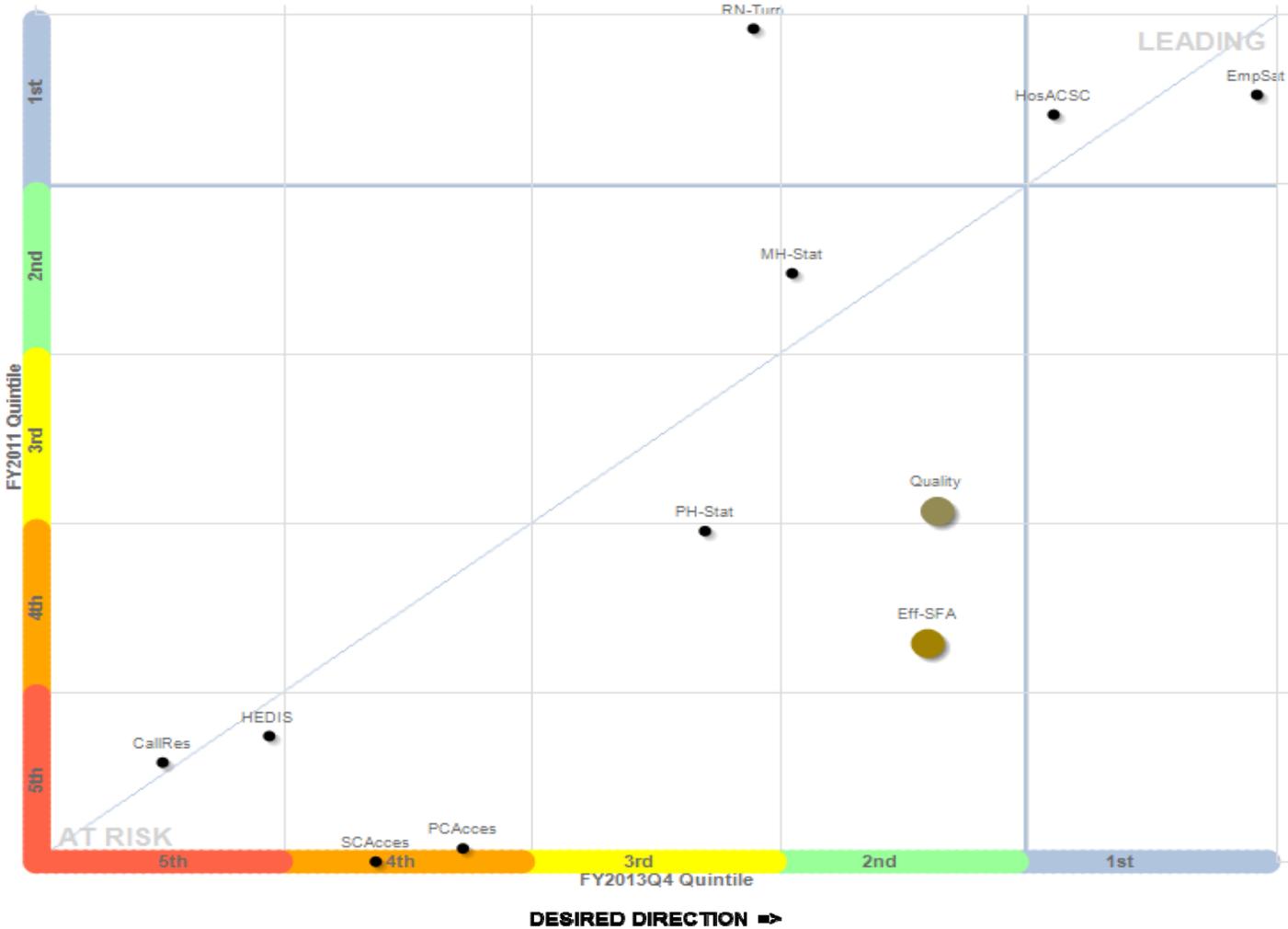


Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.  
 Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

<sup>c</sup> Metric definitions follow the graphs.

# Scatter Chart

FY2013Q4 Change in Quintiles from FY2011



**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
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 Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	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)	A higher value is better than a lower value
PSI	Patient safety indicator	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)	A higher value is better than a lower value

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** April 24, 2014

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

**Subject:** **CAP Review of the Orlando VA Medical Center, Orlando, FL**

**To:** Associate 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 the CAP Review of the Orlando VA Medical Center on the week of March 24, 2014.
2. Appropriate action has been initiated and/or completed as detailed in the attached report. Thank you!

*(original signed by:)*  
Joleen Clark, MBA, FACHE

## Facility Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** April 22, 2014

**From:** Director, Orlando VA Medical Center (675/00)

**Subject:** **CAP Review of the Orlando VA Medical Center, Orlando, FL**

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

1. We thank you for allowing us the opportunity to review and respond to the subject report.

2. We concur with the conclusions and recommendations presented by the Office of the Inspector General. We present you with the plans of action designed to correct those areas for which recommendations were provided.



Timothy W. Liezert

## 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 processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are completed within the timeframe required by facility bylaws.

Concur

Target date for completion: Initiated April 17, 2014. Monitoring for compliance started in April 2014.

Facility response:

The corrective action plan will ensure compliance with the completion of FPPEs and reporting to PSB within the required time frame per the facility by-laws and the facility's FPPE policy. This plan includes the designation of assigned credentialing staff to coordinate and utilize an electronic tracking form for each provider and FPPE with due dates on SharePoint. Assigned service level designees will complete specific portions of the tracking form and the form will be reviewed bi-weekly with appropriate updates documented. Regular monthly alerts will be utilized by the credentialing office to service level designees as an advance notification system to ensure completion and submission of data for the Professional Standards Board (PSB). The PSB will have a standing agenda item on FPPE addressing the status of each provider due dates so the Chief of Staff and all Service Chiefs are actively engaged in management of the process. This enhanced process has been documented in a Standard Operating Procedure (SOP) for staff reference. Tracking of percent compliance will be reported to PSB, as of the April 17, 2014 meeting and ongoing.

**Recommendation 2.** We recommended that processes be strengthened to ensure that EOC Committee and Administrative Executive Committee minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.

Concur

Target date for completion: Initiated January 30, 2014. Monitoring for compliance started in April 2014.

Facility response:

The process for completion of the EOC and AEC Committee minutes was strengthened in the following ways. The agenda was modified to have a standing report of deficiencies and actions resulting in minutes reflecting discussion of deficiencies,

actions, and tracking to closure. Minutes are reviewed by the Service Chief, as the content expert, prior to submission for approval ensuring a check for comprehensive presentation of each area and the deficiencies, actions, and tracking. The agenda for the following meeting will include any items not yet completed so tracking to closure occurs. The summary of the EOC Committee to the AEC Committee was enhanced so that a structured listing of topics and any deficiencies is included. The process was initiated January 30, 2014 with this set of minutes deemed acceptable during site visit. Committee minutes are maintained on a SharePoint for review and are completed for January, February, March, and April.

**Recommendation 3.** We recommended that processes be strengthened to ensure that medication/supply carts are secured at all times and that compliance be monitored.

Concur

Target date for completion: Initial training completed April 2, 2014. Monitoring for compliance started in April 2014.

Facility response:

Medication cart security has been strengthened with the following actions. A collaborative effort by Nursing Service with Medical and Surgical Services was initiated as of March 26, 2014. All staff, including nurses and providers, utilizing medication/supply carts will ensure that carts are locked prior to staff leaving an exam room in which the carts are located. One-on-one review of the process was completed with Nursing staff by the Nurse Managers of the units on March 26, 2014. Additionally, an email communication was sent to all nursing and provider staff of the units reviewing the process and requirements for 100 percent compliance with medication/supply cart security on April 2, 2014. Service Chiefs will conduct an additional training review of the process with providers and residents on May 6, 2014. Compliance with cart security will be monitored by the Nurse Managers or designee until 90 percent or greater is achieved for 3 consecutive months after the staff training, conducting random, unannounced checks of all carts.

**Recommendation 4.** We recommended that processes be strengthened to ensure that Nursing Service is represented at Radiation Safety Committee meetings.

Concur

Target date for completion: Initiated March 28, 2014. Monitoring for compliance started in April 2014.

Facility response:

Immediate action to comply with Nursing Service representation on the Radiation Safety Committee was taken by the Nurse Manager, Surgical Services on March 28, 2014, by appointing a staff nurse to the Radiation Safety Committee. The Nurse Manager will serve as the alternate for the staff nurse on the committee to ensure continuous nursing

service representation. The Radiation Safety Officer was notified to immediately add the staff nurse to the committee membership and meeting notice distribution for the quarterly meetings beginning on June 3, 2014. The committee minutes will reflect nursing representation and the committee chair will report any non-attendance by nursing to the Chief Nurses.

**Recommendation 5.** We recommended that managers initiate timely actions to address deficiencies identified during annual physical security surveys.

Concur

Target date for completion: Initiated March 19, 2014. Monitoring for compliance started in April 2014.

Facility response:

To ensure Pharmacy Service will correct deficiencies identified in the annual physical security survey within the 30 day timeframe established by VA Police, the Chief of Pharmacy Service confirmed with VA Police (on March 19, 2014) that the findings of future physical security surveys of Pharmacy areas will be directed to Pharmacy (119). The Chief of Pharmacy Service, or designee, will assess each deficiency and take appropriate actions. Results of the annual physical security survey and the actions taken by the Chief of Pharmacy Service, or designee, will be presented to the next regularly scheduled Administrative Executive Committee meeting (scheduled for May 21, 2014).

**Recommendation 6.** We recommended that processes be strengthened to ensure that pharmacy inspections are consistently completed on the same day they were initiated and that compliance be monitored.

Concur

Target date for completion: All training completed by April 18, 2014. Monitoring for compliance initiated April 1, 2014.

Facility response:

To ensure our documentation consistently reflects that controlled substance inspections are completed on the same day they are initiated, the OVAMC Controlled Substance Coordinator (CSC) notified all Controlled Substance Inspectors (CSIs) and key pharmacy staff at each facility via e-mail, on April 9, 2014, to manually include a date line next to each signature line on the pharmacy controlled substance inventory report sheets. CSC also provided one-on-one education to all inspectors by April 18, 2014, ensuring that every inspection document is signed and dated. CSC, as of April 1, 2014, is reviewing all submitted inspection documents to ensure they are signed and dated appropriately, and will continue doing so on an on-going basis to monitor for compliance.

The Pharmacy ADPAC, on March 27, 2014, submitted a New Service Request (NSR) at the national level to have date lines printed next to the signature lines on each pharmacy controlled substance inventory report to further strengthen this process.

**Recommendation 7.** We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections, daily public area inspections and bed checks, and weekly contraband inspections are completed and documented and that compliance be monitored.

Concur

Target date for completion: All actions were completed and monitoring was initiated April 2014.

Facility response:

Corrective action for the monthly self-inspections process has been implemented as of March 25, 2014. The inspection form that was changed on February 25, 2014 was accepted for use during the site visit with its minimal track record. The form is in regular monthly use with the maintenance of the forms in the Domiciliary new location, and an assigned person (Chief of Domiciliary and Nurse Manager) will address identified deficiencies with appropriate follow up action such as work orders.

Corrective action for contraband inspections, staff rounds of public spaces, daily bed checks, and resident room inspections for unsecured medications has been implemented as of April 2, 2014. The specific items were integrated into one form with assignment made daily to the Health Tech staff by the Nurse Manager. Findings on each item are reviewed by the Nurse Manager with action taken and documented on the consolidated form in the Comments section to track completion of any findings. Summary of daily inspections is reported daily to Domiciliary leadership in morning staff meeting. Additionally a 3-month random weekly room identification calendar (including days, evenings and nights) with findings was created, filed electronically and forwarded to the treatment team for follow-up in order to ensure compliance.

**Recommendation 8.** We recommended that processes be strengthened to ensure that medications in resident rooms on the MH RRTP units are secured and daily inspections for this are documented and that compliance be monitored.

Concur

Target date for completion: Initiated March 27, 2014. Monitoring was initiated April 2014.

Facility response:

The corrective action for ensuring medications in resident rooms are secured is via use of safes in each resident room. The broken medication safe in the individual resident room was repaired on March 27, 2014. To ensure enhanced action, the review of

unsecured medications is included in the daily inspection form for immediate correction if lapses are identified. Compliance monitoring is included in the 3 month overall audit of the inspection process.

**Recommendation 9.** We recommended that processes be strengthened to ensure that written agreements acknowledging MH RRTP resident responsibility for medication security are documented and that compliance be monitored.

Concur

Target date for completion: Actions completed April 10, 2014. Monitoring initiated April 2014.

Facility response:

Corrective action for lack of written agreements acknowledging resident responsibility for medication security was initiated March 27, 2014, with ongoing implementation. The use of I-Med consent was implemented on April 10, 2014, as an enhanced action so that a record of the acknowledgement by the resident is maintained in the CPRS, and so all staff can be informed regarding resident agreement. Monitoring has been established on a weekly basis to ensure the process has been integrated and present in the CPRS record. Additionally, monitoring of the process will be integrated into the established Medical Record Review process beginning with the April 2014 chart review to ensure compliance.

## OIG Contact and Staff Acknowledgments

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U.S. House of Representatives: Alan Grayson, John Mica

This report is available at [www.va.gov/oig](http://www.va.gov/oig).

## Endnotes

<sup>1</sup> References used for this topic included:

- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- 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*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

<sup>2</sup> References used for this topic included:

- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VA Radiology, "Online Guide," [http://vaww1.va.gov/RADIOLOGY/OnLine\\_Guide.asp](http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp), updated October 4, 2011.
- VA National Center for Patient Safety, "Privacy Curtains and Privacy Curtain Support Structures (e.g., Track and Track Supports) in Locked Mental Health Units," Patient Safety Alert 07-04, February 16, 2007.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- U.S. Pharmacopeia <797>, *Guidebook to Pharmaceutical Compounding—Sterile Preparations*, June 1, 2008.
- 10 CFR 20, Subpart F.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

<sup>3</sup> References used for this topic included:

- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

<sup>4</sup> The references used for this topic were:

- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

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<sup>5</sup> References used for this topic included:

- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

<sup>6</sup> References used for this topic were:

- VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
- VHA Directive 1106, *Pathology and Laboratory Medicine Service*, April 5, 2013.
- VA Radiology, "Online Guide," [http://vaww1.va.gov/RADIOLOGY/OnLine\\_Guide.asp](http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp), updated October 4, 2011.
- Various requirements of the Joint Commission.

<sup>7</sup> References used for this topic included:

- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Patients at High Risk for Suicide," memorandum, April 24, 2008.
- Various requirements of the Joint Commission.

<sup>8</sup> References used for this topic were:

- VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.
- Various requirements of the Occupational Safety and Health Administration.

<sup>9</sup> References used for this topic were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.