Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-04242-61

Combined Assessment Program Review of the Southeast Louisiana Veterans Health Care System New Orleans, Louisiana

February 11, 2014

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

CAP	Combined Assessment Program
COS	Chief of Staff
CPRS	Computerized Patient Record System
CRRC	Community Resource and Referral Center
EHR	electronic health record
EOC	environment of care
facility	Southeast Louisiana Veterans Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
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 December 9, 2013.

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

- Continuity of Care
- Management of Workplace Violence

The facility's reported accomplishments were the Community Resource and Referral Center for homeless veterans, non-veterans, and their families and the Interdisciplinary Pain Management Program for veterans with complex pain issues who require treatment from multiple specialties.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure the Operative/Invasive Procedures Committee meets monthly, includes the Chief of Staff as a member, and documents its review of National Surgical Office reports.

Environment of Care: Ensure infection prevention risk assessments prioritize risks for acquiring and transmitting infections.

Women's Health: Enter orders for mammograms in the Computerized Patient Record System.

Medication Management: Screen patients for tetanus vaccinations at clinic visits, and document all required vaccine administration elements.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–21, 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

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Continuity of Care
- WH
- Medication Management
- 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 FYs 2012, 2013, and 2014 through December 9, 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 Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana, Report No. 10-00558-176, June 17, 2010).

During this review, we presented crime awareness briefings for 210 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 128 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

The VA and City of New Orleans' CRRC

The CRRC is a collaborative, multi-disciplinary, multi-agency endeavor that provides access to housing, medical care, crisis counseling, employment assistance, and numerous other programs for homeless veterans, non-veterans, and their families. While all of these services are critical to those in need, the primary goal of the CRRC is to provide rapid, comprehensive housing assistance to the homeless, especially those who are chronically homeless, and to assist individuals who are at imminent risk of becoming homeless to maintain their current housing. Several community partners are actively supporting CRRC operations to provide services in addition to those provided by the facility. These include legal assistance and shower/laundry services.

Interdisciplinary Pain Management Program

The Interdisciplinary Pain Management Clinic was set up to help veterans with complex pain issues who require treatment from multiple specialties. The clinic is held 2 days a month, and patients are evaluated by pain physicians and assessed by a psychologist. Depending on the need for interdisciplinary pain management service, days of operation may be increased. A Tele-health Pain Education Group is held once a month. Patients are educated about chronic pain, treatments offered at the facility, expectations, goal setting, and responsible use of opioids prior to their appointment in the Interdisciplinary Pain Management Clinic. Challenging cases are discussed at Interdisciplinary Pain Committee meetings that are held once a month. The Interdisciplinary Pain Management Program is also responsible for the Chronic Opioid Management Program Clinic, a telephone-based clinic that assists PC providers in managing patients on chronic opioid medications.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[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 area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the COS and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
NA	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Operative/Invasive Procedures Committee only met 5 times over the past 12 months. Five months of Operative/Invasive Procedures Committee meeting minutes reviewed: • The COS was not a member. • There was no evidence that National Surgical Office reports were reviewed.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
NA	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendation

1. We recommended that the Operative/Invasive Procedures Committee meet monthly, include the COS as a member, and document its review of National Surgical Office reports.

EOC

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

We inspected the PC clinic area, two specialty care clinic areas, the urgent care clinic, two MH clinics, and the x-ray and fluoroscopy areas in the radiology department. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 10 radiology employee training records. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	• The facility's infection prevention risk assessment did not prioritize risks for acquiring and transmitting infections.
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
NA	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
NA	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	

NM	Areas Reviewed for Radiology (continued)	Findings
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
NA	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

2. We recommended that processes be strengthened to ensure that infection prevention risk assessments prioritize risks for acquiring and transmitting infections.

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VHA expense was available to facility providers.[3] Such information is essential to coordination of care and optimal patient outcomes.

We reviewed the EHRs of 30 patients who had been hospitalized in the local community at VHA expense during calendar year 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

WH

The purpose of the review was to determine whether the facility complied with selected VHA requirements regarding the provision of mammography services for women veterans.[4]

We reviewed relevant documents and the EHRs of 33 women veterans, and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a Women Veterans Program Manager.	
	There was evidence that the facility had processes in place to ensure that WH care needs were addressed.	
	Contracted mammography facilities were certified by the Food and Drug Administration or are in a State approved by the Food and Drug Administration to certify mammography facilities.	
X	Mammograms were initiated via a CPRS radiology order or VistA Radiology Package order, and the results were linked to the mammography or breast study order.	• Twenty-nine (88 percent) EHRs did not contain a documented CPRS order for the mammogram.
	The mammography results were entered into the VistA Radiology Reports, and if the study was interpreted elsewhere, the report was scanned in VistA and electronically filed.	
	Mammography results were documented using the American College of Radiology's BI-RADS assessment category.	
NA	The VHA provider was notified of malignancy results within 3 days.	
	Patients were notified of normal results within the required timeframe.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

3. We recommended that processes be strengthened to ensure that orders for mammograms are entered in CPRS and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements related to administration of vaccinations.[5]

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

NM	Areas Reviewed	Findings
X	Staff screened patients for the tetanus vaccination and administered the vaccination when indicated.	• Seventeen (57 percent) EHRs lacked documentation of tetanus vaccination screening.
NA	Staff screened patients for the pneumococcal vaccination and administered the vaccination when indicated.	
X	Staff documented all required vaccine administration elements.	• None of the three patients who received tetanus vaccinations had the edition date of the Vaccine Information Statements distributed documented in his or her EHR.
	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.	

Recommendations

4. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations at clinic visits.

5. We recommended that processes be strengthened to ensure that clinicians document all required vaccine administration elements and that compliance be monitored.

Management of Workplace Violence

The purpose of this review was to determine the extent to which VHA facilities managed violent incidents.[6]

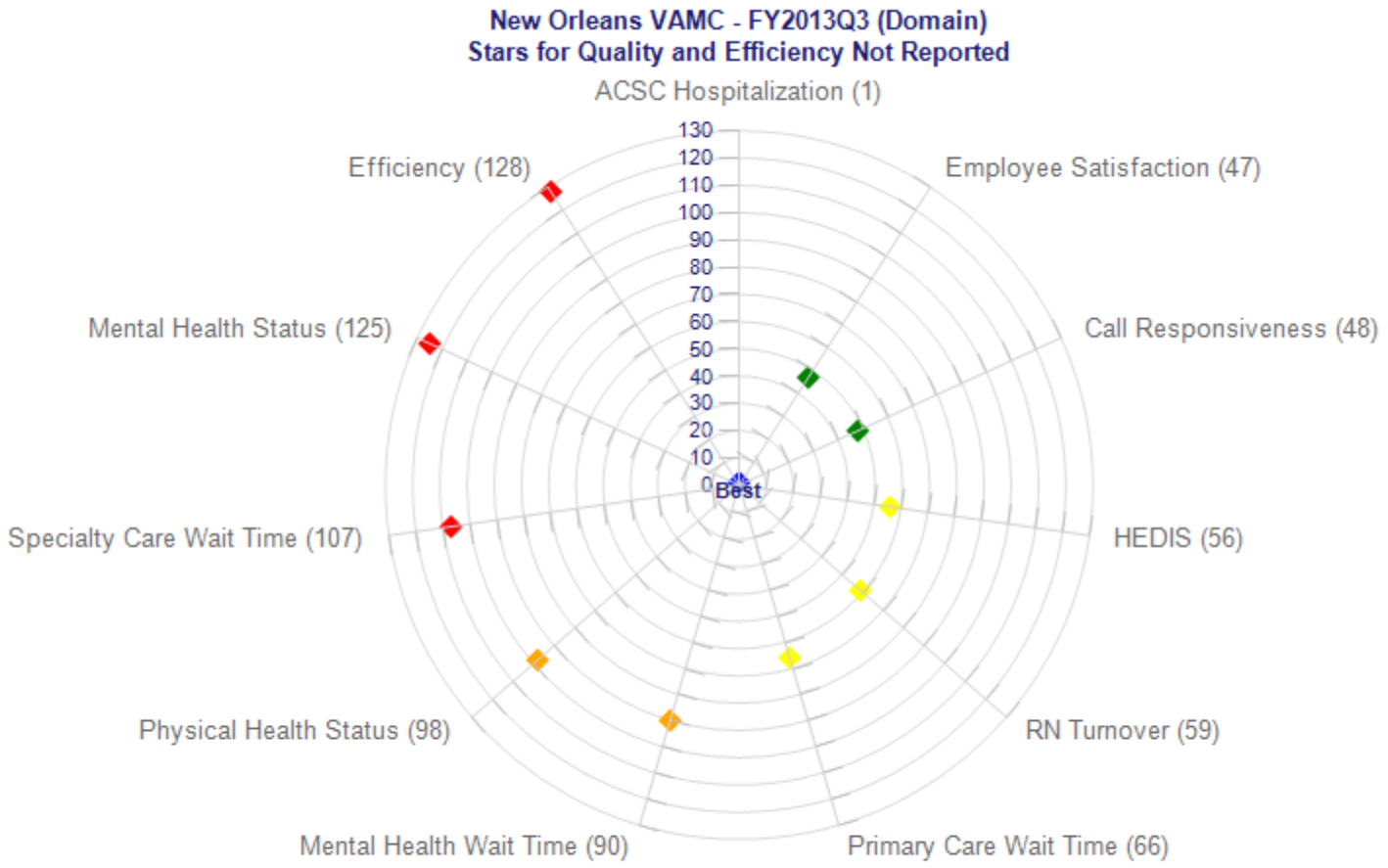
We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	The facility had policies on preventing and managing violent behavior.	
	The facility had an employee training plan that addressed preventing and managing violent behavior.	
	Selected incidents were managed appropriately according to the facility's policies.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (New Orleans/629) FY 2014 through December 2013[a]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$344.1
Number of:	
• **Unique Patients**	25,680
• **Outpatient Visits**	117,807
• **Unique Employees**[b]	1,032
Type and Number of Operating Beds (November 2013):	
• **Hospital**	N/A
• **Community Living Center**	N/A
• **MH**	N/A
Average Daily Census (November 2013):	
• **Hospital**	N/A
• **Community Living Center**	N/A
• **MH**	N/A
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Baton Rouge/629BY Houma/629GA Hammond/629GB Slidell/629GC St. John/629GD Franklin/629GE Bogalusa/629GF
VISN Number	16

[a] All data is for FY 2014 through December 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

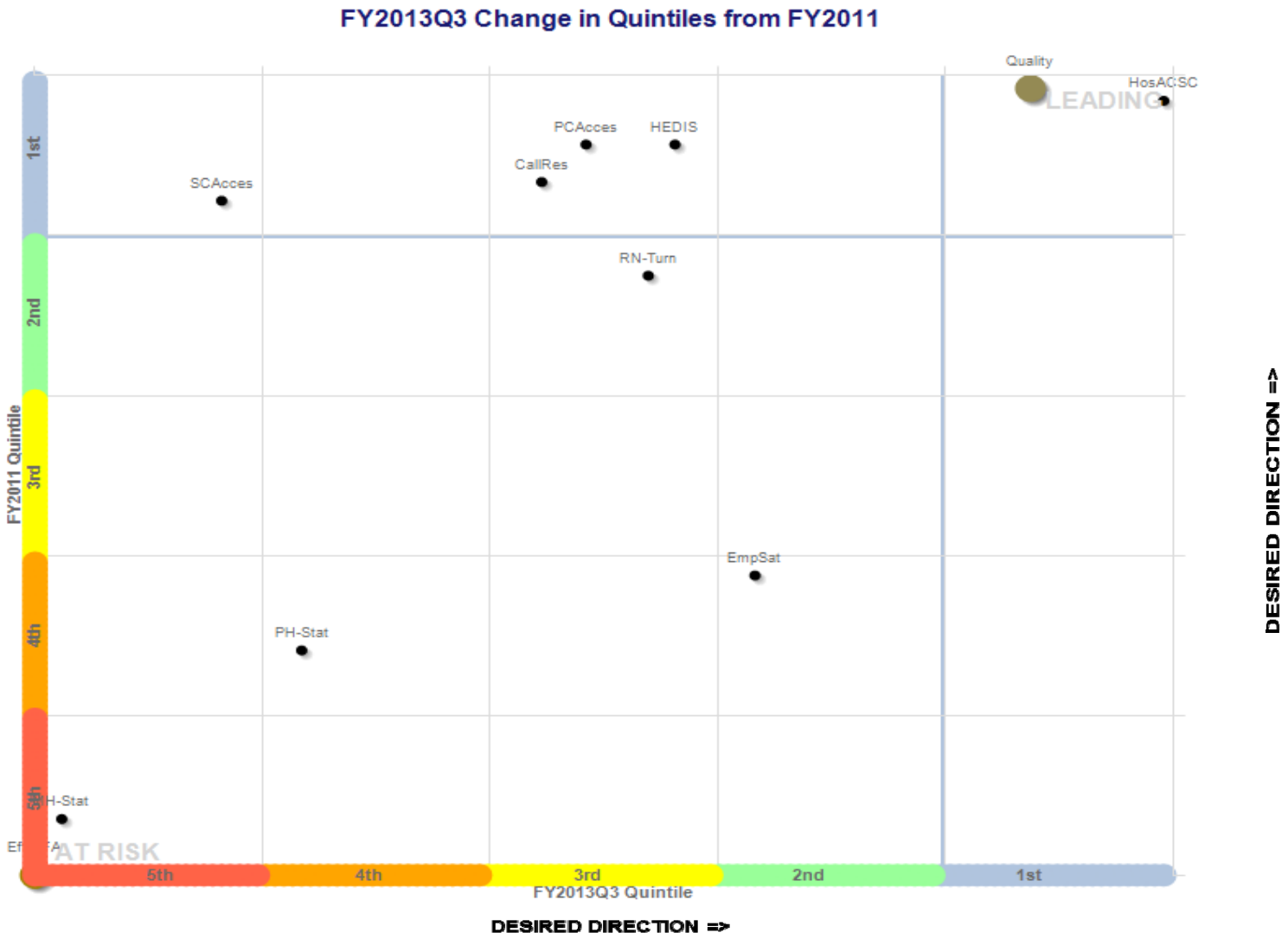
Strategic Analytics for Improvement and Learning (SAIL)[c]



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

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
PC Wait Time	PC wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 24, 2014

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Southeast Louisiana Veterans Health Care System, New Orleans, LA**

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

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the draft report submitted by the Southeast Louisiana Veterans Health Care System, New Orleans, LA.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN 16 Accreditation Specialist at (601) 206-7022.

For and in the Absence of

Rica Lewis-Payton, MHA, FACHE
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 14, 2014

From: Director, Southeast Louisiana Veterans Health Care System (629/00)

Subject: **CAP Review of the Southeast Louisiana Veterans Health Care System, New Orleans, LA**

To: Director, South Central VA Health Care Network (10N16)

1. The Southeast Louisiana Veterans Health Care System (SLVHC) concurs with the finding and submits the attached comments.

2. If you should have any questions regarding this Action Item, please contact Denise Overby-Reyes, RN, ACOS/Quality and Performance at (504) 565-4930.

Julie A. Catellier
Director, Southeast Louisiana Veterans Health Care System (629/00)

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 the Operative/Invasive Procedures Committee meet monthly, include the COS as a member, and document its review of National Surgical Office reports.

Concur

Target date for completion: Complete

Facility response: Southeast Louisiana Veterans Health Care System was unable to produce the minutes originally requested for the OIG CAP survey when requested in August 2013. Since that time, The Operative and Invasive Committee was re-organized using the Surgical Workgroup Guidelines as outlined in the VHA Handbook.

Recommended changes were put in place October 1, 2013, and to date there have been three substantial meetings (minutes reviewed by OIG on site during the survey). The minutes are sent to the Executive Committee of the Medical Staff (ECMS). Copies of the monthly meeting are regularly reviewed and monitored by Quality Management.

Recommendation 2. We recommended that processes be strengthened to ensure that infection prevention risk assessments prioritize risks for acquiring and transmitting infections.

Concur

Target date for completion: Complete

Facility response: Southeast Louisiana Veterans Health Care System's Infection Prevention Risk Assessment has been revised to a numerical system that prioritizes risk and serves as a guide for developing the Infection Prevention Plan.

Recommendation 3. We recommended that processes be strengthened to ensure that orders for mammograms are entered in CPRS and that compliance be monitored.

Concur

Target date for completion: April 1, 2014

Facility response: A new process was put in place by Ambulatory and Primary Care via the Women Veterans Program Manager in August of 2013. This process includes criteria that will ensure orders for mammograms are entered into CPRS.

- A facility report is used to identify Veterans that are due for a mammogram.
- The mammogram coordinator notifies each veteran via letter to contact the PACT team to schedule the test or send results if it was previously performed.
- Women Veterans Program Manager sends the list of veterans due for the mammogram to the RN Manager and PACT provider.
- A member of the PACT team is assigned to contact the veteran and schedule the test. They will also obtain results of the test if it was previously performed.

The Women Veterans Program Manager will use the following criteria to monitor monthly compliance and send a report to QM each month. Monitoring will continue until 90% compliance is met.

All women who have completed a mammogram in specific month
Number of women who required mammograms in specific month

Recommendation 4. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations at clinic visits.

Concur

Target date for completion: July 1, 2014

Facility response: A clinical reminder for tetanus will be developed and implemented. A random sample of 100 patient records per month of patients that should have had the tetanus vaccine will be reviewed for compliance of administration of the tetanus vaccine. Monitoring for compliance will continue until 90% compliance is achieved.

Number of patient records in compliance with receiving the tetanus vaccine
Number of patient records that should have received the tetanus vaccine

Recommendation 5. We recommended that processes be strengthened to ensure that clinicians document all required vaccine administration elements and that compliance be monitored.

Concur

Target date for completion: July 1, 2014

Facility response: The clinical reminder that is utilized to document all required vaccine administration has been updated to include the edition date of the Vaccine Information Sheet and all other required vaccine administration elements. This will strengthen the process and ensure that clinicians document appropriately.

Quality Management will review a random sample of 100 patient records monthly to ensure required documentation of the vaccine is in the medical record for those patients who received it. The review will be performed monthly until 90% compliance is reached.

Patients receiving Tetanus vaccine and all vaccine administration elements documented
Number of patients who received Tetanus vaccine for the month

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Mary L. Landrieu, David Vitter
U.S. House of Representatives: Charles W. Boustany, Jr.; William Cassidy; Vance McAllister; Cedric Richmond; Steve Scalise

This report is available at www.va.gov/oig.

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*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

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

[3] The reference used for this topic was:
- VHA Handbook 1907.01.

[4] The references used for this topic were:
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011.

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

[6] 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.