Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00894-216

Combined Assessment Program Review of the VA Manila Outpatient Clinic Manila, Philippines

June 18, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Manila Outpatient Clinic
FY	fiscal year
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH	women's health

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of April 8, 2013.

Review Results: The review covered 12 activities. We made no recommendations in the following four activities:

- Continuity of Care
- Emergency Management
- Women's Health
- Credentialing and Privileging

The facility's reported accomplishments were improved pharmacy processing, improved beneficiary travel claim processing, and improved access and coordination.

Recommendations: We made recommendations in the following eight activities:

Quality Management: Initiate monitoring of the copy and paste function. Ensure the Peer Review Committee meets at least quarterly or require a notation to be made if there are no cases to discuss for the quarter.

Environment of Care: Require Environment of Care and Infection Prevention/Control Committee minutes to reflect that actions taken in response to identified deficiencies are tracked to closure. Ensure laboratory specimens are transported in a secure manner, and conduct infection prevention risk assessments and monthly fire extinguisher inspections.

Medication Management – Controlled Substances Inspections: Ensure inspectors verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy, and monitor compliance.

Suicide Prevention: Ensure patients at high risk for suicide and/or their families receive a copy of the safety plan.

Vaccinations: Ensure clinicians administer tetanus vaccinations when indicated.

Diabetic Foot Care: Develop and implement a policy related to screening and referral for at-risk diabetic patients. Ensure that diabetic patients receive annual risk assessments with risk level scores and that the assessments are documented in the electronic health records. Require that diabetic patients at moderate or high risk receive foot exams at each routine primary care visit.

Management of Test Results: Consistently notify patients of critical/abnormal test results, and document notification in the electronic health records.

Management of Workplace Violence: Ensure debriefings occur after incidents of disruptive or violent behavior.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes B and C, pages 18–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objective and Scope

Objective

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 objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following 12 activities:

- QM
- EOC
- Medication Management – CS Inspections
- Continuity of Care
- Emergency Management
- Suicide Prevention
- WH
- Vaccinations
- Diabetic Foot Care
- Management of Test Results
- C&P
- Management of Workplace Violence

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012 and FY 2013 through April 8, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the*

VA Manila Outpatient Clinic, Manila, Philippines, Report No. 09-00858-113, April 21, 2009). We made a repeat recommendation in QM.

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 47 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

Improved Pharmacy Work Processes

From FY 2009 to FY 2013, the facility experienced a 15 percent increase in the number of prescriptions processed. In March 2013, the facility began automating prescription processing and redesigning the pharmacy area, which has resulted in improved timeliness of prescription processing. Prior to automation, the average number of days to process and mail a prescription was 11 days. Since implementing automation, the average number of days to process and mail a prescription has decreased to 1 day.

Beneficiary Travel

In August 2012, facility managers noted an increase in travel claims backlog. Additional staff were trained to support travel claims processing, and a beneficiary travel software package was applied. In addition, a new policy was implemented and a new template was initiated to facilitate communication between travel and medical staff. As of March 25, 2013, there was no backlog, and travel claims were being processed in less than 1 day.

New Facility

In January 2011, facility construction was completed. The new building includes the Manila VA Regional Office and Outpatient Clinic in one location. Co-locating these entities in the same building has improved accessibility to veterans and has resulted in more efficient scheduling of compensation and pension examinations and more timely completion of medical opinions and rating decisions. The compensation and pension physicians and raters meet each month to discuss and refine policies and procedures to continually improve services to veterans.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
NA	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
NA	Local policy for the use of observation beds complied with selected requirements.	
NA	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
X	The EHR copy and paste function was monitored.	Twelve months of Medical Executive Board meeting minutes reviewed: • There was no evidence of monitoring of the copy and paste function.

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
NA	Use and review of blood/transfusions complied with selected requirements.	
NA	CLC minimum data set forms were transmitted to the data center monthly.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	• During the period December 2011 through November 2012, the Peer Review Committee met only once while VHA policy requires that Peer Review Committees meet at least quarterly. This was a repeat finding.

Recommendations

1. We recommended that the facility initiate monitoring of the copy and paste function.

2. We recommended that the Peer Review Committee meets at least quarterly or that a notation be made if there are no cases to discuss for the quarter.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected all clinical areas. Additionally, we reviewed relevant documents and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Twelve months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions were consistently tracked to closure.
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	• An infection prevention risk assessment was not conducted.
X	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	Twelve months of Infection Prevention/Control Committee meeting minutes reviewed: • Minutes did not reflect that actions were consistently tracked to closure.
X	Fire safety requirements were met.	• Monthly fire extinguisher checks were not documented.
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
X	Laboratory specimens were transported securely to prevent unauthorized access.	• There was no process in place to ensure specimens were transported to community laboratories in a secure manner.
	Panic alarms/panic buttons were tested, and testing was documented.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

3. We recommended that processes be strengthened to ensure that EOC and Infection Prevention/Control Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

4. We recommended that processes be strengthened to ensure that infection prevention risk assessments are conducted.

5. We recommended that processes be strengthened to ensure that fire extinguisher inspections are conducted monthly and documented.

6. We recommended that a process be implemented to ensure that laboratory specimens are transported in a secure manner.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of the CS Coordinator and three CS inspectors and inspection documentation from the outpatient pharmacy. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
NA	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
NA	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
NA	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Six months of pharmacy CS inspection documentation reviewed: • CS inspectors did not verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that processes be strengthened to ensure that CS inspectors verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy and that compliance be monitored.

Continuity of Care

The purpose of this review was to evaluate whether information from patients' community hospitalizations at VA expense was available to facility providers.[4] Such information is essential to coordination of care and optimal patient outcomes.

We reviewed relevant documents and 12 EHRs of patients who had been hospitalized during calendar year 2012 in the local community at VA expense, and we conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Clinical information was available to the primary care team for the clinic visit subsequent to the hospitalization.	
	The facility complied with any additional elements required by VHA or local policy.	

Emergency Management

The purpose of this review was to determine whether the facility complied with requirements for addressing how medical and mental health emergencies are handled.[5]

We reviewed relevant documents and conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a local medical emergency management plan, and staff were able to articulate the procedural steps of the plan.	
	There was a local mental health emergency management plan, and staff were able to articulate the procedural steps of the plan.	
	The facility complied with any additional elements required by VHA or local policy.	

Suicide Prevention

The purpose of this review was to determine whether the facility complied with selected requirements related to suicide prevention.[6]

We reviewed relevant documents and five EHRs of patients at high risk for suicide, and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Patients had documented safety plans.	
	Patients and/or their families participated in plan development	
	Safety plans contained all required elements	
X	There was documented evidence that patients and/or their families received a copy of the plan.	• Two patients' EHRs did not contain documentation that the patients and/or their families received a copy of the plan.
	Patient record flags were placed before safety plans were developed.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

8. We recommended that processes be strengthened to ensure that patients at high risk for suicide and/or their families receive a copy of the safety plan.

WH

The purpose of the review was to determine whether the facility adequately managed WH care services not offered at the facility.[7] The facility is a foreign medical facility and offers WH care services only for service-connected conditions on a fee basis.

We reviewed relevant documents and the EHRs of 30 women veterans, and we conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Cervical cancer screening results were documented in patient EHRs.	
NA	The ordering VHA provider or surrogate was notified of results within the required timeframe.	
NA	Patients were notified of results within the required timeframe.	
NA	The facility had an appointed WH liaison.	
NA	There was evidence that the facility had processes in place to ensure that WH care needs were addressed.	
	The facility complied with any additional elements required by VHA or local policy.	

Vaccinations

The purpose of this review was to determine whether the facility complied with selected requirements related to administration of vaccinations.[8]

We reviewed relevant documents and the EHRs of 60 patients (30 who should have received tetanus vaccinations and 30 who should have received pneumococcal vaccinations), and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Staff screened patients for the tetanus vaccination and administered the vaccination when indicated.	• Four (13 percent) of the patients for whom it was indicated did not receive tetanus vaccinations.
	Staff screened patients for the pneumococcal vaccination and administered the vaccination when indicated.	
	Staff documented all required vaccine administration elements.	
	Managers developed a prioritization plan in the event of a vaccine shortage.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

9. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

Diabetic Foot Care

The purpose of this review was to evaluate compliance with selected requirements and clinical practice guidelines for diabetic foot care.[9]

We reviewed relevant documents and 28 EHRs of patients with diabetes and no lower limb amputations, and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility developed screening and referral guidelines for at-risk patients.	• The facility had not developed a policy related to screening and referral guidelines for at-risk patients.
	Clinicians documented annual foot care education for diabetic patients.	
X	Clinicians documented annual foot screening assessments with risk level scores.	• None of the EHRs contained documentation of annual risk assessments with risk level scores.
X	Patients at moderate or high risk received more frequent foot exams, therapeutic footwear, and/or orthotics.	• EHRs for three patients with documented abnormal foot exams did not indicate that the patients' feet were examined at each routine primary care visit.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that the facility develop and implement a policy related to screening and referral for at-risk diabetic patients.

11. We recommended that processes be strengthened to ensure that diabetic patients receive annual risk assessments with risk level scores and that the assessments are documented in the EHRs.

12. We recommended that processes be strengthened to ensure that diabetic patients at moderate or high risk receive foot exams at each routine primary care visit.

Management of Test Results

The purpose of this review was to evaluate whether the facility complied with selected requirements for managing test results.[10]

We reviewed relevant documents and 30 EHRs of patients who had critical laboratory or abnormal radiology results in FY 2012. In addition, we reviewed 30 EHRs of patients who had normal laboratory or radiology test results. We also conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The facility had a policy addressing the management of critical test results.	
	Providers were notified of abnormal test results.	
X	Patients were notified of abnormal test results.	• Six (20 percent) EHRs had no documented evidence of patient notification.
	Follow-up actions were taken in response to critical/abnormal test results.	
	Patients were notified of normal test results.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

13. We recommended that processes be strengthened to ensure that patients are consistently notified of critical/abnormal test results and that notification is documented in the EHRs.

C&P

The purpose of the review was to evaluate compliance with selected requirements for C&P.[11]

We reviewed relevant documents and 11 C&P folders and profiles, and we conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Licensed independent practitioners with less than a 2-year association with the facility (such as contract, fee basis, and temporary) had privileges appropriate for the length of the association.	
	Privileges granted to providers were setting, service, and provider specific.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and the results were reported to the medical staff's Executive Committee.	
	The determination to continue current privileges was based in part on results of Ongoing Professional Practice Evaluation activities.	
	The facility complied with any additional elements required by VHA or local policy.	

Management of Workplace Violence

The purpose of this review was to determine the extent to which VHA facilities managed violent incidents.[12]

We reviewed relevant documents and Reports of Contact from 10 disruptive patient incidents that occurred in FY 2012, and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The facility had policies on preventing and managing violent behavior.	
	The facility had an employee training plan that addressed preventing and managing violent behavior.	
X	Selected incidents were managed appropriately according to the facility's policies.	• For eight incidents, there was no evidence that debriefings were conducted.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

14. We recommended that processes be strengthened to ensure that debriefings occur after incidents of disruptive or violent behavior.

Facility Profile (Manila/358) FY 2013 through March 2013[a]	
Type of Organization	Outpatient clinic
Complexity Level	NA
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$12.5
Number of:	
• **Unique Patients**	4,420
• **Outpatient Visits**	12,894
• **Unique Employees**[b]	32.48
Type and Number of Operating Beds:	
• **Hospital**	0
• **CLC**	0
• **Mental Health**	0
Average Daily Census:	
• **Hospital**	NA
• **CLC**	NA
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	0
Location(s)/Station Number(s)	NA
VISN Number	21

[a] All data is for FY 2013 through March 2013.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 15, 2013

From: Director, VA Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Manila Outpatient Clinic, Manila, PI**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Attached is the OIG CAP action plan developed by the staff at the Manila Outpatient Clinic in response to a recent OIG CAP site visit.

2. I have reviewed their plan and agree with the actions that will be implemented to correct the identified deficiencies.

3. Should you have any questions about this plan, please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8370.

(original signed by:)
Sheila M. Cullen

Attachments

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 10, 2013

From: Acting Director, VA Manila Regional Office and Outpatient Clinic (358/00)

Subject: **CAP Review of the VA Manila Outpatient Clinic, Manila, PI**

To: Director, Sierra Pacific Network (10N21)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

I agree with the VA Manila Outpatient Clinic CAP review findings and recommendations. Attached is our improvement plan. We will follow-up monthly on the implementation of recommended improvement actions and provide the VISN with the results.

If you have questions, you may contact Ms. Vicki Randall, Clinic Manager and/or Ms. Socorro Torrijos, Quality Manager, VA Manila Outpatient Clinic.

Nick Pamperin

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 the facility initiate monitoring of the copy and paste function.

Concur

Target date for completion: July 31, 2013

Facility Response: The clinical providers will be educated about the appropriate use of the cut and paste function by the Quality Manager. The medical record review tool for primary and specialty care has been revised and the form now includes questions about evaluating the copy and paste function. Medical record reviews will be conducted monthly by the QA Physician and results reported monthly to delinquent provider staff and quarterly to the Medical Executive Board (MEB). The procedure section of the OPC Policy Memo 11-03 Progress Notes and Doctor's Orders was expanded to include how often chart reviews are conducted and to who the results of reviews are reported**.**

Recommendation 2. We recommended that the Peer Review Committee meets at least quarterly or that a notation be made if there are no cases to discuss for the quarter.

Concur

Target date for completion: April 30, 2013

Facility Response: The peer review policy 111-29 was revised to indicate that if no cases are identified then a memo will be generated stating such for presentation to the MEB and will be included as an attachment to those minutes.

Recommendation 3. We recommended that processes be strengthened to ensure that EOC and Infection Prevention/Control Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

Concur

Target date for completion: July 31, 2013

Facility Response: Deficiencies identified in the EOC and ICC minutes that remain open will be placed on a tracking log and will be followed and discussed at subsequent meetings until closure. The minutes as well as the tracking log will identify the Manila OPC staff who will be responsible for ensuring updates to the committees as well as

working with the appropriate staff whether that staff is within VHA, VBA or the State Department to bring the identified issue to closure. When actions on issues appear to be stalled, they will be brought to the attention of management to assist.

Recommendation 4. We recommended that processes be strengthened to ensure that infection prevention risk assessments are conducted.

Concur

Target date for completion: June 30, 2013

Facility Response: Infection Control Risk Assessment tool was developed and parameters for scoring have been identified. First assessment will be conducted June 3, 2013 and results will be reported by ICC chair to the Infection Control Committee. A summary report of the results of this assessment will be presented to the Joint Executive Board (JEB). The high risk areas will translate into a surveillance program for the clinic and become a recurring report to the Infection Control Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that fire extinguisher inspections are conducted monthly and documented.

Concur

Target date for completion: June 17, 2013

Facility Response: The EOC team will inspect Fire Extinguishers during their weekly rounds to ensure that all extinguishers have a documented inspection monthly. VHA's Biomedical engineer who is a member of the EOC team will be trained to inspect fire extinguishers in the event the State Department is unable to comply with timeliness requirements. Fire extinguishers inspections will be a part of the EOC report that is submitted to the safety committee.

Recommendation 6. We recommended that a process be implemented to ensure that laboratory specimens are transported in a secure manner.

Concur

Target date for completion: April 30, 2013

Facility Response: Revisions were made to the Specimen Collection. Specimen Transportation SOP, to include a process for securing biohazards that are transported. The process involves a security seal being placed on the transport bag (security tape has been procured) and should only be broken by the receiving staff at the reference laboratory. The reference laboratory staff will be required to sign on the receiving document that specimen integrity has not been compromised as evidenced by an intact security seal and have been instructed to contact the Manila laboratory if they identify that the integrity was breeched prior to receipt. Monitoring will be accomplished by

checking all send-outs before the specimen bag is taken to the reference laboratory and compliance will be recorded.

Recommendation 7. We recommended that processes be strengthened to ensure that CS inspectors verify hard copy prescriptions for 10 percent of the schedule II drugs dispensed in the outpatient pharmacy and that compliance be monitored.

Concur

Target date for completion: April 30, 2013

Facility Response: The Controlled Substance Inspection Checklist was revised to include verification on inspection of hardcopy scripts for controlled substances dispensed. Staff has been educated on the process and procedures. The form was implemented April 2013 and will be tracked and monitored by the Pharmacy and Therapeutics Committee and reported to the Medical Executive Board.

Recommendation 8. We recommended that processes be strengthened to ensure that patients at high risk for suicide and/or their families receive a copy of the safety plan.

Concur

Target date for completion: August 30, 2013

Facility Response: Staff were re-educated on the need to provide suicide safety plans to Veterans who are identified as high risk for suicide during their visit with Mental Health Providers. Documentation on the template will include understanding and agreement by the patient to the plan. Monitoring for compliance will be accomplished monthly by the Suicide Prevention Coordinator and results reported to the Mental Health providers and to the Medical Executive Board.

Recommendation 9. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

Concur

Target date for completion: April 30, 2013

Facility Response: Staff were re-educated on the indications for administering tetanus vaccine and the option “Patient does not remember” was taken out of the reminder since selecting this was considered as non-compliance to the reminder and should not be a part of the consideration as to whether a vaccination is necessary. Monitoring of the tetanus reminder will be included in the Performance measure dashboard which will be reported monthly to the medical staff and quarterly to the Medical Executive Board.

Recommendation 10. We recommended that the facility develop and implement a policy related to screening and referral for at-risk diabetic patients.

Concur

Target date for completion: July 31, 2013

Facility Response: A policy will be developed by the Chief Medical Officer of the Manila OPC that will delineate the process for identifying at-risk diabetic patients and the process for screening, treatment and referral as appropriate. Staff will be educated on the policy once it has been approved.

Recommendation 11. We recommended that processes be strengthened to ensure that diabetic patients receive annual risk assessments with risk level scores and that the assessments are documented in the EHRs.

Concur

Target date for completion: July 31, 2013

Facility Response: A clinical reminder is being developed that will identify risk level scores and provide guidance on appropriate actions that will be documented in the EHR. The clinical providers will be educated on the clinical reminder. Monitoring of the use of the clinical reminder will be accomplished by VISTA reports and the results will be reported to the Medical staff on a monthly basis. This element will also become a part of the performance measure dashboard which is reviewed and monitored by the Medical Executive Board.

Recommendation 12. We recommended that processes be strengthened to ensure that diabetic patients at moderate or high risk receive foot exams at each routine primary care visit.

Concur

Target date for completion: July 31, 2013

Facility Response: The clinical reminder being developed will identify Veterans who are at low, moderate or high risk. For Veterans identified as low risk, the reminder will be temporarily resolved for 9 months, moderate risk resolved for 6 months and for high risk resolved for 3 months, when appropriate interventions are taken. Primary Care Providers will be educated on the reminder and will be expected to check the CPRS cover sheet to determine if the reminder is due is every visit. If the reminder is due, the physician should process the reminder by ordering the appropriate interventions. Monitoring will be accomplished through clinical reminders reports and included in the Performance measure dashboard which is reported monthly to the medical staff and quarterly to the Medical Executive Board.

Recommendation 13. We recommended that processes be strengthened to ensure that patients are consistently notified of critical/abnormal test results and that notification is documented in the EHRs.

Concur

Target date for completion: July 31, 2013

Facility Response: Clinical providers will be re-educated with regard to procedures to report and document test results that show significant abnormalities and require immediate attention. OPC Policy Memo 11-08 Ordering and Reporting of Test Results will be revised to specify procedures for patient notification of critical/abnormal test results. Chart reviews will be conducted monthly and include review of patient notification with results being reported monthly to the medical staff and to the Medical Executive Board

Recommendation 14. We recommended that processes be strengthened to ensure that debriefings occur after incidents of disruptive or violent behavior.

Concur

Target date for completion: July 31, 2013

Facility Response: Debriefings will be conducted after every disruptive behavior incident and the debriefing form completed. Employees witnessing or subjected to disruptive behavior will be debriefed by a mental health provider within 24 hours of the incident. The employee will be scheduled to any of the mental health clinics for the debriefing session and the need for follow-up visits will be determined by the provider. Incidents of disruptive behavior are monitored by the Patient Advocate who reports these incidents to the Disruptive Behavior Committee during their quarterly meetings. Circular 00-13-08 Workplace Violence Prevention Program will be revised to include this procedure.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Daisy Arugay, MT, Team Leader Julie Watrous, RN, MS
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Keyla Gammarano, RN, MHA Jeff Joppie, BS Yoonhee Kim, Pharm.D Jackie Melendez, MPA Simonette Reyes, RN Victor Rhee, MHS Kathleen Shimoda, RN Jarvis Yu, MS

Report Distribution

VA Distribution

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Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Directive 2008-007, *Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, February 4, 2008.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

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

[4] The reference used for this topic was:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.

[5] The reference used for this topic was:
- VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.

[6] The reference used for this topic was:
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

[7] The reference used for this topic was:
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.

[8] The references used for this topic were:
- Centers for Disease Control and Prevention guidelines and VHA recommendations.

[9] The reference used for this topic was:
- VA/Department of Defense, *Clinical Practice Guideline for the Management of Diabetes Mellitus*, August 2010.

[10] The reference used for this topic was:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[11] The reference used for this topic was:
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

[12] The reference used for this topic was:
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.