Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues
Tennessee Valley Healthcare System
Nashville and Murfreesboro, Tennessee

Report No. 07-01181-36 **December 11, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of this inspection was to determine the validity of allegations of delay in treatment, poor communication with the family, and other quality of care issues pertaining to the care a patient received at the Tennessee Valley Healthcare System.

We substantiated that there was a delay in treating the patient's esophageal cancer. The patient was hospitalized at the Murfreesboro facility for 2 weeks waiting to be evaluated in Nashville General Surgery Clinic and to be placed on the Tumor Board schedule. We found that communication, both between the Murfreesboro and Nashville physicians and between the Murfreesboro physicians and the patient and his family, was less than optimal.

We also substantiated that the patient's nutrition was not appropriately managed at the Murfreesboro facility; he lost 13 pounds in 14 days and received only intravenous fluids for almost a week. We found the patient was not weighed again at Murfreesboro after admission, and the Nutrition Support Team was not consulted to evaluate the patient for an alternate approach to nutrition.

We found that advance directives were not documented in the patient's medical record until 16 days after his admission. We did not find, however, that the delay in treatment or the early lack of nutritional support negatively impacted the patient's long-term clinical outcome.

We identified opportunities for improvement in the following processes: consulting Murfreesboro patients to Nashville; referral to Tumor Board; interdisciplinary treatment team communication; management of patients at nutritional risk; and documentation of advance directives.

We recommended that management should: ensure that consults to Nashville for Murfreesboro inpatients are addressed within the required timeframe; develop a more systematic process for referring patients to Tumor Board; require dietitians to monitor and document the status of patients at nutritional risk and; ensure that advance directives are discussed and documented in patients' medical records, as required.

The Veterans Integrated Service Network and Interim System Directors agreed with our findings and recommendations and submitted appropriate action plans. We will follow up on proposed actions until they are completed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid South Healthcare Network (10N9)

SUBJECT: Healthcare Inspection – Quality of Care Issues, Tennessee Valley Healthcare System, Nashville and Murfreesboro, Tennessee

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed allegations regarding delay in treatment, poor communication with family, and other quality of care issues at the Tennessee Valley Healthcare System (TVHS). The purpose of the review was to determine whether the allegations had merit.

Background

TVHS (the system) consists of two medical centers, one located in Murfreesboro, TN, and another in Nashville, TN. The Murfreesboro facility provides primary care, subspecialty medical, surgical, and psychiatric services, long-term rehabilitation, and nursing home care. The Nashville facility offers primary, secondary, and tertiary care. The system has 498 operating beds, including 245 nursing home beds. The system is part of Veterans Integrated Service Network (VISN) 9, also known as the VA Mid South Healthcare Network.

The complainant is the daughter of a veteran treated at both facilities of the system. She alleged that:

- Her father was hospitalized at the Murfreesboro facility for 2 weeks but did not receive treatment or a definitive plan of treatment for his esophageal cancer during that time.
- The family did not receive consistent or timely information about her father's care.
- Her father lost 14 pounds during his stay at the Murfreesboro facility due to the delay in treatment.

Although it was not one of the complainant's allegations, we also evaluated problems with the veteran's advance directive[1] at the Murfreesboro facility.

Scope and Methodology

We visited both of the system's facilities between May 29 and May 31, 2007. We interviewed the veteran's Murfreesboro attending and resident physicians, the dietitian on a medicine unit in Murfreesboro, and other clinical staff involved in his care. We reviewed relevant system policies and procedures and the veteran's medical record. We interviewed the complainant by phone, but she asked that we not interview her father.

We performed the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case History

The patient is a 62-year-old male veteran with a long history of gastroesophageal reflux disease. On January 9, 2007, he presented to the Murfreesboro facility to establish care with a primary care provider (PCP). At that time he described 4 months of worsening dysphagia (difficulty swallowing) and a 10-pound weight loss (he weighed 158 pounds on January 9). He reported being able to take only small amounts of fluids without discomfort. Radiology studies completed that day revealed a large obstructing mass in his upper esophagus. He returned the next day for esophagogastroduodenoscopy[2] (EGD) with biopsy, which revealed a "near complete obstructing" cancerous lesion. Surgical pathology of the specimen provided a diagnosis of "squamous cell carcinoma, grade 3-4, invasive, accompanied by necrosis." A computed tomography (CT) scan of the chest revealed possible metastasis.[3]

The patient required a gastric feeding tube (G-tube) for nutrition. The most common type of G-tube is the percutaneous endoscopic gastrostomy (PEG) tube, which requires an endoscope to be passed through the mouth and esophagus into the stomach. Because the patient's esophageal tumor precluded the passing of an endoscope, a PEG tube was not an option. A G-tube can also be placed with an "open" procedure through an abdominal incision with direct visualization of the stomach. The Murfreesboro gastroenterology (GI) physician said the patient would require surgery at the Nashville facility to place an open G-tube for feeding. This physician believed that presentation of the case at TVHS

[1] A document that directs care if a person is unable to make his or her own medical decisions.
[2] Endoscopic examination of the esophagus, stomach, and duodenum.
[3] A growth of abnormal cells distant from the site primarily involved by the cancerous process.

Tumor Board[4] (which meets weekly in Nashville) was also indicated, and he copied his consultation (consult) response to the Nashville surgeon who chairs the Tumor Board.

A Murfreesboro oncologist (cancer specialist) told the patient he thought the tumor was not resectable due to its extent and location, and recommended chemotherapy and radiation therapy. For this patient, administration of chemotherapy required surgical placement of a central venous access port. Neither venous access nor G-tube placement could be done at the Murfreesboro facility and needed to be performed by Nashville General Surgery. As the patient was in otherwise good health, he opted for aggressive treatment of his cancer.

On January 10, the patient was admitted to a medicine unit at the Murfreesboro facility due to the "risk of aspiration"[5] and to wait for his Nashville General Surgery procedures. The resident physician on the patient's Murfreesboro treatment team consulted Nashville General Surgery on January 12, noting that the patient had an "extensive esophageal tumor" and requested "placement of surgical PEG tube for feeding and Port-a-Cath®[6] for chemotherapy." On January 17, Nashville General Surgery scheduled the patient to be seen in clinic on January 23.

The dietitian for that medicine unit evaluated the patient on January 11 and placed him on a pureed diet with Ensure® supplements. His meal consumption diminished as his dysphagia worsened, and he frequently refused oral medications, which he could not swallow. By the evening of January 17, he was unable to swallow sips of water. On January 18, laboratory results showed that his albumin[7] level was low and the physician ordered intravenous fluids (IVFs). The patient continued to receive his meal trays, but records indicate he consumed nothing by mouth after January 17. On January 22, the physician placed an "NPO (Nothing by Mouth) after midnight" order to prepare the patient for his Nashville General Surgery appointment the next day.

On January 23, the patient was transported to the Nashville campus for his General Surgery appointment. Nashville physicians were concerned that the patient was malnourished. Progress notes documented that the patient had "subsisted for a week on only IVF" and now weighed 145 pounds. The patient was admitted that day to Nashville medicine unit 2G. The Nutrition Support Team evaluated the patient on January 24 and recommended placement on total parenteral nutrition.[8] On January 25, the Tumor Board reviewed the patient's case and recommended definitive "chemoXRT" (concurrent chemotherapy and radiation therapy) due to the location of the tumor and the appearance

[4] Tumor Boards are meetings of surgeons, oncologists, and other physicians specializing in the treatment of cancer to present cases and determine the recommended course of treatment.
[5] When food or liquid enters the lungs.
[6] A Port-a-Cath® is the brand name of a common type of central venous access system.
[7] Low serum levels occur in protein malnutrition.
[8] Parenteral nutrition is used when nutrition must be provided through a route other than the organs of digestion. Total parenteral nutrition is administered through a large central vein.

of lymph nodes in the neck and abdomen indicating metastatic disease. On January 30, the patient had surgery to place a Port-a-Cath® and an open G-tube. He was discharged home from the Nashville facility on February 7.

The patient completed chemotherapy and radiation therapy in March, and in May he had recovered well enough to return to work, but still had dysphagia and continued with tube feedings. In June, he was readmitted to the Nashville facility with pneumonia, as well as bleeding and leakage around his G-tube. He improved, with antibiotic treatment and replacement of his G-tube, and was discharged home on July 1.

Results

Issue 1: Delay in Treatment

We substantiated the allegation that there was a delay in initiating treatment of the patient's esophageal cancer. Although the patient's esophageal cancer was diagnosed on January 10, 2007, and the patient remained hospitalized, providers did not decide on a definitive plan of care until January 25, and treatment did not start until January 31.

The Murfreesboro GI physician wrote on January 10 that the patient was at extremely high risk for aspiration, and he recommended "prompt medical admission to expedite work-up." On January 12, the Murfreesboro Oncology physician told the patient that it appeared his esophageal tumor was not resectable and that chemotherapy and radiation therapy would probably be the best treatment option for him. He was also told that he would need to have a G-tube placed for feeding and a Port-a-Cath® placed for chemotherapy. Per his physician's suggestion, the patient decided to remain an inpatient in Murfreesboro so that he could be transported quickly to Nashville when the surgery was scheduled. They also told him he would be safer waiting in the hospital instead of at home in the event his condition worsened.

On Friday, January 12 at 11:12 a.m., the patient's physician sent a consult to Nashville General Surgery Clinic (which only met on Tuesdays) for the feeding tube and Port-a-Cath® placements. Monday, January 15, was a Federal holiday. On Wednesday, January 17, the clinic scheduled the patient for an appointment the following Tuesday, January 23.

The consultation request from Murfreesboro to Nashville was sent with routine priority. According to TVHS *Bylaws, Rules and Regulations of the Medical Staff* ratified April 6, 2005, the expectation is that the receiving Service will respond to routine inpatient consults within 2 days. We were told that had the patient been an inpatient at the Nashville facility, a surgical resident would have seen him at his bedside. We were also told that the system's Chiefs of Medicine and Surgery expect inpatient consults to be evaluated within 24 hours. In this patient's case, it appears he was treated as an

outpatient, and scheduled instead for a clinic appointment 11 days from the date of request.

We were told that since the request was for a PEG tube, it was considered less urgent. The requesting physician erred when he requested a PEG tube (rather than a G-tube), but also stated the esophageal tumor was "extensive" and said the patient needed a "surgical PEG tube." Had a PEG tube been all that was required, the procedure could have been performed by GI physicians at either campus. In this case, the patient required a G-tube that could only be placed by surgeons in Nashville.

After learning of the appointment date on January 17, the Murfreesboro physicians consistently documented that the patient was "scheduled for PEG tube and Port-a-Cath® placement in Nashville on January 23." The attending physician documented in a progress note that he would attempt to expedite the appointment; however, we found no evidence that this occurred. The Murfreesboro physicians evidently believed the appointment was for surgery, rather than simply evaluation and consultation.

On January 11, 2007, the Murfreesboro GI physician copied his findings about the case to the Nashville surgeon who chairs the Tumor Board, suggesting the case should be presented to Tumor Board. We found no response to this request, and the patient was not scheduled to be presented to Tumor Board until requested by a Nashville physician after his transfer to the Nashville facility on January 23. The Cancer Program manager was responsible for the Tumor Board schedule. She told us that a physician had to call her to get a patient on the schedule. We learned that no formal process (such as a consult process) existed to refer patients to Tumor Board.

On January 25, Nashville providers discussed the patient's case in Tumor Board and agreed on a definitive plan of treatment. The surgery scheduled for January 29 to place the G-tube and Port-a Cath® was postponed until January 30 due to "lack of OR (operating room) resources." The patient first received radiation on January 31 and chemotherapy on February 1.

It appears that the initiation of treatment was delayed due to the low priority given the consult to Nashville General Surgery and the absence of a formal process for referral to Tumor Board. It also appears that the Murfreesboro treatment team misunderstood the nature of the January 23 General Surgery Clinic appointment and could have acted more aggressively to expedite the process during the 2 weeks the patient was on a medicine unit in Murfreesboro.

Issue 2: Communication with Family

We could not refute the allegation that communication between Murfreesboro clinical providers and the patient's family and between providers at the two facilities was less than optimal. The complainant told us that the patient and family did not learn of the

patient's January 23 General Surgery appointment until the day before; however, his treatment team knew the appointment date on January 17.

The complainant and other family members visited the patient frequently; however, we found no evidence that providers communicated key information about the patient's appointments and status to them. We found that unit staff did not document interdisciplinary treatment (IDT) team discharge planning that might have improved the consistency of the information provided to the family. The only references we found to an IDT team were two weekly notes by a social worker, which were not copied to any other staff.[9] These notes only documented that the patient planned to return home to receive chemotherapy. Although we found that IDT team discharge planning was inadequate or poorly documented on the medicine unit during the period of this patient's hospitalization, we learned that this condition has since improved. There are now progress notes requiring electronic signature by several team members which discuss current patient status as well as discharge plans.

The patient's treatment team changed 6 days after his admission to Murfreesboro, and a new attending physician and two new residents assumed his care. The patient's new treatment team appeared to think that the patient's surgeries for G-tube and Port-a-Cath® placements were scheduled for January 23, while this appointment was only for an evaluation in General Surgery clinic. The family was also under the impression that when the patient went to Nashville he would immediately undergo these procedures, be transported back to the Murfreesboro facility, and be discharged to begin outpatient fee-based treatment near his home. They did not expect his admission to the Nashville facility. The lack of provider-to-provider communication and coordination between Nashville and Murfreesboro contributed to the inadequacy of the information provided to the family.

Issue 3: Nutritional Management

We substantiated the allegation that the patient's nutrition was not appropriately managed while he was an inpatient on a medicine unit in Murfreesboro. He became completely unable to swallow 1 week after admission. Although IVFs were ordered, nutritional support was inadequate and the patient lost 13 pounds in 14 days.

The patient reported a 10-pound weight loss and severe dysphagia when he presented to Murfreesboro on January 9. The Murfreesboro GI physician evaluated him and recommended placement on a full liquid diet. Instead, upon admission to the medicine unit on January 10, he was placed on a pureed diet with double portions. His unintentional weight loss of 10 pounds or more in a 3-month period prompted an evaluation by the dietitian. She also felt that the patient could consume some solids, and left him on a pureed diet with Ensure® supplements. Although the dietitian documented

[9] Electronic progress notes can be forwarded to other clinical staff for their review, concurrence, and signature.

that she would follow the patient to monitor tolerance of his diet and told us that she did, we found no documentation that this occurred.

Nursing progress notes and intake and output (I&O) notes used by nursing staff to document meal and/or liquid consumption reflected steadily declining consumption of solids and liquids. They also documented the patient's frequent refusal of oral medications he couldn't swallow. These notes were written daily for every shift and every meal. By January 17, the patient was reporting to nursing staff that he could no longer swallow water. One nurse copied the resident on her note to ensure he was aware of the patient's change in status and stated that "the charge nurse was notified." On January 18, the physician ordered IVFs for the patient, who continued to receive, but not consume, his meals.

A January 18 Murfreesboro psychologist's note documented the patient's concern that he was "not getting enough sustenance to stay healthy." A January 21 nursing progress note stated the patient was complaining about "…feeling weak, [patient] suggests that it is related to not being able to eat." Nursing was consistently documenting the worsening dysphagia in their notes, and one nurse told us that he notified a physician that the patient wasn't consuming anything. This nurse also said that when the physicians were with the patient during rounds, he told the patient to tell them about the seriousness of his problem.

One resident physician told us that the patient reported inconsistently about how much of his meal he was consuming and "played down" his dysphagia. Yet, this same resident documented on January 20 that the "patient was unable to swallow neither solid nor liquid material." The attending physician's notes indicated he was aware of the worsening dysphagia as well.

Between admission on January 10 and transfer to Nashville on January 23, the patient was not weighed, nor was Nutrition Service consulted to re-evaluate the patient, even though his laboratory results of January 18 revealed a low albumin level. His Murfreesboro admission diagnosis included dysphagia, and each physician note stated "nutritional support is currently an issue"; however, an alternate approach to nutrition, such as TPN, was not initiated. His attending physician told us that TPN was available at Murfreesboro, but they thought the patient was scheduled for G-tube placement on January 23, and that he was doing well enough to wait for his tube feedings to start after that procedure.

By January 23, the patient had lost 13 pounds since admission to Murfreesboro and Nashville physicians admitted him for nutritional support. Laboratory results from January 23 showed a low prealbumin level, and he was started on TPN on January 24.

It is uncertain why Murfreesboro physicians would continue to prescribe oral medications for the patient when it was clearly documented that he could not swallow them.

Providers should have monitored weight and assured proper nutrition for this patient facing surgery and an aggressive course of chemotherapy and radiation therapy.

Issue 4: Documentation of Advance Directives

We found no documentation of discussion of advance directives during the patient's admission to the medicine unit in Murfreesboro as required. System policy on advance directives (Memorandum 626-06-11-05, *Advance Directives*, dated August 14, 2006) states that "every veteran who enters the system will be advised of their right to and be afforded the opportunity, with assistance, to formulate personal choices regarding their health care." At the time of initial enrollment or subsequent presentation for healthcare, the clerical staff enrolling or admitting the patient should determine if the patient has an existing advance directive or would like to initiate one. If one exists, the computerized patient record system (CPRS) is flagged, and a copy of the document is obtained and scanned into the medical record. If the patient would like to initiate an advance directive, a social worker provides assistance.

This process did not occur upon the patient's admission to Murfreesboro, and the absence of an advance directive was not noted by his treatment team during the 2 weeks he was there. Upon the patient's admission to Nashville unit 2G, his resident physician noted that the patient did not have an advance directive in his medical record. The physician discussed advance directives with the patient on January 26 and documented his wishes in a progress note.

Conclusions

We substantiated that there was a delay in treating the patient's esophageal cancer. The patient was hospitalized at the Murfreesboro facility for 2 weeks waiting to be evaluated in Nashville General Surgery Clinic and to be placed on the Tumor Board schedule. We found that communication, both between the Murfreesboro and Nashville physicians, and between the Murfreesboro physicians and the patient and his family, was less than optimal. We also substantiated that the patient's nutrition was not appropriately managed at the Murfreesboro facility, as he lost 13 pounds in 14 days and received IVFs alone for almost a week. We found the patient was not weighed again at Murfreesboro after admission, and the Nutrition Support Team was not consulted to evaluate the patient for TPN. We also found that advance directives were not documented in the patient's medical record until 16 days after his admission to the TVHS. We did not find, however, that the delay in treatment or the early lack of nutritional support negatively impacted the patient's long-term clinical outcome.

Recommendations

Recommendation 1. We recommended that the VISN Director requires that the Interim System Director ensures that consults to Nashville for Murfreesboro inpatients are addressed within the required timeframe.

Recommendation 2. We recommended that the VISN Director ensures that the Interim System Director develops a more systematic process for referring patients to Tumor Board.

Recommendation 3. We recommended that the VISN Director ensures that the Interim System Director requires dietitians to monitor and document the status of patients at nutritional risk.

Recommendation 4. We recommended that the VISN Director requires the Interim System Director to ensure that advance directives are discussed and documented in patients' medical records, as required.

Comments

The VISN and Interim System Directors agreed with our findings and recommendations and provided detailed and acceptable improvement plans. (See Appendixes A and B, pages 10–17, for the full text of the comments.) We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 16, 2007

From: Director, VA Mid South Healthcare Network (10N9)

Subject: Quality of Care Issues, Tennessee Valley Healthcare System – Project Number: 2007-01181-HI-0315

To: Assistant Inspector General for Healthcare Inspections

I concur with the recommendations and action plan presented by TVHS.

(original signed by:)

John Dandridge, Jr.

Appendix B

Interim System Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 15, 2007

From: Interim Director, Tennessee Valley Healthcare System (626/00)

Subject: Quality of Care Issues, Tennessee Valley Healthcare System – Project Number: 2007-01181-HI-0315

To: Director, Mid South Healthcare Network (10N9)

I concur with the findings and suggested recommendations and have attached our action plan.

(original signed by:)

Juan Morales

Interim System Director's Comments to Office of Inspector General's Report

The following Interim System Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director requires the Interim System Director to ensure that consults to Nashville for Murfreesboro inpatients are addressed within the required timeframe.

Concur **Target Completion Date:** Multiple

- When it is determined by the treating physician that the patient is acutely ill and needs an urgent consultation a consult will be entered into CPRS to the appropriate service as "STAT" and will be followed by an immediate physician to physician telephone call. The consulting service will annotate the CPRS consult form to indicate that this call was received and the patient disposition recommended. To be initiated immediately.

- Consult requests deemed emergent for inpatients at the Alvin C. York Medical Center (Murfreesboro) will be evaluated by a Murfreesboro surgery provider within one (1) hour; routine consults within twenty-four (24) hours. If the patient is expected to require a surgical procedure that cannot be performed at the Murfreesboro campus the Murfreesboro surgery provider will initiate telephone contact with a surgery counterpart at the Nashville campus to alert the Nashville provider of an impending referral for surgical intervention. The patients treating/attending provider will simultaneously contact the TVHS Transfer Coordinator to initiate and complete transfer arrangements. To be initiated immediately.

- Consult and Progress note titles will be identified for use by the providers in arranging interfacility transfers. Information Resource Management Service will establish reporting tools to track these consults and progress notes and response/processing time will be trended using automated data retrieval. This automated tracking system to be implemented on or before January 31, 2008.

- The Office of Quality Management will manually track consultation requests for all interfacility transfers involving oncology diagnoses and treatment pending implementation of the automated tracking system. To be initiated immediately.

Responsible party: COS, Medicine, Surgery, Psychiatry and Information Resource Management Service and Quality Management Service Chiefs.

Recommendation 2. We recommended that the VISN Director ensures that the Interim System Director develops a more systematic process for referring patients to Tumor Board.

Concur **Target Completion Date:** Multiple

- The Chairperson of the TVHS Cancer Committee will, in collaboration with the TVHS Bed Service Chiefs and Primary Care Chief Medical Officers and the Supervisory Clinical Applications Coordinator, design for implementation a consult template to be used by all providers making a referral to the TVHS Tumor Board. Design and testing to be completed on or before October 26, 2007. Provider education to be completed by November 2, with full implementation on November 5, 2007.

- Information Resource Management Service will establish reporting tools to track these consults (by assigned title) and response/processing time will be trended using automated data retrieval. This automated tracking system to be implemented on or before February 28, 2008.

• The Office of Quality Management will manually track consultation requests referral to the TVHS Tumor Board pending implementation of the automated tracking system. To be initiated concurrently with the implementation of the consult template (November 5, 2007).

Responsible party: COS, Chairperson, TVHS Cancer Committee, Chiefs of Medicine, Surgery, Psychiatry Services and Chief Medical officers, Primary Care, Chief, Information Resource Management and Chief, Quality Management.

Recommendation 3. We recommended that the VISN Director ensures that the Interim System Director requires dietitians to monitor and document the status of patients at nutritional risk.

Concur **Target Completion Date:** Multiple

• TVHS dietitians will review all patient cases where nutritional risk is identified, either through the Nursing Admission Intake and/or existing VistA nutritional risk tracking tools; all admissions will have weights recorded per the Nursing Admissions Intake protocol within 24 hours. Review of cases identified and nutritional intervention recommendations/actions will be documented and the attending physician will be identified as an "additional signer" to the consult/progress note. Nutrition and Food Service will follow the protocol outlined in the document entitled "Assessment and Reassessment of Patient's Medical Nutrition Care, Summary Document" To be initiated immediately.

• Information Resource Management Service will establish reporting tools to track these consult/progress notes (by assigned title) and response/processing time will be trended using automated data retrieval. This automated tracking system to be implemented on or before February 28, 2008.

- The Office of Quality Management will manually review consultative referrals to Nutrition and Food Service and dietitian progress notes involving oncology diagnoses and treatment pending implementation of the automated tracking system. To be initiated immediately.

Responsible party: COS, Medicine, Surgery, Psychiatry, Nutrition and Food Service, Information Resource Management and Quality Management Service Chiefs.

Recommendation 4. We recommended that the VISN Director requires the Interim System Director to ensure that advance directives are discussed and documented in patients' medical records, as required.

Concur **Target Completion Date:** Multiple

- The Chief, Business Office will provide additional training of business office clerks to emphasize the clerks role in obtaining Advance Directive information and making the appropriate referrals to nursing and social work staff as required by TVHS policy. To be initiated immediately with training to be completed on or before October 26, 2007.

- Discussions related to advance directive and associated actions will be monitored using consult/progress note identification tracking tolls to be developed by Information Resource Management Service. This automated tracking system to be implemented on or before February 28, 2008.

- The Office of Quality Management will manually monitor, using sampling methodology, admission notes and report policy compliance information to the Chief, Business Office pending implementation of the automated tracking system. To be initiated immediately.

Responsible party: COS, Chief, Business Office, Chief, Quality Management, Chief, Social Work Service, Associate Director, Nursing Service, Chief, Information Resource Management Service.

Comments

Additional findings that communication between the Murfreesboro and Nashville physicians, and the Murfreesboro physicians and the patient and his family was less than optimal.

Concur with findings.

Action:

- Provider to Provider Communication. Hand-off Communication Policy 626-07-OOQ-11 was published on 8/27/07 with employee notification. This policy utilizes I-SBAR (Identification, Situation, Background, Assessment and Recommendation). It is a situational briefing model that is used to standardize communication of critical patient information to decrease the likelihood of adverse patient events and outcomes; therefore, ensuring patient safety. The Associate Chief of Staff has provided to all TVHS Service Chiefs a Power Point presentation for use in educating providers to the policy requirements.

  - Service Chiefs will utilize this presentation during a Service Staff Meeting and document in their staff meeting minutes that the training was provided and a listing of those present for the training. To be completed at the next scheduled service staff meeting with a copy of the service minutes forwarded to the ACOS-E.

  - Clinical staff not present at the next scheduled service staff meeting will certify receipt of a copy of the Hand-off Communication Policy and Power Point presentation no more than 10 days following the service staff meeting at which the Hand-off Policy was presented. Certifications to be forwarded to the ACOS-E.

- Provider/Treatment Team to Family Member Communication. The Associate Director, Nursing Service and the Chief, Social Work Service will review the processes by which clinical recommendations, patient status changes, patient inter and intra facility transfers are communicated to family members/significant others and make recommendations for policy/procedure changes that will improve the quality and timeliness of these communications. Recommendations to be made to the TVHS Executive Leadership Team on or before November 19, 2007.

  Responsible party: COS, ACOS-E, Chief, Business Office, Chief, Social Work Service, Associate Director, Nursing Service.

  Responsible party: COS, Chief, Business Office, Chief, Quality Management, Chief, Social Work Service, Associate Director, Nursing Service, Chief, Information Resource Management Service.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Christa C. Sisterhen, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Jerry Herbers, M.D.

Appendix D

Report Distribution

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