Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02080-29

Combined Assessment Program Review of the West Texas VA Health Care System Big Spring, Texas

November 25, 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
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	West Texas VA Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MM	medication management
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
RRTP	residential rehabilitation treatment program
SDS	same day surgery
VARO	VA Regional Office
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 September 22, 2014.

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

- Quality Management
- Environment of Care
- Medication Management – Controlled Substances Inspection Program
- Continuity of Care
- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishments were Click 2 Benefits and the Get Well Network.

Recommendations: We made recommendations in the following two activities:

Community Living Center Resident Independence and Dignity: Document monthly restorative nursing services progress notes in residents' electronic health records. Offer to transfer residents from their wheelchairs to regular dining chairs during meal periods.

Management of Test Results: Notify all patients of normal test results/values within the expected timeframe, and document notification in the electronic health records.

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 19–22, 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
- MM – CS Inspection Program
- Continuity of Care
- CLC Resident Independence and Dignity
- Management of Test Results
- MH RRTP

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 September 25, 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 West Texas VA Health Care System, Big Spring, Texas,* Report No. 12-03076-65, December 20, 2012).

During this review, we presented crime awareness briefings for 73 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 141 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

Click 2 Benefits

In April 2013, the Click 2 Benefits program was implemented. This program is the result of a collaborative effort between the facility and the VARO in Waco, TX. Veterans can communicate directly with a VARO representative by tele-video to discuss a current claim or start a new claim. This program has been well received and has been used by more than 500 veterans since its inception. In August 2014, the Abilene Community Based Outpatient Clinic added Click 2 Benefits. Its popularity has resulted in studies to expand to other community based outpatient clinics. This program has averted the need for more than 300,000 miles of veteran travel from their residences to the VARO in Waco.

Get Well Network

The Get Well Network is interactive technology that engages CLC and domiciliary residents throughout their health care journey using the bedside/room television to entertain, educate, and empower them to be more actively engaged in their care. This resident-centered approach empowers residents across the care continuum for improved satisfaction, quality, and operations. Residents are able to access movies, games, the internet, and educational videos and look up medication information.

Implementation of the Get Well Network began in mid-FY 2014, and the network has been installed in the CLC and the domiciliary. Once fully implemented, interactive measures such as falls reduction, pain management, discharge preparation, and education/medication teaching will be available.

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. 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
	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
NA	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	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
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

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]

We inspected all primary care clinics, the dental clinic, the physical medicine and rehabilitation clinic, urgent care, and the eye clinic. We were unable to inspect SDS and the PACU due to construction. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 11 employee training records (6 SDS/PACU and 5 eye clinic). 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 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.	
	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 SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
NA	Fire safety requirements in SDS and on the PACU were met.	
NA	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
NA	Infection prevention requirements in SDS and on the PACU were met.	
NA	Medication safety and security requirements in SDS and on the PACU were met.	
NA	Auditory privacy requirements in SDS and on the PACU were met.	
NA	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.	

MM – CS Inspection Program

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

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 5 CS areas, the outpatient pharmacy, the pharmacy vault, and the emergency drug cache. 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
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Continuity of Care

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

We reviewed relevant documents and the EHRs of 30 patients who had been hospitalized at VA expense in the local community from April 1, 2013, through March 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.	
	Members of the patients' primary care teams documented that they were aware of the patients' non-VA hospitalization.	
	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 the facility 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.[e]

We reviewed 13 EHRs of residents (10 residents receiving restorative nursing services and 3 residents not receiving restorative nursing services but candidates for services). We also observed residents during 2 meal periods, reviewed 10 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.	
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on Rehabilitative/Restorative and Supportive Nursing Care Program reviewed: • Eight of the applicable 10 residents did not have a monthly restorative nursing services progress note documented in the EHR.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
X	Required activities were performed during resident meal periods.	• Eight residents were not offered transfer from their wheelchairs to regular dining chairs during meal periods.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that staff document monthly restorative nursing services progress notes in residents' electronic health records and that compliance be monitored.

2. We recommended that processes be strengthened to ensure that residents are offered transfer from their wheelchairs to regular dining chairs during meal periods.

Management of Test Results

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

We reviewed relevant policies and procedures and the EHRs of 30 patients who had critical laboratory, abnormal radiology, or abnormal cytology test results/values in FY 2014 (10 for laboratory, 10 for radiology, and 10 for cytology). In addition, we reviewed the EHRs of 30 patients who had normal laboratory, radiology, or Pap smear results/values. We also conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a written policy or guideline that addressed the management of critical/abnormal test results/values, and compliance was monitored.	
	Providers were notified of critical/abnormal test results/values by appropriate staff within the expected timeframe.	
	Patients were notified of critical/abnormal test results/values within the expected timeframe and by the approved method of communication.	
	Follow-up actions were taken in response to critical/abnormal test results/values.	
X	Patients were notified of normal test results/values within the expected timeframe.	• Twelve of the applicable 30 EHRs (40 percent) either did not contain documentation of patient notification of normal test results/values or did not contain documentation of patient notification within the expected timeframe.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

3. We recommended that processes be strengthened to ensure that all patients are notified of normal test results/values within the expected timeframe and that notification is documented in the electronic health record.

MH RRTP

The purpose of this review was to determine whether the facility's domiciliary complied with selected EOC requirements.[g]

We reviewed relevant documents, inspected the domiciliary, 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.

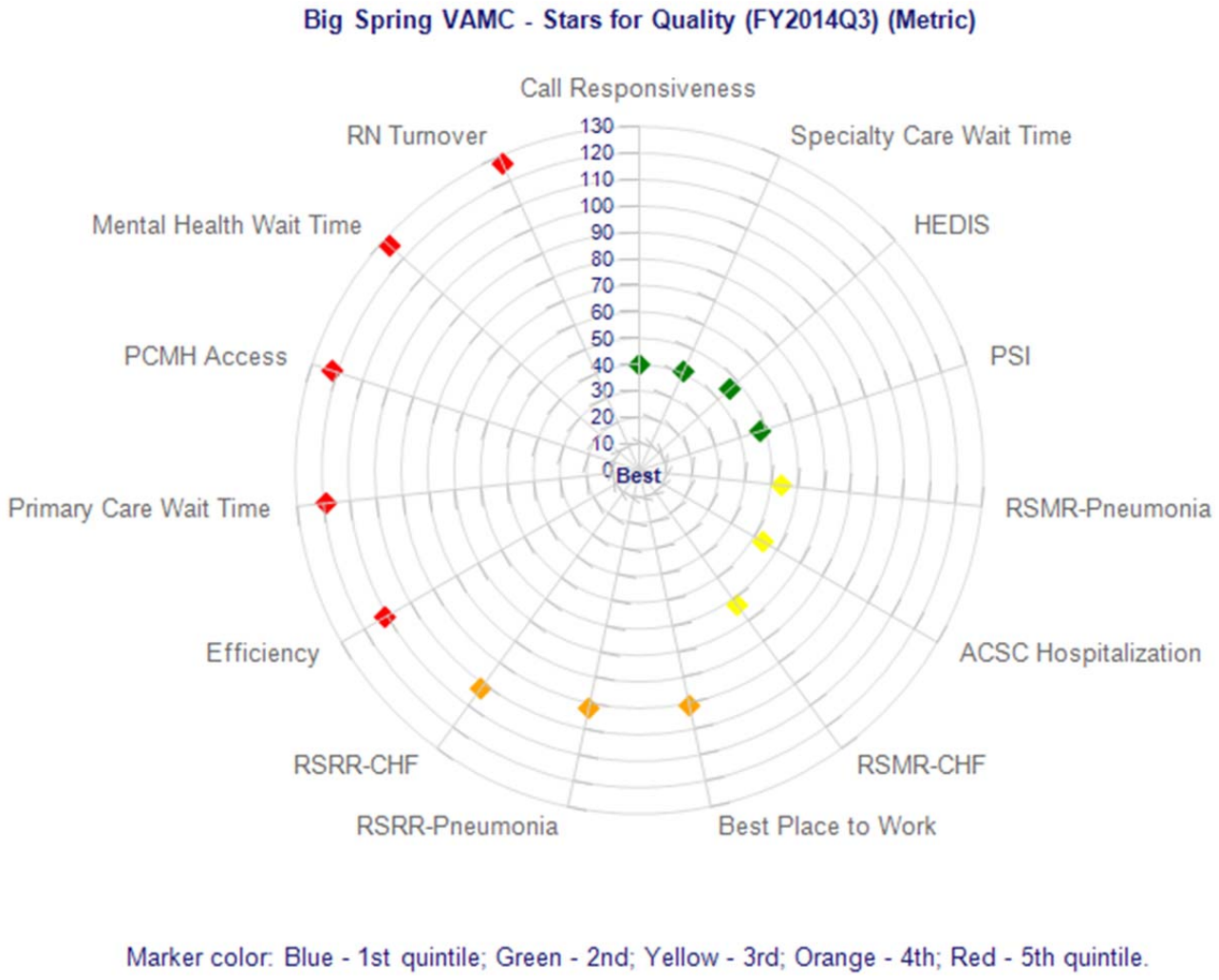
NM	Areas Reviewed	Findings
	The residential environment was clean and in good repair.	
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe MM and contraband detection.	
	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	
	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	
	Written agreements acknowledging resident responsibility for medication security were in place.	
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es).	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	

NM	Areas Reviewed (continued)	Findings
	Medications in resident rooms were secured.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Big Spring/519) FY 2014 through August 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$111.3
Number of:	
• **Unique Patients**	16,535
• **Outpatient Visits**	138,653
• **Unique Employees**[2]	383
Type and Number of Operating Beds (July 2014):	
• **Hospital**	NA
• **CLC**	40
• **MH**	40
Average Daily Census (July 2014):	
• **Hospital**	NA
• **CLC**	24
• **MH**	32
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Permian Basin/519GA Hobbs/519GB Ft. Stockton/519GD Abilene/519HC Stamford/519HD San Angelo/519HF
VISN Number	18

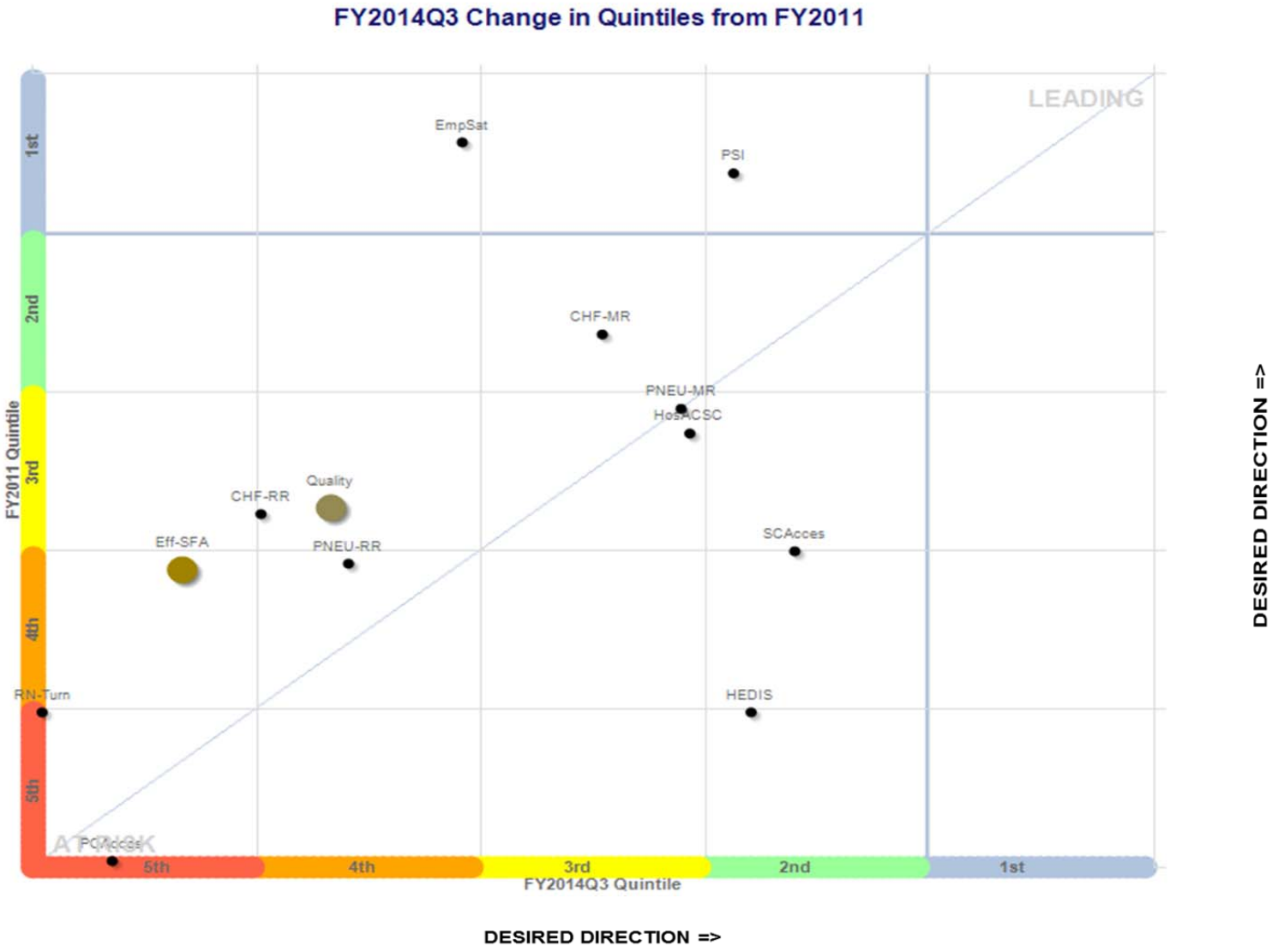
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower 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; FY13 and later)	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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	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; FY13 and later)	A higher value is better than a lower value

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 24, 2014

From: Acting Director, VA Southwest Health Care Network (10N18)

Subject: **CAP Review of the West Texas VA Health Care System, Big Spring, TX**

To: Director, San Diego Office of Healthcare Inspections (54SD)

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

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, TX.

2. If you have any questions or concerns, please contact Jennifer Kubiak, VISN 18 Quality Management Officer, at 480-397-2781.

Elizabeth Joyce Freeman

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 20, 2014

From: Director, West Texas VA Health Care System (519/00)

Subject: **CAP Review of the West Texas VA Health Care System, Big Spring, TX**

To: Director, VA Southwest Health Care Network (10N18)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, TX.

2. If you have any questions or concerns, please contact Robin Martin, Quality Management Chief, at 432-263-7361 ext.4852.

Michael L. Kiefer, MHA 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 staff document monthly restorative nursing services progress notes in residents' electronic health records and that compliance be monitored.

Concur

Target date for completion: June 2015

Facility response: WTVAHCS reviewed the Nursing Service Policy for the Rehabilitative/Restorative and Supportive Nursing Care Program on September 24, 2014. For each Veteran with a restorative plan, the Restorative Coordinator (RC) (or Nurse Manager/designee) will document a monthly summary note in the electronic health record (EHR) by the 7th day of the following month. Nurse Manager or designee will monitor compliance by auditing 100% of charts during the second week of every month. This will be reported to Quality Executive Board (QEB) and at CLC monthly staff meetings. A compliance goal of 90% must be maintained for two consecutive quarters.

Recommendation 2. We recommended that processes be strengthened to ensure that residents are offered transfer from their wheelchairs to regular dining chairs during meal periods.

Concur

Target date for completion: June 2015

Facility response: WTVAHCS reviewed the meal process at the Community Living Center (CLC). All CLC staff were educated on the proper process to offer all residents in wheelchairs the opportunity to transfer to regular dining chairs during meal periods. In addition, a memo was released on October 15, 2014, documenting the process for all CLC staff. The charge nurse will round during meal periods to ensure the offer of transfer is made, and documented on the daily worksheet. A compliance goal of 90% must be maintained for two consecutive quarters. A weekly audit of the daily flow sheet will be conducted by the Nurse Manager or designee, and a monthly summary reported to QEB.

Recommendation 3. We recommended that processes be strengthened to ensure that all patients are notified of normal test results/values within the expected timeframe and that notification is documented in the electronic health record.

Concur

Target date for completion: June 2015

Facility response: In order to strengthen the processes to ensure that all Veterans are notified of normal test results within the expected 14-day timeframe, WTVAHCS has established an action plan which delineates responsibilities across PACT Teams. All notifications whether by mail, phone contact, or in person will be documented in the EHR as required. A letter template was created for notifications by mail. A monthly audit will be performed by the Nurse Manager or designee with a goal of 90% compliance. Compliance must be maintained for two consecutive quarters. The results will be reported monthly to QEB and at the PACT staff meeting.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: K. Michael Conaway, Pete Gallego, Randy Neugebauer, Steve Pearce

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

Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
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