Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00659-111

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

April 7, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	VA Caribbean Healthcare System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of February 3, 2014.

Review Results: The review covered seven activities. We made no recommendations in the following three activities:

- Nurse Staffing
- Pressure Ulcer Prevention and Management
- Community Living Center Resident Independence and Dignity

The facility's reported accomplishments were receipt of funding from the Veterans Health Administration Innovation Initiative for implementation of a multisensory environment for dementia care and the caregivers support program.

Recommendations: We made recommendations in the following four activities:

Quality Management: Revise Peer Review Committee membership to ensure sufficient experienced senior physicians are regular members, and consistently report actions from peer reviews back to the committee. Require the Surgical Work Group to meet monthly. Report all critical incidents through the patient incident reporting process. Ensure that the Blood Utilization Review Committee members from Surgery and Anesthesia Services consistently attend meetings and that the blood usage review process includes the results of proficiency testing. Revise the local observation bed policy to include all required elements.

Environment of Care: Ensure Environment of Care and Administrative Executive Board Committee minutes reflect deficiencies identified on the locked mental health unit. In the radiology area, secure cabinets containing contrast agents, and document daily crash cart checks. Require all mental health unit staff and occasional mental health unit workers to complete required training. Include police response times in locked mental health unit panic alarm testing documentation.

Medication Management: Ensure the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered.

Coordination of Care: Provide patients with correct information on discharge instructions, and schedule patients' post-hospitalization outpatient appointments within the timeframe requested by the discharging physician.

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 20–26, for the full text of the Directors' comments.) We consider recommendation 13 closed. We will follow up on the planned actions for the open recommendations 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 seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

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

The review covered facility operations for FY 2013 and FY 2014 through February 3, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico,* Report No. 11-00025-144, April 14, 2011).

During this review, we presented crime awareness briefings for 264 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 205 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

Modality Treatment in Recreation Therapy

In 2013, the facility was awarded VHA Innovation Initiative funding to implement Snoezelen®, a multisensory environmental therapy. This type of therapy incorporates a specialized selection of sensory equipment and materials to assist patients with dementia in adapting to their environment.

Caregivers Support Program

In 2013, the facility provided education, counseling, and respite care for 350 caregivers of severely disabled veterans. The caregivers support program was expanded to the community based outpatient clinics at Ceiba, Guayama, and Ponce, as over half of all veterans with caregivers are followed in these clinics.

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 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
	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.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff 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.	Twelve months of PRC meeting minutes reviewed: • PRC membership did not include the expected experienced senior physicians, such as the critical care and emergency department service chiefs. • Of the 18 actions completed, 9 were not reported to the PRC.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were 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
	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 re-assessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	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 Surgical Work Group Committee met only 4 times in the past 10 months.
X	Critical incidents reporting processes were appropriate.	• In the past 12 months, one critical incident occurred that was not reported through the required process.
	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
X	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.	Three quarters of the Blood Utilization Review Committee meeting minutes reviewed: • Clinical representatives from Surgery and Anesthesia Services attended only one of three meetings. • The review process did not include results of proficiency testing.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
X	The facility met any additional elements required by VHA or local policy.	Local policy on the use of observation beds reviewed: • The policy did not include all VHA requirements, such as specific psychiatric, medical, and surgical conditions appropriate for observation bed usage or the hand-off of care to subsequent providers.

Recommendations

1. We recommended that the PRC's membership be revised to ensure that sufficient experienced senior physicians are regular members.

2. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently reported to the PRC.

3. We recommended that the Surgical Work Group meet monthly.

4. We recommended that processes be strengthened to ensure that all critical incidents are reported through the patient incident reporting process.

5. We recommended that processes be strengthened to ensure that the Blood Utilization Review Committee members from Surgery and Anesthesia Services consistently attend meetings and that the blood usage review process includes the results of proficiency testing.

6. We recommended that the local observation bed policy be revised to include all required elements.

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 locked MH, respiratory care, spinal cord, inpatient surgery, surgical intensive care, intermediate surgical intensive care, and open heart intensive care units and two CLC units. We also inspected the emergency department; the radiology area; and the chemotherapy, MH outpatient, and patient aligned care team clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 33 employee training records (11 radiology employees, 10 MH unit employees, 6 Multidisciplinary Safety Inspection Team members, and 6 occasional MH unit workers). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Eight months of EOC and 9 months of Administrative Executive Board Committee meeting minutes reviewed: • Minutes did not reflect discussion of deficiencies identified on the locked MH unit.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	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	
	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.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
X	Medication safety and security requirements in x-ray and fluoroscopy were met.	• Contrast agents were stored in an unlocked, unattended cabinet. • Crash cart inspections were not completed daily for the last 6 months.
	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	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
X	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.	• Four MH unit staff and four occasional MH unit workers had not completed training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.

NM	Areas Reviewed for Acute MH (continued)	Findings
X	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	• Documentation of panic alarm testing did not include police response time.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

7. We recommended that processes be strengthened to ensure that EOC and Administrative Executive Board Committee minutes reflect deficiencies identified on the locked MH unit.

8. We recommended that processes be strengthened to ensure that cabinets containing contrast agents in the radiology area are secured at all times and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that crash cart checks in the radiology area are documented daily and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that all MH unit staff and occasional MH unit workers receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that panic alarm testing documentation includes police response times and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 33 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
X	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	• Five EHRs (15 percent) did not reflect that the medication list provided to the patient/caregiver at discharge had been reconciled with the dosage and frequency ordered.
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that processes be strengthened to ensure that the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 28 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. 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
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	• Eight patients received discharge instructions that contained incorrect and conflicting information on the note template used by the facility.
X	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	• Seven patients did not have their post-hospitalization appointments scheduled within the timeframe requested by the discharging physician.
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that processes be strengthened to ensure that patients are provided with correct information on discharge instructions.

14. We recommended that processes be strengthened to ensure that patients' post-hospitalization outpatient appointments are scheduled within the timeframe requested by the discharging physician.

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 26 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 3 randomly selected units—acute medical/surgical unit 5K, CLC unit CLC-1, and MH unit PAICU—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 30 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 10 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NM	Areas Reviewed (continued)	Findings
	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 14 EHRs of residents (8 residents receiving restorative nursing services and 6 residents not receiving restorative nursing services but candidates for services). We also observed two meal periods, reviewed nine employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

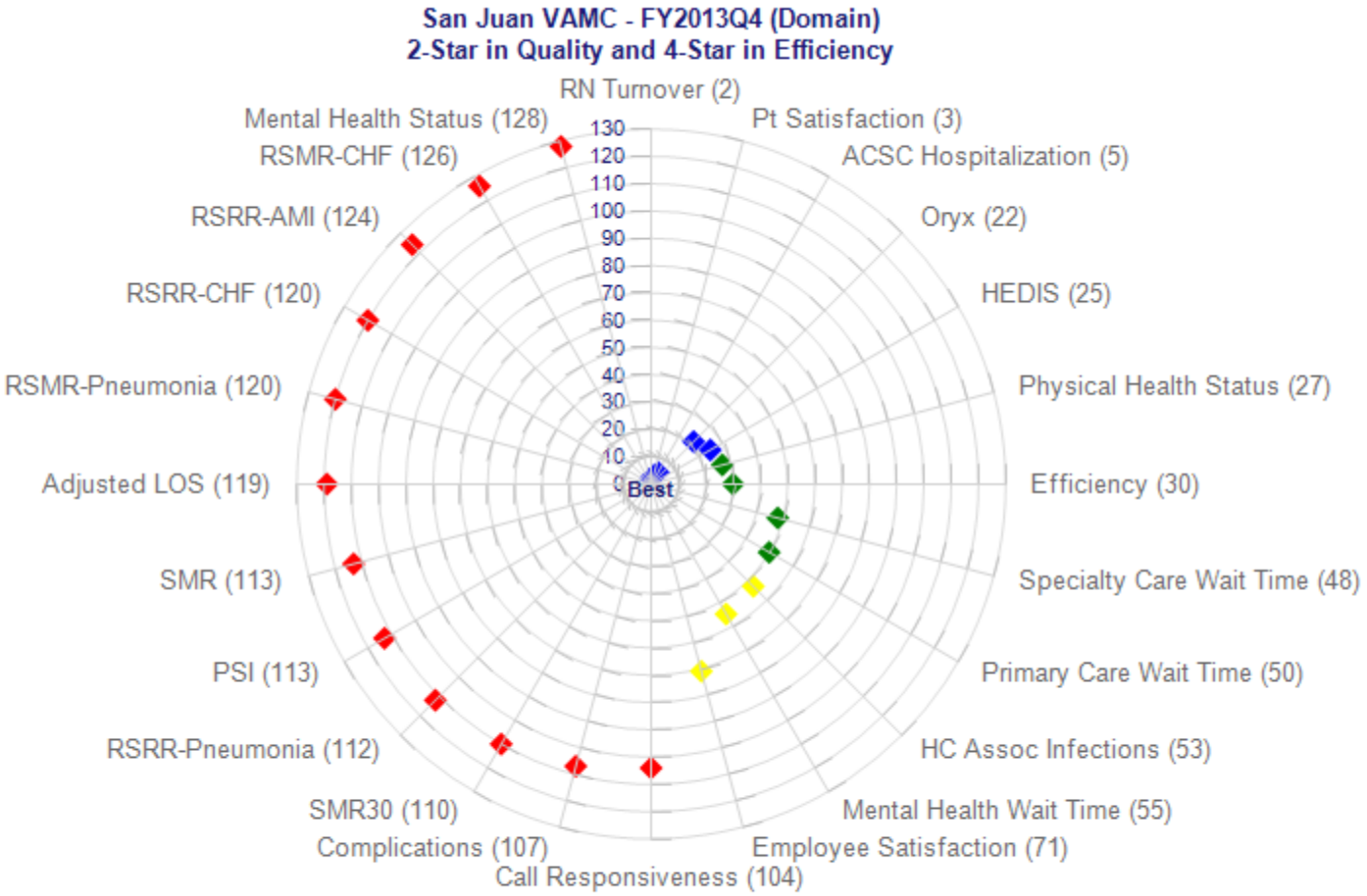
NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.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

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

Facility Profile (San Juan/672) FY 2014 through March 2014[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$489.2
Number of:	
• **Unique Patients**	57,509
• **Outpatient Visits**	438,641
• **Unique Employees**[b]	2,919
Type and Number of Operating Beds (January 2014):	
• **Hospital**	270
• **CLC**	122
• **MH**	30
Average Daily Census (February 2014):	
• **Hospital**	214
• **CLC**	110.3
• **MH**	27.2
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Ponce/672B0 Mayaguez/672BZ St. Croix/672GA St. Thomas/672GB Arecibo/672GC Ceiba/672GD Guayama/672GE
VISN Number	8

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

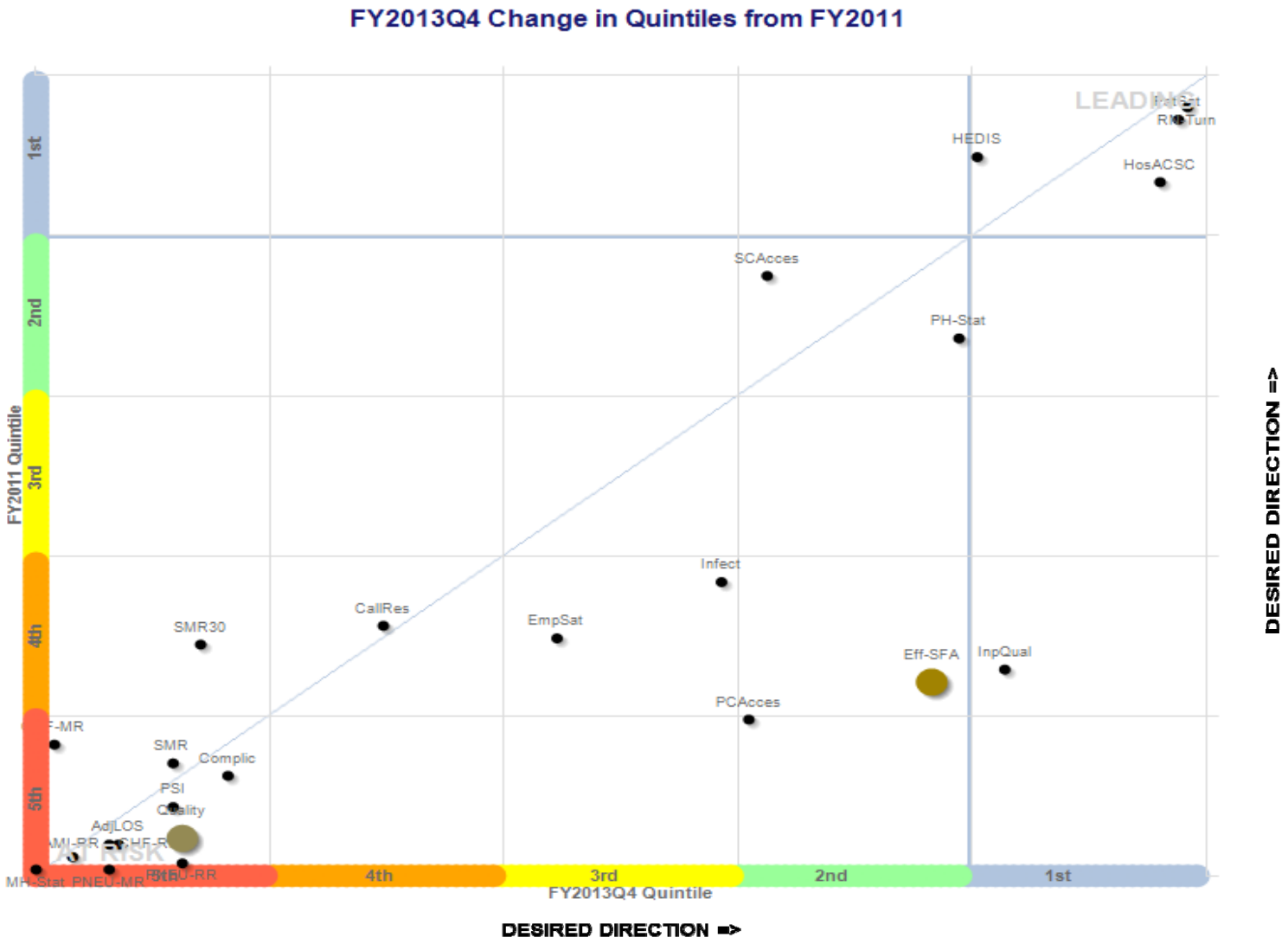
Strategic Analytics for Improvement and Learning (SAIL)[c]



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
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 18, 2014

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

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

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

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

1. I have reviewed and concur with the CAP Review of the VA Caribbean Healthcare System conducted on February 3–7, 2014.

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

Joleen Clark

Joleen Clark, MBA, FACHE

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 18, 2014

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

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

To: Director, VA Sunshine Healthcare Network (10N08)

1. I have reviewed and concur with the CAP Review of the VA Caribbean Healthcare System, San Juan, PR on February 3–7, 2014.

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

for DEWAYNE HAMLIN, MD

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 PRC's membership be revised to ensure that sufficient experienced senior physicians are regular members.

Concur

Target date for completion: March 31, 2014

Facility response: The Center Memorandum 00-13-83 "Peer Review Process for Quality Management" was reviewed with the Chief of Staff and routing for concurrences began Mar 13, 2014. These changes will address the composition of the Peer Review Committee.

Recommendation 2. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently reported to the PRC.

Concur

Target date for completion: To initiate on March 28, 2014

Facility response: Service Chiefs and their program support assistants will be engaged in the process of follow-up of actions. Risk Manager created a tracking grid to follow up cases. A status report will be provided monthly and discussed in Peer Review Committee.

Recommendation 3. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: Completed March 7, 2014

Facility response: This work group is chaired by the Surgery Service Chief and meetings are scheduled to take place the first Friday of each month. This has already started on March 7, 2014.

Recommendation 4. We recommended that processes be strengthened to ensure that all critical incidents are reported through the patient incident reporting process.

Concur

Target date for completion: Completed Effective Immediately

Facility response: Once the adverse event occurs, the first person to be aware is responsible to complete the electronic incident report (Form 10-26-33).

1. Surgery staff completes the critical incident report through the Critical Incident Tracking Notification (CITN) system and reports the same event in the Patient Safety Electronic Incident Report Program. Once the Patient Safety Manager is aware of the event, it will be closely followed up with the Chief of Surgery for timely reporting and further actions.

2. Monthly crosscheck will be performed between Surgery Service and Patient Safety Office to corroborate that required events are reported through the VACHS Electronic Incident Report System.

Recommendation 5. We recommended that processes be strengthened to ensure that the Blood Utilization Review Committee members from Surgery and Anesthesia Services consistently attend meetings and that the blood usage review process includes the results of proficiency testing.

Concur

Target date for completion: May 30, 2014

Facility response: Surgery Service and Anesthesia Section have appointed a representative to be part of the Blood Bank Committee (BBC). The Center Memo of the committee is under review with new membership added and will be completed by May 30, 2014. Proficiency reports are part of the standing agenda of the BBC.

Recommendation 6. We recommended that the local observation bed policy be revised to include all required elements.

Concur

Target date for completion: April 30, 2014 – In Progress

Facility response: The local observation bed SOP will be changed to a Center Memorandum under Medicine Service responsibility. The Center Memo will include all diagnoses required by the VHA Directive 1036 as well as the timeframe for observation. The Center memo is under revision and the team is working on the implementation of the different actions to address required elements.

Recommendation 7. We recommended that processes be strengthened to ensure that EOC and Administrative Executive Board Committee minutes reflect deficiencies identified on the locked MH unit.

Concur

Target date for completion: March 17, 2014

Facility response: The deficiencies identified on the locked MH unit are part of the standing agenda of the Environment of Care (EOC), starting February 2014, as recommended. First report was presented at the Administrative Executive Board (AEB) on March 17, 2014 and will be a standard item in the agenda.

Recommendation 8. We recommended that processes be strengthened to ensure that cabinets containing contrast agents in the radiology area are secured at all times and that compliance be monitored.

Concur

Target date for completion: February 14, 2014

Facility response: It is the policy of radiology department to assure all medications are secured at all times. Every cabinet with contrast and medication carts are to be locked at all times. The Radiology Nurse Supervisor, Radiology nursing staff and technologists have been reeducated on this policy. Nurse Supervisor will be in charge of monitoring compliance of this on a daily basis with support of CT and MRI supervisor. Any incident where a medication cart or cabinet is left unlocked or unattended the Chief of Radiology Service and Radiology Administrator will be notified. Compliance of the policy will be reported in quarterly radiology Quality Improvement Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that crash cart checks in the radiology area are documented daily and that compliance be monitored.

Concur

Target date for completion: February 7, 2014 – Monitor compliance on the next Quarterly Service Quality Improvement Committee Meeting May 1, 2014.

Facility response: Radiology Crash Cart Check Policy establishes that all radiology department crash carts need to be checked daily including weekends and holidays. Each section supervisor is responsible for evaluating daily the crash cart check list documentation is in place with signature. The Radiology Nurse Supervisor has been assigned as person in charge of overseeing all department crash carts documentation for completeness. Every Monday morning, the Radiology Nurse Supervisor will evaluate all department crash carts for daily check compliance. Any missing signature will be immediately informed via email to Radiology Service Chief and Radiology Administrator for action. In addition, the first Thursday of each month, the Nurse supervisor will inform Radiology Service Chief and Radiology Administrator status for crash cart documentation via email. This data will then be collected quarterly and informed at the Radiology Department Quality Improvement Committee as part of Performance Measure Tracking. The minutes to these meetings will be sent to Chief of Staff Office.

Recommendation 10. We recommended that processes be strengthened to ensure that all MH unit staff and occasional MH unit workers receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: July 31, 2014

All new employees were identified by December 31, 2013 who may have the potential to work in mental health. Education assigned these employees to attend M & H Checklist Training on December 31, 2013. The employee list for new and existing employees the may work in mental health will also be verified weekly by the Section Chiefs. Additionally, refresher training for Facility Management Services (FMS) will be started effective July 2014 and will be held twice a year. Employee list will be verified on April 15, 2014.

Recommendation 11. We recommended that processes be strengthened to ensure that panic alarm testing documentation includes police response times and that compliance be monitored.

Concur

Target date for completion: February 2014 – and Ongoing

Facility response: Police Service will test panic alarm on a monthly basis and the response time will be measured on a monthly basis. This requirement will be documented in the daily operations journal and the monthly alarm test report.

Recommendation 12. We recommended that processes be strengthened to ensure that the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered and that compliance be monitored.

Concur

Target date for completion: Completed February 5, 2014 and Monitor ongoing

Providers were educated on February 5, 2014 about the importance of reconciliation of Medication lists between discharge instructions and the discharge summary. This will be monitored on an ongoing basis to observe compliance in the performance measure report. The results of the monitor will be discussed at the Patient Safety Committee.

Recommendation 13. We recommended that processes be strengthened to ensure that patients are provided with correct information on discharge instructions.

Concur

Target date for completion: February 4, 2014

Facility response: Discrepancy between English and Spanish Discharge instructions templates for patients with Congestive Heart Failure were corrected the day of the findings.

Recommendation 14. We recommended that processes be strengthened to ensure that patients' post-hospitalization outpatient appointments are scheduled within the timeframe requested by the discharging physician.

Concur

Target date for completion: May 15, 2014

Facility response: Ward clerks and their supervisors were trained on March 15, 2014, on the usage of Appointment management option in VISTA. Scheduling modules and soft skills training are being taken by ward clerks and their supervisors 24 of 26 clerks completed all Scheduling modules and soft skills training. Position descriptions were updated to include this function. Ward clerks will assume the responsibility on May 15, 2014 to provide follow up appointments to all discharged patients immediately upon discharge from wards 24/7 based on MD Instructions. Local reporting mechanism will be in place to identify discharges without follow up appointments within 14 days. Local report is under development and will be completed by April 15, 2014.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Alice Morales-Rullan, MSN, RN, Team Leader Charles H. Cook, MHA David Griffith, RN Karen McGoff-Yost, MSW, LCSW Carol Torczon, MSN, ACNP David Spilker, Resident Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Darlene Conde-Nadeau, MSN, ARNP Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Jackelinne Melendez, MPA Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

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Endnotes

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