Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00626-28

Combined Assessment Program Review of the VA Pacific Islands Health Care System Honolulu, Hawaii

November 10, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CS	controlled substances
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Pacific Islands Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
VHA	Veterans Health Administration

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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 August 24, 2015.

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

- Medication Management – Controlled Substances Inspection Program
- Computed Tomography Radiation Monitoring
- Mammography Services
- Emergency Airway Management
- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishment was Office of Rural Health projects to improve access to evidenced-based care for veterans with post-traumatic stress disorder who live in rural communities.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure licensed independent practitioners' folders do not contain non-allowed information.

Environment of Care: Ensure that Environment of Care Committee meeting minutes consistently document tracking of identified deficiencies to closure and that monthly meetings consistently include community based outpatient clinic representation. Require Infection Control Committee meeting minutes to consistently reflect discussion of identified high-risk areas. Ensure furnishings and equipment in patient care areas are in good repair and have upholstery that is easily cleaned. Routinely inspect Center for Aging privacy and shower curtains, and initiate actions to replace those with stains. Ensure heavy-use public restrooms in the ambulatory care center have frequent inspections and receive cleaning as needed. Initiate corrective actions to repair the ceiling leak in the ambulatory care center. Store clean and dirty items separately, and promptly remove cardboard boxes from storage areas. Ensure negative air pressure systems are functional in all designated rooms. Require that all chairs in the acute psychiatry unit 3B2 dining/activity room are weighted. Include all required Joint Commission elements in the Emergency Operations Plan.

Suicide Prevention Program: Implement an adequate back-up plan for a Suicide Prevention Coordinator and a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.

Ensure new employees receive suicide prevention training. Implement a process to follow up on patients who miss mental health appointments. Include patients and/or their families in safety plan development. Ensure outpatients flagged as high risk for suicide have a suicide prevention safety plan completed within the first 72 hours of contact. Require that patients flagged as high risk for suicide are evaluated at least four times within 30 days of flag placement if an outpatient or at least four times within 30 days of discharge from the inpatient psychiatric unit.

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 27–34, 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 eight activities:

- QM
- EOC
- Medication Management – CS Inspection Program
- CT Radiation Monitoring
- Mammography Services
- EAM
- Suicide Prevention Program
- 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 2014 and FY 2015 through August 24, 2015, and inspectors conducted the review 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 Pacific Islands Health Care System, Honolulu, Hawaii,* Report No. 13-00274-224, June 19, 2013).

During this review, we presented crime awareness briefings for 166 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. We distributed an electronic survey to all facility employees and received 469 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Office of Rural Health Projects

The Office of Rural Health funded two projects at the facility to help improve access to evidence-based care for veterans with post-traumatic stress disorder who live in rural communities. One project provided home-based video telehealth to individual veterans with post-traumatic stress disorder, and the other provided video telehealth therapy in the home or community based outpatient clinic to couples where the veteran had post-traumatic stress disorder. These 3-year, $1.3 million projects were successful in recruiting veterans into the telehealth clinic, treating them successfully, and providing considerable cost-savings due to reduced travel time and expense and reduced clinic burden since veterans were in less need of continued clinic visits.

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, 10 credentialing and privileging folders, 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	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• All 10 licensed independent practitioners' folders contained non-allowed information.	**1.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
NA	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
NA	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM 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. We also determined whether the facility met selected requirements in emergency management.[b]

We inspected the dental, eye, women's health, and audiology clinics; specialty clinic module 8; primary care modules 2, 3, and 4; same day access; acute psychiatry unit 3B2; and the Center for Aging B and C wings. Additionally, we reviewed relevant documents and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as 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	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not consistently include tracking of identified deficiencies at the facility and community based outpatient clinic locations to closure. • Monthly meetings did not include consistent representation from the community based outpatient clinics.	**2.** We recommended that Environment of Care Committee meeting minutes consistently document tracking of identified deficiencies to closure and that monthly meetings consistently include community based outpatient clinic representation.
	The facility conducted an infection prevention risk assessment.		
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.	Six months of Infection Control Committee meeting minutes reviewed: • Minutes did not consistently include discussion of the facility's high-risk areas identified in the infection control risk assessment.	**3.** We recommended that Infection Control Committee meeting minutes consistently reflect discussion of identified high-risk areas.
	The facility had established a process for cleaning equipment.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Five of 12 patient care areas had furnishings and equipment with compromised surfaces and/or upholstery that could not be easily cleaned. • The Center for Aging B and C wings had stained privacy and shower curtains. • Heavy-use public restrooms in the ambulatory care center were dirty and required more frequent inspection and cleaning. • The facility had an ongoing ceiling leak in the ambulatory care center near the audiology clinic.	**4.** We recommended that facility managers ensure furnishings and equipment in patient care areas are in good repair and have upholstery that is easily cleaned. **5.** We recommended that facility managers ensure employees routinely inspect Center for Aging privacy and shower curtains and initiate actions to replace those with stains. **6.** We recommended that facility managers ensure heavy-use public restrooms in the ambulatory care center have frequent inspections and receive cleaning as needed. **7.** We recommended that facility managers initiate corrective actions to repair the ceiling leak in the ambulatory care center.
X	The facility met infection prevention requirements.	• Four of 12 patient care areas had clean and dirty items stored together, and most storage areas contained cardboard boxes that may potentially harbor pests. • Negative air pressure systems in designated rooms in primary care modules 2 and 3 were not functional.	**8.** We recommended that employees store clean and dirty items separately and promptly remove cardboard boxes from storage areas and that facility managers monitor compliance. **9.** We recommended that facility managers ensure negative air pressure systems are functional in all designated rooms and monitor compliance.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VA National Center for Patient Safety MH EOC Checklist reviewed, which requires locked MH unit dining and activity rooms to have weighted furniture that cannot be picked up and thrown or moved to block a door: • Acute psychiatry unit 3B2 had 10 chairs in its dining/activity room that were not weighted.	**10.** We recommended that facility managers ensure all chairs in the acute psychiatry unit 3B2 dining/activity room are weighted.
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	The facility maintained a list of resources and assets it may need during an emergency.		
X	The facility had a written Emergency Operations Plan that addressed key components.	• The facility's Emergency Operations Plan did not include all required Joint Commission elements.	**11.** We recommended that the facility's Emergency Operations Plan include all required Joint Commission elements.
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
NA	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management – 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 two CS areas, the inpatient and outpatient pharmacies, 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	Recommendations
	Facility policy was consistent with VHA requirements.		
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and the facility corrected any identified deficiencies.		
	The facility had documented instructions for inspecting automated dispensing machines that included all required elements, and CS inspectors followed the instructions.		
	The CS Coordinator provided monthly CS inspection findings summaries and quarterly trend reports to the Facility Director.		
	The CS Coordinator position description or functional statement included CS oversight duties, and the CS Coordinator completed required certification and was free from conflicts of interest.		
	The Facility Director appointed CS inspectors in writing, and inspectors were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	CS inspectors inspected non-pharmacy areas with CS in accordance with VHA requirements, and inspections included all required elements.		
	CS inspectors conducted pharmacy CS inspections in accordance with VHA requirements, and inspections included all required elements.		
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[d]

We reviewed relevant documents, including qualifications and dosimetry monitoring for two CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 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	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

Mammography Services

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

We reviewed relevant documents and the EHRs of 30 women veterans 50–74 years of age who had a screening mammogram during calendar year 2014, and we conversed with key managers and 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	Recommendations
	The facility had a policy addressing mammography services that included required elements.		
NA	If the facility outsourced mammograms, it defined requirements for turnaround time.		
	Clinicians linked mammogram results to the radiology order in the EHR.		
	Mammogram result reports included required elements.		
	Interpreting clinicians reported mammogram results using American College of Radiology codes.		
	The facility sent written summaries of the mammogram results in lay terms to patients within 30 days of the procedure date.		
	Clinicians communicated “suspicious” or “highly suggestive of malignancy” results and recommended actions to the patient within 5 business days of the procedure and documented this in the EHR.		
	Clinicians communicated incomplete or “probably benign” results to the patient within 14 days from availability of the results and documented this in the EHR.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility ensured ordering clinicians received signed written mammography reports within 30 days of the procedure date.		
	The facility ensured communication of "suspicious" or "highly suggestive of malignancy" results and the recommended course of action to the ordering clinician or responsible designee within 3 business days of the procedure date.		
	The facility designated a full-time Women Veterans Program Manager who was a health care professional with a minimal allotment of clinical time to maintain clinical competency.		
	The facility had established effective mammography oversight processes.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[f]

We reviewed relevant documents, and we conversed with key managers and 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	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
NA	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
NA	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
NA	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner		
NA	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
NA	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 30 patients assessed to be at high risk for suicide and the training records of 11 new 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	Recommendations
X	The facility had a full-time Suicide Prevention Coordinator and a plan for back-up.	• The facility did not have an adequate back-up plan for a Suicide Prevention Coordinator.	**12.** We recommended that the facility implement an adequate back-up plan for a Suicide Prevention Coordinator.
X	The facility had a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.	• There was no evidence that the facility had a process for responding to referrals from the Veterans Crisis Line and identifying and tracking patients who are at high risk for suicide.	**13.** We recommended that the facility implement a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.
X	The facility provided suicide prevention training to new employees and community organizations.	• Three training records contained no evidence of suicide prevention training.	**14.** We recommended that the facility ensure new employees receive suicide prevention training and that facility managers monitor compliance.
	The facility issued required reports regarding any patients who attempted or completed suicide within the past 12 months.		
X	The facility had a process to follow up on patients who missed MH appointments.	• The facility did not have a process to follow up on patients who missed MH appointments.	**15.** We recommended that the facility implement a process to follow up on patients who miss mental health appointments and that facility managers monitor compliance.
	Patients had documented safety plans that specifically addressed suicidality.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Patients and/or their families participated in safety plan development.	• Nine of the 27 applicable EHRs did not contain documentation that patients and/or their families participated in safety plan development.	**16.** We recommended that clinicians include patients and/or their families in safety plan development and that facility managers monitor compliance.
	Clinicians documented safety plans that contained all required elements.		
	Clinicians documented that the patients and/or their families received a copy of the safety plan.		
	Clinicians placed flags in the EHRs for high-risk patients.		
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy reviewed, which requires that outpatients flagged as high risk for suicide have a completed suicide prevention safety plan within the first 72 hours of contact and that patients are evaluated at least four times within 30 days of flagging if an outpatient or at least four times within 30 days of discharge if a flagged patient discharged from the inpatient psychiatric unit. • Nine of 23 outpatients' EHRs did not contain documentation of a completed safety plan within 72 hours of contact. • Eight of 23 outpatients' EHRs did not contain documentation of an evaluation at least four times during the first 30 days after flag placement. • Five of seven inpatients' EHRs did not contain documentation of an evaluation at least four times during the first 30 days after discharge.	**17.** We recommended that mental health providers ensure outpatients flagged as high risk for suicide have a suicide prevention safety plan completed within the first 72 hours of contact and that facility managers monitor compliance. **18.** We recommended that mental health providers ensure patients flagged as high risk for suicide are evaluated at least four times within 30 days of flag placement if an outpatient or at least four times within 30 days of discharge from the inpatient psychiatric unit and that facility managers monitor compliance.

MH RRTP

The purpose of this review was to determine whether the facility's Post-Traumatic Stress Disorder RRTP complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the Post-Traumatic Stress Disorder RRTP, 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.

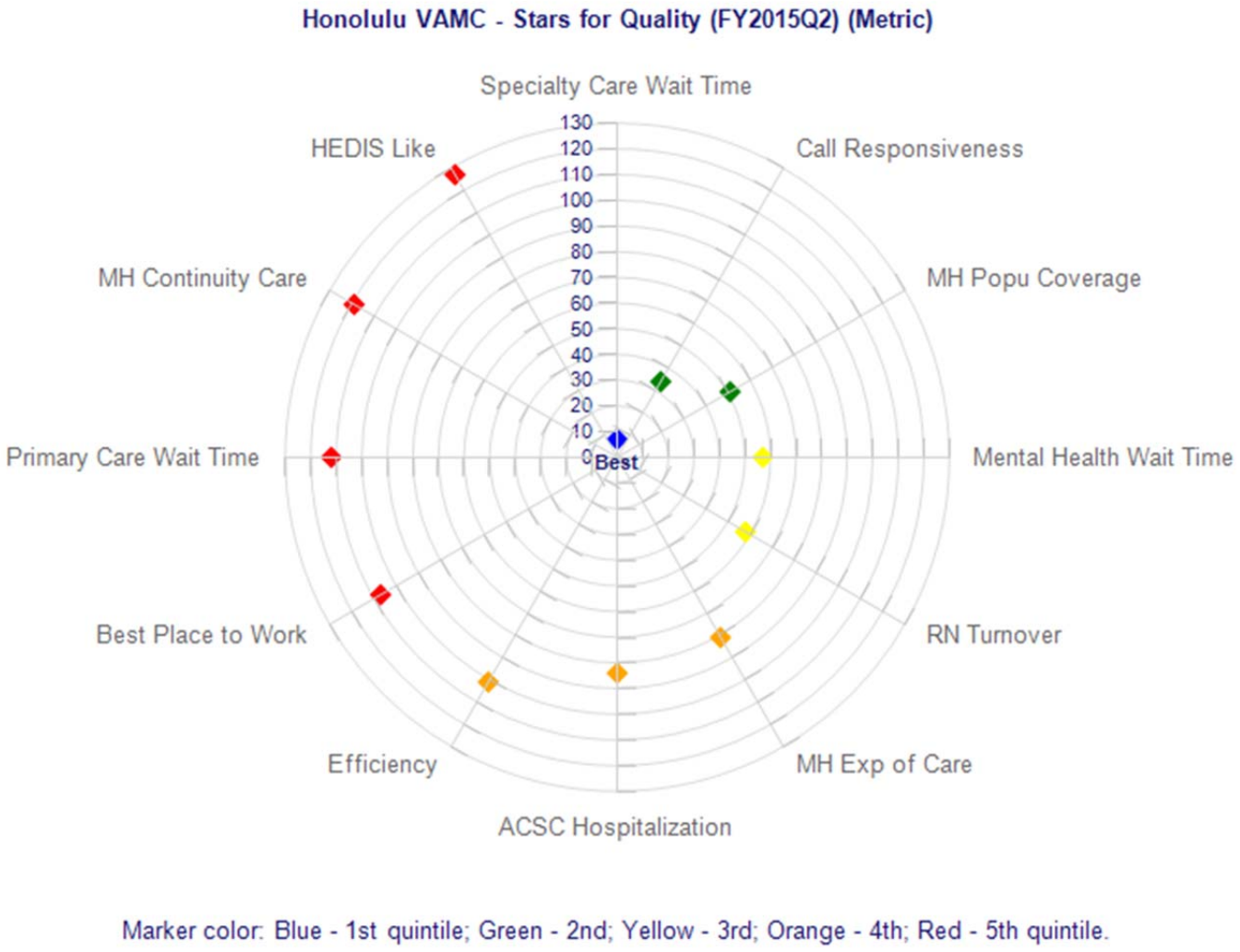
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
NA	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Honolulu/459) FY 2015 through July 2015[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$266.1
Number of:	
• **Unique Patients**	30,147
• **Outpatient Visits**	238,584
• **Unique Employees**[2]	842
Type and Number of Operating Beds:	
• **Hospital**	16
• **Community Living Center**	60
• **MH**	12
Average Daily Census:	
• **Hospital**	11
• **Community Living Center**	57
• **MH**	9
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Kahului/459GA Hilo/459GB Kailua-Kona/459GC Lihue/459GD Agana Heights/459GE Pago Pago/459GF Ewa Beach/459GG
Veterans Integrated Service Network Number	21

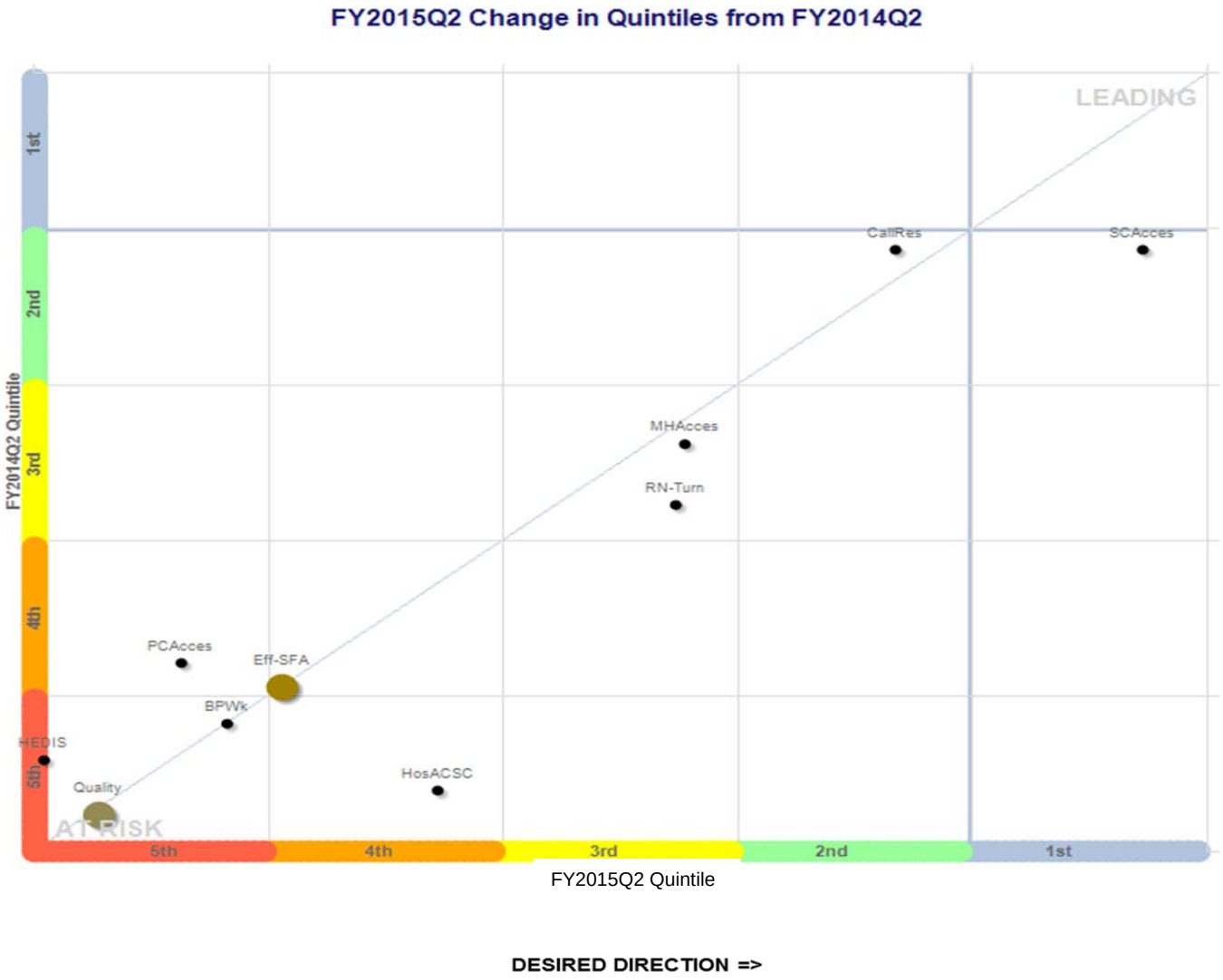
[1] All data is for FY 2015 through July 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: October 26, 2015

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Pacific Islands Health Care System, Honolulu, HI**

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

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

1. Thank you for the opportunity to review the draft report from the recent OIG site visit at Pacific Islands Health Care System. Attached is the action plan developed by the facility.

2. Should you have any questions regarding the plan, please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8350.

Sheila M. Cullen

Attachments

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 23, 2015

From: Director, VA Pacific Islands Health Care System (459/00)

Subject: **CAP Review of the VA Pacific Islands Health Care System, Honolulu, HI**

To: Director, Sierra Pacific Network (10N21)

I have reviewed and concur with the action plan regarding the Combined Assessment Program Review conducted on August 24–28, 2015 at the VA Pacific Islands Health Care System, Honolulu, Hawaii.

Wayne L. Pfeiffer, HSA, FACHE
Facility Director, VA Pacific Islands Health Care System (459/00)

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: February 1, 2016

Facility response: All non-allowable information will be removed from all VAPIHCS LIP Credentialing and Privileging folders by November 30, 2015. Then random chart audits will be conducted by the Administrative Officer for the Chief of Staff for 3 consecutive months with a target of 100% compliance.

Recommendation 2. We recommended that Environment of Care Committee meeting minutes consistently document tracking of identified deficiencies to closure and that monthly meetings consistently include community based outpatient clinic representation.

Concur

Target date for completion: February 1, 2016

Facility response: The Facility started the tracking log in August 2015. Deficiencies are discussed at every Environment of Care meeting. CBOC representatives have been identified and are participating in the monthly meetings. Compliance in reviewing deficiencies at the EOC meeting and CBOC representation will be tracked x 3 months (Target 90%).

Recommendation 3. We recommended that Infection Control Committee meeting minutes consistently reflect discussion of identified high-risk areas.

Concur

Target date for completion: June 30, 2016

Facility response: On a quarterly basis, starting at the Infection Control Committee meeting on October 28, 2015, all minutes will consistently reflect discussion of identified high-risk areas as identified in the Infection Control Risk Assessment (ICRA) document. Quarterly minutes will be monitored x 3 quarters for 100% compliance.

Recommendation 4. We recommended that facility managers ensure furnishings and equipment in patient care areas are in good repair and have upholstery that is easily cleaned.

Concur

Target date for completion: February 1, 2016

Facility response: Patient Care Line and Service Chiefs will conduct monthly environment of care rounds specifically to ensure that furnishings and equipment in patient care areas are in good repair and have upholstery that is easily cleaned. Audit sheets will be provided to the Chief of Logistics and Chief of FMES for replacement/cleaning as applicable monthly x 3 consecutive months. Copies of these reports will be provided to QMS for auditing purposes.

Recommendation 5. We recommended that facility managers ensure employees routinely inspect Center for Aging privacy and shower curtains and initiate actions to replace those with stains.

Concur

Target date for completion: December 31, 2015

Facility response: A purchase order for replacement of all privacy curtains and shower curtains has been completed. These new curtains will be installed by December 31, 2015. During the initial curtain order, an additional 20 privacy curtains and 20 shower curtains were ordered and an additional 20 curtains of each will be ordered yearly for rotational replacement to assure unstained curtains are available at all times.

Recommendation 6. We recommended that facility managers ensure heavy-use public restrooms in the ambulatory care center have frequent inspections and receive cleaning as needed.

Concur

Target date for completion: February 1, 2016

Facility response: The Ambulatory Care Center restrooms are cleaned twice per day. Checklists are posted in every restroom for quality control. Housekeeping staff respond to any calls for assistance and for any additional cleaning as necessary. VA COTR for this service will monitor ACC bathrooms weekly x 4 weeks, then monthly x 2 months. Weekly and monthly compliance reports to be provided to QMS for tracking purposes.

Recommendation 7. We recommended that facility managers initiate corrective actions to repair the ceiling leak in the ambulatory care center.

Concur

Target date for completion: February 1, 2016

Facility response: The building maintenance technicians patched the ACC roof fixing the ceiling leak on September 2, 2015. This leak was addressed as part of the ACC Facility Condition Assessment Correction project that included resurfacing of the roof. Engineering will monitor the ACC after it rains for possible recurrence of this leak. Monthly summary compliance reports x 3 months will be submitted to QMS for tracking purposes.

Recommendation 8. We recommended that employees store clean and dirty items separately and promptly remove cardboard boxes from storage areas and that facility managers monitor compliance.

Concur

Target date for completion: February 2016

Facility response: The Specialty Care and Primary Care Nurse Managers will conduct weekly rounds and assign module champions to conduct daily compliance (via check sheet) to assure separation of Service clean and dirty items including no evidence of cardboard boxes in storage areas. Three months of monitoring will be completed with compliance of 100 % times. These compliance reports will be submitted to QMS for tracking.

Recommendation 9. We recommended that facility managers ensure negative air pressure systems are functional in all designated rooms and monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: The repair of the negative pressure room in ACC was completed on October 6, 2015. Preventive maintenance is conducted monthly by the facility maintenance mechanics. The Infection Control and Prevention RN provided training on the use of the negative pressure room (e.g., reading and understanding the negative pressure monitors) to the primary care staff on October 7, 2015. This training will be repeated every October, as a refresher course. On a daily basis, the NM will assign an individual to conduct negative pressure system testing on applicable rooms using a check sheet. This will be conducted x 3 consecutive months for 100% compliance.

Recommendation 10. We recommended that facility managers ensure all chairs in the acute psychiatry unit 3B2 dining/activity room are weighted.

Concur

Target date for completion: December 31, 2015

Facility response: An order for weighted chairs was sent to Contracting on 10/07/2015 for the acute psychiatry unit 3B2 dining/activity room. It is anticipated this furniture will arrive over the next several months, NLT December 31, 2015. A picture will be provided when chairs are placed in the room.

Recommendation 11. We recommended that the facility's Emergency Operations Plan include all required Joint Commission elements.

Concur

Target date for completion: November 20, 2015

Facility response: The Emergency Operations Plan is currently being reviewed and revised so that all Joint Commission requirements are cited in one policy instead of numerous policies. This consolidation of policies will be completed, signed by the Director and posted on the policy SharePoint site.

Recommendation 12. We recommended that the facility implement an adequate back-up plan for a Suicide Prevention Coordinator.

Concur

Target date for completion: February 1, 2016

Facility response: The Suicide Prevention Program is fully staffed. The Suicide Prevention Coordinator (SPC) and the Suicide Prevention Case Manager (SPCM) are both full time employees of the program and act as "back-up" for each other. In the unanticipated event that both the (SPC) and the (SPCM) are off at the same time, the Psychiatric Evaluation Team (PET) is the designated back-up for Suicide Prevention issues. All members of the (PET) have access and knowledge of the Suicide Crisis Line functions. Over three consecutive months, coverage between the (SPC) and (SPCM) and use of PET will be monitored for any coverage issues for the Suicide Prevention Programs. These reports will be submitted to QMS for tracking through the ACOS Mental Health.

Recommendation 13. We recommended that the facility implement a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.

Concur

Target date for completion: February 1, 2016

Facility response: All calls from the Suicide Crisis Line have a designated response time frame of 24 hours as directed by the Suicide Prevention Center for Excellence, with the exception of weekends and holidays when calls are returned on the next business day. Compliance data is available via the MEDORA database that contains all referrals received from the Suicide Crisis Line. The Suicide Prevention Program staff are identifying and tracking Veteran identified as being high risk for suicide daily by entering data from the Chief of Staff report and CPRS into the locally created "high risk tracking Excel data base." Compliance reports will be run by the (SPC/SPCM) monthly x 3 month for 90% compliance and provided to QMS for tracking through the ACOS Mental Health.

Recommendation 14. We recommended that the facility ensure new employees receive suicide prevention training and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: The Suicide Prevention Team has been presenting "Operation SAVE" (VA Suicide Prevention Training) at all New Employee Orientations (NEO) since May 2015. Daily attendance records are maintained by Human Resources and there is a formal New Employee daily training calendar. In addition, there is an on-line TMS training available to staff (VA training # 6201) and completion of reports may be generated by the TMS Coordinator. CBOC providers received suicide prevention training by the SPC during the months of August and September 2015. NEO daily sign in sheets x 3 consecutive months will be collected and sent to QMS through Chief HR for 95% compliance.

Recommendation 15. We recommended that the facility implement a process to follow up on patients who miss MH appointments and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: Mental Health (MH) has a three phone calls and then follow-up letter procedure for all Veterans who miss a (MH) appointment. On a daily basis, (MH) Administrative Staff run a "No Show" report and have a formalized tracking process to follow up on all patients who have missed a MH appointment. This will be tracked for

three consecutive appointments for 90% compliance. These monthly reports will be submitted to QMS through the ACOS Mental Health.

Recommendation 16. We recommended that clinicians include patients and/or their families in safety plan development and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: Clinicians will include patients and/or their families when applicable in the safety plan development for Veterans with suicidal ideation. A request has been submitted to the Clinical Applications Coordinator (CAC) to amend the Suicide Safety Plan, so that the provider can check off a statement reflecting the veteran and/or family member participation in the Safety Plan. This will be monitored for three consecutive months and forwarded to QMS for tracking through the ACOS MH (target 90%).

Recommendation 17. We recommended that mental health providers ensure outpatients flagged as high risk for suicide have a suicide prevention safety plan completed within the first 72 hours of contact and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: Mental Health providers were reminded to complete a suicide prevention safety plan within the first 72 hours of contact for outpatients who are determined to require a high risk for suicide flag. This will be monitored for three consecutive months and submitted to QMS for tracking through the ASOS MH (target 90%).

Recommendation 18. We recommended that mental health providers ensure outpatients flagged as high risk for suicide are evaluated at least four times within 30 days of flag placement if an outpatient or at least four times within 30 days of discharge from the inpatient psychiatric unit and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: Mental Health providers were reminded of the requirement to ensure outpatients flagged as high risk for suicide are evaluated at least four times within 30 days of flag placement if an outpatient, or at least four times within 30 days of discharge from the inpatient psychiatric. This will be monitored for three consecutive months and reported to QMS for tracking through the ACOS MH (target 90%).

Office of Inspector General
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: Madeleine Bordallo, Tulsi Gabbard, Amata Radewagen, Mark Takai

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

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

[d] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

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

[f] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[g] References used for this topic included:
- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Patients at High Risk for Suicide," memorandum, April 24, 2008.
- Various requirements of The Joint Commission.

[h] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.