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Clinical Assessment Program Review of the Orlando VA Medical Center Orlando, Florida

April 13, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
ER	emergency room
facility	Orlando VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Purpose and Objectives: The review provided a focused evaluation of the quality of care provided in the inpatient and outpatient settings of the Orlando VA Medical Center. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Community Nursing Home Oversight; Management of Disruptive/Violent Behavior; and Mental Health Residential Rehabilitation Treatment Program. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic Reviews and provided crime awareness briefings.

Results: We conducted the review during the week of November 28, 2016, and identified certain system weaknesses in credentialing and privileging, environmental safety, endoscope processing, anticoagulation quality control, transfer documentation, the disruptive behavior program, and Mental Health Residential Rehabilitation Treatment Program safety measures.

Review Impact: As a result of the findings, we could not gain reasonable assurance that the facility:

1. Has an effective process for reviewing Ongoing Professional Practice Evaluation data
2. Maintains a clean and safe environment of care
3. Has an effective process for reviewing anticoagulation quality assurance data
4. Has a safe patient transfer process
5. Effectively manages disruptive/violent behavior incidents and ensures employees receive training, and
6. Maintains a safe Mental Health Residential Rehabilitation Treatment Program environment

Recommendations: We made recommendations in the following six review areas.

Quality, Safety, and Value – Ensure that:

- Clinical managers review Ongoing Professional Practice Evaluation data every 6 months.

Environment of Care – Ensure that:

- Facility managers implement use of a visitors log during non-business hours.
- The facility performs quality control testing on all endoscopes.

Medication Management: Anticoagulation Therapy – Ensure that:

- The facility reviews quality assurance data for the anticoagulation management program quarterly in accordance with local policy.

Coordination of Care: Inter-Facility Transfers – Ensure that for patients transferred out of the facility:

- Transferring providers consistently include documentation of patient or surrogate informed consent in transfer documentation.
- Providers consistently complete transfer documentation using VA Form 10-2649A as required by local policy.

Management of Disruptive/Violent Behavior – Ensure that:

- The facility implements an Employee Threat Assessment Team or acceptable alternate group.
- Clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal flag placement and that the Chief of Staff or designee approves Orders of Behavioral Restriction.
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Mental Health Residential Rehabilitation Treatment Program – Ensure that:

- Domiciliary Care for Homeless Veterans and Substance Abuse Residential Rehabilitation Treatment Program employees conduct and document daily bed checks.
- All Mental Health Residential Rehabilitation Treatment Program emergency exit door alarms are functional and turned on at all times.
- All closed circuit television monitoring cameras at the Domiciliary Care for Homeless Veterans and Substance Abuse Residential Rehabilitation Treatment Program have recording capability.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 40–48, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

This CAP review provided a focused evaluation of the quality of care provided in the inpatient and outpatient settings of the facility.

Objectives

CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care.

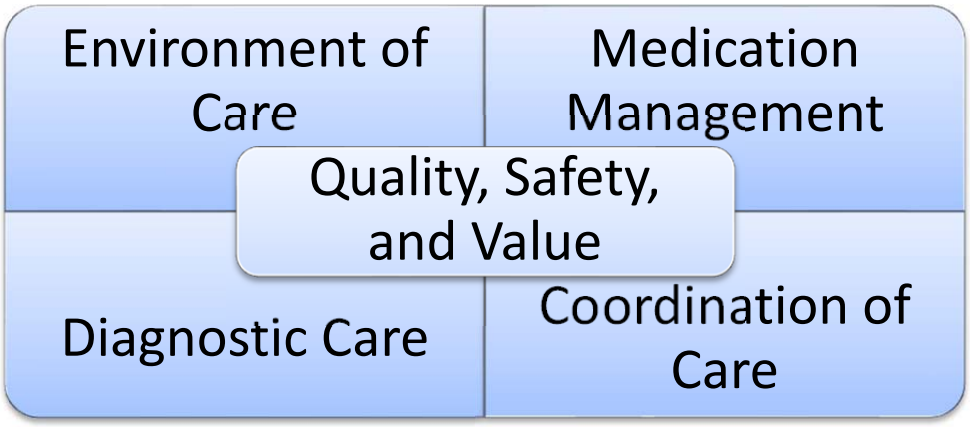
During this cycle, CNH Oversight, Management of Disruptive/Violent Behavior, and MH RRTP are processes that are high risk and problem-prone. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and PC Clinic Reviews.

Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the Institute of Medicine (now the National Academy of Medicine), there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).[1]

VA states that one of its strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.[2]

Environment of Care

All facilities face risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people, patients, and anyone else who enters the environment.[3]

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental features, such as the

[1] Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.
[2] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[3] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.[4]

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine (now the National Academy of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

Coordination of care is the process of coordinating care, treatment, or services provided by a facility, including referring individuals to appropriate community resources to meet ongoing identified needs, implementing the plan of care, and avoiding unnecessary duplication of services. Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, and services likely will involve an array of providers in a variety of health care settings, including the patient's home.[7]

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services whether tests, consultations, or procedures to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

[4] Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.
[5] Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.
[6] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Medication Management (MM).
[7] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Provision of Care, Treatment, and Services (PC).
[8] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; March 2001.

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.[11] Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety.[12]

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[13] These CNHs may be within close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This involves annual reviews and monthly patient visits unless otherwise specified.[14]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined, and many of these assaults and violent

[9] Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.
[10] Department of Veterans Affairs. Patient Care Services. Diagnostic Services. http://www.patientcare.va.gov/diagnosticservices.asp. Accessed September 21, 2016.
[11] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.
[12] Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare.
[13] VA Corporate Data Warehouse. Accessed October 31, 2016.
[14] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

acts are perpetrated by patients.[15] Management of disruptive/violent behavior is the process of reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.[16] VHA has a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility; however, staff training deadlines have been postponed several times.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home beds as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[17]

Scope

To evaluate for compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following five aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: Point-of-Care Testing

[15] U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf. August 30, 2010. Accessed October 28, 2016.
[16] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
[17] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

We also evaluated three additional review areas because of inherent risks and potential vulnerabilities.

- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Mental Health Residential Rehabilitation Treatment Program

We list the review criteria for each of the review areas in the topic checklists. Some of the items listed may not have been applicable because of a difference in size, function, or frequency of occurrence.

The review covered operations for FY 2015, FY 2016, and FY 2017 through November 28, 2016, and inspectors conducted the reviews 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 Combined Assessment Program report (*Combined Assessment Program Review of the Orlando VA Medical Center, Orlando, Florida,* Report No. 14-00689-142, May 6, 2014) and Community Based Outpatient Clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Orlando VA Medical Center, Orlando, Florida,* Report No. 14-00224-83, February 27, 2014). We made a repeat recommendation in MH RRTP. (See page 27.)

We presented crime awareness briefings for 477 employees. These briefings covered procedures for reporting suspected criminal activity to 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 1,037 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 OIG to monitor until the facility implements corrective actions. Issues and concerns that come to our attention but are outside the scope of this CAP review will be considered for further review separate from the CAP process and may be referred accordingly.

Reported Accomplishments

SimLearn (Simulation Learning, Education, and Research Network)

The SimLearn National Simulation Center officially opened in September 2016 at the facility at Lake Nona. It is a state-of-the-art simulation center for health care training. Prior to the opening of the Lake Nona facility, the SimLearn team collaborated with facility employees to rehearse patient flow and test hospital systems for unanticipated events or situations. In performing these evaluations, the SimLearn team applied high

fidelity simulation technology to address challenges facing clinical employees and managers when opening new facilities.

Emergency Management Team Support of the Community

In 2016, the facility Emergency Management Team provided support for an international sporting event and responded to a mass shooting in the community.

The Invictus Games, held in Orlando, collaborated with local partners, including Walt Disney World, Reedy Creek emergency medical services, and local Vet Centers, to provide medical and MH care for athletes participating in the games. The facility's emergency management team included more than 70 physicians, nurses, health care technicians, emergency managers, and logistics personnel.

On June 12, 2016, the facility emergency management team provided emergency MH assistance to veterans, employees, and the public in wake of a mass shooting in Orlando. The facility deployed a mobile medical unit and command post in support of the local community.

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Utilization management
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 licensed independent practitioner profiles, 10 protected peer reviews, 5 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.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified 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.	• Seven profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.
	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.		
	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. • An interdisciplinary group reviewed utilization management data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

Environment of Care

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 SPS.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

At the facility at Lake Nona, we inspected the surgical, medical, stepdown, intensive care, and locked MH units; urgent care; the community living center/dementia unit; the infusion clinic; and the SPS area. At the Port Orange clinic, we inspected the Psychosocial Rehabilitation and Recovery Center, and at the Viera VA Outpatient Clinic, we inspected the SPS area. Additionally, we reviewed relevant documents and 12 employee competency records, and we interviewed 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.

Checklist 2. EOC Areas Reviewed, Findings, and 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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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 procedure for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
X	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.	Facility policy for identification of individuals entering the facility reviewed: • The facility did not have a log for recording facility visitors during non-business hours.	**2.** We recommended that facility managers implement the use of a visitors log during non-business hours and monitor compliance.
	The facility met general safety requirements.		
	The facility met environmental cleanliness requirements.		
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		
X	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.	• The facility did not perform quality control testing on two of three endoscopes at the facility and one of two endoscopes at the Viera Outpatient Clinic.	**3.** We recommended that the facility perform quality control testing on all endoscopes and that facility managers monitor compliance.

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year		
	The facility met infection prevention requirements in SPS areas.		
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
	Areas Reviewed for the Hemodialysis Unit		
NA	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
NA	Selected hemodialysis unit employees had evidence of blood borne pathogens training within the past 12 months.		
NA	The facility met environmental safety requirements on the hemodialysis unit.		
NA	The facility met infection prevention requirements on the hemodialysis unit.		
NA	The facility met medication safety and security requirements on the hemodialysis unit.		
NA	The facility met privacy requirements on the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[18] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of 12 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 27 randomly selected patients who were prescribed new anticoagulant medications July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had policies and processes for anticoagulation management that included required content.		
	The facility used algorithms, protocols or standardized care processes for the: • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin		

[18] Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.		
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
X	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.	• The facility did not review quality assurance data for the anticoagulation management program quarterly as defined in local policy.	**4.** We recommended that the facility review quality assurance data for the anticoagulation management program quarterly as defined by local policy and that facility managers monitor compliance.
	For inpatients with newly prescribed anticoagulant medications, clinicians provided transition follow-up and education specific to the new anticoagulant.		
	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy		
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		
	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.		

Coordination of Care: Inter-Facility Transfers

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[d] Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services. The movement of an acutely ill person from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately, under circumstances that provide maximum safety for patients, and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 49 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 4. Coordination of Care: Inter-Facility Transfers Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
	The facility collected and reported data about transfers out of the facility.		
X	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent, VA Form 10-2649B • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed	• Provider transfer documentation did not include documentation of patient or surrogate informed consent, VA Form 10-2649B, in 8 of the 49 EHRs (16 percent).	**5.** We recommended that for patients transferred out of the facility, transferring providers consistently include documentation of patient or surrogate informed consent, VA Form 10-2649B, in transfer documentation and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note		
	When the facility transferred patients out, sending nurses documented transfer assessments/notes.		
	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity		
	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests		
X	The facility complied with local policy when transferring patients.	Local policy requires the use of VA Form 10-2649A when transferring patients out of the facility. • Providers did not complete VA Form 10-2649A in 32 of the 49 EHRs (65 percent).	**6.** We recommended that providers consistently complete VA Form 10-2649A for patients transferred out of the facility and that facility managers monitor compliance.

Diagnostic Care: Point-of-Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and pro-thrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.[19]

We reviewed relevant documents, the EHRs of 50 randomly selected inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 10 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the 4 West, 4 East, 3 West, and 3 East units and the Viera VA Outpatient Clinic to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service.		
	The facility had a designated POCT/Ancillary Testing Coordinator.		
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		

[19] The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
	Clinicians initiated appropriate clinical action and follow-up for test results.		
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[f] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[20] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 33 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed 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.

Checklist 6. CNH Oversight Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.		
	The facility integrated the CNH Program into its quality improvement program.		
NA	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		
NA	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		
	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.		

[20] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.[g] VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents, the EHRs of 38 patients who exhibited disruptive or violent behavior, a report of a non-patient violent or disruptive incident that occurred during the 12-month period July 1, 2015 through June 30, 2016, and the training records of 33 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

Checklist 7. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
X	The facility had implemented: • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system	• The facility had not implemented an Employee Threat Assessment Team or acceptable alternate group.	**7.** We recommended that the facility implement an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior.
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• In 25 of 37 applicable EHRs (68 percent), there was no evidence that clinicians informed the patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement. • In two of nine applicable EHRs, there was no evidence of Chief of Staff or designee approval of the Order of Behavioral Restriction.	**8.** We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement and ensure Chief of Staff or designee approval of Orders of Behavioral Restriction.
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
NA	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Eight of the 33 employee training records (24 percent) did not contain documentation of Level I prevention and management of disruptive behavior training within 90 days of hire. • Twenty-seven of the applicable 32 employee training records (84 percent) did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**9.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Mental Health Residential Rehabilitation Treatment Program

The purpose of this review was to determine whether the facility's MH RRTPs (more commonly referred to as domiciliary or residential treatment programs) complied with selected EOC requirements. The Domiciliary Care for Homeless Veterans Program was established through legislation in the late 1860s with the purpose of providing a home for disabled volunteer soldiers of the Civil War. In 1995, VA established the Psychosocial RRTP bed level of care. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment. In 2005, the Domiciliary RRTP became fully integrated with other RRTPs of the Office of MH Services.[h]

We reviewed relevant documents; inspected the Domiciliary RRTP at the facility at Lake Nona and the Domiciliary Care for Homeless Veterans and Substance Abuse RRTPs, which shared space at the Lake Baldwin Outpatient Clinic; and interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 8. MH RRTP Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.	• For the 14-day period November 13–26, 2016, Domiciliary Care for Homeless Veterans and Substance Abuse RRTP employees did not consistently conduct and document daily bed checks. This was a repeat finding from the previous two Combined Assessment Program reviews.	**10.** We recommended that Domiciliary Care for Homeless Veterans and Substance Abuse Residential Rehabilitation Treatment Program employees at Lake Baldwin conduct and document daily bed checks and that program managers monitor compliance.
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
X	The 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.	• One of the three emergency exit doors at the Domiciliary Care for Homeless Veterans and Substance Abuse RRTPs had a non-functional alarm. • Two of the eight emergency exit doors at the Domiciliary RRTP had their alarms turned off.	**11.** We recommended that facility managers ensure all Mental Health Residential Rehabilitation Treatment Program emergency exit door alarms are functional and turned on at all times and that program managers monitor compliance.
X	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and had signage alerting veterans and visitors of recording.	• Six of the 14 closed circuit television monitoring cameras at the Domiciliary Care for Homeless Veterans and Substance Abuse RRTPs did not have recording capability.	**12.** We recommended that facility managers ensure all closed circuit television monitoring cameras at the Domiciliary Care for Homeless Veterans and Substance Abuse Residential Rehabilitation Treatment Programs have recording capability and that program managers monitor compliance.
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks.		
	Residents secured medications in their rooms.		

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Orlando (675) for FY 2016

Profile Element	Facility Data
VISN Number	8
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$754
Number of:	
• **Unique Patients**	110,404
• **Outpatient Visits**	1,509,029
• **Unique Employees**[21]	3,224
Type and Number of Operating Beds:	
• **Acute**	46
• **MH**	NA
• **Community Living Center**	120
• **Domiciliary**	60
Average Daily Census:	
• **Acute**	10
• **MH**	NA
• **Community Living Center**	114
• **Domiciliary**	52

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

[21] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[22]

The VA outpatient clinics in the communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[23] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[24] Provided	Diagnostic Services[25] Provided	Ancillary Services[26] Provided
Viera, FL	675GA	59,159	30,711	Allergy Cardiology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Blind Rehab Rehab Physician Spinal Cord Injury Amputation Anesthesia ENT Eye General Surgery Gynecology Orthopedics Podiatry Urology	EKG Laboratory and Pathology Nuclear Medicine Radiology	Dental Nutrition Pharmacy Prosthetics Social Work Weight Management

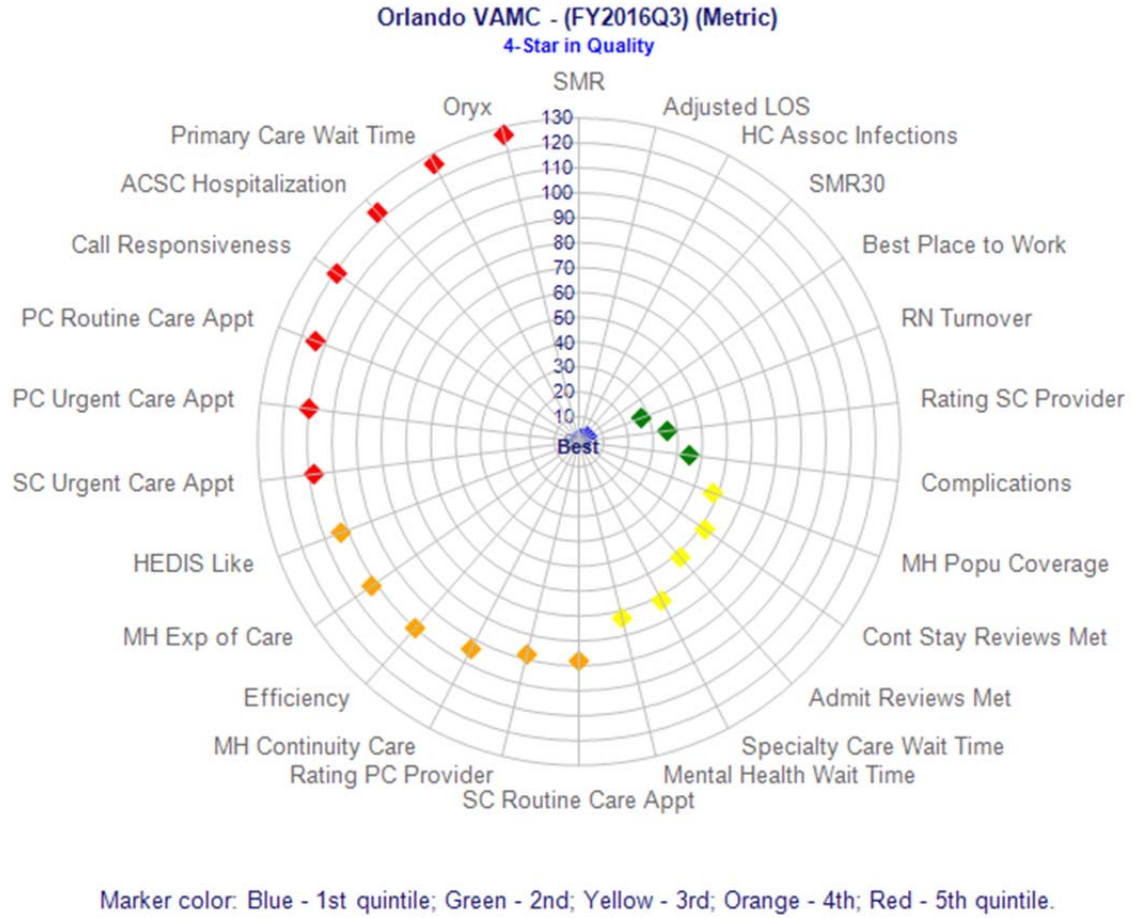
[22] Includes all outpatient clinics in the community that were in operation before February 15, 2016.
[23] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[24] Specialty care services refer to non-PC and non-MH services provided by a physician.
[25] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[26] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Daytona Beach, FL	675GB	46,897	20,656	Cardiology Endocrinology Gastroenterology Nephrology Rheumatology Blind Rehab Rehab Physician Amputation Anesthesia Eye Orthopedics Podiatry Urology	EKG Laboratory and Pathology Radiology	Dental Nutrition Pharmacy Prosthetics Social Work Weight Management
Kissimmee, FL	675GC	15,732	6,773	Endocrinology Eye Urology	NA	Pharmacy
Orange City, FL	675GD	9,753	7,313	Endocrinology Gastroenterology Eye	NA	Pharmacy Weight Management
Tavares, FL	675GE	12,504	3,134	Cardiology Dermatology Endocrinology Gastroenterology Nephrology Eye Podiatry	NA	Pharmacy Weight Management
Clermont, FL	675GF	8,677	2,649	Endocrinology Gastroenterology Eye	NA	Pharmacy Social Work Weight Management
Orlando, FL	675GG	62,030	45,116	Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Neurology Poly-Trauma Rehab Physician Amputation Anesthesia ENT Eye General Surgery Orthopedics Plastic Podiatry Urology Vascular	EKG Laboratory and Pathology Nuclear Medicine Radiology	Dental Nutrition Pharmacy Prosthetics Social Work Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

Strategic Analytics for Improvement and Learning (SAIL)[27]

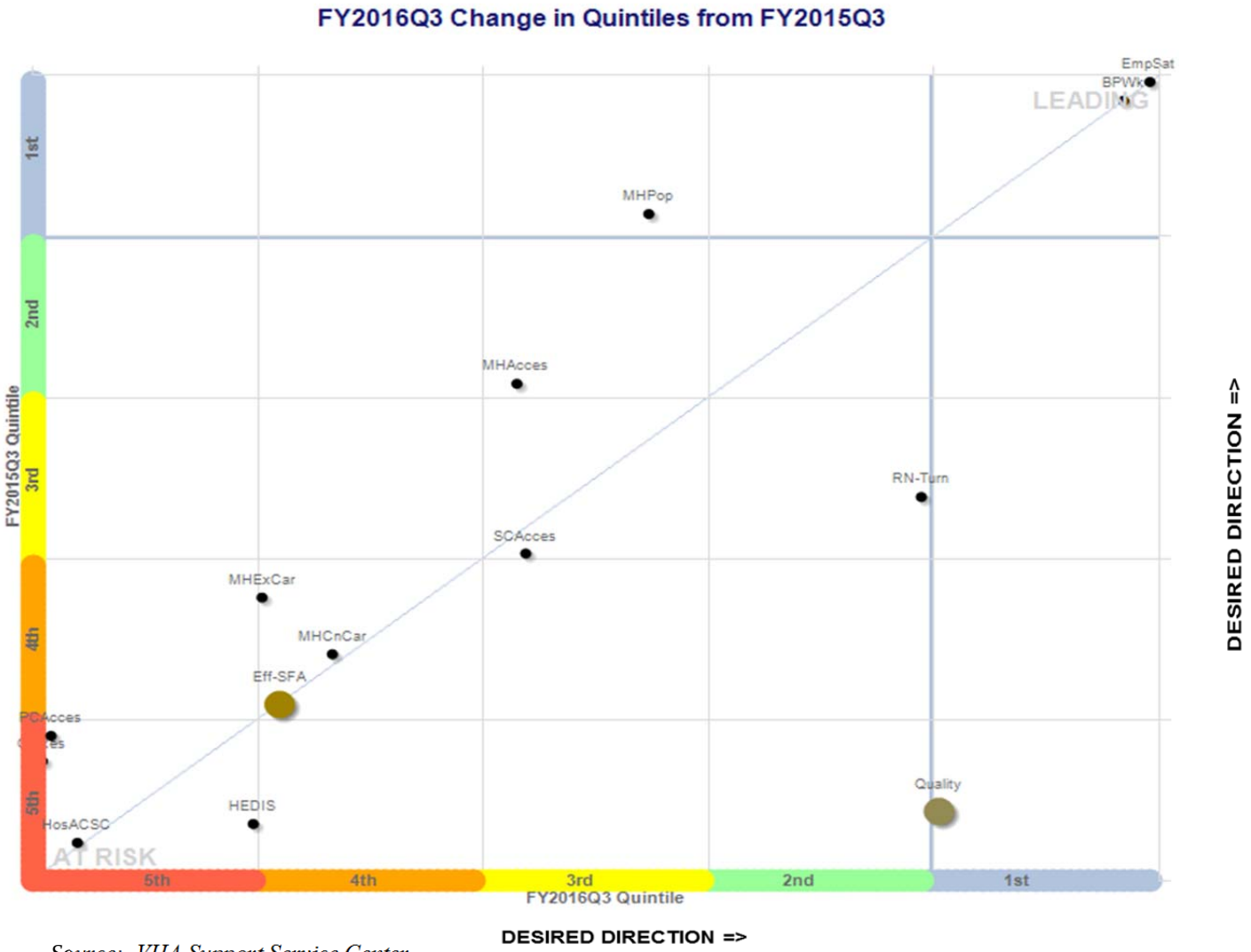


Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

[27] 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.

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Metric Definitions[i]

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
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower 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
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower 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 Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
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
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	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
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	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

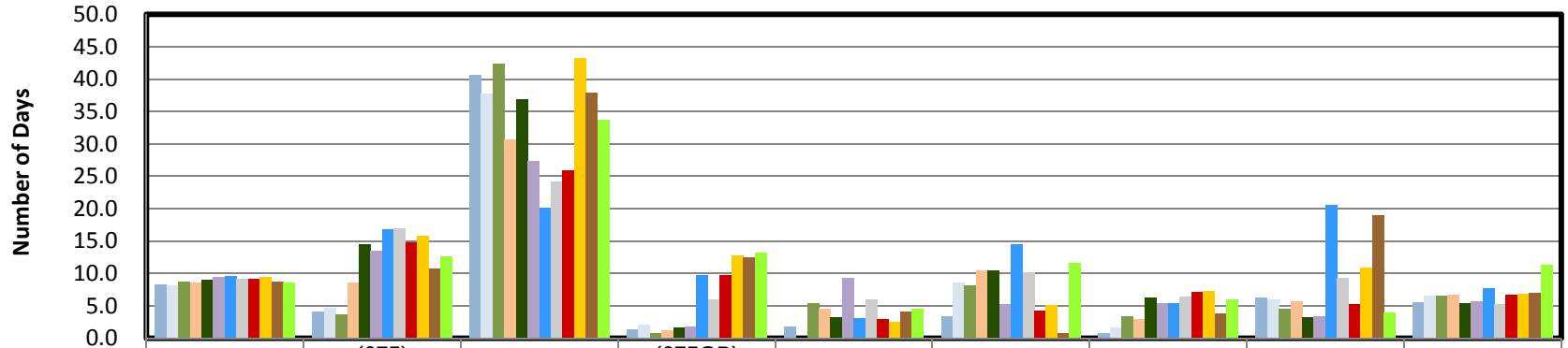
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	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-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	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
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower 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 patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

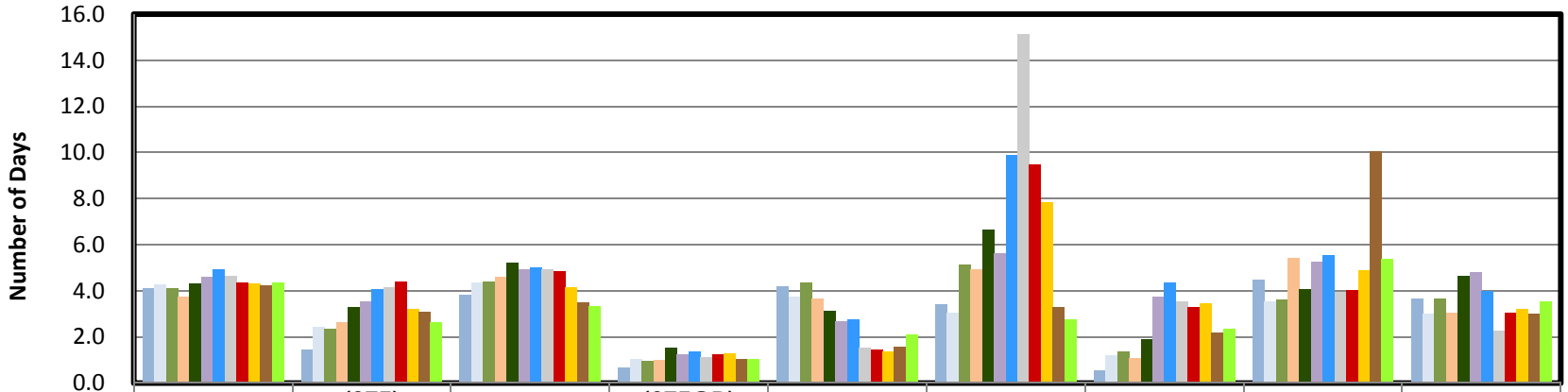


	VHA Total	(675) Orlando VA Medical Center	(675GA) Viera	(675GB) William V Chappell Jr VA OPC	(675GC) Kissimee	(675GD) Orange City	(675GE) Tavares VA Clinic	(675GF) Clermont	(675GG) Lake Baldwin
JUL-FY15	8.3	4.1	40.6	1.4	1.7	3.3	0.8	6.3	5.6
AUG-FY15	8.1	4.6	37.8	2.1	0.1	8.6	1.6	6.0	6.5
SEP-FY15	8.7	3.7	42.4	0.8	5.4	8.2	3.4	4.5	6.6
OCT-FY16	8.6	8.6	30.7	1.2	4.6	10.5	2.9	5.8	6.7
NOV-FY16	9.1	14.5	36.9	1.7	3.3	10.4	6.3	3.2	5.4
DEC-FY16	9.5	13.5	27.3	1.8	9.3	5.3	5.4	3.4	5.7
JAN-FY16	9.6	16.8	20.1	9.8	3.1	14.5	5.4	20.5	7.7
FEB-FY16	9.1	17.0	24.2	6.0	5.9	10.1	6.5	9.3	5.3
MAR-FY16	9.2	14.8	26.0	9.7	2.9	4.3	7.2	5.3	6.7
APR-FY16	9.5	15.7	43.2	12.7	2.6	5.2	7.2	10.9	6.9
MAY-FY16	8.7	10.8	37.9	12.5	4.1	0.7	3.8	19.0	7.0
JUN-FY16	8.6	12.6	33.7	13.2	4.6	11.6	5.9	4.0	11.3

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition[j]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

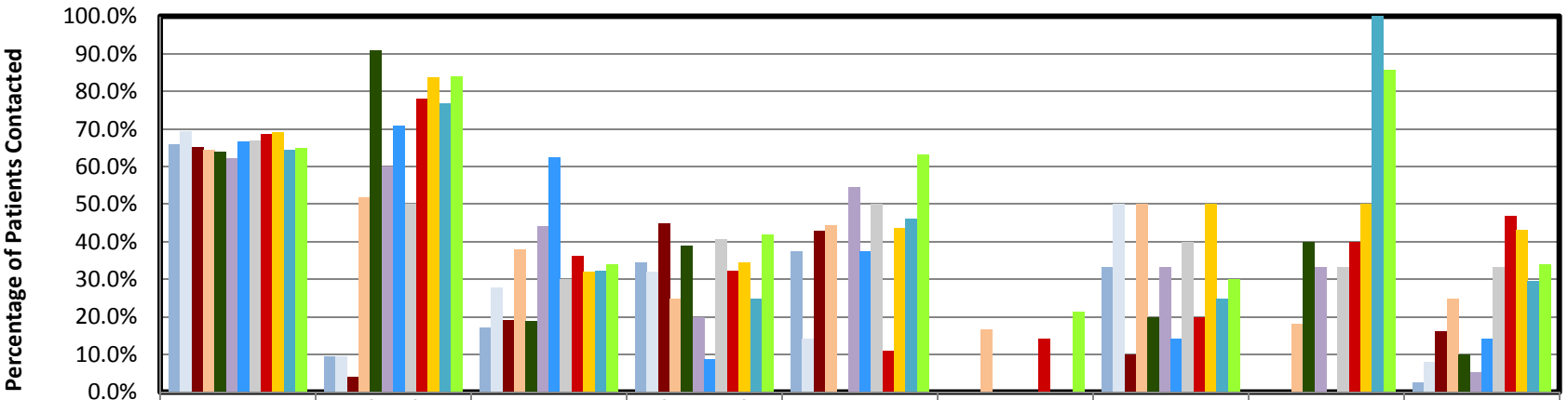


	VHA Total	(675) Orlando VA Medical Center	(675GA) Viera	(675GB) William V Chappell Jr VA OPC	(675GC) Kissimee	(675GD) Orange City	(675GE) Tavares VA Clinic	(675GF) Clermont	(675GG) Lake Baldwin
JUL-FY15	4.1	1.5	3.8	0.7	4.2	3.4	0.5	4.5	3.7
AUG-FY15	4.3	2.5	4.4	1.0	3.8	3.0	1.2	3.5	3.0
SEP-FY15	4.1	2.4	4.4	1.0	4.4	5.1	1.4	3.6	3.6
OCT-FY16	3.8	2.6	4.6	1.0	3.7	4.9	1.1	5.4	3.0
NOV-FY16	4.3	3.3	5.2	1.5	3.1	6.7	1.9	4.1	4.7
DEC-FY16	4.6	3.5	4.9	1.3	2.7	5.6	3.7	5.2	4.8
JAN-FY16	4.9	4.1	5.0	1.4	2.7	9.9	4.4	5.5	4.0
FEB-FY16	4.7	4.2	4.9	1.1	1.5	15.2	3.5	3.9	2.3
MAR-FY16	4.4	4.4	4.9	1.2	1.5	9.5	3.3	4.0	3.1
APR-FY16	4.3	3.2	4.1	1.3	1.4	7.9	3.4	4.9	3.2
MAY-FY16	4.3	3.1	3.5	1.0	1.6	3.3	2.2	10.1	3.0
JUN-FY16	4.4	2.6	3.3	1.1	2.1	2.8	2.4	5.4	3.5

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.

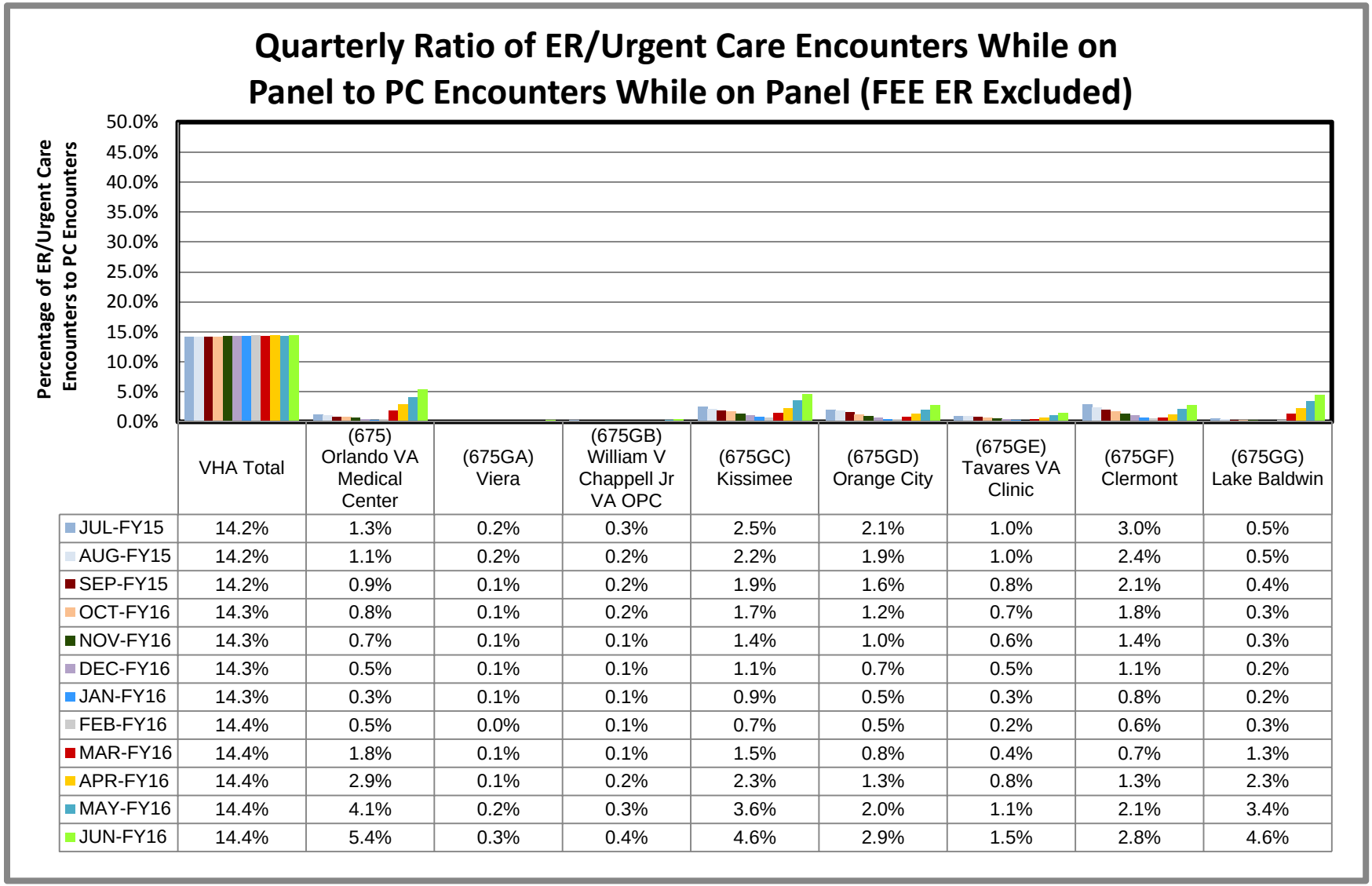


	VHA Total	(675) Orlando VA Medical Center	(675GA) Viera	(675GB) William V Chappell Jr VA OPC	(675GC) Kissimee	(675GD) Orange City	(675GE) Tavares VA Clinic	(675GF) Clermont	(675GG) Lake Baldwin
JUL-FY15	65.9%	9.5%	17.2%	34.6%	37.5%	0.0%	33.3%	0.0%	2.6%
AUG-FY15	69.4%	9.5%	27.8%	32.1%	14.3%	0.0%	50.0%	0.0%	8.2%
SEP-FY15	65.1%	4.2%	19.2%	45.0%	42.9%	0.0%	10.0%	0.0%	16.2%
OCT-FY16	64.3%	51.9%	38.1%	25.0%	44.4%	16.7%	50.0%	18.2%	25.0%
NOV-FY16	64.0%	90.9%	19.0%	38.9%	0.0%	0.0%	20.0%	40.0%	10.0%
DEC-FY16	62.3%	60.0%	44.1%	20.0%	54.5%	0.0%	33.3%	33.3%	5.3%
JAN-FY16	66.7%	70.8%	62.5%	8.8%	37.5%	0.0%	14.3%	0.0%	14.3%
FEB-FY16	66.9%	50.0%	30.0%	40.7%	50.0%	0.0%	40.0%	33.3%	33.3%
MAR-FY16	68.6%	78.0%	36.4%	32.3%	11.1%	14.3%	20.0%	40.0%	46.8%
APR-FY16	69.1%	83.7%	32.0%	34.6%	43.8%	0.0%	50.0%	50.0%	43.1%
MAY-FY16	64.5%	76.9%	32.3%	25.0%	46.2%	0.0%	25.0%	100.0%	29.7%
JUN-FY16	64.9%	84.0%	34.1%	41.9%	63.2%	21.4%	30.0%	85.7%	33.9%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge.



	VHA Total	(675) Orlando VA Medical Center	(675GA) Viera	(675GB) William V Chappell Jr VA OPC	(675GC) Kissimee	(675GD) Orange City	(675GE) Tavares VA Clinic	(675GF) Clermont	(675GG) Lake Baldwin
JUL-FY15	14.2%	1.3%	0.2%	0.3%	2.5%	2.1%	1.0%	3.0%	0.5%
AUG-FY15	14.2%	1.1%	0.2%	0.2%	2.2%	1.9%	1.0%	2.4%	0.5%
SEP-FY15	14.2%	0.9%	0.1%	0.2%	1.9%	1.6%	0.8%	2.1%	0.4%
OCT-FY16	14.3%	0.8%	0.1%	0.2%	1.7%	1.2%	0.7%	1.8%	0.3%
NOV-FY16	14.3%	0.7%	0.1%	0.1%	1.4%	1.0%	0.6%	1.4%	0.3%
DEC-FY16	14.3%	0.5%	0.1%	0.1%	1.1%	0.7%	0.5%	1.1%	0.2%
JAN-FY16	14.3%	0.3%	0.1%	0.1%	0.9%	0.5%	0.3%	0.8%	0.2%
FEB-FY16	14.4%	0.5%	0.0%	0.1%	0.7%	0.5%	0.2%	0.6%	0.3%
MAR-FY16	14.4%	1.8%	0.1%	0.1%	1.5%	0.8%	0.4%	0.7%	1.3%
APR-FY16	14.4%	2.9%	0.1%	0.2%	2.3%	1.3%	0.8%	1.3%	2.3%
MAY-FY16	14.4%	4.1%	0.2%	0.3%	3.6%	2.0%	1.1%	2.1%	3.4%
JUN-FY16	14.4%	5.4%	0.3%	0.4%	4.6%	2.9%	1.5%	2.8%	4.6%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

Prior OIG Reports
[December 1, 2013 through December 1, 2016]

Facility Reports

Review of VHA's Patient-Centered Community Care (PC3) Provider Network Adequacy
9/29/2015 | 15-00718-507 | Summary | Report

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | 15-01579-457 | Summary | Report

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Audit of VHA's Mobile Medical Units
5/14/2014 | 13-03213-152 | Summary | Report

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 24, 2017

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

Subject: **CAP Review of the Orlando VA Medical Center, Orlando, FL**

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

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

I have reviewed and concur with the response from the Orlando VA Medical Center Orlando, Florida.

Miguel H. LaPuz, M.D., MBA

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 24, 2017

From: Director, Orlando VA Medical Center (675/00)

Subject: **CAP Review of the Orlando VA Medical Center, Orlando, FL**

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

1. We thank you for the opportunity to submit responses to the proposed recommendations for the Orlando VA Medical Center, Orlando, FL.

2. We concur with the conclusions and recommendations presented by the Office of the Inspector General. Corrective action plans and compliance monitoring plans have been established and target dates have been set for the recommendations as detailed in the attached report.

Timothy W. Liezert

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 facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: Orlando VA Medical Center self-identified this non-compliance following an audit at the direction of the Chief of Staff. A Credentials Workgroup was formed and has responsibilities for improving compliance with the Ongoing Professional Practice Evaluation (OPPE). A set schedule for OPPE was established to take place October and April of each fiscal year. OPPE forms were revised and standardized to provide a more comprehensive evaluation of the practitioner's professional practice. Forms were provided to the Clinical Service Chiefs prior to October 1, 2016. After each OPPE cycle the Credentials Workgroup will perform a random audit of practitioner's folders to ensure compliance with OPPE. Initial audit showed 90 percent compliance of timely OPPE. Audit results will be submitted to the Professional Standards Board (PSB).

Recommendation 2. We recommended that facility managers implement the use of a visitors log during non-business hours and monitor compliance.

Concur

Target date for completion: Completed

Facility response: VA Police Standard Operating Procedure (SOP), Chapter V, Section B "Closing of Property to the public & use of the Visitor Register" was revised to include the Orlando Lake Nona VAMC [VA medical center]. The policy/procedure was approved by the Chief of Police on December 1, 2016. The education to all police personnel and contract security guards was completed via email and through security staff training on December 1, 2017. VA Police have implemented a visitor register (VA FORM 4793) sign in/out procedure for all visitors who enter the premises between 1900 hours and 0600 hours, as well as weekends and holidays. The front gate entrance is the only means for accessing the grounds after business hours. Non-employees entering the medical center will present a valid reason for their presence and record their presence on a Visitor's Register (VA FORM 4793). Additionally, a temporary badge is provided to the non-employee that includes the person's name, date, and authorized area. VA Police personnel will perform random

checks to ensure ongoing compliance. The month of December showed 100 percent compliance. Random checks will be conducted to ensure sustained compliance.

Recommendation 3. We recommended that the facility perform quality control testing on all endoscopes and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: The Chief, Sterile Processing Service (SPS), reviewed and revised Standard Operating Procedure (SOP) #140D and related Competency, Use of Channel Check 3 in 1 Residual Soil Test on December 2, 2016. The revised SOP includes the following: (1) performing complete decontamination process, including Channel Check, on all scopes being reprocessed which includes those that exceeded hanging time; (2) record the results on the Channel Check Log located in the service shared drive; (3) updating time for control from 90 seconds to 5 minutes; (4) performing audits on Channel Check process at least twice a month on all scopes, including those that exceeded hanging time. The Reusable Medical Equipment (RME) Educator provided an in-service to all Medical Supply Technicians regarding the changes to the SOP/Competency #140D on December 8, 2016. The SPS Quality Assurance designee (Lead Technician) will perform audits twice per month to ensure the compliance of channel checks on scopes that are being reprocessed due to 12 day hang time expiration date. Audits were completed on December 30, 2016 and January 13, 2017 and showed 100 percent compliance. Audits will continue to ensure sustained compliance. Results will be reported to the RME Committee.

Recommendation 4. We recommended that the facility review quality assurance data for the anticoagulation management program quarterly as defined by local policy and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: Orlando VA Medical Center self-identified that the Anticoagulation quality assurance data was not being reported to the Pharmacy and Therapeutic (P&T) Committee at least quarterly following a self-assessment. The facility had implemented an Anticoagulation Subcommittee; however, due to the extended vacancy of the Anticoagulation Program Manager the subcommittee was not meeting and therefore was not providing quarterly reports to P&T. During the absence of the subcommittee a Pharmacy representative was regularly attending the monthly VISN 8 Anticoagulation Workgroup meetings but not reporting the data to the local P&T. The VISN 8 meetings included a review of anticoagulation data from across all VISN 8 sites. Of note, the Orlando VA Medical Center is leading the VISN in many of the quality metrics. The Anticoagulation Subcommittee was reinstituted on September 20, 2016. The new Anticoagulation Program Manager started on October 16, 2016. The first report to P&T

committee was at the September 27, 2016 meeting. An Anticoagulation Subcommittee report was sent electronically to P&T Committee members on December 14, 2016.

Recommendation 5. We recommended that for patients transferred out of the facility, transferring providers consistently include documentation of patient or surrogate informed consent, VA Form 10-2649B, in transfer documentation and that facility managers monitor compliance.

Concur

Target date for completion: February 28, 2017

Facility response: Orlando VA Medical Center self-identified the non-compliance during the self-assessment of the Coordination of Care guide on October 4, 2016. The self-assessment was completed by the Medical Director/Urgent Care Clinic (UCC), Assistant Chief/Medicine, and Quality Management. Hospitalists and Urgent Care staff were notified of the results of the self-assessment and education was provided. The Transfer Coordinator provides a daily report on inter-facility transfers to Medical Director/UCC, Assistant Chief/Medicine, and the Chief, Health Administration Service and appropriate follow-up is conducted. The Transfer Coordinator was added to the Patient-Flow/Utilization Management Committee as a member and provided the inter-facility transfer report at the October 20, 2016 meeting. Quality Management designed a record review tool and has conducted three monthly random record reviews and provided the results to the Medical Director/UCC, Assistant Chief/Medicine, and the Chief of Staff. November data showed compliance of 85 percent; December showed a compliance of 67 percent; and January data showed 93 percent compliance. Compliance data is submitted to the Patient-Flow/Utilization Management. Quality Management will continue to monitor until such time that sustained compliance is reached and then randomly thereafter.

Recommendation 6. We recommended that providers consistently complete VA Form 10-2649A for patients transferred out of the facility and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: Orlando VA Medical Center self-identified the non-compliance during the self-assessment of the Coordination of Care guide on October 4, 2016. The self-assessment was completed by Medical Director/Urgent Care Clinic (UCC), Assistant Chief/Medicine, and Quality Management. During the self-assessment it was noted that the Urgent Care providers were not aware of the requirement for the Transfer Form. Hospitalists and Urgent Care staff were notified of the results of the self-assessment and education was provided. The Transfer Coordinator provides a daily report on inter-facility transfers to Medical Director/UCC, Assistant Chief/Medicine, and the Chief, Health Administration Service and appropriate follow-up is conducted. The Transfer Coordinator was added to the Patient-Flow/Utilization Management

Committee as a member and provided the inter-facility transfer report at the October 20, 2016 meeting. Quality Management designed a record review tool and has conducted three monthly random record reviews and provided the results to the Medical Director/UCC, Assistant Chief/Medicine, and the Chief of Staff. November data showed compliance of 100 percent; December showed a compliance of 83 percent; and January data showed 100 percent compliance. Compliance data is submitted to the Patient-Flow/Utilization Management. Quality Management will continue to monitor on a random basis to ensure sustained compliance.

Recommendation 7. We recommended that the facility implement an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior.

Concur

Target date for completion: February 28, 2017

Facility response: Orlando VA Medical Center has been adhering to the March 13, 2014 memo sent by the Acting Deputy Under Secretary for Health for Operations and Management which states facilities without a previously established Employee Threat Assessment Team (ETAT) will cease developing and implementing such team. In lieu of the formal ETAT, the Medical Center has an established process whereby employee disruptive behavior and threats are routed to Human Resources, Employee Relations (ER) Specialist. The ER Specialist assists management in fact finding and coordination of actions. Management reviews the facts with the ER Specialist and makes a recommendation for actions. The Medical Center Policy (MCP) 138-36, Violence Prevention and Management Program, is being revised to include the information.

Recommendation 8. We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement and ensure Chief of Staff or designee approval of Orders of Behavioral Restriction.

Concur

Target date for completion: January 31, 2017

Facility response: Effective December 5, 2016, all actions taken by the Orlando Disruptive Behavior Committee with regard to a veteran's Category I Behavioral Patient Record Flag (PRF) will be described in a letter, sent through certified mail to the veteran, along with instructions and forms involved in the options for appeal/amendment procedures (if the veteran wishes to request changes to the flag). These actions will include but are not limited to the placement of a flag, the acceptance of a flag from another facility and edits to the text, any restrictions required by the flag, and the removal/inactivation of a flag. CPRS [Computerized Patient Record System]/EHR notes describing any actions taken by the Orlando Disruptive Behavior Committee (DBC) will now contain the following notification: "The veteran will be notified via certified mail of

this action and provided information regarding options for the appeal/amendment process to the medical record." Letters involving these notifications of PRF activity will be signed by the Chief of Staff [COS] and scanned into the veteran's EHR to demonstrate that the COS has concurred with/approved of the DBC decisions and communication with the veteran. Additionally, the Medical Center Policy (MCP) 138-36, Violence Prevention and Management Program, will be revised to include the information. The Workplace Violence Prevention Program (WVPP) Program Manager will conduct monthly reviews until sustained compliance is achieved and then randomly thereafter. December review showed 100 percent compliance.

Recommendation 9. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Concur

Target date for completion: February 28, 2017

Facility response: Seven of the eight new employees have completed the Level 1 PMDB [prevention and management of disruptive behavior] training. Of the 3,922 OVAMC [Orlando VA Medical Center] employees, 98 percent have completed the Level 1 PMDB training. For CY16 [calendar year], 351 of the 437 (80 percent) new employees completed the Level 1 training within 90 days of being assigned the TMS [Talent Management System] Level 1 PMDB training module. All supervisors were notified, via email, on December 19, 2016 of their responsibility to ensure staff complete the Level 1 training timely. The email included a TMS report that lists staff that are deficient as well as those that are due within the next 90 days.

A critical review of the PMDB training process was completed, gaps and challenges identified, and actions to be taken have been developed. The PMDB Training Coordinator identified additional training dates to enable employees to complete Level 2A-4 training as indicated for their work area. Supervisors have been notified of their staff needing the Level 2A-4 training. For new employees, Education Service will assign Levels 2A-4 as indicated by the Workplace Behavioral Risk Assessment (WBRA). Education Service and the PMDB Training Coordinator will send quarterly TMS reports to supervisors on the status of PMDB training.

The Workplace Violence Prevention Program (WVPP), Manager, in collaboration with Education Service, developed an article for the 675 newsletter (published January 11 and January 18, 2017) that describes the PMDB training requirements of the Workplace Violence Prevention Program and included an overview of the training requirements. Additionally, the WVPP Manager is developing a short PPT [PowerPoint] tutorial on the WVPP which will be posted as part of the February 7, 2017 training day agenda for supervisors to review with employees. On the OVAMC home page we have added a news slider link that will take employees and supervisors to the local PMDB Share Point site. The PMDB Share Point includes the training dates for Level 2–4 and

directions to registering for the training. TMS provides reminder emails to supervisors and employees when they are getting closer to the due date as well as when they are past due. Supervisors are encouraged to use their service TMS administrators to assist in monitoring training compliance. The PMDB Coordinator provides training compliance data to the Environment of Care Committee at least quarterly.

Recommendation 10. We recommended that Domiciliary Care for Homeless Veterans and Substance Abuse Residential Rehabilitation Treatment Program employees at Lake Baldwin conduct and document daily bed checks and that program managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: The MHRRTP Standard Operating Procedure (SOP)-11, indicates that physical accountability of all registered Veterans is to be completed by a Health Technician/Registered Nurse five times per day: once at curfew (9:30 pm–10 pm), once after the doors are locked at approximately midnight, at approximately 5 am, at 10 am, and again at 4 pm. Unit Nurse Manager, Assistant Nurse Unit Manager, and Charge Nurse began educating staff on December 9, 2016 on the need for bed checks per SOP-11. Additionally, the Unit Nurse Manager and Assistant Unit Nurse Manager addressed at staff meetings on December 23, 2016 and January 18, 2017. Random reviews of the documented daily bed checks have been implemented and show 100 percent compliance for December and first part of January. Random reviews will continue to ensure sustained compliance.

Recommendation 11. We recommended that facility managers ensure all Mental Health Residential Rehabilitation Treatment Program emergency exit door alarms are functional and turned on at all times and that program managers monitor compliance.

Concur

Target date for completion: February 28, 2017

Facility response: A temporary door alarm was installed on November 28, 2016 at the Lake Baldwin MHRRTP site. Facilities Management Service (FMS) ordered the necessary parts for the permanent alarm on November 28, 2016. The permanent door sensor was installed on December 19, 2016. Weekly testing shows the alarm is activated and functioning properly. On January 23rd the MHRRTP Program Manager, MHRRTP Nurse Manager, and Risk Manager conducted a risk assessment of the emergency exit doors at the Lake Nona MHRRTP site to determine appropriate alarm system. There is only one entry and non-emergency exit to the building and it is monitored. All stairwell doors on the south side of the building are alarmed. All stairwell doors on the north side of the building (except for the one that leads to the outside) are alarmed in the evening and at night. The purpose of using the north stairwells is for the health and well-being of residents in the way of exercise and for those that may have a phobia of elevators. The one leading to the exterior is alarmed at all times. All

stairwells are monitored by cameras. A standard operating procedure is being written and will include a description of the doors that must be continuously alarmed and those that are alarmed only in the evening and at night. The SOP will also include a description of the scheduled system check to ensure the alarms are functional. Random audits of the alarm system checks will occur to ensure sustained compliance.

Recommendation 12. We recommended that facility managers ensure all closed circuit television monitoring cameras at the Domiciliary Care for Homeless Veterans and Substance Abuse Residential Rehabilitation Treatment Programs have recording capability and that program managers monitor compliance.

Concur

Target date for completion: February 28, 2017

Facility response: The MHRRTP Program Manager and the Police Security Specialist will complete a risk assessment of the cameras that are out of service to determine actual need of the cameras by January 31, 2017. Cameras will be removed if deemed not necessary. Police Security Specialist is currently working with Contracting Office to complete the renovation of the CCTV [closed circuit television] system within the Lake Baldwin MHRRTP.

OIG Contact and Staff Acknowledgments

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

Endnotes

[a] The references used for QSV 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] The references used for EOC included:
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1); *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

[c] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[e] The references used for Diagnostic Care: POCT included:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

[f] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[g] The references used for Management of Disruptive/Violent Behavior included:
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[h] The references used for MH RRTP 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.

[i] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.

[j] The reference used for Patient Aligned Care Team Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 25, 2016.