Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00025-144

Combined Assessment Program Review of the VA Caribbean Healthcare System San Juan, Puerto Rico

April 14, 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

ACLS	Advanced Cardiac Life Support
BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CEB	Clinical Executive Board
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CPRS	Computerized Patient Record System
EOC	environment of care
facility	VA Caribbean Healthcare System
FY	fiscal year
IC	infection control
MDRO	multidrug-resistant organisms
MH	mental health
MSDS	material safety data sheet
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Caribbean Healthcare System, San Juan, PR

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 February 7, 2011.

Review Results: The review covered seven activities and one follow-up review area. We made no recommendations in the following activities:

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

The facility's reported accomplishments were improved access to care through the telehealth program and earning several special designations and certifications.

Recommendations: We made recommendations in the following four activities and follow-up review area:

Quality Management: Ensure that mandatory reports are submitted quarterly to the Clinical Executive Board for review. Require that airway assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored. Establish a process to collect and analyze all required data elements and review each resuscitation event for performance improvement opportunities.

Management of Test Results: Ensure that normal test results are consistently communicated to patients and that compliance is monitored. Consistently use the required template to document communication of test results, and consistently monitor the process of communicating test results to providers and patients for effectiveness.

Environment of Care: Complete and document annual N95 respirator fit testing and bloodborne pathogens training. Ensure material safety data sheet logs are consistently updated.

Coordination of Care: Ensure that advance directive notifications and screenings are consistently documented in the electronic medical record and that screenings are accurate.

Follow-Up on Customer Service Training: Ensure that mandatory customer service training is completed and monitored.

Comments

The Veterans Integrated Service Network and System 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 and follow-up review area.

- COC
- EOC
- Follow-Up on Customer Service Training
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FYs 2008–2010 and for FY 2011 through February 7, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA*

Caribbean Healthcare System, San Juan, Puerto Rico, Report No. 07-02948-81, February 21, 2008). (See Appendix B for further details.) The facility had a repeat finding in the area of customer service training.

During this review, we also presented crime awareness briefings for 2,613 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 Accomplishments

Telehealth

Telehealth care utilizes medical information from CPRS and telecommunications technology. It encompasses diagnosis, treatment, follow-up, and education. The facility's Care Coordination Home Telehealth program delivers care to 1,156 veterans at home and has been successful in improving patient outcomes in specific areas, increasing access to care, and reducing waiting times and emergency room and clinic visits. The program moves care from a provider-centric model toward a patient-centered model that sees the home as the preferred place of care. By improving access to care and reducing unnecessary travel, the program aims to improve the patient's overall health care outcomes and quality of life. Currently, the facility is utilizing telehealth at the Ponce and Mayaguez outpatient clinics; the Arecibo, St. Thomas, St. Croix, and Guayama CBOCs; and the Utuado and Vieques rural clinics.

Special Designations and Certifications

The facility is the first local institution to have its nursing education department earn the certificate of accreditation from the American Nurses Credentialing Center and is the largest American Heart Association BLS and ACLS Community Training Center in Puerto Rico. Additionally, the facility earned the designation of Accredited Chest Pain Center from the Society of Chest Pain Centers and is the only facility in the Caribbean with this designation.

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.

QM Oversight. Local policy requires quarterly submission of Blood Bank and Transfusion Committee reports and patient safety and mortality assessment reports. VHA requires each facility to provide oversight to ensure that QM components are implemented, integrated, and documented.[1] The facility utilized both the CEB and the PI Board to provide oversight of QM activities. We found that committees appropriately analyzed data for PI opportunities; however, results of these activities were not consistently submitted to the CEB for review. Mandatory reports were submitted for only 1 of the past 4 quarters for the Blood Bank and Transfusion Committee and 3 of the past 4 quarters for patient safety and mortality assessment.

Moderate Sedation. VHA requires providers to document a complete history and physical within 30 days of a procedure and to re-evaluate the patient immediately prior to sedation.[2] These evaluations must include an assessment of the airway. We reviewed the medical records of 10 patients who underwent selected procedures where moderate sedation was used and found that only eight of the pre-sedation evaluations contained airway assessments.

Resuscitation Outcomes. VHA requires that each facility have a policy mandating the membership and responsibilities of a CPR committee or its equivalent.[3] The facility CPR Committee, formed in January 2011, is responsible for review of individual cardiopulmonary arrests occurring at the facility as well as oversight review of aggregate data to identify and address any trends. We found that data on

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

malfunctioning equipment, errors or deficiencies in technique, and delays in initiating CPR was not collected. Additionally, the committee did not review individual CPR event outcomes.

Recommendations

1. We recommended that processes be strengthened to ensure that mandatory reports are submitted quarterly to the CEB for review.

2. We recommended that processes be strengthened to ensure that airway assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored.

3. We recommended that the CPR Committee establish a process to collect and analyze all required data elements and review each resuscitation event for PI opportunities.

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.[4]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following areas 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 the results were available to the ordering provider.[5] We reviewed the medical records of 20 patients who had normal results and found that 15 of the 20 records contained documented evidence that the facility had communicated the results to the patients.

Documentation of Test Result Communication. Facility policy requires that diagnostic laboratory, pathology, and radiology clinicians use a specific template to document in the medical record the time and means of critical test result communication and the name of the ordering provider contacted. We reviewed the medical records of 25 patients who had critical results and found documentation of ordering

[4] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[5] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

provider notification in all 25 records; however, the template required by the facility was not used.

Monitoring Test Result Communication. VHA requires facilities to monitor the effectiveness of communication of test results to providers and patients.[6] In addition, local policy requires that timeliness of reporting critical test/critical values results be monitored for PI opportunities and reported to the CEB quarterly. We determined that the facility monitored communication of critical laboratory results to ordering providers; however, results of these monitors were not reported to the CEB. Additionally, we did not find evidence that communication of critical radiology test results to providers was monitored or that communication of critical, abnormal, and normal test results to patients was monitored.

Recommendations

4. We recommended that processes be strengthened to ensure that normal test results are consistently communicated to patients and that compliance is monitored.

5. We recommended that the required template be consistently used to document communication of test results.

6. We recommended that the process of communicating test results to providers and patients be consistently monitored for effectiveness and reported.

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 the medical/oncology, medical/telemetry, surgical intensive care, locked inpatient MH, and hospice units; dialysis; the emergency department; and one CLC unit. We also inspected the dental, chemotherapy, and women's clinics; the inpatient pharmacy; interventional and general radiology; and nuclear medicine. The facility maintained a generally clean and safe environment.

OSHA requires radiation warning labels on x-ray room doors. VHA requires facilities to periodically inspect the integrity of radiation shields and aprons.[7] We found that three x-ray room doors in Radiology Service did not have radiation

[6] VHA Directive 2009-019.
[7] VA Radiology, "Online Guide," <http://vaww1.va.gov/RADIOLOGY/Online_Guide.asp>, updated December 20, 2007.

warning labels. We inspected six lead aprons and found that only three had documented inspection dates. The facility corrected these conditions while we were onsite; therefore, we made no recommendations for these findings. However, we identified the following conditions that needed improvement.

IC. OSHA requires that facilities using N95 respirators fit test designated employees annually. We reviewed the training records of 26 selected employees and determined that 15 employees had the required annual fit testing.

OSHA requires that all employees receive initial and annual training on the OSHA Bloodborne Pathogens Rule. We reviewed training records for 20 selected employees and found that 17 employees had this training documented for FY 2010.

Environmental Safety. OSHA and The Joint Commission require that facilities maintain current MSDS inventory lists and hazardous material information for chemicals used in clinical areas. We reviewed 11 MSDS inventory lists and found that 7 of the inventory lists were current and contained all required information. While we were onsite, managers began updating the remaining MSDS inventory lists; however, the process was not completed in all areas.

Recommendations

7. We recommended that annual N95 respirator fit testing and bloodborne pathogens training be completed and documented.

8. We recommended that MSDS logs be consistently updated.

COC

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

We interviewed staff and reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification. VHA requires that patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance

directive.[8] This notification is required to be documented in the patient's medical record. We reviewed the medical records of 20 recently discharged patients and found that 17 of the records contained documentation that notification was provided at admission.

Advance Directive Screening. VHA requires that patients be screened for advance directive status at each admission to a VHA facility and that the screening be documented in the medical record.[9] Patients without an advance directive need to be asked if they would like additional information. We found that screening was documented for 18 of the 20 patients whose medical records we reviewed. Additionally, we found that 2 of the 18 screenings were inaccurate relative to the existence of an advance directive.

Recommendations

9. We recommended that processes be strengthened to ensure that advance directive notifications are consistently documented in the electronic medical record.

10. We recommended that processes be strengthened to ensure that advance directive screenings are accurate and consistently documented in the electronic medical record.

Follow-Up on Customer Service Training

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with completion of customer service training. At the time of our prior review, local policy required all employees to complete 1 hour of customer service training every 3 years. VISN policy required new employees to complete a 6-hour class (Treating Veterans with CARE) within the first 90 days of their employment. We found that some services had less than 50 percent compliance with customer service training. We also found that only 7 (13 percent) of the 53 new employees whose records we reviewed had received the 6-hour training. We recommended that the facility monitor completion of mandatory customer service training.

We interviewed the Customer Service Program manager and reviewed committee minutes, action plans, and policies related to customer service. At the time of this review, local policy required all employees to complete 1 hour of customer service training every 2 years and the Treating Veterans with CARE training at least once. We found that

[8] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[9] VHA Handbook 1004.02.

compliance with training was not monitored or reported after FY 2009. Training documentation showed that from October 1, 2008, to January 31, 2011, 80 percent of employees had completed customer service training. As of February 7, 2011, 60 percent of employees had completed the Treating Veterans with CARE training.

Recommendation

11. We recommended that processes be strengthened to ensure that mandatory customer service training is completed and monitored.

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 the medical/oncology and infectious disease units 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, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of an intravenous chemotherapy medication and the administration of that medication in the outpatient chemotherapy clinic. We also reviewed policies and procedures and interviewed pharmacy and nursing employees. 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 15–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[10]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	8	
Community Based Outpatient Clinics **Rural Clinics**	Mayaguez, PR Ponce, PR Arecibo, PR Guayama, PR St. Thomas, VI St. Croix, VI Utuado, Comerio, and Vieques, PR	
Veteran Population in Catchment Area	113,866	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	300	
• **CLC/Nursing Home Care Unit**	122	
• **Other**	None	
Medical School Affiliation(s)	University of Puerto Rico Ponce School of Medicine Universidad Central del Caribe San Juan Bautista School of Medicine	
• **Number of Residents**	82.9	
	Current FY (through November 2010)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$459	$496
• **Medical Care Expenditures**	$90	$496
Total Medical Care Full-Time Employee Equivalents	3,307	3,227
Workload:		
• **Number of Station Level Unique Patients**	44,761	60,903
• **Inpatient Days of Care:**		
o **Acute Care**	14,919	85,597
o **CLC/Nursing Home Care Unit**	6,671	40,121
Hospital Discharges	2,789	11,437
Total Average Daily Census (including all bed types)	340.5	343.3
Cumulative Occupancy Rate (in percent)	85	84
Outpatient Visits	166,642	965,860

[10] 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**
QM			
1. Ensure adverse events are evaluated and disclosed in accordance with VHA policy.	VHA policy requires that adverse events are evaluated, disclosed, and documented. The disclosure process is completed as required by the patient safety manager.	Y	N
2. Require the peer review process to comply with facility and VHA policy.	The peer review process complies with facility and VHA policy.	Y	N
3. Ensure the completion of the RCA process in accordance with VHA policy.	For FY 2010, RCAs were completed within the required timeframes.	Y	N
4. Require the mortality review process to comply with VHA policy.	A risk manager was hired to ensure that all mortality screening and reviews are completed according to VHA policy. Inpatient Evaluation Center mortality data are reviewed at appropriate levels.	Y	N
5. Require the utilization management program to comply with VHA policy.	Staff training was completed, and physician advisors were appointed. The utilization management program complies with VHA policy.	Y	N
6. Require that high-risk area reviews and oversight comply with facility and VHA policy.	The quality and analysis of data from high-risk review areas has improved.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
7. Ensure that supplies and materials are stored in accordance with National Fire Protection Association standards.	This is monitored during EOC rounds. In addition, quarterly e-mails on this topic have been sent to staff.	Y	N
8. Require that two fire egress doors in the CLC are repaired or replaced.	This has been corrected.	Y	N
9. Ensure that preventative maintenance inspections are appropriately completed and documented.	Preventative maintenance inspections are monitored by Biomedical Engineering and reported quarterly to the EOC Committee.	Y	N
10. Ensure that housekeeping closets containing hazardous chemicals are secured when unattended.	Training has been accomplished. This is monitored during EOC rounds and reported to the EOC Committee.	Y	N
11. Require that high-volume public bathrooms are cleaned frequently enough to maintain a safe and hygienic environment.	An action plan was developed to monitor bathroom cleanliness. This issue is addressed during EOC rounds, monitored, and reported to the EOC Committee.	Y	N
12. Require that ceiling tiles and ceiling tile grids are cleaned and replaced as needed.	This issue is addressed during EOC rounds, monitored, and reported to the EOC Committee.	Y	N
13. Ensure that Interim Life Safety Measures assessments and fire safety inspection data are reported to and reviewed by the EOC Committee.	Interim Life Safety Measures assessments and fire safety inspection data are presented and discussed in EOC Committee meetings.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Customer Service Training			
14. Require that completion of mandatory customer service training be monitored.	Training compliance was monitored and reported only through FY 2009.	N	Y (see pages 7–8)

VHA Satisfaction Surveys

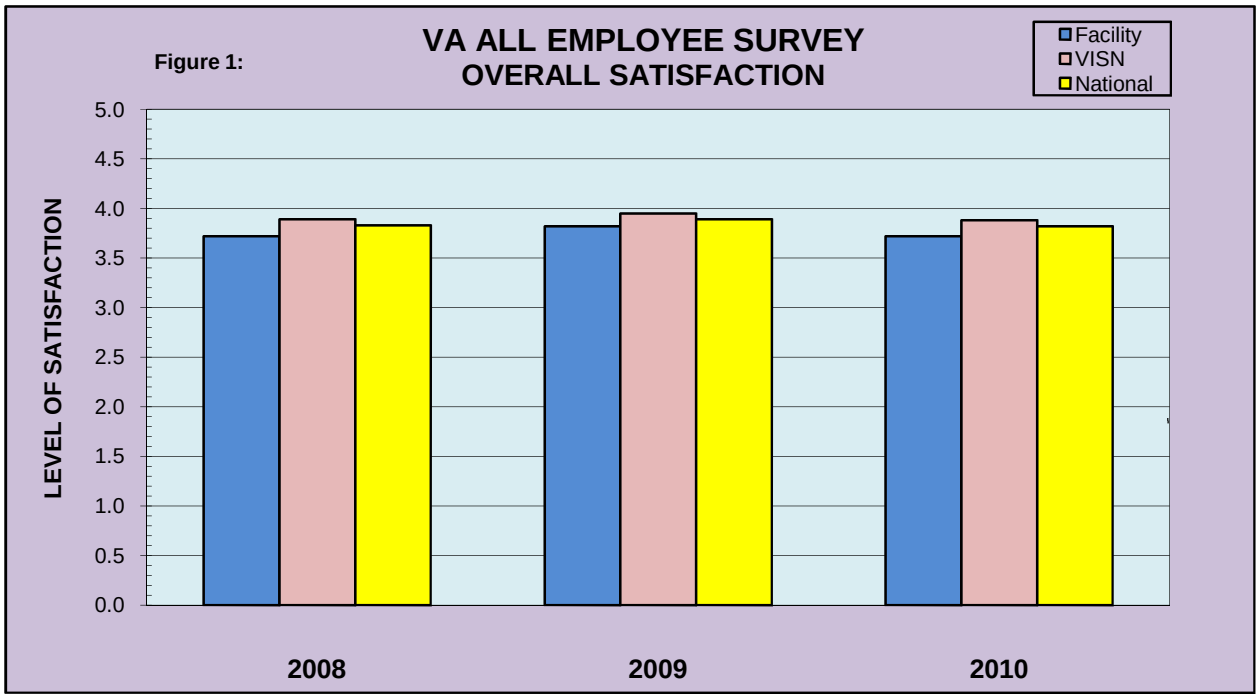
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	73.5	78.6	68.3	69.6	59.8	54.3	62.1	54.3
VISN	65.8	68.3	64.3	65.1	58.1	56.8	56.5	56.4
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

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.

Figure 1:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 7, 2011

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

Subject: **CAP Review of the VA Caribbean Healthcare System, San Juan, PR**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I have reviewed and concur with the findings and recommendations contained in the Healthcare Inspection report, as it relates to the Combined Assessment Program Review at the VA Caribbean Healthcare System.

2. Appropriate action has been initiated and/or completed, as detailed in the attached report.

(original signed by:)
Nevin M. Weaver, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 7, 2011

From: Director, VA Caribbean Healthcare System (672/00)

Subject: **CAP Review of the VA Caribbean Healthcare System, San Juan, PR**

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

1. On behalf of the VA Caribbean Healthcare System, I want to express my appreciation to the Office of Inspector General (OIG), Office of Healthcare Inspections for their professional and comprehensive Combined Assessment Program Review at this facility, conducted on February 07–11, 2011.

2. I concur with the findings and recommendations of this Office of Inspector General report. The VA Caribbean Healthcare System welcomes the external perspective provided by this report. The VA Caribbean Healthcare System's reply outlines the actions taken in response to these findings.

Wanda Mims, MBA

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 processes be strengthened to ensure that mandatory reports are submitted quarterly to the CEB for review.

Concur: We concur that the processes be strengthened to ensure that mandatory reports are submitted quarterly to the CEB for review. All reports have been scheduled for presentation in the CEB for the completion of the fiscal year and this process will be followed consistently.

Target date for completion: Completed

Recommendation 2. We recommended that processes be strengthened to ensure that airway assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored.

Concur: We concur that the processes be strengthened to ensure that airway assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored. An airway assessment is already included in a standardized Pre-Anesthesia Assessment as part of the Anesthesia Record. This form is the only approved documentation template for moderate sedation. All providers with moderate sedation privileges have been trained on the use of this form. A modified version of the Pre-Anesthesia form is being presented to the record review committee in April 2011 for final approval. This form will be used by all providers who perform moderate sedation. Monthly monitoring by QM will commence upon implementation of the form. Results of the monitor will be seen by the Moderate Sedation Committee and the CEB.

Target date for completion: April 2011

Recommendation 3. We recommended that the CPR Committee establish a process to collect and analyze all required data elements and review each resuscitation event for PI opportunities.

Concur: We concur that the CPR Committee establish a process to collect and analyze all required data elements and review each resuscitation event for PI opportunities. The Critical Care Sub Committee began meeting weekly in January 2011. Each CPR event is reviewed and discussed in detail with members. The team created a document to standardize data collection, which is in line with Joint Commission elements related to code analysis. The Critical Care Sub Committee reports the findings at the monthly

Critical Care Committee meeting where trends and areas of improvement are discussed, and improvement opportunities identified and tracked.

Target date for completion: Completed

Recommendation 4. We recommended that processes be strengthened to ensure that normal test results are consistently communicated to patients and that compliance is monitored.

Concur: We concur that the processes be strengthened to ensure that normal test results are consistently communicated to patients and that compliance is monitored. A center memorandum on the communication of test results was published in January 2011 prior to the OIG visit. Training on the center memorandum to Primary Care and other staff is scheduled on April 7, 2011. Ongoing compliance is being monitored by the QM office and is reported to the Patient Safety Committee and the CEB.

Target date for completion: April 2011

Recommendation 5. We recommended that the required template be consistently used to document communication of test results.

Concur: We concur that the required template be consistently used to document communication of test results. Use of the template has been reinforced and the QM office has established a monitor to track compliance. The current compliance rate for the 2nd quarter of 2011 is 80 percent and QM reports this monitor to the Patient Safety Committee and the CEB.

Target date for completion: Completed

Recommendation 6. We recommended that the process of communicating test results to providers and patients be consistently monitored for effectiveness and reported.

Concur: We concur that the process of communicating test results to providers and patients be consistently monitored for effectiveness and reported. Communication of test results has been reinforced and the QM office has established a monitor to track compliance. The current compliance rate for the 2nd quarter of 2011 is 80 percent. Findings of non-compliance are reported to the Nursing Service Performance Improvement Coordinator for direct intervention with staff, and the QM office reports the monitor to the Patient Safety Committee and the CEB.

Target date for completion: Completed

Recommendation 7. We recommended that annual N95 respirator fit testing and bloodborne pathogens training be completed and documented.

Concur: We concur that the annual N95 respirator fit testing and bloodborne pathogens training be completed and documented. To improve compliance, the respirator

database will be monitored on a monthly basis to ensure that annual fit testing is completed in a timely manner. Supervisors are being provided a list identifying employees who are due to have a fit test to ensure employees are scheduled for the fit testing. As of March 2011, 93 percent of employees have been fit tested. The remaining will be fit tested by April 30, 2011. The bloodborne pathogens training is provided as part of New Employee Orientation and during mandatory training fairs, and the compliance rate is monitored by Education Service.

Target date for completion: April 2011

Recommendation 8. We recommended that MSDS logs be consistently updated.

Concur: We concur that the MSDS logs be consistently updated. A meeting with safety representatives from each area is being conducted and a standardized MSDS binder format is being implemented.

Target date for completion: April 2011

Recommendation 9. We recommended that processes be strengthened to ensure that advance directive notifications are consistently documented in the electronic medical record.

Concur: We concur that the processes be strengthened to ensure that advance directive notifications are consistently documented in the electronic medical record. The Chief of Health Administration Service and the Supervisor of Admissions will ensure that VA form 672-02-03-10-122 Rev., "Patient Acknowledgement of Admission and D/C Planning Issues" is scanned in the veteran's medical record. A monitor has been established to track compliance. The achievement level for this monitor is 95 percent and this monitor will be reported to the PI Board.

Target date for completion: September 2011

Recommendation 10. We recommended that processes be strengthened to ensure that advance directive screenings are accurate and consistently documented in the electronic medical record.

Concur: We concur that processes be strengthened to ensure that advance directive screenings are accurate and consistently documented in the electronic medical record. The Chief of Health Administration Service and the Supervisor of Admissions will ensure that VA form 672-02-03-10-122 Rev., "Patient Acknowledgement of Admission and D/C Planning Issues" is scanned in the veteran's medical record. Nursing in-patient supervisors will ensure compliance with advance directive screening. A monitor has been established to track compliance. The achievement level for this monitor is 95 percent and this monitor will be reported to the PI Board.

Target date for completion: September 2011

Recommendation 11. We recommended that processes be strengthened to ensure that mandatory customer service training is completed and monitored.

Concur: We concur that the processes be strengthened to ensure that mandatory customer service training is completed and monitored. A system has been established to report and monitor compliance with customer service training. Reports will be submitted to the Customer Service Committee and Executive Leadership Board monthly. To date, 85 percent of staff have received mandatory customer service training.

Target date for completion: August 2011

OIG Contact and Staff Acknowledgments

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