



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

July 18, 2014

U.S. OFFICE OF
SPECIAL COUNSEL
WASHINGTON, D.C.
JUL 21 2014 3:51 PM

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-12-4027

Dear Ms. Lerner:

This letter responds to the Office of Special Counsel's (OSC) request that the Department of Veterans Affairs provide additional information describing the status and details of the corrective actions recommended in the Department's report on OSC File No. DI-12-4027. Enclosed is a supplemental report that responds to the specific issues you raised.

Thank you for the opportunity to respond and provide additional information. If you have any questions, please contact Ms. Jennifer Gray in the Office of General Counsel at (202) 461-7634.

Sincerely,

Carolyn M. Clancy, MD
Interim Under Secretary for Health

Enclosure

**Office of the Medical Inspector
Supplemental Report to the
Office of Special Counsel
VA Caribbean Healthcare System
San Juan, Puerto Rico
OSC File No. DI-12-4027
June 17, 2014**

Background:

The Under Secretary for Health (USH) requested that the Office of Geriatrics & Extended Care Operations investigate complaints submitted to the Office of Special Counsel (OSC) by a whistleblower (a former nursing assistant) at the Community Living Center (CLC), Department of Veterans Affairs (VA), VA Caribbean Healthcare System (HCS), San Juan, Puerto Rico, hereafter, the Medical Center. The whistleblower alleged that the CLC is engaging in conduct that may constitute violations of law, rule, or regulation, gross mismanagement, and substantial and specific danger to public health. In brief, the allegations are:

- Nursing staff at the CLC neglect the elderly residents at the facility by failing to assist with essential activities of daily living.
- Nursing staff failed to record and report adverse events, namely patient falls, as required.

Based on its findings, there were 10 recommendations made for the Medical Center, all endorsed by the Under Secretary for Health. Geriatrics and Extended Care, the Office of the Medical Inspector and the Office of the Deputy Under Secretary for Health for Operations and Management reviewed and concurred with the Medical Center's action plan in response to report recommendations.

As requested, the following updates are provided on outstanding recommended actions:

a) AIB Recommendation 2 –

Recommendation 2: It is recommended that a culture of trusting interpersonal communication, collaboration, and accountability at all levels of staff within the GEC Service and the CLC be fostered and expected, in order to consistently deliver patient-centered care at all times. All interdisciplinary CLC staffing levels should be commensurate with the complexity of the care being delivered. Day-to-day operations of the CLC and nursing staffing should be guided by Veterans Health Administration (VHA) Directive 2010-034, Staffing Methodology for VHA Nursing Personnel, dated July 19, 2010, which clearly provides guidance regarding nursing staffing analysis when peer activity suggests that outcomes may be impacted by staffing levels and any triggers of adverse patient or resident outcomes.

Action Plan: San Juan HCS has made efforts to temporarily reduce the effective operational beds in the CLC-2, in order to optimize available nursing staffing of this neighborhood, until additional nursing staffing is recruited. Staffing levels have been reviewed, using staffing methodology in areas where applicable, in addition to benchmarking with similar facilities. Significant progress has been made. All actions are completed, except the recruitment for an additional Recreation Therapy Assistant.

Resolution – Hours per patient day (HPPD) are tracked on a spreadsheet on a daily basis for each CLC unit. A total of 25 additional nursing FTEE (LPN) have been recruited. This has resulted in an average HPPD to 5.78 for all three CLCs.

Action Ongoing

Discipline	Actual FTEE	Actions	Status
Nursing	134, 92 LPNs and 42 RNs	Nursing: Currently we have 5.49 NHPPD and are ongoing and actively recruiting vacancies.	<u>Completed</u>
Medical	3 MD's, 3 NPs	Medical: CLC Medical Director was recruited and started on December 2013. We also recruited an additional NP for CLC-2 and is in the credentialing process.	<u>Completed</u>
Nutrition	1.5	Nutrition: Was increased from 1.5 FTEE to 2 FTEE on January 2014.	<u>Completed</u>
Recreational Therapy	3RT , 2 RTA	Recreation Therapy: Increased to 3 RT and 2 RTA; pending re-announcement for an additional RTA since interviews were not successful.	<u>In progress</u>
Skin nurse	1	Skin Nurse: Credentialed Wound Care Specialist was recruited and started on March 2014	<u>Completed</u>

b) VHA Team Recommendations 2 and 3:

Recommendation 2: Take resident and/or family complaints of care issues seriously, and take immediate and appropriate action.

Resolution – The process for handling patient and/or family complaints is as follows: when a complaint is sent to the patient representative it is also sent to the CLC Medical Director and Chief Nurse CLC, via e-mail and a fact-finding is conducted. Those results go back to the patient representative thru the chain of command. If the complaint comes to the Nurse Manager (NM), she/he does a report of contact and submits it to the Chief Nurse with a fact-finding which goes thru the chain of command. During fiscal year (FY) 2013 we had 31 complaints of which 3 had no resolution (no evidence of closed loop); in FY 2014 we have had 16 complaints (50-percent decrease) of which all have had resolution.



Resident
Concerns&Complaints

Action Completed

Recommendation 3: Investigate any occurrences of failure to report resident and/or family complaints, and take appropriate action.

Resolution – No occurrences of failure to report have been detected since these actions are in place. In addition, 100 percent of the staff was re-educated on the process of reporting resident and/or family complaints. Currently the Chief Nurse CLC provides daily rounds in each area, meets with residents and family as necessary, discusses ongoing issues with the NMs and observes staff to ensure excellent customer service is provided. The importance of notifying any and all resident/family complaints to the Chief Nurse CLC was re-enforced with the NMs. Depending on the magnitude of the complaint corresponding appropriate actions are taken.

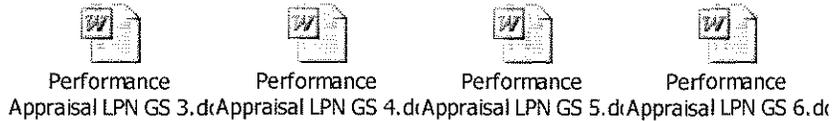
Action Completed

c) VHA Team Recommendation 4 –

Recommendation 4: Implement a plan to observe direct care staff to ensure each resident is provided assistance with assigned care and activities of daily living as needed.

Resolution – One hundred percent of the staff was directly observed by the NM during FY 2013, outcomes discussed with the Chief Nurse and feedback given to staff. For FY 2014 it was established that this round would continue. This

expectation was discussed immediately with the staff and is now included in the yearly performance appraisals as supporting documentation.



In addition, the Chief Nurse rounds daily with documented rounds utilizing the Chief Nurse Supervisory Round Form. During the daily rounds, the Chief Nurse explores/observes resident/family satisfaction, visits new admissions and residents with any type of change in condition. In addition, the RN in charge of each shift performs supervisory rounds which are documented and discussed with the Chief Nurse.



Action Completed

d) VHA Team Recommendation 5 –

Recommendation 5: Implement a plan to ensure ongoing education, competency validation and observation of direct care staff.

Resolution – Educational retreats started on March 20-21, 2013. One hundred percent of all licensed nursing staff (41/41 RNs and 86/86 LPNs) attended the retreats. Parallel to the educational retreats the Clinical Nurse Specialist validated (by either return demonstration in a lab or observing the care on the CLC) 100 percent of the licensed nursing staff's competency in feeding, pain management, suctioning, Protective Personnel Equipment with MRSA Positive High Risk and Head to Toe Skin Inspections.

A revamping of the Preceptorship Program for new employees was completed to include all the education topics from the retreats. The new employee spends the first 2 weeks with the Clinical Nurse Specialist. Prior to working with the assigned preceptor on the CLC the Clinical Nurse Specialist validates the new employee's competency and skill by either observing a return demonstration in a simulated situation or by observing the employee provide the care. This will ensure that new employees receive the same education and competency validation as was offered in the educational retreats.

Action Completed/Ongoing

e) VHA Team Recommendations 8, 9, 10 –

Recommendation 8: Assure that the Quality Improvement committee evaluates each resident with documented weight change on the CMS-802 to determine each resident's nutritional needs.

Resolution – The CLC Resident Assessment Coordinator (RAC) is evaluating each resident's documented weight change on the CMS 802; results are discussed in the CLC Performance Improvement Committee. Additionally a subcommittee composed of RAC, care coordinator, dietitian, and Chief Nurse was created to develop an action plan for weight loss management. Among the issues discussed are: selection of base weight, calibration of scales; weight selection in dialysis residents; revision of weight policy was completed on September 18, 2013. During FY 2014, the prevalence of weight loss is 7.9 percent. Reasons for weight loss are 44.4 percent were Absent Sick in Hospital or sick, 33.3 percent were hospice, 11.1 percent with morbid obesity and 11.1 percent with dementia.



Weight Loss Monitor
FY 14.pdf



GUIDELINES FOR
MONITORING UNINTI

Action Ongoing

Recommendation 9: Continue carrying out the action plans identified through the Falls Prevention Collaborative.

Resolution – We are monitoring falls on a daily basis and perform a post fall safety huddle to evaluate the cause of the fall and what can be done to avoid a future fall. In addition, residents with more than one fall are discussed in the interdisciplinary care planning meeting and their plan of care is revised accordingly. During FY 2014, the fall rate is 6.7 with a 70-percent decrease in the amount of falls with injuries when compared to FY 2013. We have noticed an increase in the amount of residents admitted with Dementia/Cognitive impairment and 65 percent of all the falls are residents with this diagnosis. We sent two employees to the Staff Training in Assisted Living Residences VA training for management of residents with dementia, and are working on enhancing the fall prevention program tailored to this resident population. We continue to monitor all aspects of falls on a monthly basis with compliance rates of 96-98 percent.



Falls FY 2014.pptx

Action Completed

Recommendation 10: Monitor status of progress to the Performance Improvement Committee and provide updates to leadership until resolution of corrective actions is reached and improved performance is evident.

Resolution – The CLC Chief Nurse and CLC Medical Director have overall responsibility for the CLC Performance Improvement (PI) Committee. A new PI Nurse was recruited for the CLC. The CLC PI nurse tracks the action plans and compliance. The CLC PI Nurse or Chief Nurse CLC/CLC Medical Director lead the monthly CLC PI Committee on third Wednesday of each month. During FY 2013 the CLC PI Nurse presented the CLC data to the VACHS Performance Improvement Board. During FY 2014 the monthly CLC PI Committee minutes are and will continue to be sent to the Associate Director, Patient Care Services who reads and provides the final approval.



Monthly PI Monitors
Compliance-FY 2013 I



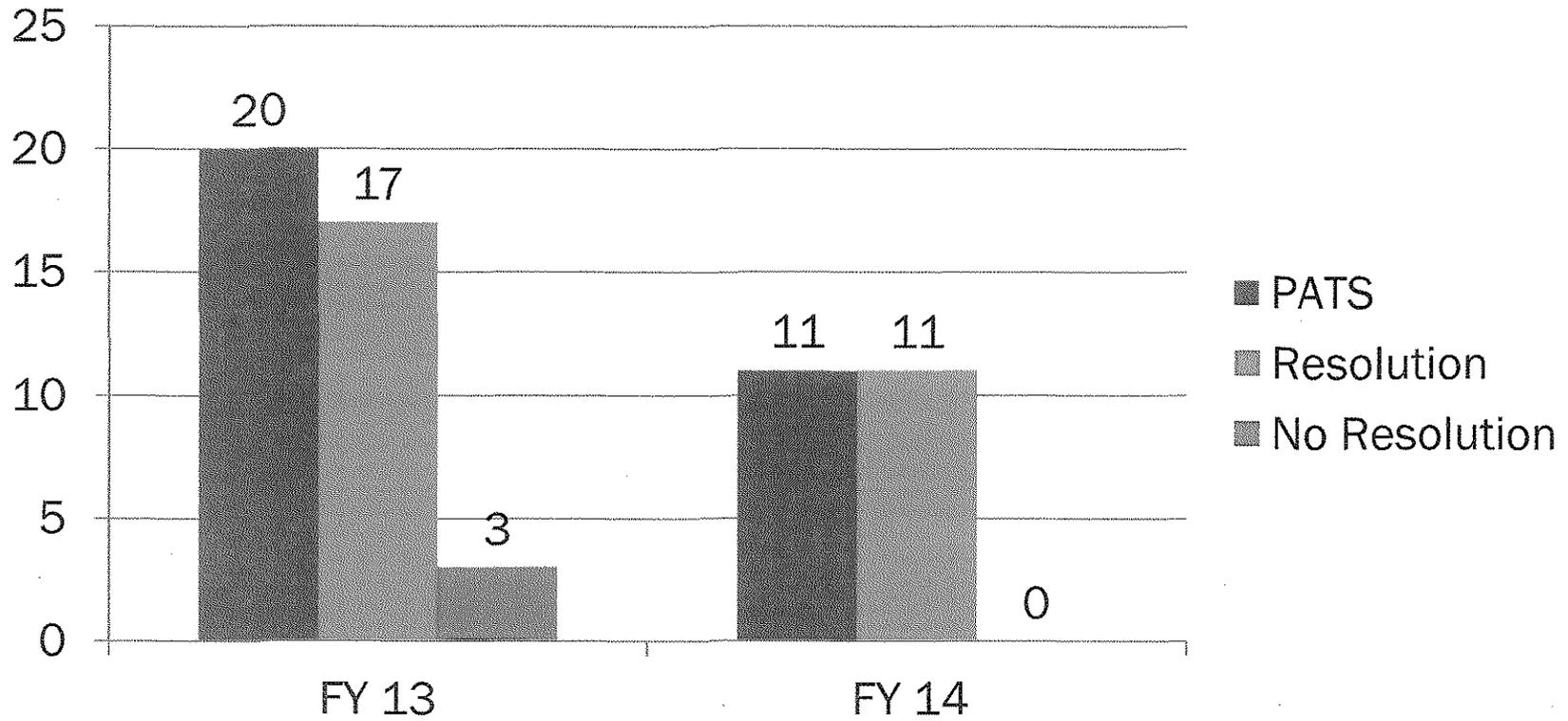
PI Committee
Minutes May 2014.pdf

Action Completed

**RESIDENT
CONCERNS/COMPLAINTS
FY 2013 & FY 2014**

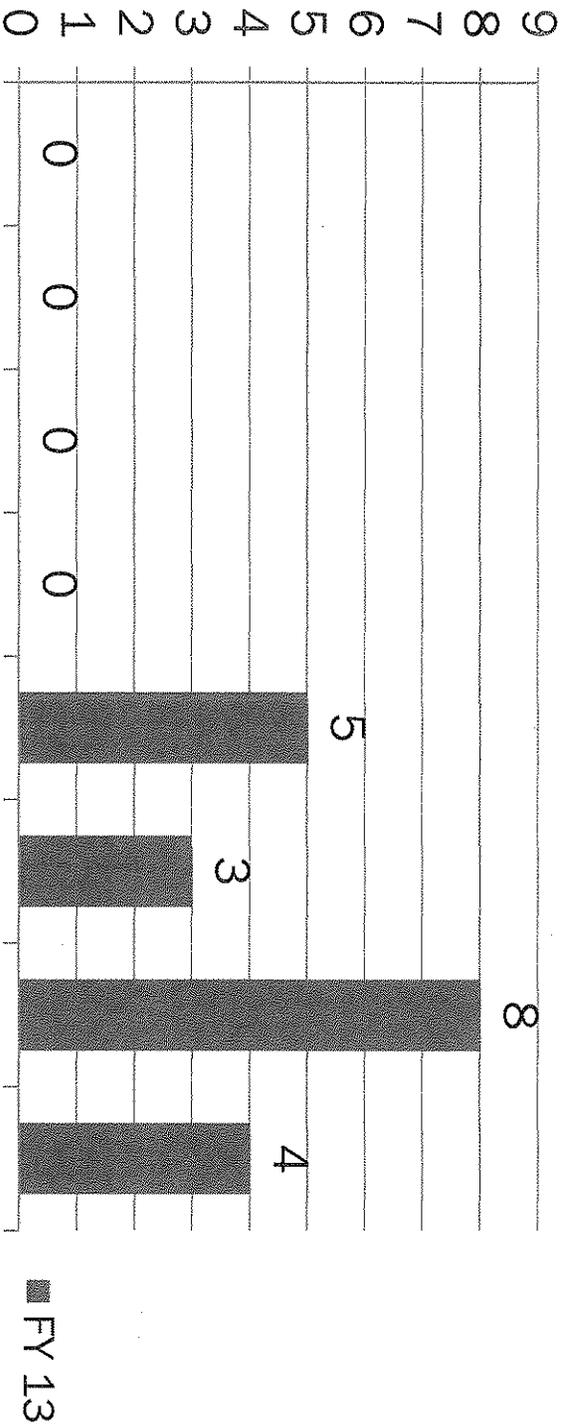
VACHS COMMUNITY LIVING CENTER

COMPLAINTS WITH PATIENT REPRESENTATIVE FY 13 & FY 14



PATIENT REPRESENTATIVE COMPLAINT CLASSIFICATION

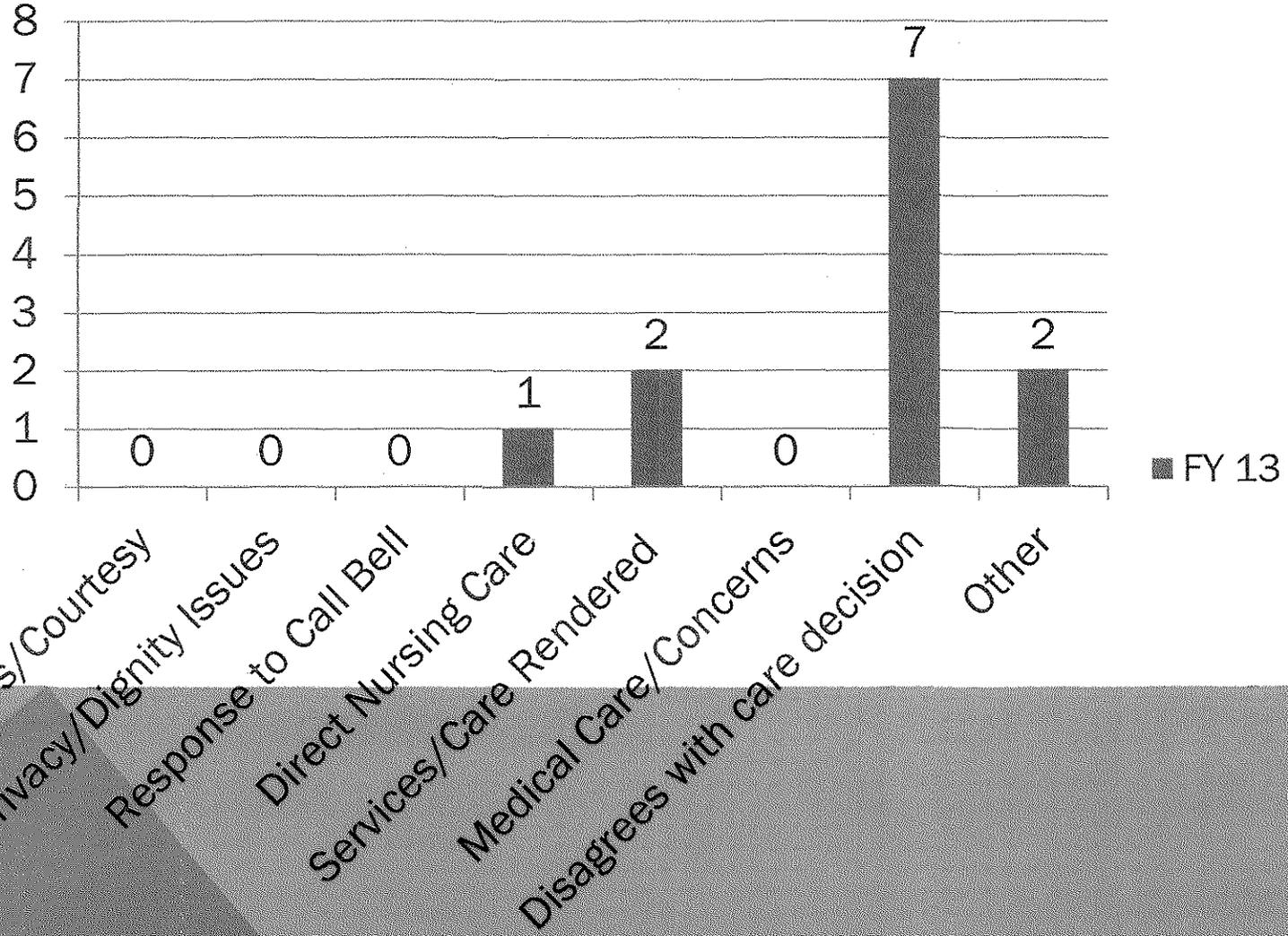
FY 13



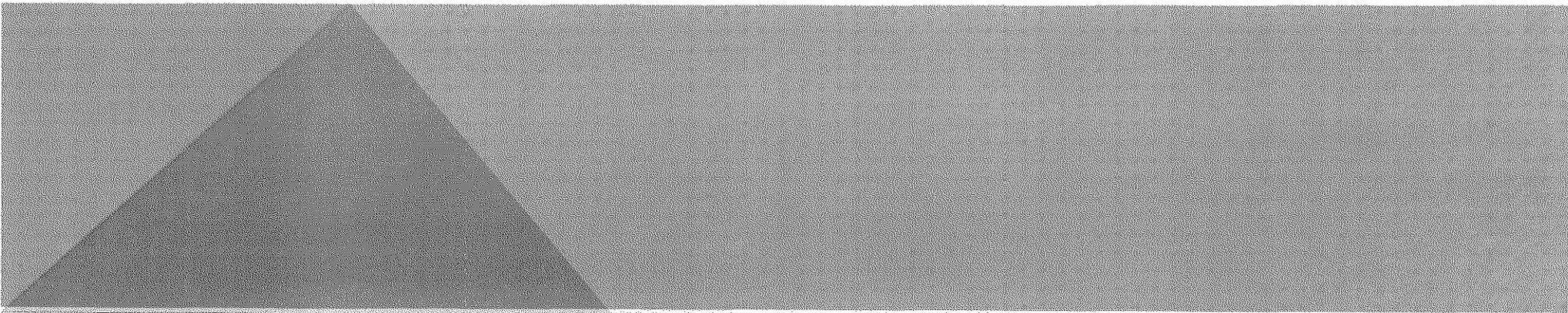
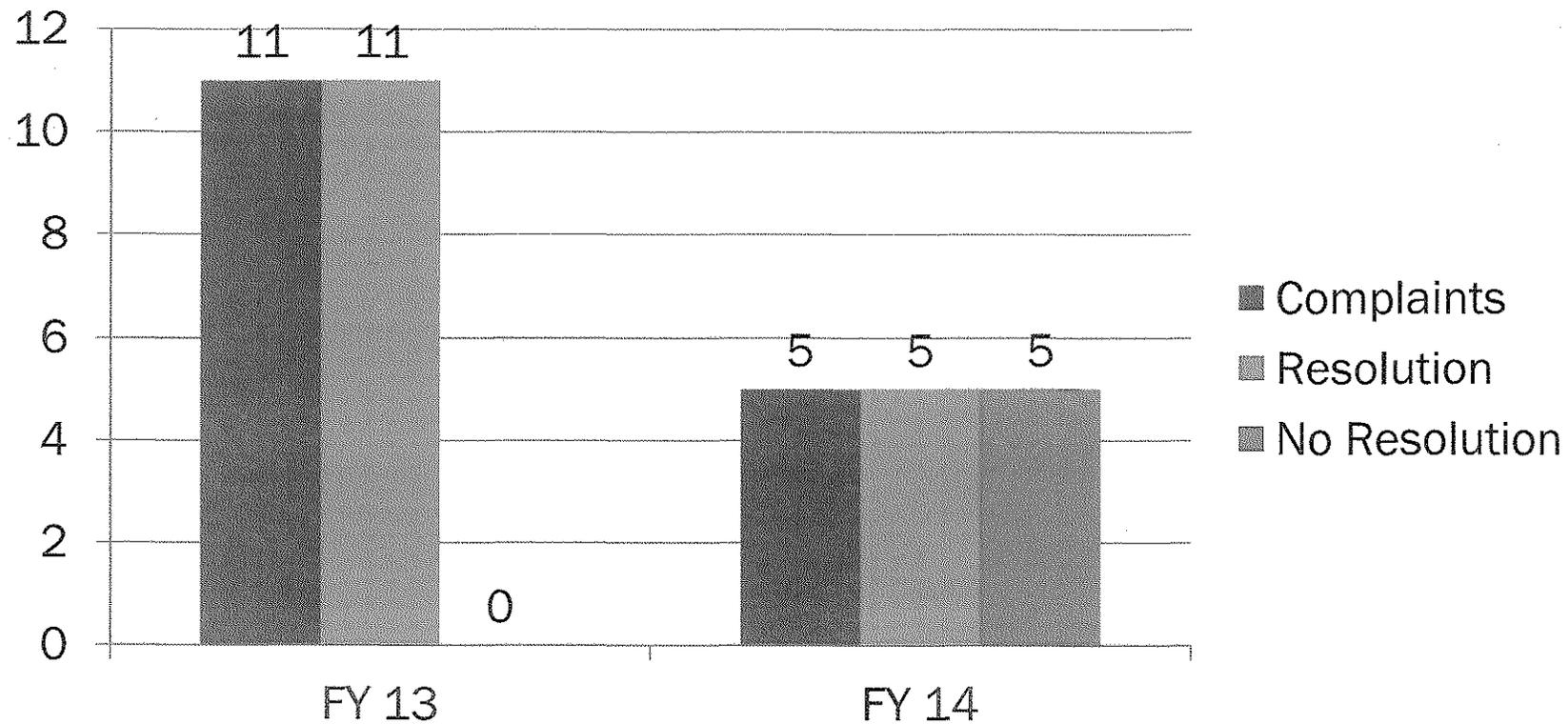
Staff Attitudes/Courtesy
Privacy/Dignity Issues
Response to Call Bell
Direct Nursing Care
Services/Care Rendered
Medical Care/Concerns
Disagrees with care decision
Other

PATIENT REPRESENTATIVE COMPLAINT CLASSIFICATION

FY 14

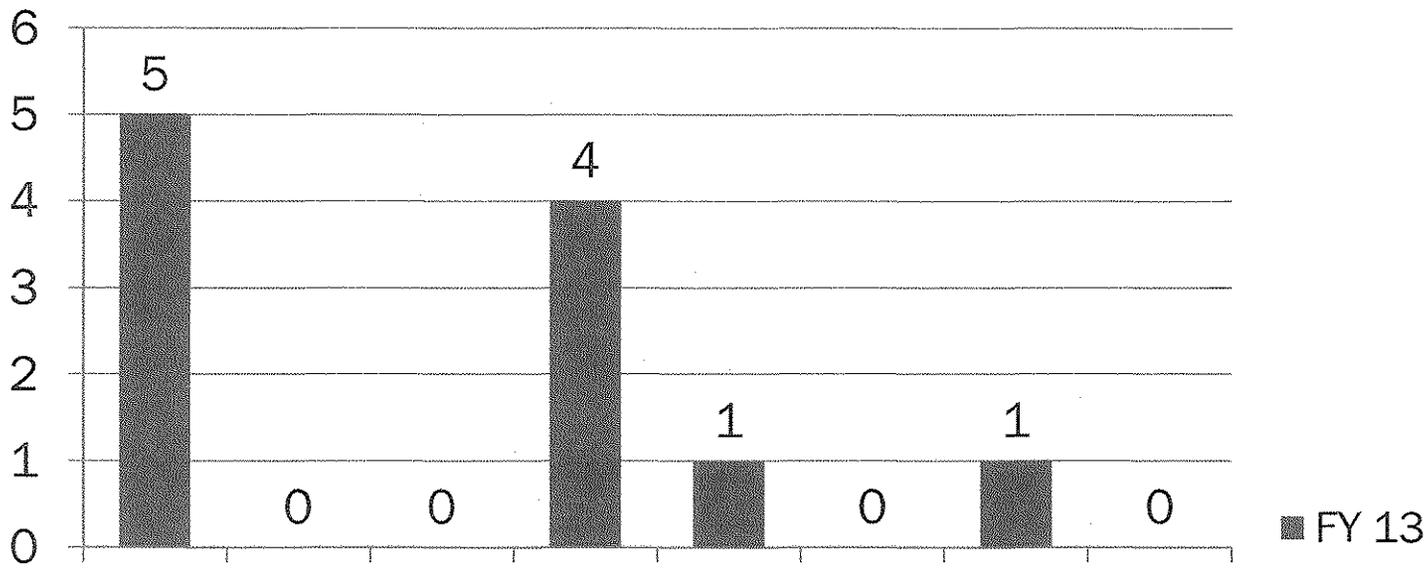


RESIDENT/FAMILY COMPLAINTS THRU OTHER CHANNELS (NOT PATIENT REPRESENTATIVE) FY 13 & FY 14



RESIDENT/FAMILY COMPLAINTS THRU OTHER CHANNELS (NOT PATIENT REPRESENTATIVE)

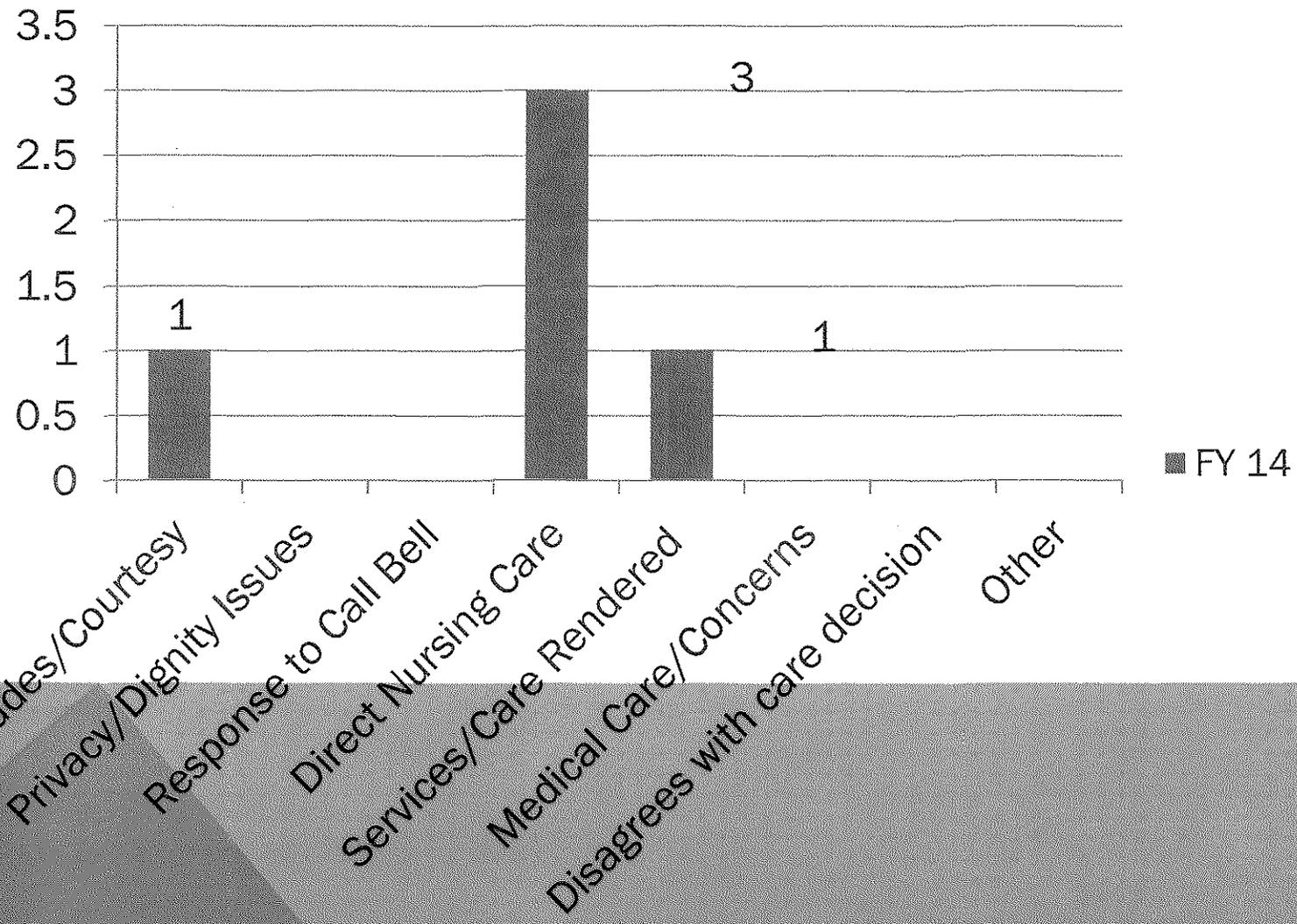
FY 13



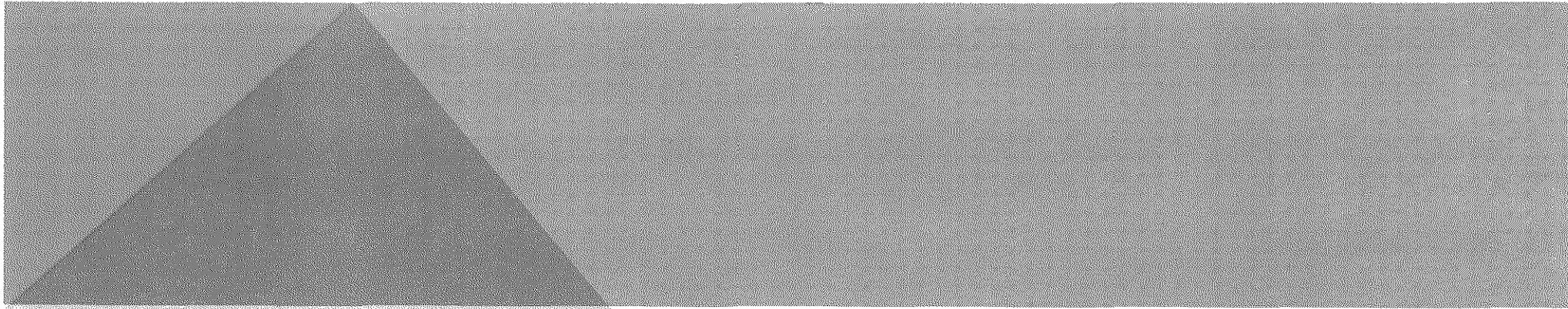
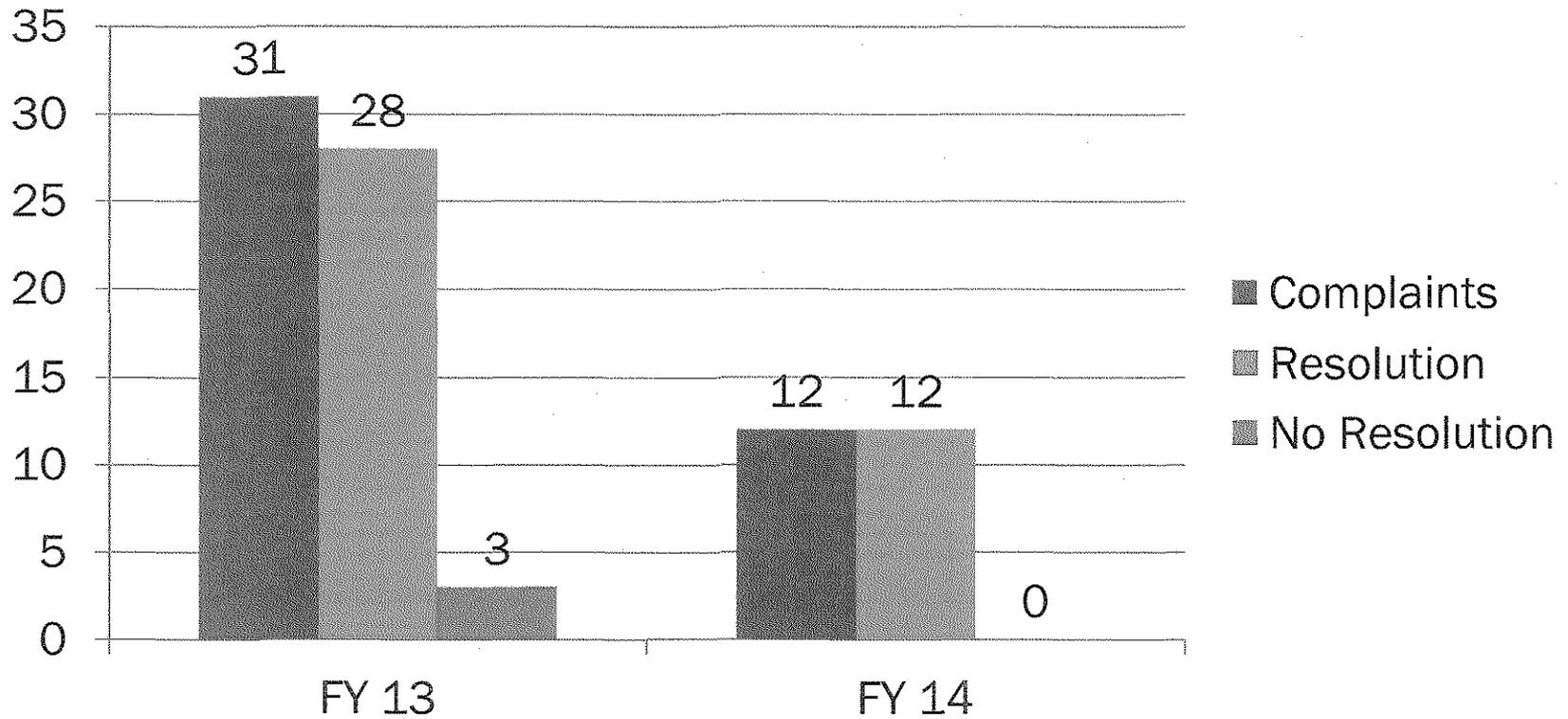
Staff Attitudes/Courtesy
Privacy/Dignity Issues
Response to Call Bell
Direct Nursing Care
Services/Care Rendered
Medical Care/Concerns
Disagrees with care decision
Other

RESIDENT/FAMILY COMPLAINTS THRU OTHER CHANNELS (NOT PATIENT REPRESENTATIVE)

FY 14



SUMMARY OF ALL COMPLAINTS FY 13 & FY 14



IMPORTANT: For additional information see VA Handbook 5013/1, Part 1. If additional space is needed for any item on this form, use page 6.

PERFORMANCE PLAN AND APPRAISAL OF

EMPLOYEE'S NAME (Last, First, Middle Initial)		POSITION TITLE, SERIES AND NUMBER		GRADE/SALARY
		Licensed Practical Nurse GS-0620		GS-3
DEPARTMENT/OFFICE			LOCATION	
Nursing Service/			VA Caribbean Healthcare System San Juan, PR	
DATE ASSIGNED PRESENT POSITION	DUE DATE OF WITHIN-GRADE INCREASE	PERIOD COVERED BY THIS PERFORMANCE PLAN:		
MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	
		FROM:	TO:	
SIGNATURE AND TITLE OF RATER PREPARING THIS PERFORMANCE PLAN	DATE: MM/DD/YYYY	SIGNATURE OF EMPLOYEE		DATE: MM/DD/YYYY

SECTION A - PERFORMANCE PLAN

Reflect the performance elements for the position to be rated. An element is defined as a component of a position that is sufficiently important to warrant written appraisal. Normally each position has four or five elements. Designate with an **asterisk** the element(s) considered critical. Specific performance standards must be written for each element. There are usually three to five performance standards for each element. When writing performance standards, only the fully successful level of achievement need be defined.

PERFORMANCE ELEMENTS/ STANDARDS

*** Direct Patient Care:**

1. Accurately and timely identifies and performs direct patient care following established clinical guidelines, policies, and procedures, to ensure satisfactory resolution of patient needs.
2. Demonstrates technical competency in performing assigned clinical task.
3. Follows infection control guidelines, policies and procedures.
4. Provides care which is consistent to the cognitive emotional and chronological maturation needs of the adult and/or geriatric patient.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

***Dependability:**

1. Plans, organizes, and completes assignment under the supervision of the RN within the scheduled tour of duty.
2. Observes patients condition and reports patients change in condition.
3. Recognizes and initiates proper interventions when an emergency arises and acts according by own initiative.
4. Fiscally responsible for use of supplies and equipment.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

SECTION A – PERFORMANCE PLAN (Continued).

PERFORMANCE ELEMENTS/STANDARDS

Interpersonal Effectiveness:

1. Treats and communicates with patient / significant other with respect and courtesy, using clear and precise information to facilitate their understanding.
2. Attends patient care needs and works toward problem resolution.
3. Communicates with internal/external customers in a courteous, tactful and helpful manner.
4. Demonstrates a cooperative attitude and fosters a positive work environment.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

Recording and Reporting:

1. Documents nursing care provided timely and accurately.
2. Reports relevant observations concerning patient/significant other and/or any significant event to the Registered Nurse and /or Nurse Manager as pertinent.
3. Reinforce patient/family education initiated by the Registered Nurse.

Three exceptions are accepted if they are of minor nature and not result in adverse impact to the patient.

Performance Improvement:

1. Participates in the unit's performance improvement activities.
2. Assists with implementation of changes in processes to improve patient care.

Three exceptions are accepted if they are of minor nature and not result in adverse impact to the patient.

***Safe Patient Care:**

1. Lifts and turns patients utilizing safe patient handling techniques appropriately.
2. Reports and responds appropriately to breakage/malfunction or loss of equipment, safety hazards and supply deficiencies.
3. Promotes safe environment of care including maintaining a clutter free environment, assuring equipment has the inspection tag, and active patient identification.
4. Follows safety policies and procedures in the delivery of patient care.

One exception is acceptable if it is of minor nature and does not result in adverse impact to the patient.

SECTION A – PERFORMANCE PLAN (Continued).

PERFORMANCE ELEMENTS/STANDARDS

CHANGES TO PERFORMANCE PLAN (Changes may be recorded anytime during the rating period)

ELEMENT DESCRIPTION/TITLE

STANDARD(S)

ELEMENT DESCRIPTION/TITLE

STANDARD(S)

SIGNATURE OF RATER

DATE: MM/DD/YYYY

SIGNATURE OF EMPLOYEE

DATE:MM/DD/YYYY

SECTION B - PROGRESS REVIEW

At least one progress review is required during the appraisal year. Employee must be informed of his/her progress as measured against the performance plan. Additional progress reviews may be documented on page 6.

A performance review was conducted and discussed, and the employee's performance as of this date:

- Is considered Fully Successful or better.
- Needs improvement to be Fully Successful or better. *(See VA Handbook, 5013/1, Part I, Paragraph 7, for additional required action.)*

SIGNATURE OF RATER

DATE: MM/DD/YYYY

SIGNATURE OF EMPLOYEE

DATE:MM/DD/YYYY

SECTION C - ACTUAL ACHIEVEMENT

Indicate the single, overall level of achievement that best describes the employee's performance for each ELEMENT shown in Section A. Do not indicate achievement for each individual standard. Specific examples of performance must be provided in the space below for each element where a level of achievement other than Fully Successful has been assigned. **Assignment of the Exceptional level means that Fully Successful performance standards have been significantly surpassed. This level is reserved for employees whose performance in the element far exceeds normal expectations and results in major contributions to the accomplishment of organizational goals.**

ELEMENTS <i>(Use the same keyword description for each element as in Section A)</i>	LEVELS OF ACHIEVEMENT		
	EXCEPTIONAL	FULLY SUCCESSFUL	UNACCEPTABLE
*DIRECT PATIENT CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*DEPENDABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTERPERSONAL EFFECTIVENESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RECORDING AND REPORTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PERFORMANCE IMPROVEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*SAFE PATIENT CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe specific examples of performance for each element where a level of achievement other than Fully Successful has been assigned above. Specific achievements at the Fully Successful level may be described

ELEMENTS/ACHIEVEMENT(S)

NARRATIVE SUMMARY - OPTIONAL (Provide any additional significant accomplishments, as well as other factors such as details or training experiences related to the overall performance plan. Capacity to assume a more responsible position may also be addressed.)

SECTION D - OVERALL RATING

TYPE OF RATING:

ANNUAL RATING OF RECORD

SPECIAL RATING OF RECORD

SUMMARY RATING
(POSITION CHANGES - EMPLOYEE OR RATER)

PERIOD COVERED BY THIS APPRAISAL: MM/ DD/ YYYY

FROM:

TO:

NOTE: Recommended Performance Rating - Using achievement levels assigned in Section C and the criteria described below, check the appropriate rating.

PERFORMANCE RATING

OUTSTANDING - Achievement levels for all elements are designated as Exceptional.

EXCELLENT - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for non-critical elements are designated as at least Fully Successful. Some, but not all, non-critical elements may be designated as Exceptional.

FULLY SUCCESSFUL - The achievement level for at least one critical element is designated as Fully Successful. Achievement levels for other critical and non-critical elements are designated as at least Fully Successful or higher.

MINIMALLY SATISFACTORY - Achievement levels for all critical elements are designated as at least Fully Successful. However, the achievement level(s) for one (or more) noncritical elements is (are) designated as unacceptable.

UNACCEPTABLE - The achievement level(s) of one (or more) critical elements(s) is (are) designated as unacceptable.

SIGNATURE AND TITLE OF RATER

DATE: MM/DD/YYYY

SECTION E - HIGHER LEVEL REVIEW/APPROVAL

Required only for Minimally Satisfactory and Unacceptable ratings of record; unless organization has chosen to have higher level approval required for Outstanding ratings of record.

Concur with recommended rating.

Do not concur with rating. Approve rating of _____.

BASIS FOR PERFORMANCE RATING CHANGE

SIGNATURE AND TITLE OF APPROVAL OFFICIAL

DATE: MM/DD/YYYY

A copy of this performance appraisal was given to me ►

SIGNATURE OF EMPLOYEE

DATE: MM/DD/YYYY

USE THIS AREA FOR ANY ADDITIONAL INFORMATION



IMPORTANT: For additional information see VA Handbook 5013/1, Part 1. If additional space is needed for any item on this form, use page 6.

PERFORMANCE PLAN AND APPRAISAL OF

EMPLOYEE'S NAME (Last, First, Middle Initial)		POSITION TITLE, SERIES AND NUMBER	GRADE/SALARY
		Licensed Practical Nurse GS-0620	GS-4
DEPARTMENT/OFFICE		LOCATION	
Nursing Service/		VA Caribbean Healthcare System San Juan, PR	
DATE ASSIGNED PRESENT POSITION	DUE DATE OF WITHIN-GRADE INCREASE	PERIOD COVERED BY THIS PERFORMANCE PLAN:	
MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
		FROM:	TO:
SIGNATURE AND TITLE OF RATER PREPARING THIS PERFORMANCE PLAN	DATE: MM/DD/YYYY	SIGNATURE OF EMPLOYEE	DATE: MM/DD/YYYY

SECTION A - PERFORMANCE PLAN

Reflect the performance elements for the position to be rated. An element is defined as a component of a position that is sufficiently important to warrant written appraisal. Normally each position has four or five elements. Designate with an asterisk the element(s) considered critical. Specific performance standards must be written for each element. There are usually three to five performance standards for each element. When writing performance standards, only the fully successful level of achievement need be defined.

PERFORMANCE ELEMENTS/ STANDARDS

* **Direct Patient Care:**

1. Accurately and timely identifies and performs direct patient care following established clinical guidelines, policies, and procedures, to ensure satisfactory resolution of patient needs.
2. Demonstrates technical competency in performing assigned clinical task.
3. Follows infection control guidelines, policies and procedures.
4. Provides care which is consistent to the cognitive emotional and chronological maturation needs of the adult and/or geriatric patient.
5. Administers medications following the established policy and procedures.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

***Dependability:**

1. Plans, organizes, and completes assignment requiring less supervision of the RN within the scheduled tour of duty to maximize productivity.
2. Observes patients condition and reports patients change in condition.
3. Recognizes and initiates proper interventions when an emergency arises and acts according by own initiative.
4. Fiscally responsible for use of supplies and equipment.

Responds to and assists in the management of patients who exhibit disturbed behavior in accordance with established guidelines, policies and procedures.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

SECTION A – PERFORMANCE PLAN (Continued).

PERFORMANCE ELEMENTS/STANDARDS

Interpersonal Effectiveness:

1. Treats and communicates with patient / significant other with respect and courtesy, using clear and precise information to facilitate their understanding.
2. Anticipates patients care needs and works toward problem resolution.
3. Communicates with internal/external customers in a courteous, tactful and helpful manner.
4. Demonstrates a cooperative attitude and fosters a positive work environment.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

Recording and Reporting:

1. Competence in documenting and reporting nursing care administered in accordance with established guidelines for frequency, quantity and quality.
2. Records and reports relevant observations concerning patient/significant other and/or any significant event to the Registered Nurse and /or Nurse Manager as pertinent.
3. Provides and documents effective education to patients and/or family members in relation to common disease processes, medication, and/or prescribed treatment regimens.

Three exceptions are accepted if they are of minor nature and not result in adverse impact to the patient.

Performance Improvement:

1. Participates in the unit's performance improvement activities; collects data and makes recommendations.
2. Implements changes in processes to improve patient care.

Three exceptions are accepted if they are of minor nature and not result in adverse impact to the patient.

***Safe Patient Care:**

1. Lifts and turns patients utilizing safe patient handling techniques appropriately.
2. Reports and responds appropriately to breakage/malfunction or loss of equipment, safety hazards and supply deficiencies.
3. Promotes safe environment of care including maintaining a clutter free environment, assuring equipment has the inspection tag, and active patient identification.
4. Follows safety policies and procedures in the delivery of patient care.
5. Identifies and reports potential safety hazards consistent with safety policies and procedures to prevent injury to self and to others.

One exception is acceptable if it is of minor nature and does not result in adverse impact to the patient.

SECTION A – PERFORMANCE PLAN *(Continued)*

PERFORMANCE ELEMENTS/STANDARDS

CHANGES TO PERFORMANCE PLAN *(Changes may be recorded anytime during the rating period)*

ELEMENT DESCRIPTION/TITLE

STANDARD(S)

ELEMENT DESCRIPTION/TITLE

STANDARD(S)

SIGNATURE OF RATER

DATE: MM/DD/YYYY

SIGNATURE OF EMPLOYEE

DATE:MM/DD/YYYY

SECTION B - PROGRESS REVIEW

At least one progress review is required during the appraisal year. Employee must be informed of his/her progress as measured against the performance plan. Additional progress reviews may be documented on page 6.

A performance review was conducted and discussed, and the employee's performance as of this date:

- Is considered Fully Successful or better.
- Needs improvement to be Fully Successful or better. *(See VA Handbook, 5013/1, Part 1, Paragraph 7, for additional required action.)*

SIGNATURE OF RATER

DATE: MM/DD/YYYY

SIGNATURE OF EMPLOYEE

DATE:MM/DD/YYYY

SECTION C - ACTUAL ACHIEVEMENT

Indicate the single, overall level of achievement that best describes the employee's performance for each ELEMENT shown in Section A. Do not indicate achievement for each individual standard. Specific examples of performance must be provided in the space below for each element where a level of achievement other than Fully Successful has been assigned. **Assignment of the Exceptional level means that Fully Successful performance standards have been significantly surpassed. This level is reserved for employees whose performance in the element far exceeds normal expectations and results in major contributions to the accomplishment of organizational goals.**

ELEMENTS <i>(Use the same keyword description for each element as in Section A)</i>	LEVELS OF ACHIEVEMENT		
	EXCEPTIONAL	FULLY SUCCESSFUL	UNACCEPTABLE
*DIRECT PATIENT CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*DEPENDABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTERPERSONAL EFFECTIVENESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RECORDING AND REPORTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PERFORMANCE IMPROVEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*SAFE PATIENT CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe specific examples of performance for each element where a level of achievement other than Fully Successful has been assigned above. Specific achievements at the Fully Successful level may be described

ELEMENTS/ACHIEVEMENT(S)

NARRATIVE SUMMARY - OPTIONAL (Provide any additional significant accomplishments, as well as other factors such as details or training experiences related to the overall performance plan. Capacity to assume a more responsible position may also be addressed.)

SECTION D - OVERALL RATING

TYPE OF RATING:

ANNUAL RATING OF RECORD

SPECIAL RATING OF RECORD

SUMMARY RATING
(POSITION CHANGES -- EMPLOYEE OR RATER)

PERIOD COVERED BY THIS APPRAISAL: MM/ DD/ YYYY

FROM:

TO:

NOTE: Recommended Performance Rating - Using achievement levels assigned in Section C and the criteria described below, check the appropriate rating.

PERFORMANCE RATING

OUTSTANDING - Achievement levels for all elements are designated as Exceptional.

EXCELLENT - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for non-critical elements are designated as at least Fully Successful. Some, but not all, non-critical elements may be designated as Exceptional.

FULLY SUCCESSFUL - The achievement level for at least one critical element is designated as Fully Successful. Achievement levels for other critical and non-critical elements are designated as at least Fully Successful or higher.

MINIMALLY SATISFACTORY - Achievement levels for all critical elements are designated as at least Fully Successful. However, the achievement level(s) for one (or more) noncritical elements is (are) designated as unacceptable.

UNACCEPTABLE- The achievement level(s) of one (or more) critical elements(s) is (are) designated as unacceptable.

SIGNATURE AND TITLE OF RATER

DATE: MM/DD/YYYY

SECTION E - HIGHER LEVEL REVIEW/APPROVAL

Required only for Minimally Satisfactory and Unacceptable ratings of record; unless organization has chosen to have higher level approval required for Outstanding ratings of record.

Concur with recommended rating.

Do not concur with rating. Approve rating of _____.

BASIS FOR PERFORMANCE RATING CHANGE

SIGNATURE AND TITLE OF APPROVAL OFFICIAL

DATE: MM/DD/YYYY

A copy of this performance appraisal was given to me ►

SIGNATURE OF EMPLOYEE

DATE: MM/DD/YYYY

USE THIS AREA FOR ANY ADDITIONAL INFORMATION



PERFORMANCE APPRAISAL PROGRAM

IMPORTANT: For additional information see VA Handbook 5013/1, Part 1. If additional space is needed for any item on this form, use page 6.

PERFORMANCE PLAN AND APPRAISAL OF

EMPLOYEE'S NAME (Last, First, Middle Initial)		POSITION TITLE, SERIES AND NUMBER	GRADE/SALARY
		Licensed Practical Nurse GS-0620	GS-5
DEPARTMENT/OFFICE		LOCATION	
Nursing Service/		VA Caribbean Healthcare System San Juan, PR	
DATE ASSIGNED PRESENT POSITION	DUE DATE OF WITHIN-GRADE INCREASE	PERIOD COVERED BY THIS PERFORMANCE PLAN:	
MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
		FROM:	TO:
SIGNATURE AND TITLE OF RATER PREPARING THIS PERFORMANCE PLAN	DATE: MM/DD/YYYY	SIGNATURE OF EMPLOYEE	DATE: MM/DD/YYYY

SECTION A - PERFORMANCE PLAN

Reflect the performance elements for the position to be rated. An element is defined as a component of a position that is sufficiently important to warrant written appraisal. Normally each position has four or five elements. Designate with an **asterisk** the element(s) considered critical. Specific performance standards must be written for each element. There are usually three to five performance standards for each element. When writing performance standards, only the fully successful level of achievement need be defined.

PERFORMANCE ELEMENTS/ STANDARDS

*** Direct Patient Care:**

1. Demonstrates knowledge and ability to provide a full range of practical nursing care to patients with a variety of physical and/or behavioral problems, following established clinical guidelines, policies, and procedures, to ensure satisfactory resolution of patient needs.
2. Follows infection control guidelines, policies and procedures.
3. Provides care which is consistent to the cognitive emotional and chronological maturation needs of the adult and/or geriatric patient.
4. Performs and records a complex range of procedures as described in the functional statement correctly, safety, cost effective utilizing appropriate equipment and supplies.
5. Knowledge and skill sufficient to prepare, administer, and appropriately document actions taken specific to commonly prescribed oral, topical, subcutaneous, intramuscular, and/or intravenous medications as permitted by approved local facility policies and procedures. Observation and documentation will include patient's response to medication administered and the reporting of any noted change in patient's condition to RN and/or NM.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient

***Dependability:**

1. Plans, organizes, and completes assignment requiring general supervision of the RN within the scheduled tour of duty to maximize productivity.
2. Observes patients condition and reports patients change in condition.
3. Knowledge and ability to recognize the need for and to institute emergency measures when indicated, promptly seek the assistance of the RN and assist in resuscitation procedures in cardiac and/or pulmonary arrest.

SECTION A – PERFORMANCE PLAN (Continued).

PERFORMANCE ELEMENTS/STANDARDS

4. Fiscally responsible for use of supplies and equipment.
5. Responds to and assists in the management of patients who exhibit disturbed behavior in accordance with established guidelines, policies and procedures.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

Interpersonal Effectiveness:

1. Treats and communicates with patient / significant other with respect and courtesy, using clear and precise information to facilitate their understanding.
2. Anticipates patients care needs and works toward problem resolution.
3. Communicates with internal/external customers in a courteous, tactful and helpful manner.
4. Demonstrates a cooperative attitude and fosters a positive work environment.
5. Participates and makes suggestions to the interdisciplinary team members and to the care plan of the patients.

Two exceptions are acceptable if they are of minor nature and do not result in adverse impact to the patient.

Recording and Reporting:

1. Competence in documenting and reporting nursing care administered in accordance with established guidelines for frequency, quantity and quality.
2. Records and reports relevant observations concerning patient/significant other and/or any significant event to the Registered Nurse and /or Nurse Manager as pertinent.
3. Provides and documents effective education to patients and/or family members in relation to common disease processes, medication, and/or prescribed treatment regimens.

Three exceptions are accepted if they are of minor nature and not result in adverse impact to the patient.

Performance Improvement:

1. Actively participates in the unit's performance improvement activities; collects data and makes recommendations.
2. Initiates and implements changes in processes to improve patient care.

Three exceptions are accepted if they are of minor nature and not result in adverse impact to the patient.

***Safe Patient Care:**

1. Lifts and turns patients utilizing safe patient handling techniques appropriately.
2. Recognizes and responds appropriately to breakage/malfunction or loss of equipment, safety hazards and supply deficiencies.
3. Promotes safe environment of care including maintaining a clutter free environment, assuring equipment has the inspection tag, and active patient identification.

SECTION A – PERFORMANCE PLAN (Continued).

PERFORMANCE ELEMENTS/STANDARDS

- 4. Follows safety policies and procedures in the delivery of patient care. Identifies and reports potential safety hazards consistent with safety policies and procedures to prevent injury to self and to others.

One exception is acceptable if it is of minor nature and does not result in adverse impact to the patient.

CHANGES TO PERFORMANCE PLAN (Changes may be recorded anytime during the rating period)

ELEMENT DESCRIPTION/TITLE

STANDARD(S)

ELEMENT DESCRIPTION/TITLE

STANDARD(S)

SIGNATURE OF RATER

DATE: MM/DD/YYYY

SIGNATURE OF EMPLOYEE

DATE:MM/DD/YYYY

SECTION B - PROGRESS REVIEW

At least one progress review is required during the appraisal year. Employee must be informed of his/her progress as measured against the performance plan. Additional progress reviews may be documented on page 6.

A performance review was conducted and discussed, and the employee's performance as of this date:

Is considered Fully Successful or better.

Needs improvement to be Fully Successful or better. *(See VA Handbook, 5013/1, Part I, Paragraph 7, for additional required action.)*

SIGNATURE OF RATER

DATE: MM/DD/YYYY

SIGNATURE OF EMPLOYEE

DATE:MM/DD/YYYY

SECTION C - ACTUAL ACHIEVEMENT

Indicate the single, overall level of achievement that best describes the employee's performance for each ELEMENT shown in Section A. Do not indicate achievement for each individual standard. Specific examples of performance must be provided in the space below for each element where a level of achievement other than Fully Successful has been assigned. Assignment of the Exceptional level means that Fully Successful performance standards have been significantly surpassed. This level is reserved for employees whose performance in the element far exceeds normal expectations and results in major contributions to the accomplishment of organizational goals.

ELEMENTS <i>(Use the same keyword description for each element as in Section A)</i>	LEVELS OF ACHIEVEMENT		
	EXCEPTIONAL	FULLY SUCCESSFUL	UNACCEPTABLE
*DIRECT PATIENT CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*DEPENDABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTERPERSONAL EFFECTIVENESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RECORDING AND REPORTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PERFORMANCE IMPROVEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*SAFE PATIENT CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe specific examples of performance for each element where a level of achievement other than Fully Successful has been assigned above. Specific achievements at the Fully Successful level may be described

ELEMENTS/ACHIEVEMENT(S)

NARRATIVE SUMMARY - OPTIONAL (Provide any additional significant accomplishments, as well as other factors such as details or training experiences related to the overall performance plan. Capacity to assume a more responsible position may also be addressed.)

SECTION D - OVERALL RATING

TYPE OF RATING:

ANNUAL RATING OF RECORD

SPECIAL RATING OF RECORD

SUMMARY RATING
(POSITION CHANGES - EMPLOYEE OR RATER)

PERIOD COVERED BY THIS APPRAISAL: MM/ DD/ YYYY

FROM:

TO:

NOTE: Recommended Performance Rating - Using achievement levels assigned in Section C and the criteria described below, check the appropriate rating.

PERFORMANCE RATING

OUTSTANDING - Achievement levels for all elements are designated as Exceptional.

EXCELLENT - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for non-critical elements are designated as at least Fully Successful. Some, but not all, non-critical elements may be designated as Exceptional.

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SIGNATURE AND TITLE OF RATER

DATE: MM/DD/YYYY

SECTION E - HIGHER LEVEL REVIEW/APPROVAL

Required only for Minimally Satisfactory and Unacceptable ratings of record; unless organization has chosen to have higher level approval required for Outstanding ratings of record.

Concur with recommended rating.

Do not concur with rating. Approve rating of _____.

BASIS FOR PERFORMANCE RATING CHANGE

SIGNATURE AND TITLE OF APPROVAL OFFICIAL

DATE: MM/DD/YYYY

A copy of this performance appraisal was given to me ►

SIGNATURE OF EMPLOYEE

DATE: MM/DD/YYYY

USE THIS AREA FOR ANY ADDITIONAL INFORMATION

Nurse Manager Supervisory Round

Date: _____ Time: _____ Legend: + Acceptable - Needs Improvement N/A - Not applicable

Equipment in room inspected									
Closet /skin care drawer organized									
Room organized and clutter free									
Nasal canula/suction catheters in plastic bag									
Mattress pressure adequate /documented									
Hydration provided									
Change of positions given/ documented									
Hourly rounds given/documentated									
Went to appointments including PT/OT									
Attended Dining Room									
Taken out of bed									
Orthotic/Prosthetic Devices applied									
Tracheotomy care provided									
Pressure Ulcer/Wound Care provided (date/time/initials)									
Nails (hands/feet) trimmed and clean									
Oral care adequate									
Cystoflow/Indwelling covered and within timeframe									
Well groomed									
Overall Resident satisfaction									
Resident Initials									
Room #									

Employee's Signature: _____ NM Signature: _____

CLC Charge Nurse Report

CLC: 1 2 3 Neighborhood: _____ Staffing: RN _____ LPN: _____ NA: _____

Date: _____ Shift: 12-8: _____ Day: _____ Evening: _____ Census: _____ ASIH: _____ Beds Available: _____

Name Charge RN: _____ Signature CH RN: _____

Care Activity	Amount of Residents	Comments	
Residents taken out of bed			
Residents remained bedfast			
<ul style="list-style-type: none"> • Order for bed rest • Refused • Sick 			
Ate in the Dining Room			
<ul style="list-style-type: none"> • Refused • Sick • PEG/NGT 			
Food Consumption			
<ul style="list-style-type: none"> • 100% • 75% • 50% • 25% • NPO/Refused 			
Snacks Consumed			
<ul style="list-style-type: none"> • 100% • 75% • 50% • 25% 			
Falls			
Acquired Ulcers			
Admitted ASIH			
Sent to ED			
Deaths			
Special Incidents/Unusual Events			
Resident/Family/Staff Complaints			
*Require Report of Contact			
Care Issues Charge RN is responsible for monitoring			
Adequate Oral care	Hourly/Comfort Rounds given	Skin local care given/skin inspections	Resident choices honored
Nail Care (hands/feet) trimmed and clean	Hydration round given	Foley/condom changed accordingly	Proper alignment while feeding
Orthotic/Prosthetic devices used accordingly	Before bedtime Snacks round given (offer to all)	Responsiveness to call bells within 1 minute	Continuous feedings properly aligned
Change of positions/ROM given	Care plans updated according to changes	Equipment inspection spot checks	Interventions for frequent fallers
Noise level control			

Weight Loss Monitor

FY 2014

VACHS
Community Living Center

PDSA: Plan

- * Involuntary weight loss is commonly observed in the older population, affecting 50% to 60% of nursing-home residents but unintended weight loss can be an important indicator of significant decline in health and function, resulting in higher morbidity and mortality.
- * Weight loss not detected or treated may be seen as elderly neglect inclusive giving the impression that residents are not being adequately fed.

PDSA: Plan

- * A wide range of prevalence of weight loss, low BMI, poor appetite, malnutrition, and eating disability has been reported among nursing home residents.
- * Of all the measures, the MDS weight loss definition of $\geq 5\%$ in 1 month or $\geq 10\%$ in 6 months had the narrowest range of prevalence rate: 6% to 15%.
- * Weight loss is expected when a resident is under end-of-life or palliative care

PDSA: Plan

- Aim: Prevalence of weight loss is 10% or less
- Unavoidable Weight Loss: Resident did not maintain acceptable parameters even though :
 - Resident's clinical condition and nutritional risk factors were evaluated
 - Interventions that are consistent with resident's needs, goals and recognized standards of practice were defined and implemented
 - Impact of interventions were monitored and evaluated or approaches were revised appropriately

PDSA: Plan

INTERVAL	SIGNIFICANT WEIGHT LOSS/GAIN	SEVERE LOSS/GAIN
1 month	5.0%	>5.0%
3 months	7.5%	>7.5%
6 months	10.0%	>10.0%

PDSA: Do

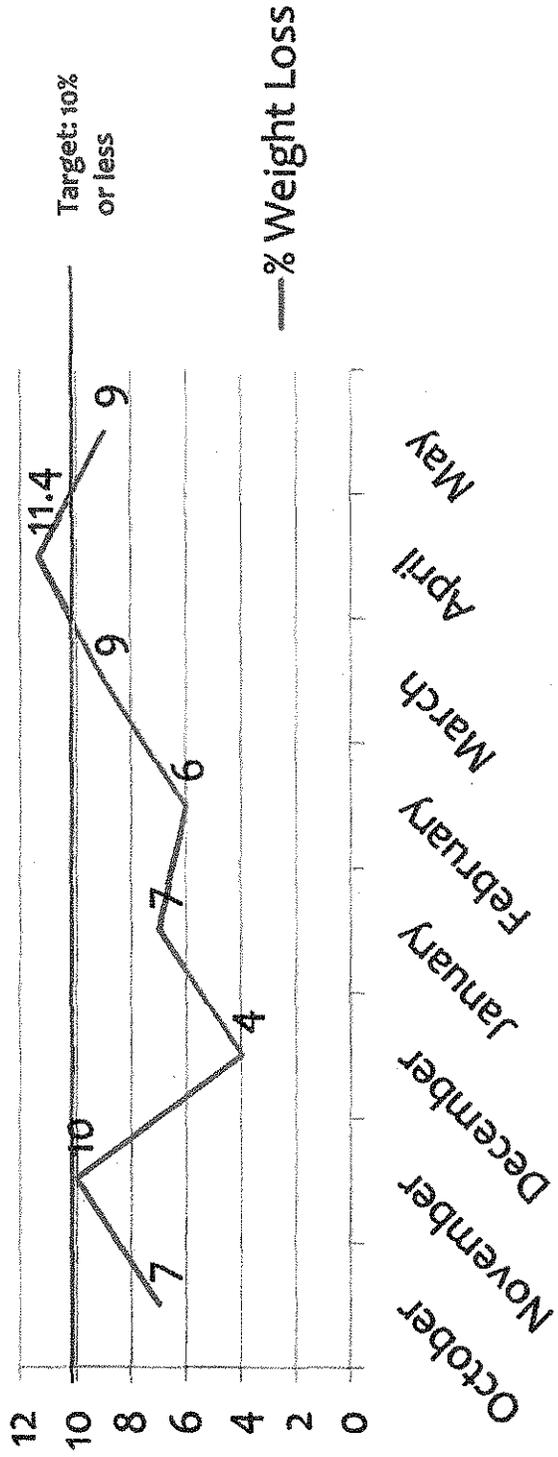
- * All residents will be weighted upon admission/re-admission, then weekly for the first four (4) weeks.
- * In addition, weekly weight will be ordered by the provider when:
 - * Significant unintended weight loss is observed during monthly weights.
 - * Persistent decrease in food intake. Decrease in food intake is defined as meal consumption at 50% or less for two meals in one day at least one time during one week.

PDSA: Do

- * The RN/CC/designee will notify the provider and dietitian in cases where there is significant/severe weight loss/gain and document progress note in CPRS.
- * The progress note will be send to the provider and dietitian for additional signatures.
- * Care Plan will be revised accordingly.
- * The provider and dietitian will document interventions in CPRS.
- * RN/CC, RD and Provider will meet to debrief cases of residents that have loss weight

PDSA: Study

% Weight Loss



PDSA: Study

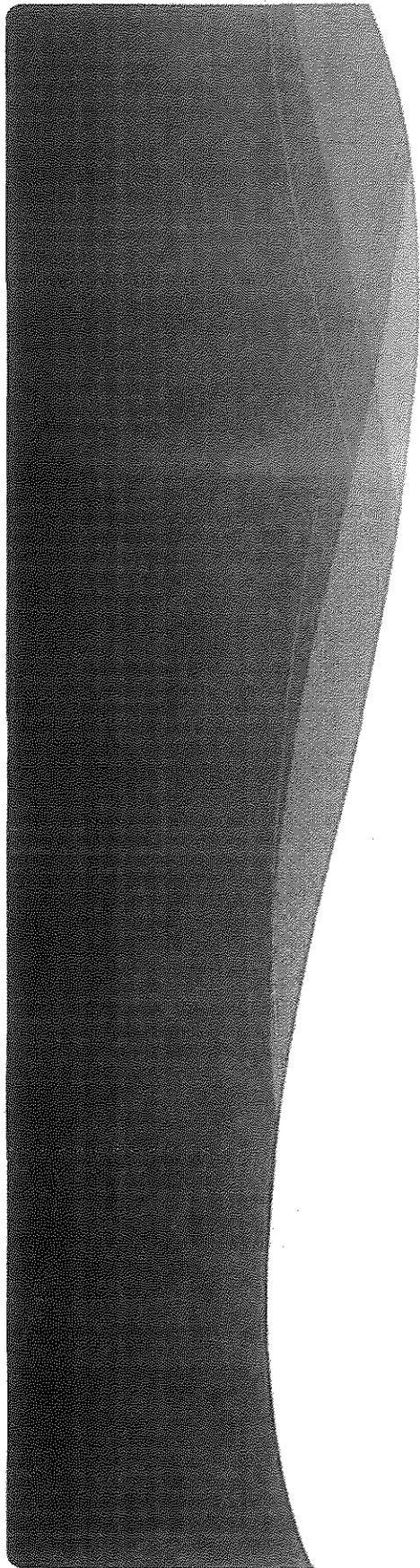
Reasons for weight loss	%
ASIH / Sick	44.4
Hospice	33.3
Morbid Obesity	11.1
Dementia	11.1

PDSA: Act

- * Continue to assess all residents for risk factor for nutrition problems
- * Continue to develop and implement care plans based on the assessments
- * Develop training in the principles of assisting residents with dementia/cognitive impairment when feeding
- * Implement the “all offices closed-hands on deck” approach at meal times.

PDSA: Act

- * Weekly nursing staff huddle to discuss challenging cases and brainstorm methods for increasing food/fluid intake
- * Monthly meetings with nurse care coordinators, dietitian and providers to analyze aspects related to weight monitoring.



**GUIDELINES FOR MONITORING UNINTENDED OR INSIDIOUS
WEIGHT LOSS OR GAIN IN LONG TERM CARE RESIDENTS**

I. **PURPOSE:** To establish guidelines for systematic monitoring of significant/severe weight loss/gain of residents admitted to the Long Term Care Units (Community Living Center (CLC) 1, 2 & 3).

II. **POLICY:**

A. Resident's weight is taken and analyzed to monitor unintended or insidious weight loss/gain.

III. **RESPONSIBILITIES:**

A. The Chief Nurse for CLC is responsible for the implementation of this policy in the CLC. This responsibility is delegated to the Nurse Manager (NM).

B. The Permanent Charge Nurse (PCN) is responsible for assuring weight is taken accordingly, entered in CPRS and assuring significant/severe gain/loss weight is notified to the provider and dietitian.

C. The Registered Nurse/Care Coordinator (RN/CC) is delegated the responsibility for maintaining and tracking weight loss or gain of his/her group of residents, assuring changes have been notified to the provider/dietitian and revising the care plan accordingly.

D. The Registered Nurse/Licensed Practical Nurse (RN/LPN) is responsible for weighting those residents assigned to him/her, documenting the weight in the medical record (CPRS) and determining if there has been significant/severe gain/loss weight.

E. The Provider and Dietitian are responsible for evaluating residents with significant/severe weight loss/gain, and documenting actions and/or interventions in the medical record.

IV. **PROCEDURE:**

A. In order to establish a baseline weight, all residents will be weighted upon admission/re-admission, then weekly for the first four (4) weeks. This excludes residents admitted for Hospice care, unless otherwise indicated.

B. In addition of the weekly weight during the first four weeks of admission/re-admission, weekly weight will be ordered by the provider when:

1. Significant unintended weight loss is observed during monthly weights (see criteria for significant/severe weight loss/gain in section F).

2. Persistent decrease in food intake. Decrease in food intake is defined as meal consumption at 50% or less for two meals in one day at least one time during one week or less 50% of food consumed for greater than 3 days.

C. The RN/CC/designee will notify the provider and dietitian in cases where there is significant/severe weight loss/gain and document progress note in CPRS. The progress note will be send to the provider and dietitian for additional signatures. Care Plan will be revised accordingly. The provider and dietitian will document interventions in CPRS.

D. For obtaining accurate weight nurses have to follow the below consistent approach:

1. Weight resident wearing similar type of clothing.
2. Assure resident is clean, dry and urine bag is empty.
3. Weight resident approximately at the same time of the day.
4. Use the same scale assuring it is calibrated.
5. Weight consistently without orthotics/prosthetic devices.

6. If resident is chair bound, weight the wheelchair first with all its parts and then weight resident on chair. Subtract the amount of the chair's weight to the total weight given with resident on chair and that will give you the resident's total weight. Make sure resident doesn't have additional items such as shopping bags on his lap or in back of wheelchair. The weight of the chair may be written down as to have for future weights.

E. If resident weight has changed more than 2 pounds from previous weight, immediately reweigh resident. If for any reason a weight is entered on CPRS incorrectly, it should be corrected immediately after the error is identified, this will avoid confusion due to unreliable information.

F. In case of significant/severe weight loss:

a. Weight resident weekly, until no significant weight loss/gain is evidenced in a period of two consecutive months or otherwise indicated.

- b. Consider making available a variety of snacks for resident to choose from.
- c. Consider combining recreational activities with use of supplemental feedings.
- d. Consider offering nutritional supplements with the meals or as a snack.

e. Liberalize Dietary Restrictions following LTC Policy "Liberalizing Dietary Restrictions in the Community Living Center".

G. The following criteria are used to evaluate weight gain and loss to determine the need for further assessment, utilizing this formula:

Actual weight/previous x 100 = n then 100 - n = % weight loss/gain		
INTERVAL	SIGNIFICANT WEIGHT LOSS/GAIN	SEVERE LOSS/GAIN
1 month	5.0%	>5.0%
3 months	7.5%	>7.5%
6 months	10.0%	>10.0%

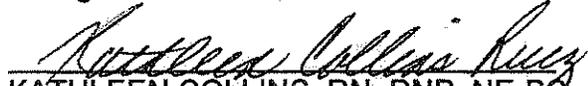
V. REFERENCES:

- A. VHA HANDBOOK 1180.02, JULY 1, 2011 "Assessment and Prevention of Pressure Ulcers".
- B. CAMLTC Joint Commission Standards.
- C. Unintended Weight Loss in Older Adults, Academy of Nutrition and Dietetics, Evidence Analysis Library 2011.
- D. Nutrition Care Manual, Academy of Nutrition and Dietetics, 2012.
- E. Nutritional Management in Long Term Care: Development of a Clinical Guideline, Journal of Gerontology, Medical Sciences, 2000, Vol.55A, M725-M734
- F. Agency for Healthcare Research and Quality, On Time Quality Improvement Manual for LTC Facilities, <http://www.ahrq.gov/research/ltc/ontimeqmanual/gimanual14a.htm>

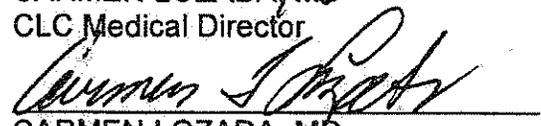
VI. RESCISSION: LTC Memorandum No. 11G-09-29, dated 09/15/12

VII. EXPIRATION DATE: January, 2016.

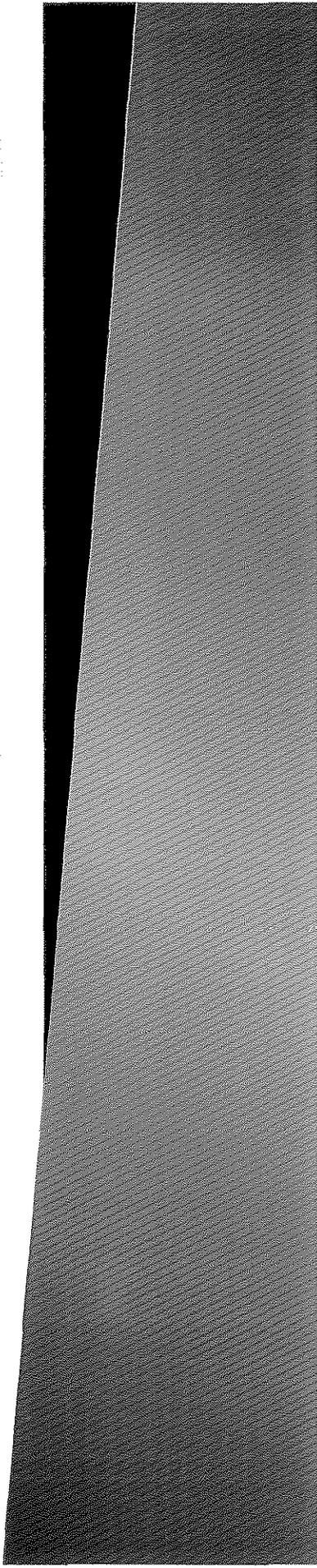

GLADYS NAVARRO, RN, MSN, NEA-BC
Acting Nurse for CLC


KATHLEEN COLLINS, RN, DNP, NE-BC
Associate Director Patient Care Services

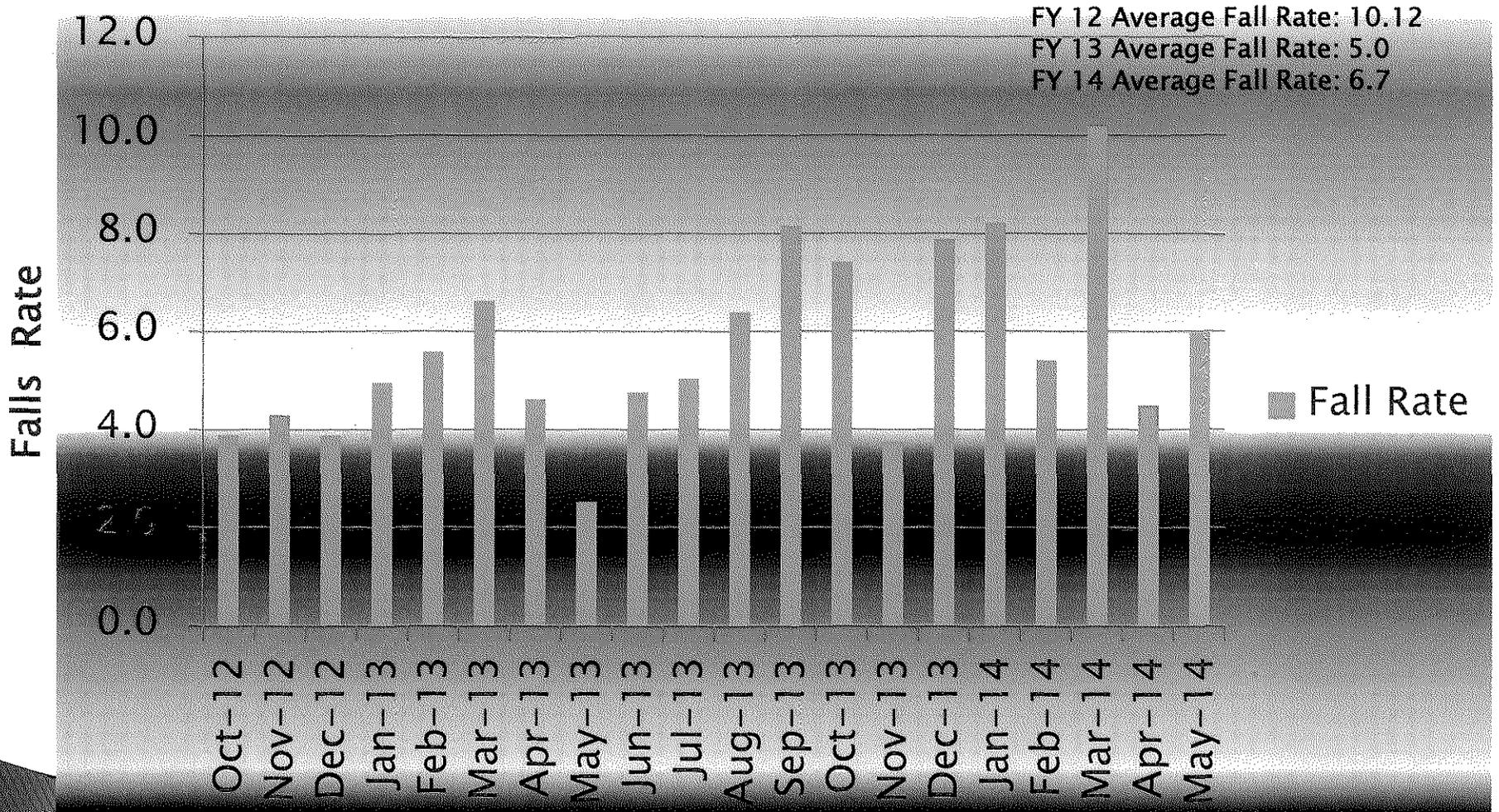

CARMEN LOZADA, MD
CLC Medical Director


CARMEN LOZADA, MD
Acting ACOS/Geriatric & Extended Care

Caribbean Healthcare System CLC- Falls



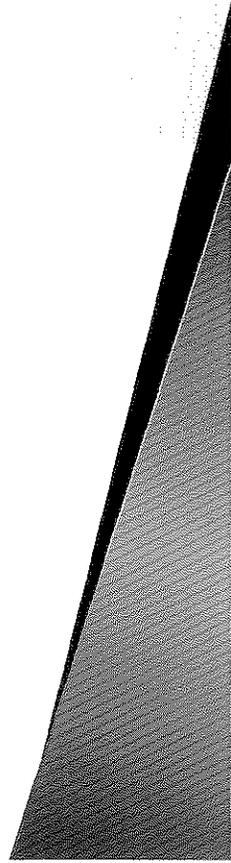
CLC -Fall Rate FY 2013 & FY 2014



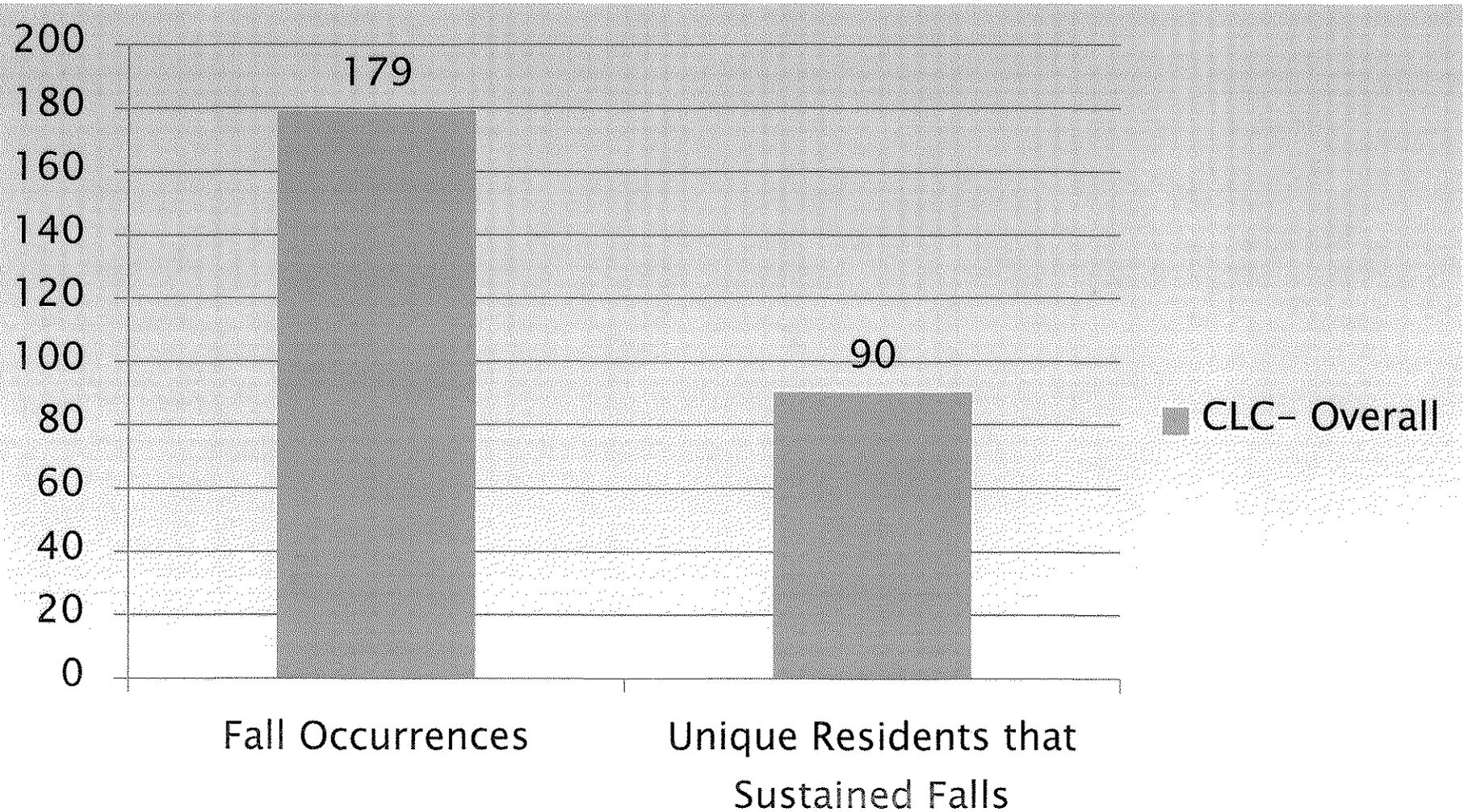
$$\frac{\text{\# of Falls}}{\text{BDOC}} = \text{Falls Rate}$$

CLC- Fall related Injuries and Fall Rate

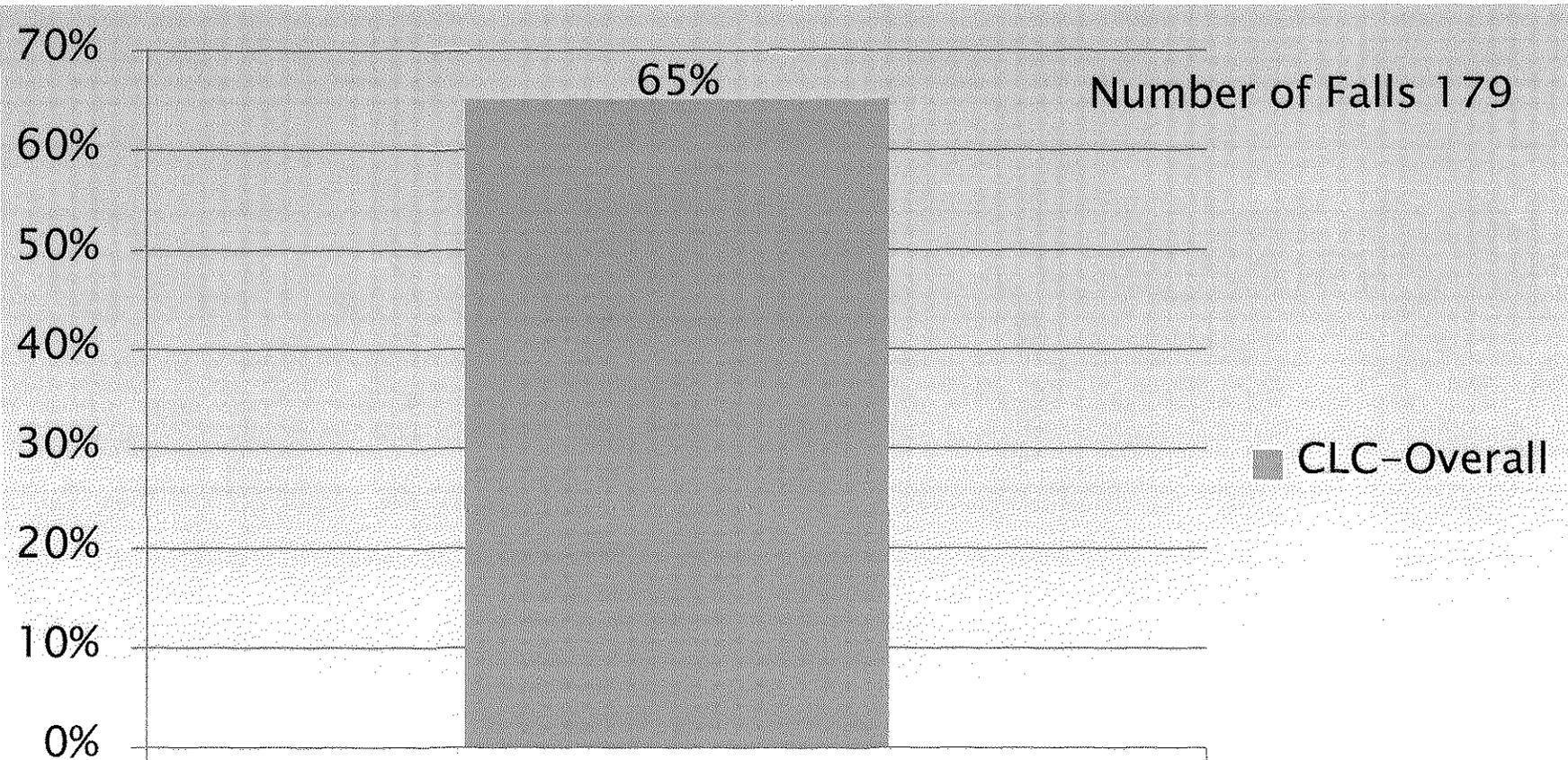
Fiscal Year	Fall related Injuries	Falls Rate
FY 12	10	10.12
FY 13	3	5.0
FY 14 (Until June)	2	6.7



CLC- Fall Occurrences and Unique Residents FY 2014 (Until May)



CLC– Fall Occurrences of Residents with Dementia or Cognitive Impairments FY 2014 (Until May)



Fall Occurrences of Residents with Dementia or Cognitive Impairments

PLAN

Knowing how serious the problem of falls injuries among the elderly has been and our increase of fall injuries rate in CLC, we created an Interdisciplinary Fall prevention team to improve our preventive measures and interventions to prevent injuries.

In 2013 we had an aim to *Reduce 20% of the fall injuries in CLC and we reduced them by 70%*

DO

- Incorporate Residents and Relatives into fall preventive measures. (Partnership in fall Prevention Contract)
- Post-Fall Debriefing Implementation
 - Identify factors that predisposed residents to fall
 - Identify possible frequent fallers
 - Improve communication between team members
 - Categorize type of fall, accidental, anticipated, none anticipated (physiological), and intentional
- An interdisciplinary team meeting for residents with more than one falls will be held and documented to discuss the trends and patterns of falls, modify interventions to care plan and avoid future falls.
- Modification of comfort rounds with integration of "ICARE" model.
- Care plans of all resident's high risk to fall / injury will be immediately revised to include updated fall prevention interventions.
- Discussions of monthly falls monitor at the PI with emphasis on trends, patterns and repeat falls

ACT

- Continue Fall Prevention Measures as established.
- Ensure that Morse Scale Assessments are performed accurately.
- Continue monitoring post fall debriefings to monitor and trend patterns of occurrences.
- Focus on tailoring fall prevention measures for cognitive impaired residents that sustain frequent falls.
- Continue to develop our fall prevention champions.

Falls
CLC

STUDY

CLC- Falls related Injuries and Falls Rate

Fiscal Year	Fall related Injuries	Falls Rate
FY 12	10	10.12
FY 13	3	5.0
FY 14 (Until June)	2	6.7

Monthly PI Monitors Compliance-2013 Dashboard

Dysphagia- Consult

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	93%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator		15	15	11	13	8	8	9				
Compliance Goal	100%											
Threshold	95%											

Dysphagia- Recommendations

Maria Mongil

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	93%	91%	100%	100%	100%	89%	100%	100%	90%	
Numerator		15	15	11	13	8	8	9	5		10	
Compliance Goal	100%											
Threshold	95%											

Use of thickener: Included in Hand off Report Inabelle

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	72%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator		15	12	11	10	12	10	12				
Compliance Goal	100%											
Threshold	95%											

Use of thickener: Included in Residents Name Plate Inabelle

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance			100%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator			12	11	10	12	10	12				
Compliance Goal	100%											
Threshold	95%											

Monthly PI Monitors Compliance-2013 Dashboard

Use of thickener: included in Residents ID Band												InIabelle
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance			93%	100%	100%	83%	80%	100%	100%	100%	Compliance maintained over time. Will monitor prn.	
Numerator			12	11	10	12	10	12	9	9		
Compliance Goal	100%											
Threshold	95%											
Use of thickener: included in Care Plan												InIabelle
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		87%	92%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator		15	12	11	10	12	10	12				
Compliance Goal	100%											
Threshold	95%											
Proper Body Alignment during Mealtimes-Regular												TL/NM
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	84%	100%	90%	100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator		15	15	15	15	15	15	15				
Compliance Goal	100%											
Threshold	95%											
Proper Body Alignment during Mealtimes-Tube Feeding 30-45 degrees TL/NM												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance				100%	100%	86%	100%	100%	100%	Compliance maintained over time. Will monitor prn.		
Numerator				1		7	6	12	6			
Compliance Goal	100%											
Threshold	95%											
Skin Inspections Done and Documented												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.						
Numerator		35	35	35	35							
Compliance Goal	100%											
Threshold	95%											

Monthly PI Monitors Compliance-2013 Dashboard

Acquired Ulcers- Debriefing Done												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.						
Numerator		15	12	13								
Compliance Goal	100%											
Threshold	95%											
Acquired Ulcers- Care Plan Reviewed												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.						
Numerator		15	12	13	13							
Compliance Goal	100%											
Threshold	95%											
Acquired Ulcers- If avoidable, additional preventive interventions were implemented.												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.						
Numerator				5								
Compliance Goal	100%											
Threshold	95%											
Skin-Inter rater reliability Braden Scale												
Yosuel & Iniabelle											Oct	Nov
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						100%	70%	100%	95%	100%	Compliance maintained over time. Will monitor prn.	
Numerator						20	20	20	20	20		
Compliance Goal	95%											
Threshold	90%											

Monthly PI Monitors Compliance-2013 Dashboard

Care Plans of Residents with PU							Elsa						
Overall Compliance							80%	80%	80%	100%	100%	100%	
Numerator							10	10	10	10	10	10	10
Compliance Goal	90%												
Threshold	85%												
Skin- Change of Positions							Yosuel & Iniabelle						
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	
Overall Compliance							100%	85%	100%	100%	100%	Compliance maintained over time. Will monitor prn.	
Numerator							20	20	20	20	20		
Compliance Goal	95%												
Threshold	90%												
Skin- Required orthotic/prosthetic devices placed							Yosuel & Iniabelle						
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	
Overall Compliance							85%	100%	100%	100%	Compliance maintained over time. Will monitor prn.		
Numerator							20	20	20	20			
Compliance Goal	95%												
Threshold	90%												
Residents with More than One Fall- Int. Team Meeting Performed													
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	
Overall Compliance		100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.							
Numerator		4	4	7	2								
Compliance Goal	95%												
Threshold	90%												

Monthly PI Monitors Compliance-2013 Dashboard

Residents with More than One Fall- At a minimum the following disciplines attended: PT/OT, Restorative, Pharmacist and RT.												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	84%	100%	100%	Compliance maintained over time. Will monitor prn.						
Numerator		4	4	7	2							
Compliance Goal	95%											
Threshold	90%											
Post Fall- Debriefing Done												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	92%	100%	100%	Compliance maintained over time. Will monitor prn.						
Numerator		9	8	16								
Compliance Goal	95%											
Threshold	90%											
Post Fall- Care Plans Updated NM												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	92%	94%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator		9	8	16		12	16	16				
Compliance Goal	90%											
Threshold	85%											
Responsiveness To Call Bell- Answering Call Bell Within one minute- Iniabelle												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		67%	67%	100%	93%	93%	93%	87%	93%	100%	Compliance maintained over time. Will monitor prn.	
Numerator		6	6	15	15	15	15	15	15	15		
Compliance Goal	90%											
Threshold	85%											

Monthly PI Monitors Compliance-2013 Dashboard

Responsiveness To Call Bell- Arriving Physically Within one minute- Iniabelle												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		50%	50%	60%	73%	100%	93%	87%	87%	93%	Compliance maintained over time. Will monitor prn.	
Numerator		6	6	15	15	15	15	15	15	15		
Compliance Goal	90%											
Threshold	85%											
Use of Helmets- Assessment for the use of Helmet Completed- Liduvina												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.				
Numerator		5	6	9	6	8	6					
Compliance Goal	90%											
Threshold	85%											
Use of Helmets- If helmet is required the assessment includes risks and benefits and when helmet is to be utilized. Liduvina												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.				
Numerator		5	6	9	6	8	6					
Compliance Goal	90%											
Threshold	85%											
Use of Helmets- Resident is utilizing helmet as per assessment and care plan. Liduvina												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	67%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.				
Numerator		5	6	9	6	8	6					
Compliance Goal	90%											
Threshold	85%											

Monthly PI Monitors Compliance-2013 Dashboard

Restorative- Assessment for Restorative Completed											NM	
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		80%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.				
Numerator		5	4	5	7	8	4					
Compliance Goal	90%											
Threshold	85%											

Restorative- Resident is on Restorative Program and has Care Plan Developed.											NM	
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		80%	100%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.				
Numerator		5	4	5	7	6	4					
Compliance Goal	90%											
Threshold	85%											

Residents with Psychopharmacologic Medications-Sleep assessment											Dr. Lozada	
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		0%	100%	95%	90%	93%	90%	95%	Compliance maintained over time. Will monitor prn.			
Numerator		25	20	20	20	15	20	20				
Compliance Goal	90%											
Threshold	85%											

Residents with Psychopharmacologic Medications											Dr. Lozada	
Consult to Psychiatry was Performed												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		88%	90%	95%	100%	90%	90%	100%	Compliance maintained over time. Will monitor prn.			
Numerator		10	10	10	10	10	10	10				
Compliance Goal	90%											
Threshold	85%											

Monthly PI Monitors Compliance-2013 Dashboard

Annual H&P Assessments												Dr. Lozada
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator						6	1	2				
Compliance Goal	100%											
Threshold	95%											
Monthly Notes addressing issues that arouse over the past month												Dr. Lozada
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						80%	100%	100%	100%	Compliance maintained over time. Will monitor prn.		
Numerator						10	10	10	10			
Compliance Goal	90%											
Threshold	85%											
Review all medical orders during previous month and discontinue all obsolete entries.-Eval. During Monthly Provider Review												Dr. Lozada
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						60%	96%	95%	98%	Compliance maintained over time. Will monitor prn.		
Numerator						10	10	10	10			
Compliance Goal	90%											
Threshold	85%											
Documentation of Rationale for All Medications												Dr. Lozada
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						100%	99.5%	97.5	Compliance maintained over time. Will monitor prn.			
Numerator						10	193 orders	199 orders				
Compliance Goal	95%											
Threshold	90%											

Monthly PI Monitors Compliance-2013 Dashboard

Audit residents receiving iron vs. justified indication Dr. Lozada

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						80%	90%	90%	80%	100%	90%	
Numerator						10	10	10	10	10	10	
Compliance Goal	95%											
Threshold	90%											

Non Pharmacological interventions to treat constipation-Orders Dr. Lozada

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						20%	80%	100%	To be reviewed locally			
Numerator							5	5	5	5	5	5
Compliance Goal	95%											
Threshold	90%											

Personal Protective Equipment (PPE)

TL/NM

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		100%	93%	93%	100%	100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator		15	15	15	20	20	20	20				
Compliance Goal	95%											
Threshold	90%											

Care Plans- Individualized Care Plans

Elsa/MDS Liaisons

Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		73%	80%	88%	86%	95%	90%	88%	92%	82%	83%	
Compliance Goal	95%											
Threshold	90%											

Monthly PI Monitors Compliance-2013 Dashboard

Care Plans- Revised According to Changes in Condition									Elsa/MDS Liaisons			
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		85%	90%	83%	86%	93%	85%	100%	78%	85%	98%	
Compliance Goal	95%											
Threshold	90%											

Care Plans- Revised According to Target Dates									Elsa/MDS Liaisons			
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance		80%	100%	100%	93%	98%	93%	100%	98%	97%	100%	
Compliance Goal	95%											
Threshold	90%											

Interdisciplinary Assessments									Medical Clerks thru NM			
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Physical Therapy						100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Occupational Therapy						100%	100%	100%				
Nursing						100%	100%	100%				
Dietitian						100%	100%	100%				
Chaplain						100%	100%	100%				
Social Work						100%	100%	100%				
Recreational Therapist						100%	85%	100%	80%	100%	100%	
Pharmacist						55%	100%	100%	Compliance maintained over time. Will monitor prn.			
Physician/NP						100%	100%	100%				
Numerator						10	20	20	20	20	20	20
Compliance Goal	95%											
Threshold	90%											

Residents with Assistive Devices for Compliance with Medical Order									Dr. Lozada			
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator						10	10	10				
Compliance Goal	95%											

Monthly PI Monitors Compliance-2013 Dashboard

Threshold	90%											
Pain Assessment												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						93%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator						15	15	15				
Compliance Goal	95%											
Threshold	90%											
Re-assessment												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						100%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator						15	15	15				
Compliance Goal	95%											
Threshold	90%											
Resident's Perception												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						93%	100%	100%	Compliance maintained over time. Will monitor prn.			
Numerator						14	15	15				
Compliance Goal	95%											
Threshold	90%											
Nails Trimmed and Clean												
NM/TL												
Period	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Overall Compliance						80%	95%	95%	100%	Compliance maintained over time. Will monitor prn.		
Numerator						20	20	20	20			
Compliance Goal	95%											
Threshold	90%											

Monthly PI Monitors Compliance-2013 Dashboard

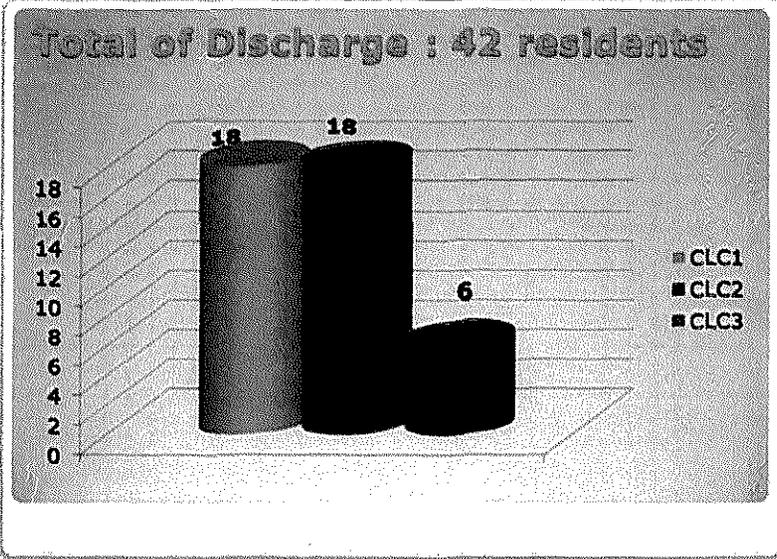


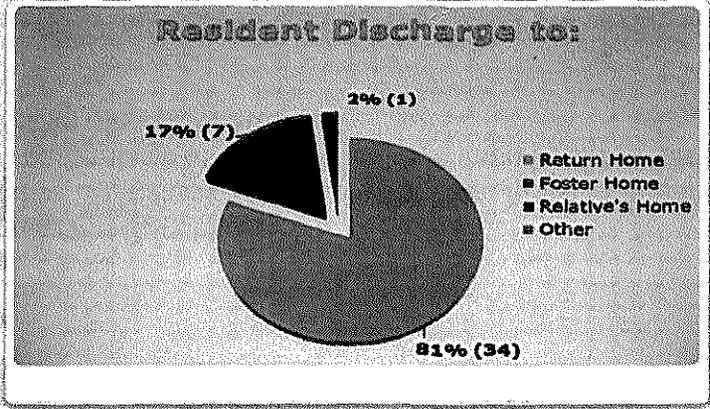
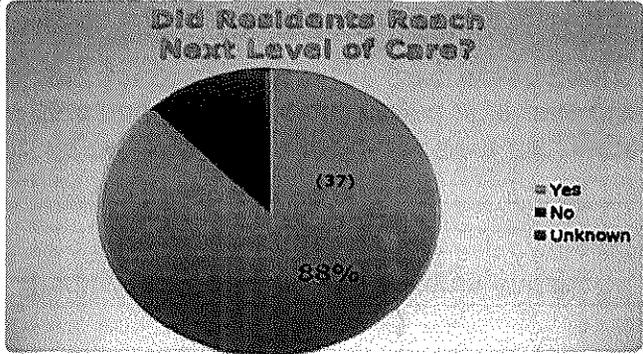
**VA CARIBBEAN HEALTHCARE SYSTEM
SAN JUAN, PUERTO RICO**

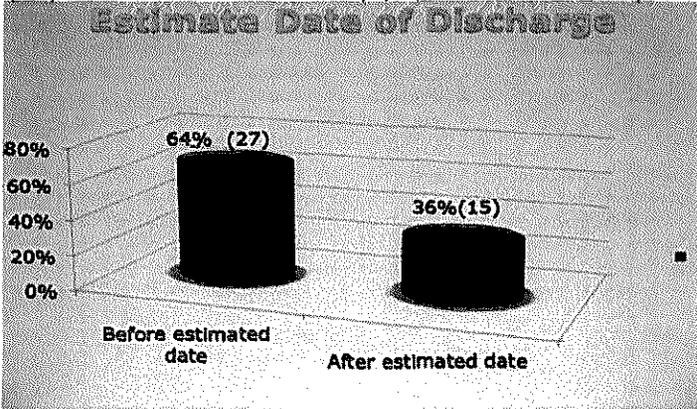
PI Meeting

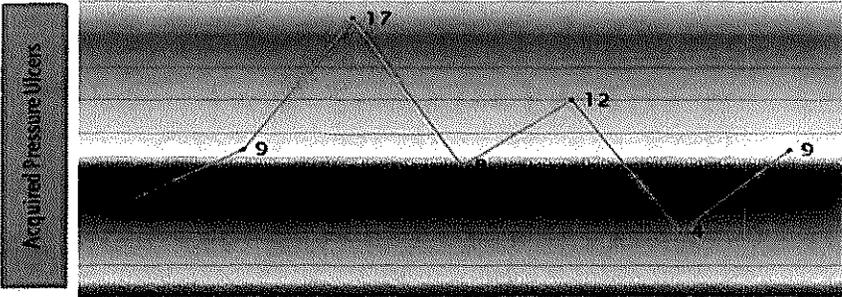
DATE: 05/21/14 TIME: 1:00 PM ROOM: J6608 Conf. Room

Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date
ATTENDANCE:	<p><u>Present</u> Gladys Navarro, Chief Nurse CLC Carmen Lozada, ACOS/GEC Gretchen Collazo, CLC Medical Director Inibelle Rosado, PI Nurse Gladys Rodriguez, CNS Liduvina Soto, CNS Luz Santiago Marrero, RN/ANM Maritza Carrasquillo, MD CLC2 Edgardo Torres, PTA Norma Arocho, PharmD Myrna Jimenez, RN, NM CLC-2 Daniel Pelaez, MSW CLC2 Marie C. Weil, Psychologist Lillian Hernández, PSA Elsa Velez, MDS Coordinator Jesus Marin, MD</p> <p><u>Excused:</u> Eyllin Martinez Myrna Jimenez, RN, NM CLC-2 Ana Mislán, SW Ivahoca Ramos, RT Rafael Navarro, HSS</p>		

Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date										
I. REVIEW OF PREVIOUS MINUTES	Previous minute from April 16, 2014 were revised, correction submitted and approved by CLC Interdisciplinary Team.												
II. OLD BUSINESS													
1. Resident Satisfaction 2 nd Qtr. FY14	Deferred.												
III. NEW BUSINESS <ul style="list-style-type: none"> Post Discharge Report for 2nd Qtr. FY14 by Daniel Pelaez, Social Worker 	<p>Discussion: Daniel Pelaez presented the Post Discharge Report. During 2nd Qtr. 2 FY14; 42 residents were discharged. (See attachments).</p>  <table border="1"> <caption>Total of Discharge : 42 residents</caption> <thead> <tr> <th>Category</th> <th>Number of Residents</th> </tr> </thead> <tbody> <tr> <td>CLC1</td> <td>18</td> </tr> <tr> <td>CLC2</td> <td>18</td> </tr> <tr> <td>CLC3</td> <td>6</td> </tr> <tr> <td>Total</td> <td>42</td> </tr> </tbody> </table>	Category	Number of Residents	CLC1	18	CLC2	18	CLC3	6	Total	42		
Category	Number of Residents												
CLC1	18												
CLC2	18												
CLC3	6												
Total	42												

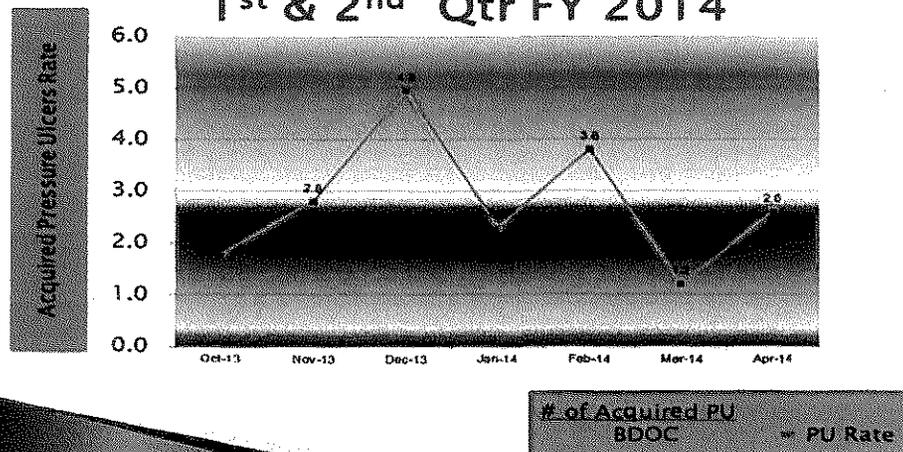
Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date																											
	<p data-bbox="569 375 1493 440">During 2nd Qtr. FY14 81% of the residents Returned Home, 17% to Foster Home and 2% to Relative's Home.</p> <div data-bbox="699 480 1409 889">  <p data-bbox="856 496 1276 529">Resident Discharge to:</p> <table border="1" data-bbox="835 570 1388 841"> <thead> <tr> <th>Discharge Type</th> <th>Percentage</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Return Home</td> <td>81%</td> <td>34</td> </tr> <tr> <td>Foster Home</td> <td>17%</td> <td>7</td> </tr> <tr> <td>Relative's Home</td> <td>2%</td> <td>1</td> </tr> <tr> <td>Other</td> <td>0%</td> <td>0</td> </tr> </tbody> </table> </div> <p data-bbox="569 971 1535 1068">The majority (88%) of the residents reached the next level of care. The other 12% experienced Deterioration in Health, Lack of support and Transportation difficulty.</p> <div data-bbox="730 1109 1373 1463">  <p data-bbox="877 1117 1220 1170">Did Residents Reach Next Level of Care?</p> <table border="1" data-bbox="835 1179 1360 1458"> <thead> <tr> <th>Response</th> <th>Percentage</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Yes</td> <td>88%</td> <td>37</td> </tr> <tr> <td>No</td> <td>12%</td> <td>5</td> </tr> <tr> <td>Unknown</td> <td>0%</td> <td>0</td> </tr> </tbody> </table> </div>	Discharge Type	Percentage	Count	Return Home	81%	34	Foster Home	17%	7	Relative's Home	2%	1	Other	0%	0	Response	Percentage	Count	Yes	88%	37	No	12%	5	Unknown	0%	0		
Discharge Type	Percentage	Count																												
Return Home	81%	34																												
Foster Home	17%	7																												
Relative's Home	2%	1																												
Other	0%	0																												
Response	Percentage	Count																												
Yes	88%	37																												
No	12%	5																												
Unknown	0%	0																												

Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date																		
	<p>During 2nd Qtr. FY14, 64% of the residents were discharge before the estimated date and 36% were discharged after date due to ongoing treatment (10) and social difficulties (5). (See attachment).</p>  <p>Estimate Date of Discharge</p> <table border="1"> <thead> <tr> <th>Category</th> <th>Percentage</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Before estimated date</td> <td>64%</td> <td>27</td> </tr> <tr> <td>After estimated date</td> <td>36%</td> <td>15</td> </tr> </tbody> </table> <p><u>Recommendation/Conclusion:</u></p> <ol style="list-style-type: none"> 1. Include the Definition of Next Level of Care in next meeting. 2. Include percentage of veterans that are seen by their Primary Care Provider (PCP) after discharge. 	Category	Percentage	Count	Before estimated date	64%	27	After estimated date	36%	15											
Category	Percentage	Count																			
Before estimated date	64%	27																			
After estimated date	36%	15																			
<p>2. Care Plans by Elsa Velez Roche, MDS Coordinator</p>  <p>Care Plan May 21 2014 ok.docx</p>	<p>Discussion: Elsa Vález presented CLC Care Plans overall compliance for 2nd quarter -FY14. A great improvement was reported on the Individualized Care Plan monitor from March to April 2014. (See chart)</p> <table border="1"> <thead> <tr> <th>Monitors</th> <th>March</th> <th>April</th> </tr> </thead> <tbody> <tr> <td>802</td> <td>96%</td> <td>97%</td> </tr> <tr> <td>Individualized CP</td> <td>90%</td> <td>100%</td> </tr> <tr> <td>CP revised according to changes</td> <td>92%</td> <td>93%</td> </tr> <tr> <td>CP revised –Target Date</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>CP revised –PU prevention f/u</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table>	Monitors	March	April	802	96%	97%	Individualized CP	90%	100%	CP revised according to changes	92%	93%	CP revised –Target Date	100%	100%	CP revised –PU prevention f/u	100%	100%		
Monitors	March	April																			
802	96%	97%																			
Individualized CP	90%	100%																			
CP revised according to changes	92%	93%																			
CP revised –Target Date	100%	100%																			
CP revised –PU prevention f/u	100%	100%																			

Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date																
	<p>CP revised-Fall prevention f/u 100% 100%</p> <p>CP revised-dysphagia interventions 100% 100%</p> <p>CP revised- restorative 100% 100%</p> <p>CP revised for pain, cause and 100% 98%</p> <p>intervention.</p> <hr/> <p><u>Improvements : from March to April FY14:</u></p> <ul style="list-style-type: none"> • Individual Care Plans :from 90% to 100%. • 802 Report: from 96% to 97%. • CP revised according to changes: from 92% to 93%. <p><u>Recommendation:</u> Continue to monitor for sustainability.</p>																		
3. Vaccine	Discussion: Deferred.																		
<p>4. CLC Pressure Ulcer for 1st and 2nd Qtr. FY14 by Vivian Suarez, WC Nurse</p> <p> CLC PU 2013 1st Qtr FY 2014.pptx</p>	<p>Discussion: Vivian Suárez presented Pressure Ulcer report for 1st and 2nd Qtr. FY14.</p> <p style="text-align: center;">CLC's Total Acq Pressure Ulcers 1st & 2nd Qtr FY 2014</p>  <table border="1" style="margin-left: auto; margin-right: auto;"> <caption>CLC's Total Acq Pressure Ulcers Data</caption> <thead> <tr> <th>Month</th> <th>Acquired Pressure Ulcers</th> </tr> </thead> <tbody> <tr><td>Oct-13</td><td>9</td></tr> <tr><td>Nov-13</td><td>17</td></tr> <tr><td>Dec-13</td><td>9</td></tr> <tr><td>Jan-14</td><td>12</td></tr> <tr><td>Feb-14</td><td>9</td></tr> <tr><td>Mar-14</td><td>9</td></tr> <tr><td>Apr-14</td><td>9</td></tr> </tbody> </table>	Month	Acquired Pressure Ulcers	Oct-13	9	Nov-13	17	Dec-13	9	Jan-14	12	Feb-14	9	Mar-14	9	Apr-14	9		
Month	Acquired Pressure Ulcers																		
Oct-13	9																		
Nov-13	17																		
Dec-13	9																		
Jan-14	12																		
Feb-14	9																		
Mar-14	9																		
Apr-14	9																		

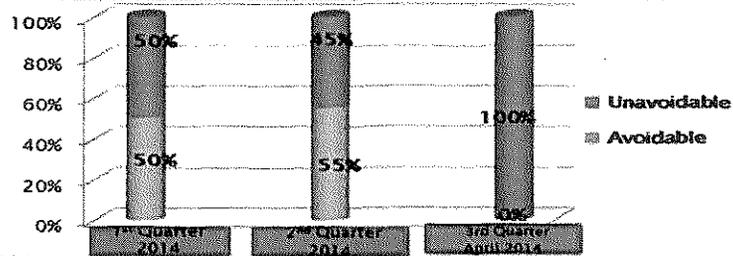
Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date
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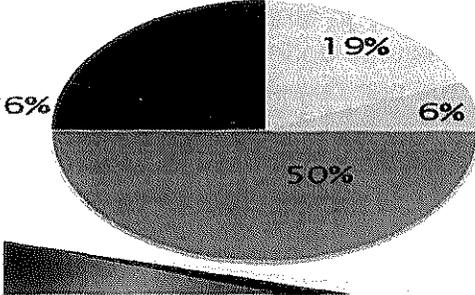
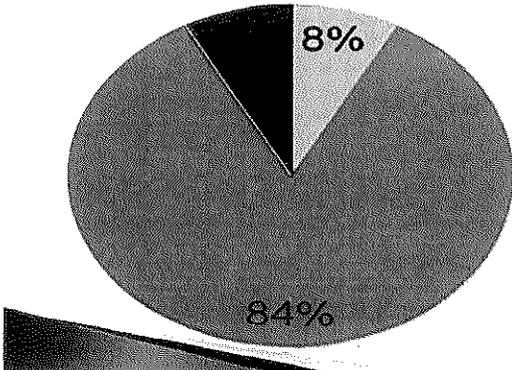
CLC's - Acquired PU Rate 1st & 2nd Qtr FY 2014



CLC Avoidable vs Unavoidable Ulcers

Total Pressure Ulcers	Avoidable PU	Unavoidable PU
FY 2014 1 st & 2 nd Quarter	1 st 18(50%) 2 nd 13(55%)	1 st 18(50%) 2 nd 11(45%)



Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date																
	<p data-bbox="571 407 1304 443"><u>Reasons for the 18 Avoidable PU during 1st qtr. FY14:</u></p> <p data-bbox="676 472 1440 532">Avoidable Pressure Ulcers 1st Quarter FY 2014</p> <p data-bbox="659 529 879 548">18 Avoidable PU</p>  <table border="1" data-bbox="1136 521 1461 846"> <tr> <td>6%</td> <td>Lack of Protective Duoderm</td> </tr> <tr> <td>6%</td> <td>Inconsistency with Orthotic Device</td> </tr> <tr> <td>6%</td> <td>Inadequate Mattress</td> </tr> <tr> <td>19%</td> <td>Inconsistency with Documentation</td> </tr> <tr> <td>50%</td> <td>Inconsistency with treatment</td> </tr> </table> <p data-bbox="571 922 1241 958"><u>Reason for 13 Avoidable PU during 2nd Qtr FY 14</u></p> <p data-bbox="779 967 1341 1027">Avoidable Pressure Ulcers 2nd Quarter FY 2014</p> <p data-bbox="632 1019 842 1039">13 Avoidable PU</p>  <table border="1" data-bbox="1136 1073 1482 1422"> <tr> <td>8%</td> <td>Inconsistency with Orthotic Device</td> </tr> <tr> <td>8%</td> <td>Inadequate Mattress</td> </tr> <tr> <td>84%</td> <td>Inconsistency with Treatment</td> </tr> </table>	6%	Lack of Protective Duoderm	6%	Inconsistency with Orthotic Device	6%	Inadequate Mattress	19%	Inconsistency with Documentation	50%	Inconsistency with treatment	8%	Inconsistency with Orthotic Device	8%	Inadequate Mattress	84%	Inconsistency with Treatment		
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Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date
	<p><u>Actions for Improvements:</u></p> <ol style="list-style-type: none"> 1. Implement Wound Care (WC) Surveillance Model based on resident's risk. 2. Reinforce WC Educational Program. 3. Continue Skin Care Champions program in CLC's. 4. Continue skin care competencies of all staff. 5. Consolidate all WC reports in one database in order to better analyze data and observe trends/patterns. 		
<p>5. CAP Monitors report by Iniabelle Rosado, PI Nurse</p>	<p><u>Discussion:</u> Iniabelle Rosado presented the CAP Monitors for 2014 due to Findings in last LTCI visit on April 2014.</p> <p><u>Findings, actions and monitors:</u></p> <ol style="list-style-type: none"> 1. <u>Temperature of water exceeds expected temperature of 125 degrees Fahrenheit.</u> Actions follow: <ul style="list-style-type: none"> • Determine risk scalding and provide list to FMS. • Assess residents upon admission and weekly monitors. • Evaluate temperature of water on a weekly basis. • FMS to repair and adjust thermostatic valve measuring temperature in CLC1 and CLC2 on April 2014. • Installation of manual adjusting valves and measure faucet water after installation (April 2014). • Evaluate temperature of water for 3 months. 2. <u>Infection Control:</u> Staff that provides service but is not permanent employees in CLC enters to rooms without observing Infection Control precautions. Actions follow: <ul style="list-style-type: none"> • Action: Weekly random spot check of staff entering to residents rooms. 3. Nursing staff observed not following the <u>PPE</u> sequence when 		

Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date
	<p>administering medications.</p> <ul style="list-style-type: none"> ◦ Action: Live validation of staff competencies and monitor through competency validation certification by NMs. <p>4. <u>PEG Tubes</u>: Nurse observed not verifying PEG tube or flushing prior to medication administration.</p> <ul style="list-style-type: none"> ◦ Action: Live validation to all staff competencies and monitor through competency validation certification by NM. <p>5. <u>Restorative</u>:</p> <p>- Nurse did not perform the ROM during bath as indicated in care plan.</p> <ul style="list-style-type: none"> ◦ Action: Live validation of all staff competencies to assure proper practice and monitor through competency validation certification by NM. <p>-Resident didn't have splint place as indicated in the care plan, without medical order.</p> <ul style="list-style-type: none"> ◦ Action: Assure residents with restorative needs have evaluation and documented in the care plan. (Audit to 5 records on a monthly basis). <p>6. <u>Bathing</u>: Nurse bathing resident with multiple gloves and another didn't change gloves or wash his hands after removing condom catheter. Action follow:</p> <ul style="list-style-type: none"> ◦ Live validation to staff competencies and monitor through competency validation certification by the NM. <p>7. <u>Care Plan</u>: Care Plan has use of splint without medical order.</p> <p>Actions:</p> <ul style="list-style-type: none"> ◦ Care Plans revised according to resident changes and audit records to update care plans. ◦ Random audit of care plans on a monthly basis. 		

Topic	Discussion/Conclusions/Recommendations	Action and Effectiveness of the action	Due Date
IV. AROUND THE ROOM	<p>Discussion:</p> <ol style="list-style-type: none"> 1. Elsa Vélez announced that MDS assessment changes. She will schedule a meeting to discuss changes with MDS liaisons. 2. Marie Weill announced Caregiver group activity to be held at Hospice on Friday May 23, 2014 at 1:30 PM. Also announced that Glenda Ortiz, MDS Liaison and she were selected to participate in the Star VA Dementia Training (purpose: provide techniques and strategies to treat resident with psychosocial problems). 3. Maritza Carrasquillo announced the new Guidelines of VA Vaccines. 4. Carmen Lozada announced that the Advancing Excellence of Pain will start on FY 14. 		
V. ADJOURNMENT	Meeting adjourned at 2:50 PM. Next meeting is scheduled for June 18, 2014 at 1:00 PM- M232 Administrative Building.		

Approval of Minutes:


GLADYS NAVARRO, RN, MSN, NEA-BC/ Chief Nurse for CLC
 Chairperson PI Committee


CARMEN LOZADA, MD
 ACOS/Geriatric for Extended Care
 Concur


GRETCHEN COLLAZO, MD
 CLC Medical Director


 for **KATHLEEN RUIZ, RN, DNP, BE-BC**
 Associate Director Patient Care Service
 Approved