Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01290-222

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

July 24, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(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	South Texas Veterans Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
tPA	tissue plasminogen activator
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 May 5, 2014.

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

- Coordination of Care

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure the Blood Utilization Committee member from Surgery Service consistently attends meetings.

Environment of Care: Ensure patient care areas are clean. Repair damaged doors and floors and rusted lockers in patient care areas. Ensure damaged furniture in patient care areas is repaired or removed from service.

Medication Management: Complete and document discharge progress notes or patient discharge instructions.

Acute Ischemic Stroke Care: Complete and document the National Institutes of Health Stroke Scale for each stroke patient. Provide printed stroke education to patients upon discharge. Ensure staff involved in assessing and treating stroke patients receive the training required by the facility. Collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans. Document resident progress towards restorative nursing goals and the reasons for not providing restorative nursing services when those services are care planned. Ensure the restorative registered nurse or designee signs and provides feedback, if indicated, on restorative aide notes.

Magnetic Resonance Imaging Safety: Conduct initial patient safety screenings. Complete secondary patient safety screenings immediately prior to magnetic resonance imaging (MRI). Ensure that Level 2 MRI personnel review secondary patient safety screenings on the same day as the MRI and that Level 2 MRI personnel conducting secondary patient safety screenings sign the forms prior to MRI. Require that radiologists and/or Level 2 MRI personnel document resolution of all identified contraindications in patients' electronic health records prior to the scan. Ensure all designated Level 1 ancillary staff receive annual level-specific MRI safety training.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–28, 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 seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

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, FY 2013, and FY 2014 through May 5, 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 South Texas Veterans Health Care System, San Antonio, Texas,* Report No. 12-00370-156, April 17, 2012).

During this review, we presented crime awareness briefings for 330 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 589 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.

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.[a]

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 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.	
	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 reassessed 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.	
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely 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
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.	Twelve months of Blood Utilization Committee meeting minutes reviewed: • The clinical representative from Surgery Service attended only 5 of 10 meetings.
	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 processes be strengthened to ensure that the Blood Utilization Committee member from Surgery Service consistently attends meetings.

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 the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

At the San Antonio division, we inspected medical, surgical, medical intensive care, and MH inpatient units; the eye clinic; the emergency department; SDS; the PACU; and the two CLCs. At the Kerrville division, we inspected the eye clinic and two CLCs. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 35 employee training records (10 SDS, 10 operating room, 10 PACU, and 5 eye clinic). 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.	
	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.	
X	Environmental safety requirements were met.	• Four of nine patient care areas had dirty floors and/or bathrooms. • Four of nine patient care areas had damaged floors, damaged doors, and/or rusted patient lockers. • Five of nine patient care areas had damaged furniture.
	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.	

NM	Areas Reviewed for SDS and the PACU	Findings
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

2. We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that damaged doors and floors and rusted lockers in patient care areas are repaired and that ongoing maintenance be monitored.

4. We recommended that processes be strengthened to ensure that damaged furniture in patient care areas is repaired or removed from service.

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.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 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.	
X	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	• Twenty-nine EHRs (85 percent) did not contain documented physician discharge progress notes or discharge instructions.
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent 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

5. We recommended that processes be strengthened to ensure that physicians complete and document discharge progress notes or patient discharge instructions and that compliance be monitored.

Coordination of Care

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 29 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. 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
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	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.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether VHA facilities complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 43 randomly selected patients who experienced stroke symptoms, and 10 employee training records, and we conversed with key employees. We also conducted onsite inspections of the emergency department, one critical care unit, and two acute inpatient units. 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
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health Stroke Scale for each patient within the expected timeframe.	• Thirty of the 34 applicable EHRs (88 percent) did not contain documented evidence of completed stroke scales.
NA	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 30 applicable EHRs contained documentation that stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• Three employees had not completed the web-based training required by the facility.
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and/or reported to VHA: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

6. We recommended that processes be strengthened to ensure that clinicians complete and document the National Institutes of Health Stroke Scale for each stroke patient and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that staff who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

9. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

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.[f]

We reviewed 11 EHRs of residents (10 residents receiving restorative nursing services and 1 resident not receiving restorative nursing services but a candidate for services). We also observed three residents during 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. 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
	The facility offered restorative nursing services.	
X	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.	• In 5 of the 10 applicable EHRs, there was no documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• In five of the nine applicable EHRs, there was no evidence that facility staff documented resident progress towards restorative nursing goals.
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• None of the five EHRs where restorative nursing services were care planned but not provided reflected the reasons.
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on additional signature and feedback on the restorative aide note by the restorative registered nurse or designee, when indicated, reviewed: • None of the 10 applicable patients' EHRs contained restorative aide notes with additional signatures.

Recommendations

10. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that staff document the reasons for not providing restorative nursing services when those services are care planned and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that the restorative registered nurse or designee signs and provides feedback, if indicated, on restorative aide notes.

MRI Safety

The purpose of this review was to determine whether VHA facilities ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 29 employees (23 randomly selected Level 1 ancillary staff and 6 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 34 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. 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
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Fifteen of the 34 EHRs (44 percent) did not contain initial patient safety screenings. • Six of the 34 EHRs (18 percent) did not contain secondary patient safety screenings prior to MRI. • Four of the 28 secondary patient safety screening forms were not reviewed by Level 2 MRI personnel on the same day as the MRI. • Twenty-four of the 28 secondary patient safety screening forms were not signed by a Level 2 MRI personnel prior to MRI.
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Sixteen of the 21 applicable EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Twelve Level 1 ancillary staff did not receive level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	

NM	Areas Reviewed (continued)	Findings
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

14. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that secondary patient safety screenings are reviewed by Level 2 magnetic resonance imaging personnel on the same day as the magnetic resonance imaging and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to magnetic resonance imaging and that compliance be monitored.

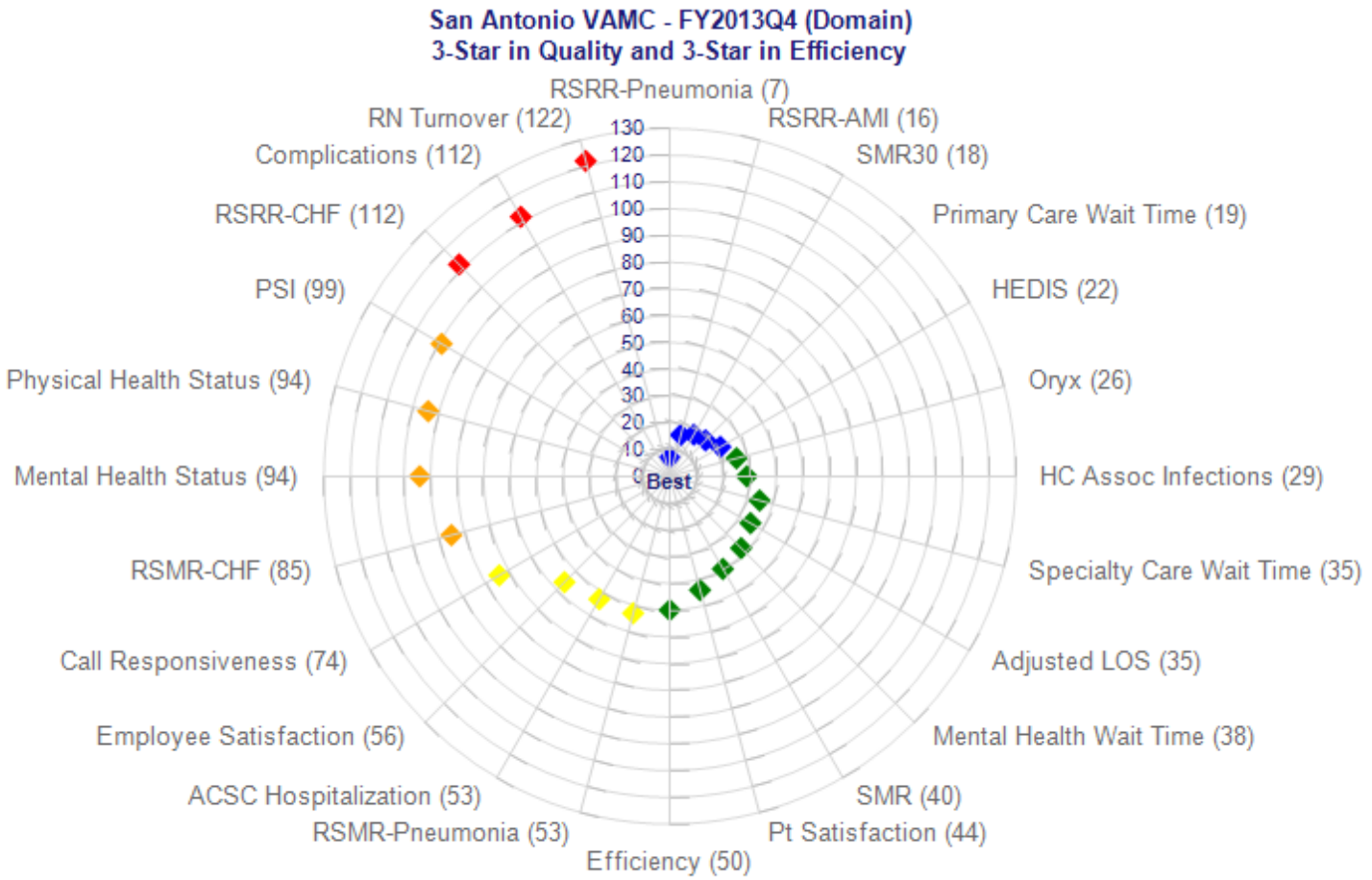
18. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

19. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Facility Profile (San Antonio/671) FY 2014 through May 2014[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$658.2
Number of:	
• **Unique Patients**	73,118
• **Outpatient Visits**	678,318
• **Unique Employees**[2]	2,948
Type and Number of Operating Beds (April 2014):	
• **Hospital**	250
• **CLC**	185
• **MH**	66
Average Daily Census (April 2014):	
• **Hospital**	150
• **CLC**	133
• **MH**	57
Number of Community Based Outpatient Clinics	15
Location(s)/Station Number(s)	McAllen/671B0 Frank M. Tejeda/671BY Corpus Christi/671BZ Harlingen/671GA Victoria/671GB Del Rio/671GC Laredo/671GE South Bexar/671GF Beeville/671GH Kingsville/671GI Uvalde/671GJ San Antonio PCN/671GK New Braunfels/671GL Seguin/671GN San Antonio/671GO
VISN Number	17

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

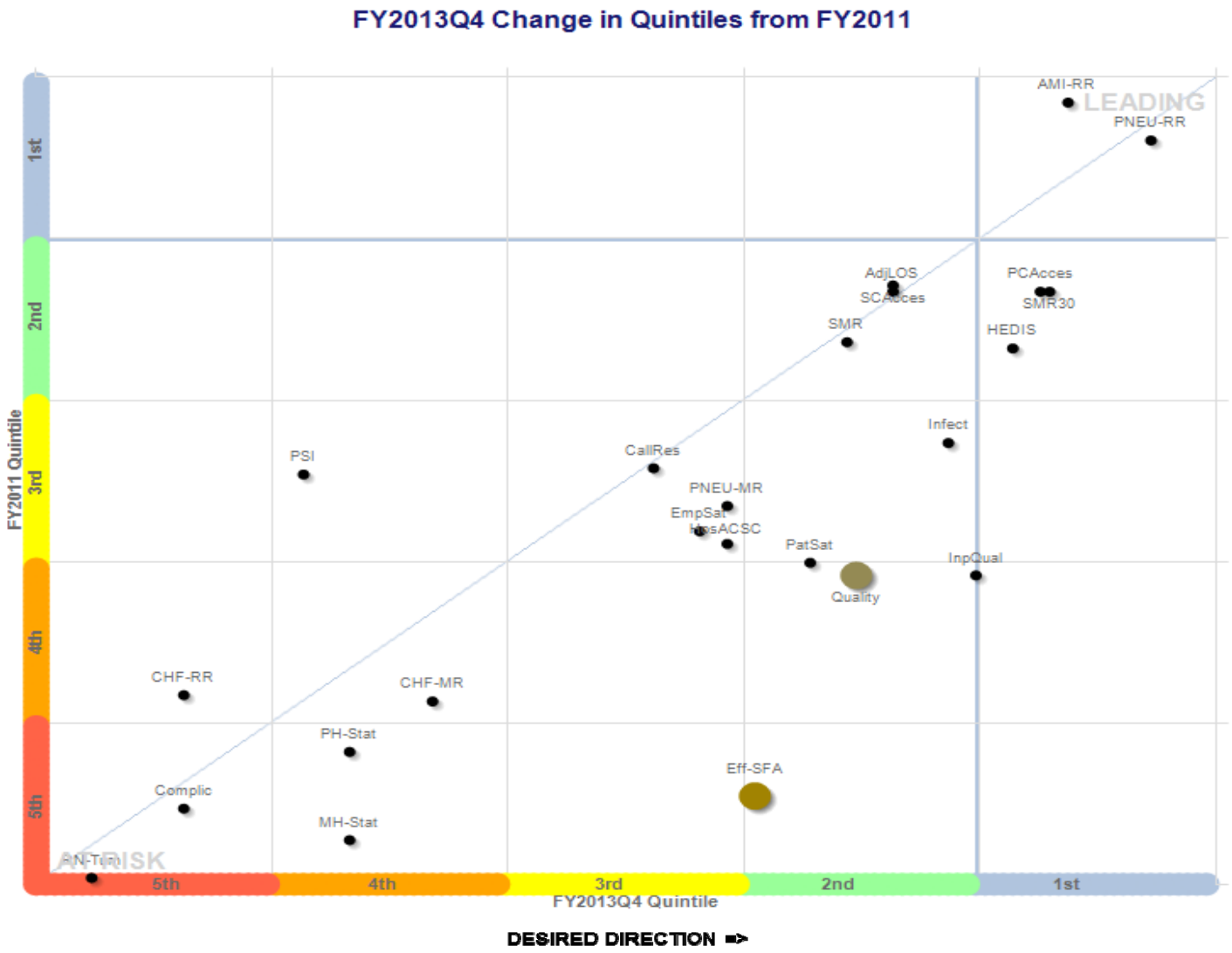
Strategic Analytics for Improvement and Learning (SAIL)[3]



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.

[3] 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

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 25, 2014

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

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

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

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

1. Thank you for allowing me to respond to this CAP review of South Texas Veterans Health Care System.

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

3. If you have further questions regarding this review, please contact Denise B. Elliott, Quality Management Officer at 817-385-3734.

Wendell E. Jones, MD, MBA
Acting Director, VA Heart of Texas Health Care Network (10N17)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 25, 2014

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

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

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

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

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

Marie L Weldon

MARIE L. WELDON, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the Blood Utilization Committee member from Surgery Service consistently attends meetings.

Concur

Target date for completion: 8/1/14

Facility response: The Surgical Service representative has been identified as a standing member of the Blood Utilization Committee. If member is unable to attend they must send a substitute in their place. Compliance will be monitored through the committee attendance roster.

Recommendation 2. We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: 8/31/14

Facility response: To ensure cleanliness of patient care areas, EMS supervisors will perform daily inspection of patient care areas and document findings. Findings will be communicated with EMS staff responsible for that area to ensure findings are corrected. Supervisors will document that the inspections were performed daily on each patient care area and that findings were corrected.

Recommendation 3. We recommended that processes be strengthened to ensure that damaged doors and floors and rusted lockers in patient care areas are repaired and that ongoing maintenance be monitored.

Concur

Target date for completion: 9/30/14

Facility response: On June 2, 2014, Engineering Service initiated monthly Engineering Walk Through Rounds of all patient care areas to provide ongoing maintenance monitoring to identify items in patient care areas requiring repair. During the monthly walks, work orders will be generated to correct issues observed and will be tracked until completed. Patient Care Services will continue to report any environmental issues requiring immediate attention through the work order process.

Recommendation 4. We recommended that processes be strengthened to ensure that damaged furniture in patient care areas is repaired or removed from service.

Concur

Target date for completion: 8/31/14

Facility response: The identified damaged furniture was immediately removed from patient care areas. To ensure ongoing compliance, the Interior Designer was added as a member of the Environment of Care (EOC) Team to perform bi-weekly rounds throughout the facility to assess and correct any newly identified damaged furniture. Employee education regarding the proper method for requesting repairs or replacement furniture will be incorporated within the facility's weekly newsletter and/or on the intranet.

Recommendation 5. We recommended that processes be strengthened to ensure that physicians complete and document discharge progress notes or patient discharge instructions and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: A discharge progress note for use by providers has been implemented to ensure that providers complete and document a discharge progress or discharge planning instructions. Compliance will be monitored through the retrospective review process of all discharges for the prior month until compliance is greater than 90% for 3 consecutive months.

Recommendation 6. We recommended that processes be strengthened to ensure that clinicians complete and document the National Institutes of Health Stroke Scale for each stroke patient and that compliance be monitored.

Concur

Target date for completion: 9/1/14

Facility response: All neurology clinicians have been re-educated on the requirements to complete and document the National Institutes of Health Stroke Scale for each stroke patient in the electronic health record within the expected timeframe. Quality Management will monitor all Acute Ischemic Stroke cases reported in IPEC for a period of not less than 90 days to ensure 100% compliance.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: 9/1/14

Facility response: At the time of discharge, nursing staff provides printed stroke educational materials to stroke patients. This is documented in the patient's electronic health record. Quality Management will monitor all Acute Ischemic Stroke cases reported in IPEC for a period of not less than 90 days to ensure 100% compliance.

Recommendation 8. We recommended that processes be strengthened to ensure that staff who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target date for completion: 10/1/14

Facility response: Facility policy requires that staff who are involved in assessing and treating stroke patients to include ED, ICU and Neurology providers, ED and ICU staff nurses will receive TMS web-based training on the recognition and identification of patients with acute ischemic stroke symptoms. This education will occur once at orientation and should be completed within 90 days of employment. Additional educational opportunities will be provided on an as needed basis. Compliance will be monitored to ensure that not less than 90% of identified staff receive required web based training.

Recommendation 9. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: 9/1/14

Facility response: IPEC has been updated with Acute Ischemic Stroke data for the period October 2013 to May 2014. Required data will continue to be entered into the IPEC tool for the previous month following review and approval at the monthly Acute Ischemic Stroke meeting.

Quality Management will collect data on 100% of Acute Ischemic Stroke cases for entry into IPEC. Quality Management will monitor all Acute Ischemic Stroke cases reported in IPEC for a period of not less than 90 days to ensure 100% compliance. Compliance will be documented in the minutes.

Recommendation 10. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: 9/30/14

Facility response: Training was provided on documentation of restorative services to staff on May 14, 2014 by the restorative registered nurse to ensure staff provide and document restorative services according to clinician orders and/or residents' care plans. Documentation will be monitored monthly by the restorative nurse to ensure 90% or greater compliance for three consecutive months.

Recommendation 11. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

Concur

Target date for completion: 9/30/14

Facility response: The restorative nurse assessment template was revised on May 23, 2014, to include mandatory fields requiring documentation of residents' progress towards restorative nursing goals by staff. Compliance will be monitored monthly by the restorative nurse to ensure 90% or greater compliance for three consecutive months.

Recommendation 12. We recommended that processes be strengthened to ensure that staff document the reasons for not providing restorative nursing services when those services are care planned and that compliance be monitored.

Concur

Target date for completion: 9/30/14

Facility response: The restorative aide note was revised on May 23, 2014, to include areas for staff to document reasons for not providing restorative services or patient refusal of services according to care plan. Documentation will be monitored monthly by the restorative nurse to ensure 90% or greater compliance for three consecutive months.

Recommendation 13. We recommended that processes be strengthened to ensure that the restorative registered nurse or designee signs and provides feedback, if indicated, on restorative aide notes.

Concur

Target date for completion: 9/30/14

Facility response: Restorative RNs who have completed the restorative service training are designated as additional signers for restorative aide's notes. This will ensure the restorative aide notes are reviewed and restorative aides are provided feedback on restorative services, if needed, in a timely manner. Documentation will be monitored monthly by the restorative nurse to ensure 90% or greater compliance for three consecutive months.

Recommendation 14. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

Concur

Target date for completion: 9/30/14

Facility response: STVHCS Imaging Services will develop an electronic Initial Patient Safety Screening form by June 14, 2014, that contains mandatory fields which require ordering providers to answer pre-screening questions at the same time of ordering any MRI examination. The prescreening questions will be visible on each MRI request and exams will not be scheduled until prescreening is completed. Providers will be notified to complete the required screening. Imaging Services will monitor all MRI requests for each month for a period of not less than 90 days to ensure compliance.

Recommendation 15. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 10/31/14

Facility response: The secondary screenings will be required to be completed immediately prior to any MRI examination and will be signed by the technologist. Imaging Services will monitor all monthly MRI requests for completion of the screening prior to MRI for a period of not less than 90 days to ensure 90% or greater compliance.

Recommendation 16. We recommended that processes be strengthened to ensure that secondary patient safety screenings are reviewed by Level 2 magnetic resonance imaging personnel on the same day as the magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 10/31/14

Facility response: To ensure that all MRI Level 2 trained personnel review and sign the secondary patient safety screening forms on the same day as MRI procedures, Imaging Services will monitor all monthly MRI requests for the presence of a signature for a period of not less than 90 days to ensure 90% or greater compliance.

Recommendation 17. We recommended that processes be strengthened to ensure that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 10/31/14

Facility response: To ensure that all MRI Level 2 trained personnel sign the secondary patient safety screening form prior to MRI procedures, Imaging Services will monitor all monthly MRI requests for the presence of a signature for a period of not less than 90 days to ensure 90% or greater compliance.

Recommendation 18. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: 10/31/14

Facility response: The STVHCS secondary patient safety screening form will also be modified to allow an area for a Level 2 trained staff or a Board Certified Radiologist to enter comments and/or recommendations for any contraindications. Imaging Services will monitor all monthly MRI requests for a period of not less than 90 days to ensure compliance.

Recommendation 19. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: 10/31/14

Facility response: Level 1 ancillary staff will be designated by Imaging Service and will be required to complete TMS course 9696 “MRI Safety.” Upon successful completion of the training course, staff will be issued an MRI Level 1 access card. The access card will be valid for one year and will require successful completion of the MRI safety course annually for renewal. A current list of Level 1 trained staff will be kept with the MRI Safety Officer and will be reviewed by the MRI Safety Committee for compliance. Imaging Services will monitor completion of the designated TMS course to ensure 100% of designated Level 1 ancillary staff receives annual MRI safety training.

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Endnotes

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[c] References used for this topic included:
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- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

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