Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00370-156

Combined Assessment Program Review of the South Texas Veterans Health Care System San Antonio, Texas

April 17, 2012

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
CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EOC	environment of care
facility	South Texas Veterans Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
MRI	magnetic resonance imaging
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
SPD	supply, processing, and distribution
TMS	Talent Management System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, TX

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 6, 2012.

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

- Coordination of Care
- Psychosocial Rehabilitation and Recovery Centers

Recommendations: We made recommendations in the following six activities:

Environment of Care: Ensure patient care areas on the locked mental health units are clean. Perform and document daily functionality checks of elopement prevention system critical components. Conduct an infection control risk assessment annually. Establish a residential animal policy.

Colorectal Cancer Screening: Notify patients of positive screening test and biopsy results within the required timeframe. Develop follow-up plans or document that no follow-up is indicated within the required timeframe. Ensure patients with positive screening test results receive diagnostic testing within the required timeframe.

Polytrauma: Assign Case Managers to outpatients, and develop treatment plans that contain all required elements. Provide required services, and maintain minimum staffing levels. Communicate with inpatients and/or their family at the required intervals, and complete all documentation. Discuss care plans with inpatients and/or their family within 24 hours of the interdisciplinary team meeting.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation. Document patient vital signs at 5-minute intervals during procedures using moderate sedation, or document exceptions.

Medication Management: Administer pneumococcal vaccinations when indicated.

Quality Management: Ensure results of medical record quality reviews are reported at least quarterly to the Medical Record Committee.

Comments

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

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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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 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 eight activities:

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might 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 2010, FY 2011, and FY 2012 through February 6, 2012, 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 South Texas Veterans Health Care System, San Antonio, Texas,* Report No. 10-01233-136, April 26, 2010). The facility had corrected all previous findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 341 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 1,078 responded. Survey results were shared 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.

Results

Review Activities With Recommendations

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 and whether the facility's Homeless/Substance Abuse RRTP was in compliance with selected MH RRTP requirements.

At the San Antonio division, we inspected the medical, surgical, medical intensive care, MH, and polytrauma inpatient units; the dental, internal medicine, and polytrauma clinics; the emergency department; the surgical suite; and the CLC. At the Kerrville division, we inspected the medical inpatient unit, the neurology and primary care clinics, and the CLC. We also inspected the dental clinic at the Datapoint Clinic and the Homeless/Substance Abuse RRTP at Villa Serena. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
X	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
X	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Cleanliness. The Joint Commission requires that areas used by patients are clean. On the locked inpatient MH units, we found dirty floors in the common areas and showers

that required deep cleaning. Environmental Management Service deep cleaned the shower floors and the floors in the common areas while we were onsite and will increase the frequency of routine deep cleanings of the common areas.

Patient Safety. VHA requires that daily checks be performed on elopement prevention systems in CLCs.[1] CLC staff at the Kerrville division were not documenting the daily functionality checks of all critical components.

Infection Prevention. The Joint Commission requires that the facility have an annual infection control risk assessment. The facility had not completed this assessment since May 2010.

Residential Animal Policy. VHA requires that if the facility has a residential animal program, a policy be established for the regular cleaning of fish tanks, birdcages, rodent cages, and any other animal dwellings by non-patient care personnel.[2] The CLC has resident fish, but there is no facility residential animal policy.

Recommendations

1. We recommended that processes be strengthened to ensure that patient care areas on the locked MH units are clean.

2. We recommended that processes be strengthened to ensure that daily functionality checks of all elopement prevention system critical components at the Kerrville CLC are performed and documented.

3. We recommended that processes be strengthened to ensure that an infection control risk assessment is conducted annually.

4. We recommended that the facility establish a residential animal policy.

[1] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
[2] Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[3] Five patients' records did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[4] Five patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[5] Six of the 20 patients who received diagnostic testing did not receive that testing within the required timeframe.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that

[3] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[4] VHA Directive 2007-004.
[5] VHA Directive 2007-004.

clinicians document notification.[6] Of the nine patients who had a biopsy, six records did not contain documented evidence of timely notification.

Recommendations

5. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

6. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

7. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

8. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[6] VHA Directive 2007-004.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, 9 medical records of patients admitted to the polytrauma program, and training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
X	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
X	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
X	The interdisciplinary team coordinated inpatient care planning and discharge planning.
X	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a Case Manager assigned and a specific interdisciplinary treatment plan developed.[7] The plan developed by the interdisciplinary team must address specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. Six of the 10 polytrauma outpatients did not have a Case Manager assigned. In addition, eight treatment plans did not contain all required elements.

Available Services and Staffing. VHA requires that specific services be available for polytrauma patients and that minimum staffing levels be maintained.[8] The facility did not have all required programs available, such as the Residential Transitional

[7] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[8] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Rehabilitation Program and family therapy. The facility's Polytrauma Rehabilitation Center was still under construction and actively recruiting to meet all program requirements. In addition, the facility did not meet the minimum staffing requirement for a nurse educator, a clinical nurse leader, social workers, speech pathologists, physical therapists, occupational therapists, recreational therapists, a family therapist, a certified prosthetist, and a certified driver trainer.

Inpatient Case Management. VHA requires that Case Managers communicate with the patient and/or their family at specific intervals, such as prior to an inpatient polytrauma admission, on the day of admission, and each day during the inpatient stay.[9] The Case Manager is required to complete a psychosocial assessment, a psychosocial treatment plan, and a detailed interdisciplinary discharge plan. None of the nine inpatients' medical records contained evidence that Case Managers communicated with the patients and/or their family on the day of admission or on a daily basis. In addition, two medical records did not contain evidence that Case Managers completed psychosocial assessments or psychosocial treatment plans, and eight did not include detailed discharge plans.

Inpatient Care Plans. VHA requires that the inpatient polytrauma interdisciplinary team establish and update patients' care plans to reflect progress and set new goals.[10] The Case Manager is to review the plans with the patient and/or their family within 24 hours of the interdisciplinary team meeting. Four of the nine inpatients' medical records did not contain evidence that Case Managers discussed care plans with the patients and/or their family within 24 hours of the interdisciplinary team meetings.

Recommendations

9. We recommended that processes be strengthened to ensure that Case Managers are appropriately assigned to polytrauma outpatients and that interdisciplinary teams develop treatment plans that contain all required elements.

10. We recommended that all required services be made available to polytrauma inpatients and that minimum staffing levels be maintained.

11. We recommended that processes be strengthened to ensure that Case Managers consistently communicate with the inpatient and/or their family at the required intervals and that all required documentation is completed.

12. We recommended that processes be strengthened to ensure that Case Managers consistently discuss inpatients' care plans with the patient and/or their family within 24 hours of the interdisciplinary team meeting.

[9] VHA Directive 2006-043, *Social Work Case Management in VHA Polytrauma Centers*, July 10, 2006.
[10] VHA Handbook 1172.1, *Polytrauma Rehabilitation Procedures*, September 22, 2005.

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 23 medical records, and 27 training/competency records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
X	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[11] Three patients' medical records did not include all required elements of the history and physical examination, such as a review of substance use or abuse, assessment of risk, and an airway assessment.

Monitoring. VHA requires that patient vital signs be documented at 5-minute intervals during a procedure where moderate sedation is used and that any exception and the reason for exception be documented.[12] Nine patients' medical records did not consistently document patient vital signs at 5-minute intervals during the procedure or document an exception to the requirement.

Recommendations

13. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[11] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[12] VHA Directive 2006-023.

14. We recommended that processes be strengthened to ensure that patient vital signs are documented at 5-minute intervals during procedures where moderate sedation is used or that exceptions and reasons for exception are documented.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
X	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Administration. The Centers for Disease Control and Prevention recommends that when indicated, clinicians administer pneumococcal and tetanus vaccinations. None of the three applicable records contained documentation that indicated pneumococcal vaccinations had been administered.

Recommendation

15. We recommended that processes be strengthened to ensure that clinicians administer pneumococcal vaccinations when indicated.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current ACLS certification.
X	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that 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.
	The facility complied with any additional elements required by local policy.

Medical Record Review. VHA requires that facilities' medical record review committees provide oversight and coordination of quality reviews and ensure quarterly reporting.[13] Although medical records quality reviews were being completed, the results of the reviews were not reported quarterly.

Recommendation

16. We recommended that processes be strengthened to ensure that results of medical record quality reviews are reported at least quarterly to the Medical Record Committee.

[13] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 27 HF patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

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 22–33, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[14]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	17	
Community Based Outpatient Clinics	San Antonio, TX (9 clinics) Victoria, TX New Braunfels, TX Seguin, TX Beeville, TX Del Rio, TX Uvalde, TX	
Veteran Population in Catchment Area	245,445	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	315	
• **CLC/Nursing Home Care Unit**	170	
• **Other**	0	
Medical School Affiliation(s)	The University of Texas Health Science Center at San Antonio	
• **Number of Residents**	213.27	
	Current FY (through October 2011)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$496.9	$634.3
• **Medical Care Expenditures**	$48.4	$742.3
Total Medical Care Full-Time Employee Equivalents	3,279.3	3,321.8
Workload:		
• **Number of Station Level Unique Patients**	32,339	85,658
• **Inpatient Days of Care:**		
o **Acute Care**	6,845	82,302
o **CLC/Nursing Home Care Unit**	574	43,735
Hospital Discharges	839	10,461
Total Average Daily Census (including all bed types)	239	345
Cumulative Occupancy Rate (in percent)	49.3	71.1
Outpatient Visits	75,339	924,047

[14] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Require that designated staff maintain current ACLS certification, in accordance with local policy.	ACLS certification is now tracked in TMS. Staff members mandated to complete ACLS certification have ACLS as a curriculum assignment on their learning plans. TMS automatically sends alert of an impending expiration at 45-day, 30-day, and 15-day intervals.	N
Medication Management		
2. Require that clinicians consistently document all required influenza vaccine elements.	The note titles *Immunization Note, Flu Shot Group Note, and Employee Health Nurse Flu Shot Note* were all modified in January 2010 to include a mandatory field requiring the Centers for Disease Control and Prevention Vaccination Information Statement edition date be entered on each of these notes.	N
MRI Safety		
3. Require that MRI personnel complete an MRI screening form for each patient and scan it to the medical record, as required by local policy.	The Chief Technologist audited 70 charts per month through June 2011 for completion and scanning of an MRI screening form for every patient. Results were reported on the Quality Executive Board dashboard monthly. Due to 100 percent compliance through 3 quarters of FY 2011, the Quality Executive Board concluded the audit process in July 2011.	N
RME		
4. Require SPD to maintain a clean environment.	The issues identified related to repairs needed to the ceiling and walls requiring painting. The repairs were completed by April 16, 2010.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
5. Require staff to wear appropriate personal protective equipment, in accordance with VA policy.	The shoe covers were received from the company on January 26, 2010. All SPD employees were retrained on proper wear of personal protective equipment on March 12, 2010, which included a review of policy 7176 related to personal protective equipment.	N
6. Require SPD staff to clean RME according to the manufacturer's instructions.	This recommendation related to one scope. That piece of equipment was cleaned thoroughly at the time. Training to follow the standard operating procedures exactly as written was provided. Annual competencies are performed to ensure steps are performed in the exact order per the manufacturer's recommendations. RME tracer rounds are performed in all RME sites annually at a minimum.	N
7. Require a written emergency action plan to be located adjacent to the ethylene oxide sterilizer, in accordance with VA policy.	The written Emergency Action Plan for the ethylene oxide leaks/spills that was obscured by a temporary construction wall was immediately relocated to a more visible location, and an additional plan was placed on the ethylene oxide sterilizer panels.	N
8. Require the humidity range in the SPD sterile storage area to be maintained in accordance with VA policy.	Humidity is monitored routinely in sterile storage areas. A notification system is in place to alert supervisors and/or engineering of out-of-range humidity readings.	N
EOC		
9. Require that staff identified as at risk for exposure to a harmful atmosphere receive annual respirator fit testing and training, as required by the Occupational Safety and Health Administration.	To ensure ongoing compliance, employees at risk for tuberculosis exposure have a curriculum assignment on their TMS learning plans so that the employees and supervisors receive TMS reminders prior to their expiration dates.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
10. Require staff to consistently complete and document daily emergency cart checks, as required by local policy.	Facility policy was revised May 13, 2010, to designate the nurse manager or his/her designee as responsible for completing and annotating the daily crisis cart checklist and eliminated a requirement that SPD also perform a daily check. Compliance to daily checks of all crisis carts are monitored by the nurse manager or designee and tracked monthly on the Nursing Service Dashboard. Compliance with the requirement is assessed during EOC rounds and by QM during tracer activities.	N

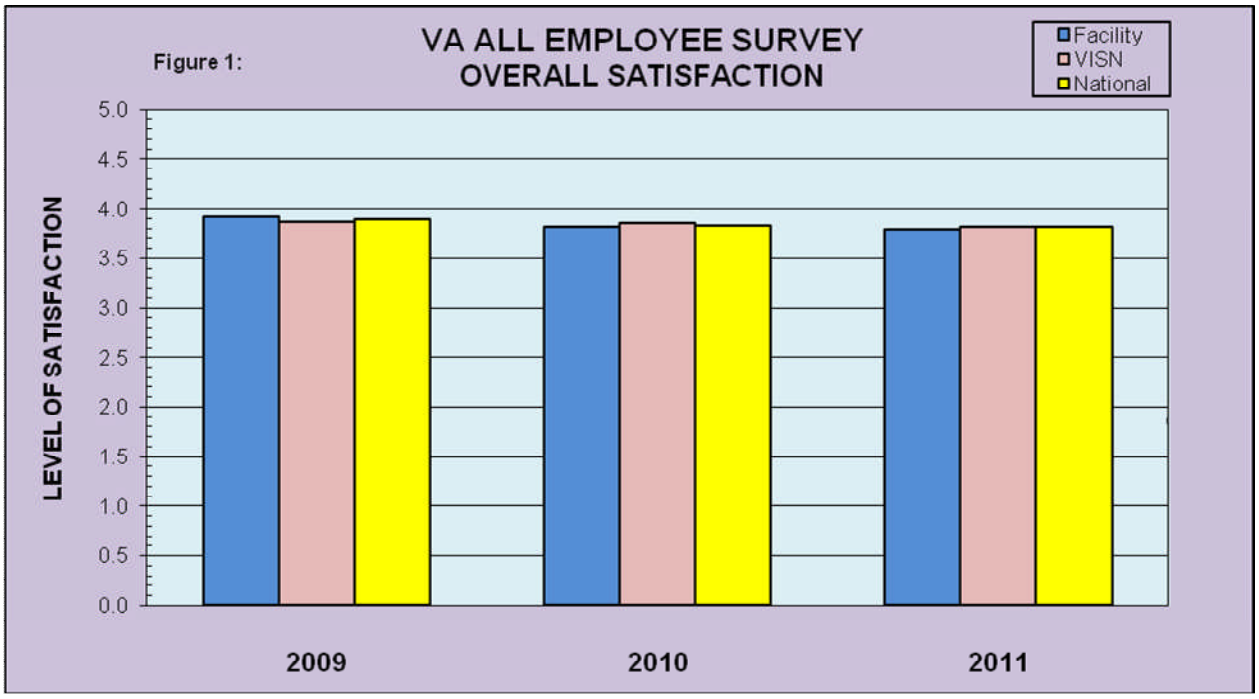
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	62.3	65.4	51.0	50.5	52.5	51.3
VISN	60.8	60.7	52.7	51.1	46.5	47.5
VHA	63.9	64.1	55.9	55.3	54.2	54.5

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[15] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[16]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	14.4	10.4	12.4	20.3	24.4	19.5
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[15] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[16] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 28, 2012

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **CAP Review of the South Texas Veterans Health Care System, San Antonio, TX**

To: Director, Dallas Regional Office of Healthcare Inspections (54DA)

Director, Management Review Service (VHA 10A4A4 Management Review)

1. Thank you for allowing me to respond to this CAP Review of the South Texas Veterans Health Care System, San Antonio, TX.

2. I concur with the recommendations and have ensured that action plans with target dates for completion were developed.

3. If you have further questions regarding this CAP review, please contact Judy Finley, Quality Management Officer at 817-385-3761 or Denise B. Elliott, VISN 17 HSS at 817-385-3734.

(*original signed by*:)
Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 27, 2012

From: Director, South Texas Veterans Health Care System (671/00)

Subject: **CAP Review of the South Texas Veterans Health Care System, San Antonio, TX**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. Attached please find the response from the South Texas Veterans Health Care System.

2. If you have any questions, please contact Amjed Baghdadi, Chief Quality Management Officer at 210-617-5205.

(*original signed by*:)
Marie L. Weldon, FACHE
Director, South Texas Veterans Health Care System (671/00)

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 patient care areas on the locked MH units are clean.

Concur

Target date for completion: June 15, 2012

Facility Response: An Environmental Management Service (EMS) schedule has been developed to monitor and ensure the Mental Health inpatient units remain clean. The floors in the main corridors throughout the Mental Health wards, the nurses stations, the showers, the common restrooms and the restrooms in each patient room are composite and require deep scrubbing. Composite floors will be scrubbed weekly in accordance with the schedule provided. The floors in the remaining rooms are tile. Tile floors will be maintained as needed with each floor being buffed at least weekly, restored with wax monthly, and will be stripped and waxed a minimum of twice annually. All restrooms will be thoroughly cleaned twice daily, once by the day shift and once by the evening shift. They will also be monitored from 8:00 a.m. to midnight to ensure they are properly serviced and maintained. High and low dusting will be completed weekly. Baseboards, walls, bumper guards, handrails, doors, and kick plates will be cleaned daily as needed and thoroughly cleaned twice monthly in the first and third weeks of each month by the evening shift. An updated EMS employee work schedule for the day and evening shifts for the Mental Health inpatient units was issued to assigned supervisors and staff on March 16, 2012. All cleaning schedules will be monitored by the assigned day and evening shift supervisor. Inspection sheets will be provided by the supervisors to the Environment of Care Specialist weekly to ensure cleanliness is properly and adequately maintained. Compliance will be monitored until three (3) consecutive months of compliance is demonstrated.

Recommendation 2. We recommended that processes be strengthened to ensure that daily functionality checks of all elopement prevention system critical components at the Kerrville CLC are performed and documented.

Concur

Target date for completion: June 1, 2012

Facility Response: The elopement prevention system processes were strengthened to ensure that daily functionality checks of all elopement prevention system critical components at the Kerrville (KD) CLC are performed and documented. Starting March 1, 2012, the Kerrville Division CLC Staff Nurses are required to conduct testing

and documenting of all individual use alarms daily on a quality checklist. The Quality Checklist for Monitoring of Electronic Prevention Elopement System will be maintained by the Charge RNs. The Charge RNs will be responsible for ensuring that the functionality checks are conducted daily on the day shift. Starting March 1, 2012, KD CLC Staff Nurses conduct and document daily testing of each patient alarm in use and of the door by activating it at least once and recording the response in the quality checklist maintained by the charge RNs. KD CLC Nurse Managers from each KD CLC unit are responsible for ensuring these tests are conducted daily (including weekends and holidays). The KD CLC Nurse ACNS met with the CLC Nurse Managers on February 29, 2012, to instruct the CLC Nurse Managers on the strengthened process for daily functionality checks of the KD elopement prevention system. KD CLC Staff Nurses were instructed by the Nurse Managers on the strengthened process for daily functionality checks on March 1, 2012. Compliance will be monitored until three (3) consecutive months of compliance is demonstrated.

Recommendation 3. We recommended that processes be strengthened to ensure that an infection control risk assessment is conducted annually.

Concur

Target date for completion: Completed February 27, 2012

Facility Response: The FY12 Infection Control Risk Assessment was completed with respective Service Chiefs and Program Coordinators/Directors. The Risk Assessment was presented to and approved by the Infection Control Committee on January 31, 2012. The Risk Assessment was approved by the Clinical Executive Board on February 27, 2012.

Recommendation 4. We recommended that the facility establish a residential animal policy.

Concur

Target date for completion: May 31, 2012

Facility Response: A second draft of the Pet Visitation Policy, which includes residential animals, was submitted through a multidisciplinary work group for review on March 6, 2012. Recommendations of the group related to the management and care of resident animals, safety and environmental cleanliness, and infection prevention issues will be incorporated into a final draft for presentation to the Facility Director for approval. The final policy draft will be submitted through the Internal Readiness Committee and the Quality Executive Board to the Joint Leadership Council for final approval.

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: July 6, 2012

Facility Response: Primary Care will notify patients of positive Immunochemical Fecal Occult Blood Test (iFOBT) screening test results within 14 days of the "laboratory receipt date". Gastroenterology will notify patients of positive colonoscopy screening test results within 14 days of the procedure.

Primary Care began utilizing an available Vista report on March 13, 2012, to ensure that all positive iFOBT CRC screening test results are identified in a timely manner and that the Primary Care Provider (PCP) is made aware of the positive iFOBT screening test result in sufficient time to be able to notify the Veteran patient of the positive result within 14 days of the "laboratory receipt date". By April 6, 2012, the PCP will notify patients of test results either at a face-to-face visit (documented in a progress note), in a telephone visit (documented in a phone note), in a Secure Message (documented in a SM note) or by utilizing a test result notification letter (this letter is a templated progress note available in CPRS that serves as documentation). Ideally, a positive screening test is best communicated to a patient in a manner that allows discussion (face-to-face or phone visit), but if this is not able to be accomplished, then the test result notification letter is an acceptable alternative. Secure Messaging (SM) may be used based on patient preference (meaning that the patient has signed up for this and is authenticated and this is available for use) and provider judgment (meaning that if the provider was unable to verbalize the result to patient during a face-to-face visit or phone visit, then SM is acceptable).

Primary Care will run reports for all PC sites by March 23, 2012. Primary Care will develop a method to distribute reports to PC teamlets by March 30, 2012, and will email PC leadership (utilizing the already established email group for STX PC Chief Medical Officers, Nurse Managers, and Administrative Officers) of the defined distribution method with instructions by March 30, 2012. Beginning April 6, 2012, Primary Care teamlets will utilize the distributed report to create a separate "high risk disease registry" specifically for the follow-up of positive iFOBT test results. The high risk disease registry report will have columns to notate the date of the positive iFOBT laboratory receipt date, the date the patient was notified, and the appropriate follow-up action taken (patient referred to GI by consult for follow-up colonoscopy or to document that no follow-up action is indicated within the time required time frame). The GI consult for colonoscopy serves as documentation in CPRS of referral for follow-up action. A note (a phone note or a chart check note, as indicated) in CPRS will be necessary to document the reason for no colonoscopy referral (if the patient has contraindications, if patient declines/refuses, etc). The registry tracks the PC teamlet's actions. Compliance will be monitored until three (3) consecutive months of compliance is demonstrated.

Recommendation 6. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: July 6, 2012

Facility Response: Primary Care will run Vista reports of positive iFOBT CRC screening for all PC sites by March 23, 2012. Primary Care will develop a method to distribute reports to PC teamlets by March 30, 2012, and will email PC leadership (utilizing the already established email group for STX PC Chief Medical Officers, Nurse Managers, and Administrative Officers) of the defined distribution method with instructions by March 30, 2012. Beginning April 6, 2012, Primary Care teamlets will utilize the distributed report to create a separate "high risk disease registry" specifically for the follow-up of positive iFOBT test results. The high risk disease registry report will have columns to notate the date of the positive iFOBT laboratory receipt date, the date the patient was notified, and the appropriate follow-up action taken (patient referred to GI by consult for follow-up colonoscopy or to document that no follow-up action is indicated within the time required time frame). The GI consult for colonoscopy serves as documentation in CPRS of referral for follow-up action. A note (a phone note or a chart check note, as indicated) in CPRS will be necessary to document the reason for no colonoscopy referral (if the patient has contraindications, if patient declines/refuses, etc). Compliance will be monitored until three (3) consecutive months of compliance is demonstrated.

Recommendation 7. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: July 6, 2012

Facility Response for Management of Colonoscopy Consults: GI Service has assigned a designated provider who will screen all consults referred for positive iFOBT CRC screening. The screener was instructed by the Section Chief, Gastroenterology, on February 10, 2012, to identify all consults with positive CRC screening Immunochemical Fecal Occult Blood Test (iFOBT) as an indication for a procedure. Once identified, he forwards these consults to the GI Medical Support Assistant (MSA) and the GI Physician Assistant (PA) for appointment scheduling. All appointments for positive iFOBT are handled exclusively by the GI MSA in an effort to ensure these cases are managed timely. Primary Care Providers will clearly stipulate in their consult request that the consult is for a positive iFOBT. The GI MSA calls all patients with consults for positive iFOBT, then schedules and sends an appointment letter for the procedure to be performed ideally within 30 days, but in no case later than 60 days from the day the patient's positive result was available. For any GI MSA absence of more than two

(2) days, a designated trained clerk provides coverage to schedule these appointments. The GI PA maintains an electronic list of all positive iFOBT consults and checks periodically to ensure patients have been scheduled and that patients have followed through with scheduled procedure and are in compliance with all timeframes in the Veterans Affairs (VA) mandate. Compliance will be monitored until three (3) consecutive months of compliance is demonstrated. Any instances of noncompliance will be evaluated for implementation of appropriate actions.

Recommendation 8. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: July 6, 2012

Facility Response: A process was developed and implemented to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document the notification. This process is described in Policy Memorandum 111-12-11 *Colorectal Cancer Screening and Surveillance Management,* effective February 8, 2012. A biopsy results letter template was in use at the time of the OIG survey and is available in the Computerized Patient Record System (CPRS); however, was not being utilized at the Kerrville Division. The Kerrville Division GI provider scheduled the patient for a follow-up appointment for discussion of procedure results. The cases cited involved follow-up appointments that were beyond the 14-day interval. The process at the Kerrville Division was corrected immediately to align with the System process. The strengthened System process, implemented February 14, 2012, requires that Pathology notify the Gastroenterology (GI) provider through a view alert in CPRS that biopsy results are ready. The providers then create a GI result letter in CPRS, electronically sign it as part of the documentation process and send it via standard government mail to the patient. All critical results (such as a cancer diagnosis) are communicated to the patient personally by the provider. This is accomplished by an in-person visit or a telephone call and the communication is documented in CPRS. Once this direct communication is accomplished, a result letter, with a reference to the personal communication, is written and sent to the patient. All of this is accomplished within 14 days of results being available. As a redundancy measure, all GI providers will keep a secure electronic list of the procedures performed that have biopsies, facilitating a cross check of view alerts to the electronic list, assuring biopsy results are not lost to follow-up. GI maintains an electronic spreadsheet of all biopsies obtained by the service. This list is scrutinized twice weekly to assure that there are no biopsies that have not had results sent out within 14 days. Education was provided to all practitioners in GI at the Audie Murphy and Kerrville Divisions February 10, 2012, to ensure uniform implementation of the policy across the system. All rotating GI Fellows are instructed on this process on the morning of their first day of their VA rotation before they engage in patient care. To ensure compliance with the new process, current Procedural Terminology (CPT) codes for GI procedures with biopsies are pulled for random auditing. Audits will continue until three consecutive months of compliance is

demonstrated. Any instances of noncompliance will be evaluated for implementation of appropriate actions.

Recommendation 9. We recommended that processes be strengthened to ensure that Case Managers are appropriately assigned to polytrauma outpatients and that interdisciplinary teams develop treatment plans that contain all required elements.

Concur

Target date for completion: July 6, 2012

Facility Response: The Polytrauma Network Site (PNS) Clinic has been revised to include three (3) separate tracks which will direct the flow of care and will dictate the need for Polytrauma intervention (including the Reintegration Plan of Care notes) as recommended/dictated by the VHA Directive and DoD/VA Clinical Practice Guidelines for the Management of Mild TBI.

- The Trans-disciplinary Polytrauma Track
- The Multi-disciplinary Polytrauma Track
- The Integrated Health Rehabilitation Track

After a Veteran has screened positive on the initial TBI screening and the results of the screening have been reviewed by a Polytrauma provider, the Veteran will be placed into the Polytrauma New Evaluation Clinic. During this clinic they will be evaluated by the Polytrauma Physician, Polytrauma Social Work Case Manager, Polytrauma Behavioral Health provider (either Psychology or Neuropsychology), and Polytrauma Clinic Registered Nurse.

Following the interdisciplinary Polytrauma New Evaluation Clinic, the Veteran will be assigned to the appropriate track or will be discharged from clinic.

- Veterans will be formally enrolled into the Polytrauma Network Site Clinic if assigned to the Trans-disciplinary or Multi-disciplinary Polytrauma Track.
- Trans-disciplinary Polytrauma Track is reserved for Veterans that have a confirmed TBI or Polytrauma diagnosis and will be receiving three or more Polytrauma therapies (PT, OT, SLP, Neuropsych, Health Psych, BROS) and will require an initial Reintegration Plan of Care note.
- Multi-disciplinary Polytrauma Track is reserved for Veterans that have a confirmed TBI or Polytrauma diagnosis and will be receiving one or two Polytrauma therapies and will require an initial Reintegration Plan of Care note.
- Integrated Health Rehabilitation Track is reserved for Veterans that will not be enrolled into the Polytrauma Network Site Clinic. These Veterans may or may not have a confirmed TBI or Polytrauma diagnosis, but would benefit from recommendations and co-management by a Polytrauma physician. No Polytrauma therapies will be ordered for these Veterans, but recommendations may be made for non-Polytrauma therapies (PT, OT, SLP, KT, Mental Health, etc.). These Veterans do not require a Reintegration Plan of Care note as they are not enrolled into the Polytrauma Network Site Clinic.

All Veterans seen in the Polytrauma New Evaluation Clinic are seen by a Polytrauma Social Work Case Manager, and will be assigned to that Case Manager only if they are admitted to the Polytrauma Network Site Clinic. All Veterans admitted to the PNS Clinic will be followed by a Polytrauma physician and the assigned Social Work Case Manager from initial evaluation until discharge from clinic. Interim and Discharge Reintegration Plan of Care Notes will be determined by the Polytrauma physician and will be scheduled by the Polytrauma Social Work Case Manager. This process was discussed at weekly interdisciplinary team meetings for 6 weeks prior to full implementation on February 15, 2012. Compliance will be monitored monthly beginning April 1, 2012, and will continue until three consecutive months of compliance is demonstrated.

Recommendation 10. We recommended that all required services be made available to polytrauma inpatients and that minimum staffing levels be maintained.

Concur

Target date for completion: December 31, 2012

Facility Response: At the time of the OIG survey, based on the current staffing grid requirements, the Polytrauma program met the staffing requirements, with the exception of the clinic nurse, the Clinical Nurse Leader and the nurse educator. Since the survey, the Polytrauma Rehabilitation Center has filled the nurse educator position and an occupational therapy position. The speech pathologist positions were filled at the time of survey; however, program is recruiting for two additional positions in accordance with VHA Directive 2009-028. Recruitment is ongoing for a Polytrauma Social Work Case Manager, a Clinical Nurse Leader, a family therapist, two recreation therapists, two occupational therapists, one physical therapist, a certified prosthetist and a psychologist. While recruitment is ongoing, PM & R therapists are being utilized to ensure minimum staffing levels are maintained and provide required services to Polytrauma patients. The Polytrauma Network Site has filled the clinic nurse position and the physical therapy position. Recruitment is ongoing for an occupational therapist, a certified driver trainer and Blind Rehabilitation Outpatient Specialist (BROS). The Polytrauma Center revised the open continuous recruitment posting February 2012 to include a 25% signing bonus and an Education Repayment Program (EDRP). The targeted construction completion date for the Polytrauma Transitional Rehabilitation Program (PTRP) is September 2012. Staffing recruitment will begin June 2012, with an estimated opening date December 2012.

Recommendation 11. We recommended that processes be strengthened to ensure that Case Managers consistently communicate with the inpatient and/or their family at the required intervals and that all required documentation is completed.

Concur

Target date for completion: July 6, 2012

Facility Response: All Polytrauma Rehabilitation Center inpatients have an assigned Social Work Case Manager upon admission who interacts with the patient and family prior to admission, on the day of admission and daily thereafter. These interactions are documented in the electronic medical record. The psychosocial assessment is completed and documented within 24 hours of admission and includes a psychosocial treatment plan. The Social Work Case Manager will have daily contact to continuously assess patient and caregiver needs and to ensure provision of case management services to Polytrauma patients. Social Work Case Managers received training and education on expected outcomes at the Social Work Section meeting March 19. 2012. Compliance with documentation of required contacts will be monitored monthly by the Social Work Supervisor beginning April 1, 2012, and will continue until three consecutive months of compliance is demonstrated.

Recommendation 12. We recommended that processes be strengthened to ensure that Case Managers consistently discuss inpatients' care plans with the patient and/or their family within 24 hours of the interdisciplinary team meeting.

Concur

Target date for completion: July 6, 2012

Facility Response: VHA Handbook 1172.04 *Responsibilities of the Polytrauma-TBI Case Manager* outlines the Polytrauma-TBI Case Manager is responsible for reviewing the care plan with the patient (if this does not occur in an Interdisciplinary Team (IDT) patient family conference) and providing a copy to the patient and family within 24 hours of completion of the plan. The South Texas Veterans Health Care System Polytrauma Rehabilitation Center conducts routine IDT patient family conferences on all admissions. Care plans are reviewed with patient and family during conferencing. The Social Work Case Manager is responsible to provide a copy of the care plan to patient/family and serve as liaison between patient/family and the IDT. Patient/family conferences were in place at the time of the CAP review and continue to date. This contact is documented in the electronic record; all IDT members involved are cosigned to the note as of January 2012. Social Work Case Managers received training and education on expected outcomes at the Social Work Section meeting March 19, 2012. Compliance with providing a copy of the care plan to patient/family will be monitored monthly by the Social Work Supervisor beginning April 1, 2012, and will continue until three consecutive months of compliance is demonstrated.

Recommendation 13. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: July 6, 2012

Facility Response: Moderate sedation processes were reviewed by the Moderate Sedation Committee on February 28, 2012. At this meeting, the Committee Chair informed committee members, service chiefs and providers of the appropriate template

to use and requested removal of older templates from personal files. To strengthen the process and to ensure the pre-sedation assessment documentation include all required elements, Information Technology has modified the Pre-sedation assessment to ensure mandatory categories for social history, history/physical and airway assessments. The modified template was implemented March 9, 2012. The Moderate Sedation Committee will conduct monthly audits until three consecutive months of compliance is demonstrated.

Recommendation 14. We recommended that processes be strengthened to ensure that patient vital signs are documented at 5-minute intervals during procedures where moderate sedation is used or that exceptions and reasons for exception are documented.

Concur

Target date for completion: July 6, 2012

Facility Response: Vital signs are continuously monitored and read at 5-minute intervals during all moderate sedation procedures utilizing a programmed vital signs machine. The deficiency identified by OIG during survey was that the times recorded in the medical record did not accurately correspond to these five minute intervals. During the survey, these deficiencies were reviewed immediately in the sites where found and expectations for accurate documentation of these 5-minute intervals was conveyed. An audit of compliance on March 14, 2012, confirmed 100% compliance in all sites. Formal education regarding the responsibility of the Moderate Sedation nurse to provide continuous monitoring of vital signs, to document vital signs at baseline and at 5-minute intervals during the procedure, and to document a legitimate explanation for any exception to the 5-minute interval will be completed for 100% of moderate sedation nurses by March 30, 2012. Ongoing monitoring of compliance will be conducted for each moderate sedation site until three consecutive months of compliance is demonstrated.

Recommendation 15. We recommended that processes be strengthened to ensure that clinicians administer pneumococcal vaccinations when indicated.

Concur

Target date for completion: July 6, 2012

Facility Response: The physicians and midlevels are practicing the following for assuring compliance with immunization recommendations in the CLC. As an integral part of the completion of the initial history and physical, patient's immunization status is reviewed both by using the available CPRS database and by using outside sources including patient history. Immunizations obtained in non-VA settings will be added to the CPRS database. Immunization status is assessed and listed as a separate item in the assessment. The patient is offered any immunizations which may be due. If the patient accepts the immunization, the clinician will enter an order for administration of the immunization within a week of admission. In the event the patient declines

immunization or has had an adverse effect, a note to that effect will be entered in CPRS by the patient's primary provider or the attending physician. Concurrent with renewal of medications, immunization and skin testing will be assessed on a monthly basis to determine if the patient is current with all recommended immunizations and skin tests. This monthly assessment will be included in the monthly summary progress note. All required/recommended skin tests and immunizations will be administered within a week. Attending physicians and mid levels will maintain up-to-date knowledge of immunization guidelines through a periodic review of literature. Compliance will be monitored until three (3) consecutive months of compliance is demonstrated.

Recommendation 16. We recommended that processes be strengthened to ensure that results of medical record quality reviews are reported at least quarterly to the Medical Record Committee.

Concur

Target date for completion: July 6, 2012

Facility Response: The Medical Record Committee voted and approved a recommendation to reinstate medical record quality review reporting to the Committee at the January 20, 2012, meeting. At the February 17, 2012, Medical Record Committee, a quarterly reporting calendar and reporting process was approved for immediate implementation. All clinical services will be required to submit reviews in their designated month, ensuring all clinical services report at least once each quarter. The reviews will be documented and discussed in the monthly Medical Record Committee meeting. Any opportunities for improvement identified by the Committee will be discussed with the respective Service Chief. Action plans will be required from services with opportunities for improvement. These medical record quality review reports will be a standing agenda item. This process will be presented for approval at the March 26, 2012, meeting of the Clinical Executive Board (Medical Executive Committee). The first set of quarterly reports was submitted from designated services and reviewed by the Committee at the February 17, 2012 meeting.

OIG Contact and Staff Acknowledgments

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