Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04696-107

Combined Assessment Program Review of the VA Texas Valley Coastal Bend Health Care System Harlingen, Texas

February 9, 2016

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CS	controlled substances
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	VA Texas Valley Coastal Bend Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

Table of Contents

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 November 2, 2015.

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

- Environment of Care
- Continuity of Care
- Computed Tomography Radiation Monitoring

Recommendations: We made recommendations in the following four activities:

Quality, Safety, and Value: Complete eight root cause analyses each fiscal year.

Medication Management – Controlled Substances Inspection Program: Reconcile 1 day's dispensing from the pharmacy to each automated unit. Include controlled substances oversight duties in the Controlled Substances Coordinator's position description. Ensure controlled substances inspectors receive annual updates and refresher training. Randomly schedule non-pharmacy area inspections with no distinguishable patterns. Validate transfers from one storage area to another. Verify hard copy orders for five randomly selected dispensing activities (or a minimum of two if less than five). Perform 72-hour inventories of the main vault. Compare drugs held for destruction with the Destruction File Holding Report for 10 randomly selected drugs. Verify completion of drug destructions at least quarterly.

Mammography Services: Send written lay mammogram results to patients within 30 days of the procedure, and reflect this in electronic health records. Communicate incomplete or "probably benign" results to patients within 14 days from availability of the results, and document this in the electronic health record.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within the required timeframe. Include the contact numbers of family or friends for support in Suicide Prevention Safety Plans.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 23–29, for the full text of the Directors' comments.) We consider recommendations 3 and 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

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

Scope

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

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

- QSV
- EOC
- Medication Management – CS Inspection Program
- Continuity of Care
- CT Radiation Monitoring
- Mammography Services
- Suicide Prevention Program

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, FY 2015, and FY 2016 through November 2, 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 Texas Valley Coastal Bend Health Care System, Harlingen, Texas,* Report No. 13-00893-195, May 9, 2013). We made repeat recommendations in medication management – CS inspection program.

During this review, we presented crime awareness briefings for 180 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 104 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.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 7 root cause analyses, 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 QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
NA	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.		
X	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.	• During FY 2015, the facility only completed seven root cause analyses.	**1.** We recommended that the Patient Safety Manager ensure completion of eight root cause analyses each fiscal year and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	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 the dental clinic.[b]

We inspected the behavioral health, multispecialty, orthopedic, ophthalmology, primary care, and dental clinics. Additionally, we reviewed relevant documents and four dental employee training records, and we conversed with key employees and managers. 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	Recommendations
	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.		
	The facility conducted an infection prevention risk assessment.		
	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.		
	The facility had established a process for cleaning equipment between patients.		
NA	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
NA	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
NA	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
NA	The facility monitored OR temperature, humidity, and positive pressure.		
NA	The facility met fire safety requirements in the OR.		
NA	The facility met environmental safety requirements in the OR.		
NA	The facility met infection prevention requirements in the OR.		
NA	The facility met medication safety and security requirements in the OR.		
NA	The facility met laser safety requirements in the OR.		
NA	The facility complied with any additional elements required by VHA, 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 the CS Coordinator and 10 CS inspectors and inspection documentation from 4 CS areas and the pharmacy. 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
	Facility policy was consistent with VHA requirements.		
	VA police conducted annual physical security surveys of the pharmacy, and the facility corrected any identified deficiencies.		
X	The facility had documented instructions for inspecting automated dispensing machines that included all required elements, and CS inspectors followed the instructions.	Automated dispensing machine inspection instructions reviewed: • Although instructions required reconciliation of 1 day's dispensing from the pharmacy to each automated unit, CS inspectors did not consistently do this. This was a repeat finding from the previous CAP review.	**2.** We recommended that controlled substances inspectors consistently reconcile 1 day's dispensing from the pharmacy to each automated unit and that the Controlled Substances Coordinator monitors compliance.
	The CS Coordinator provided monthly CS inspection findings summaries and quarterly trend reports to the facility Director.		
X	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.	Position description and certification reviewed: • The CS Coordinator's position description did not include coordinator duties.	**3.** We recommended that the facility ensure the Controlled Substances Coordinator's position description includes controlled substances oversight duties.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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.	Appointments, certifications, and training records reviewed: • Six of eight applicable CS inspectors did not receive annual updates and refresher training. This was a repeat finding from the previous CAP review.	**4.** We recommended that the facility ensure controlled substances inspectors receive annual updates and refresher training.
X	CS inspectors inspected non-pharmacy areas with CS in accordance with VHA requirements, and inspections included all required elements.	Documentation of four CS areas inspected during the past 6 months reviewed: • We identified distinguishable patterns, and most inspections occurred during the last week of the month. • CS inspectors did not consistently validate transfers from one storage area to another. • CS inspectors did not consistently verify hard copy orders for five randomly selected dispensing activities (or a minimum of two if less than five dispensing activities on the unit).	**5.** We recommended that the Controlled Substances Coordinator ensure random scheduling of non-pharmacy area inspections with no distinguishable patterns and that facility managers monitor compliance. **6.** We recommended that controlled substances inspectors consistently validate transfers from one storage area to another and that the Controlled Substances Coordinator monitors compliance. **7.** We recommended that controlled substances inspectors consistently verify hard copy orders for five randomly selected dispensing activities (or a minimum of two if less than five dispensing activities on the unit) and that the Controlled Substances Coordinator monitors compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	CS inspectors conducted pharmacy CS inspections in accordance with VHA requirements, and inspections included all required elements.	Documentation of pharmacy CS inspections conducted during the past 6 months reviewed: • Pharmacy employees did not consistently perform 72-hour inventories of the main vault. • CS inspectors did not consistently verify the audit trail by comparing drugs held for destruction with the destroyed drugs report for 10 randomly selected drugs. • CS inspectors did not consistently verify completion of drug destructions at least quarterly.	**8.** We recommended that pharmacy employees consistently perform 72-hour inventories of the main vault and that facility managers monitor compliance. **9.** We recommended that controlled substances inspectors consistently compare drugs held for destruction with the Destruction File Holding Report for 10 randomly selected drugs and that the Controlled Substances Coordinator monitors compliance. **10.** We recommended that controlled substances inspectors consistently verify completion of drug destructions at least quarterly and that the Controlled Substances Coordinator monitors compliance.
	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]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 30 patients who had been hospitalized at VA expense in the local community from September 1, 2014, to August 31, 2015. 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
	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.		

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.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for four CT technologists and CT scanner inspection reports, and 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		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
NA	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.		
NA	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.[f]

We reviewed relevant documents and the EHRs of 30 women veterans 50–74 years of age who had a screening mammogram July 1, 2014, to June 30, 2015, and we conversed with key managers and 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
	The facility had a policy addressing mammography services that included required elements.		
	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.		
X	The facility sent written summaries of the mammogram results in lay terms to patients within 30 days of the procedure date.	• Nine EHRs (30 percent) did not contain documentation that the facility sent lay mammogram results to patients within 30 days of the procedure.	**11.** We recommended that the facility send written lay mammogram results to patients within 30 days of the procedure, that electronic health records reflect this, and that facility managers monitor compliance.
NA	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians communicated incomplete or "probably benign" results to the patient within 14 days from availability of the results and documented this in the EHR.	• Three of the five applicable EHRs did not contain documentation that clinicians communicated incomplete or "probably benign" results to the patients within 14 days from availability of the results.	**12.** We recommended that clinicians communicate incomplete or "probably benign" results to patients within 14 days from availability of the results and document this in the electronic health record and that facility managers monitor compliance.
	The facility ensured ordering clinicians received signed written mammography reports within 30 days of the procedure date.		
NA	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.		

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. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 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.

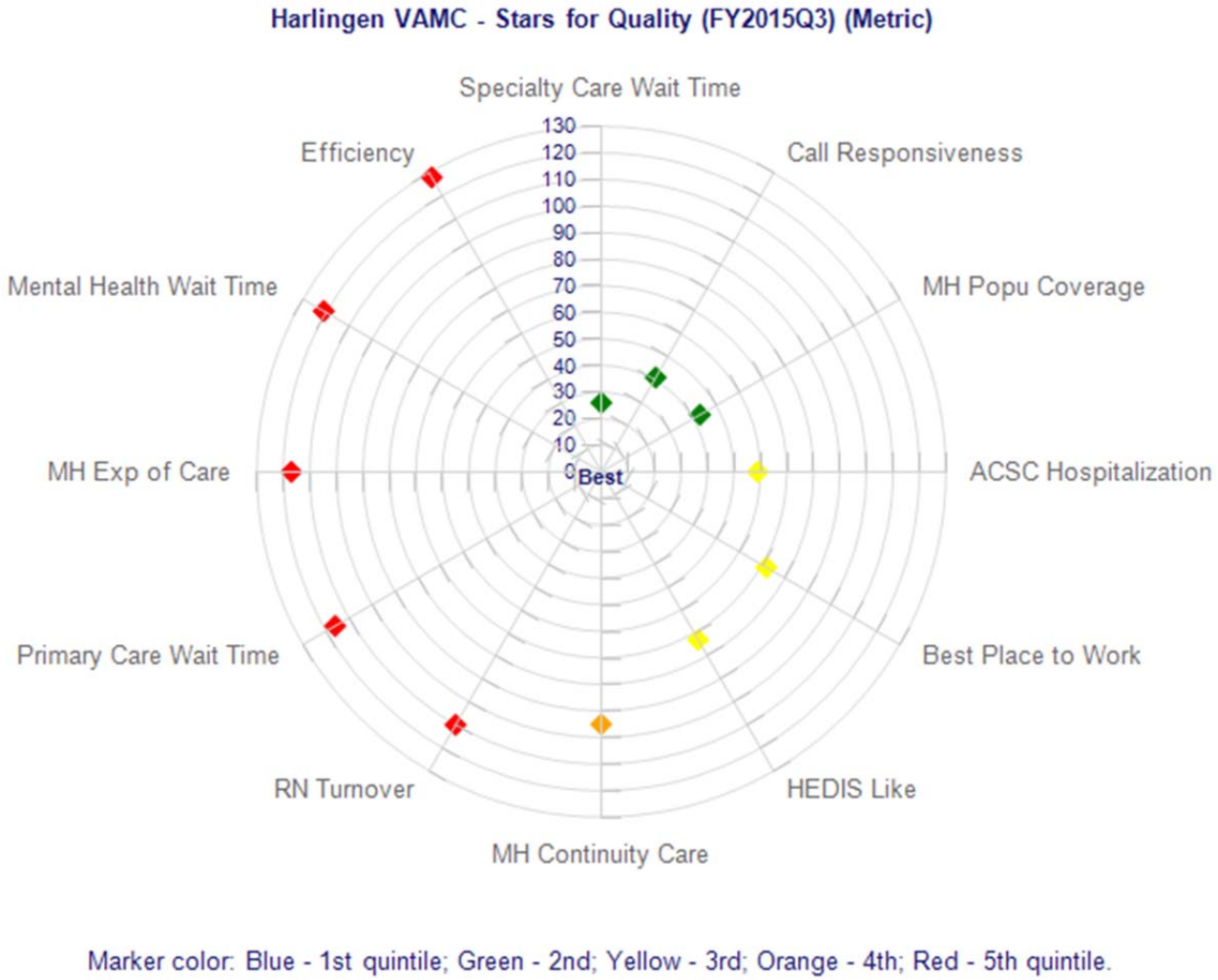
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Three of the seven applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**13.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
NA	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
X	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe	• Fourteen safety plans (35 percent) lacked documentation of the identification of contact numbers of family or friends for support.	**14.** We recommended that clinicians include the contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
NA	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge. • Every 90 days to review Patient Record Flags.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Harlingen/740) FY 2016 through November 2015[1]	
Type of Organization	Secondary
Complexity Level	1c – High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$50.3
Number (as of December 7, 2015) of:	
• **Unique Patients**	19,843
• **Outpatient Visits**	59,419
• **Unique Employees**[2]	663
Type and Number of Operating Beds:	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	NA
Average Daily Census:	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Harlingen/740GA McAllen/740GB Corpus Christi/740GC Laredo/740GD
Veterans Integrated Service Network Number	17

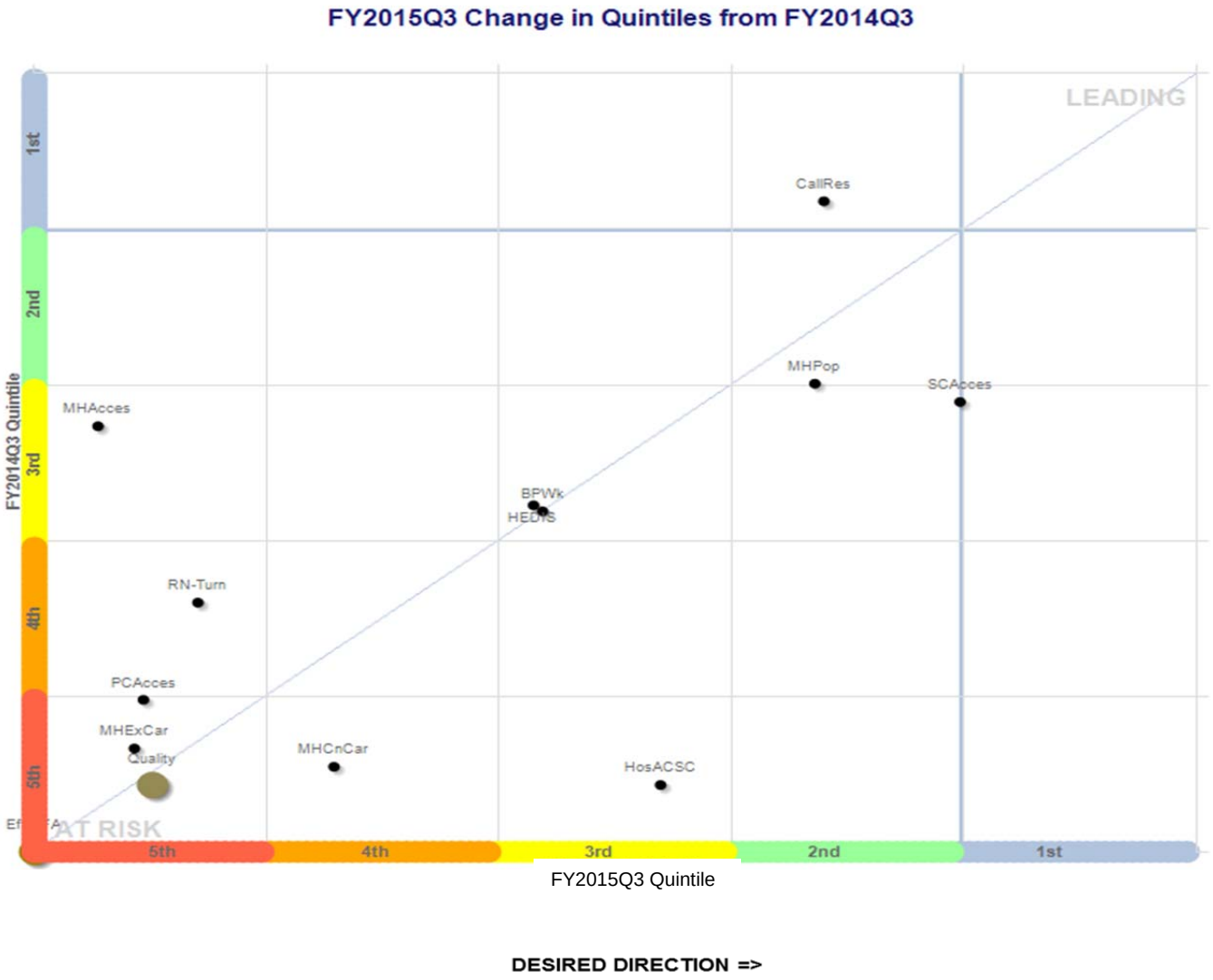
[1] All data is for FY 2016 through November 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: January 5, 2016

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

Subject: **CAP Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX**

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

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

1. Thank you for allowing me to respond to the CAP Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX.

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

3. If you have further questions regarding this CAP review please contact Denise B. Elliot, VISN 17 Quality Management Officer at (817) 385-3734.

Joseph M. Dalpiaz
VISN 17 Network Director (ND)

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 5, 2016

From: Interim Director, VA Texas Valley Coastal Bend Health Care System (740/00)

Subject: **CAP Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX**

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

1. I concur with the findings noted in this report. Action plans have been developed and monitoring will be conducted on a regular basis.

2. Should you require additional information, please contact Catherine Mezmar, Chief Quality Management, (956) 430-9343.

Joe A. Perez, MBA
Interim Director

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 Patient Safety Manager ensure completion of eight root cause analyses each fiscal year and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Root Cause Analyses Process Requirement for Aggregated Reviews and Individual Root Cause Analyses has been reviewed by the Patient Safety Manager. Eight Root Cause Analyses and Aggregated Reviews will be completed as indicated in 1050.01 VHA National Patient Safety Improvement Handbook. Compliance will be monitored through the Patient Safety Committee and the Quality Executive Board.

Recommendation 2. We recommended that controlled substances inspectors consistently reconcile 1 day's dispensing from the pharmacy to each automated unit and that the Controlled Substances Coordinator monitors compliance.

Concur

Target date for completion: March 15, 2016

Facility response: Controlled Substance Inspection (CSI) Check Sheet has been revised and CSI staff was trained on November 6, 2015 and November 13, 2015. The Controlled Substance Coordinator (CSC) will monitor the inspections monthly for a period of three months to provide evidence that 100% compliance is sustained in dispensing from the pharmacy to each automated unit. Results will be reported to the Chief of Quality Management (QM).

Recommendation 3. We recommended that the facility ensure the Controlled Substances Coordinator's position description includes controlled substances oversight duties.

Concur

Target date for completion: November 16, 2015

Facility response: The position description (functional statement) for the CSC was revised to include controlled substances oversight duties.

Recommendation 4. We recommended that the facility ensure controlled substances inspectors receive annual updates and refresher training.

Concur

Target date for completion: November 12, 2015

Facility response: TMS CSI automated reminders were entered by Educator/TMS Coordinator on November 12, 2015 to ensure CSIs met the annual requirement for CSI updates and training. These TMS Reminders will be sent to all CSI and their supervisors when they become due for completion. The CSC also reviews the CSI education spreadsheets monthly and requests a CSI completed education certificate to confirm compliance with required education. Currently, all CSI's are compliant with annual updates and refresher training.

Recommendation 5. We recommended that the Controlled Substances Coordinator ensure random scheduling of non-pharmacy area inspections with no distinguishable patterns and that facility managers monitor compliance.

Concur

Target date for completion: March 15, 2016

Facility response: The Controlled Substances Coordinator created a monitoring spreadsheet and a process to ensure random non-pharmacy area inspections. The CSC provides a variable date range for inspections at each site each month, thereby ensuring randomness. The CSC's process for inspections combined with spreadsheet reviews ensures that there are no distinguishable patterns.

Recommendation 6. We recommended that controlled substances inspectors consistently validate transfers from one storage area to another and that the Controlled Substances Coordinator monitors compliance.

Concur

Target date for completion: March 15, 2016

Facility response: The Controlled Substance Inspection Check Sheet was revised on November 5, 2015 to ensure validation documentation of transfers from one storage area to another. CSC will monitor documentation on a monthly basis for a period of three months to ensure 100% compliance. Results will be reported to the Chief of QM.

Recommendation 7. We recommended that controlled substances inspectors consistently verify hard copy orders for five randomly selected dispensing activities (or a minimum of two if less than five dispensing activities on the unit) and that the Controlled Substances Coordinator monitors compliance.

Concur

Target date for completion: March 15, 2016

Facility response: Pharmacy employees consistently perform 72-hour inventories of the main vault, but the Controlled Substance Inspection Check Sheet lacked documentation of this activity. The Controlled Substance Inspection Check Sheet was revised on November 5, 2015 to ensure documentation. The CSC will monitor documentation on a monthly basis for a period of three months to ensure 100% compliance. Results will be reported to the Chief of QM.

Recommendation 8. We recommended that pharmacy employees consistently perform 72-hour inventories of the main vault and that facility managers monitor compliance.

Concur

Target date for completion: March 15, 2016

Facility response: Pharmacy employees consistently perform 72-hour inventories of the main vault, but the Controlled Substance Inspection Check Sheet lacked documentation of this activity. The Controlled Substance Inspection Check Sheet was revised on November 5, 2015 to ensure documentation. The CSC will monitor documentation on a monthly basis for a period of three months to ensure 100% compliance. Results will be reported to the Chief of QM.

Recommendation 9. We recommended that controlled substances inspectors consistently compare drugs held for destruction with the Destruction File Holding Report for 10 randomly selected drugs and that the Controlled Substances Coordinator monitors compliance.

Concur

Target date for completion: March 15, 2016

Facility response: The Controlled Substance Inspection Check Sheet was revised on November 5, 2015 to ensure that CSIs consistently document their comparison of drugs held for destruction with the Destruction File Holding Report for 10 randomly selected drugs. The CSC will monitor documentation on a monthly basis for a period of three months to ensure 100% compliance. Results will be reported to the Chief of QM.

Recommendation 10. We recommended that controlled substances inspectors consistently verify completion of drug destructions at least quarterly and that the Controlled Substances Coordinator monitors compliance.

Concur

Target date for completion: March 15, 2016

Facility response: The Controlled Substance Inspection Check Sheet was revised on November 5, 2015 to ensure CSIs document verification of completion of drug destructions at least quarterly. CSC will monitor documentation on a monthly basis for a period of 3 months to ensure 100% compliance. Results will be reported to the Chief of QM.

Recommendation 11. We recommended that the facility send written lay mammogram results to patients within 30 days of the procedure, that electronic health records reflect this, and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: The Mammogram Coordinator will re-educate the PACT teams on the mandatory process for sending written lay mammogram results to patients within 30 days of the procedure.

One hundred percent of the mammogram reports completed within the previous 30 days will be reviewed by the by the Mammogram Coordinator for the presence of written lay mammogram results. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Women Veteran's Health Committee.

Recommendation 12. We recommended that clinicians communicate incomplete or "probably benign" results to patients within 14 days from availability of the results and document this in the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: The Mammogram Coordinator will re-educate the PACT teams on the mandatory process for documenting communication of incomplete or "probably benign" results to patients within 14 days from availability of the results.

One hundred percent of the monthly mammogram reports will be reviewed by the Mammogram Coordinator for the presence of electronic health record documentation within 14 days of result availability of incomplete or "probably benign" results to patients.

Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Women Veteran's Health Committee.

Recommendation 13. We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: VCB-002 TMS Suicide Risk Management training has been added to mandatory training for all clinical health system employees to be completed within the first 90 days of employment.

Compliance with Suicide Risk Management training will be monitored by the Suicide Prevention Coordinator through monthly checks of TMS training for all new clinical employees. Monthly monitoring reports will be completed until the target of 90% has been sustained for three consecutive months. Results will be reported to the Associate Chief of Staff for Mental Health and Quality Executive Board.

Recommendation 14. We recommended that clinicians include the contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: The Suicide Safety Plan template has been modified to incorporate inclusion of phone numbers.

Compliance will be monitored by the Suicide Prevention Coordinator through random checks of Suicide Safety Plans to assess for appropriate completion. Thirty Safety Plans will be reviewed per month until the target of 90% has been sustained for three consecutive months. Results will be reported to the Associate Chief of Staff for Mental Health and Quality Executive Board.

Office of Inspector General
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Endnotes

[a] References used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- 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, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[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] The references used for this topic included:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.
- Various requirements of the Joint Commission.

[e] 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.

[f] The 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.

[g] References used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- 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.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.