Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-03443-46

Combined Assessment Program Review of the VA Medical Center Durham, North Carolina

December 19, 2007

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of November 5–8, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the VA Medical Center (the medical center), Durham, NC. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 684 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

Results of the Review

The CAP review covered four operational areas and activities. We made six recommendations related to two of the activities reviewed. For these activities, the medical center needed to comply with Veterans Health Administration (VHA) policies and guidance regarding:

- Mortality review processes.
- Peer review processes.
- Adverse event disclosure requirements.
- Root cause analysis (RCA) processes.
- Medical record review requirements.
- Electronic medical record (EMR) business rules.

The medical center complied with selected standards in the following two activities:

- Environment of Care (EOC).
- Patient Satisfaction.

This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–19, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Profile

Organization. The medical center is a tertiary care facility located in Durham, NC, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) located in Greenville, Morehead City, Raleigh, and Durham, NC. The medical center is part of VISN 6 and serves a veteran population of about 195,000 throughout 26 counties in central and eastern North Carolina. In November 2007, the medical center was a recipient of the Robert W. Carey Performance Excellence Award.[1]

Programs. The medical center provides diagnostic and therapeutic services in medicine, surgery, neurology, and psychiatry. It also provides skilled nursing home care and complete ambulatory care services. The medical center has 154 hospital beds, 27 intensive care beds, and 120 onsite nursing home beds.

The medical center serves as a major referral center for North Carolina, southern Virginia, northern South Carolina, and eastern Tennessee for subspecialty treatment, radiation therapy, neurological disorders, therapeutic endoscopy, high-risk open heart surgery, and other special procedures. Special programs include a comprehensive Women's Health Center; a Home Based Primary Care Program; a Geriatric Research, Education, and Clinical Center (GRECC); the VISN 6 Mental Illness, Research, Education, and Clinical Center (MIRECC); the Center for Health Services Research in Primary Care; and the Epidemiology Research and Information Center (ERIC).

Affiliations and Research. The medical center is affiliated with Duke University's School of Medicine, the University of North Carolina's School of Dentistry, and East Carolina University's Brody School of Medicine and provides training for 130 medical resident positions in a wide range of training programs. The medical center has an active research program with 146 investigators conducting 419 active projects. In fiscal year (FY) 2006, the medical center research program had a research budget that exceeded

[1] Awarded to VHA facilities that have implemented management approaches that have resulted in high levels of performance and service to veterans.

$26.2 million. The FY 2007 budget was not available at the time of our review.

Resources. In FY 2007, medical care expenditures totaled $281.7 million. The FY 2008 medical care budget is projected to be $291.6 million. FY 2007 staffing was 1,204 full-time employee equivalents (FTE), including 144 physician and 443 nursing FTE.

Workload. In FY 2007, the medical center treated about 46,400 unique patients and provided 40,710 inpatient days in the hospital and 36,410 inpatient days in the nursing home. The inpatient care workload totaled 6,298 discharges, and the average daily census, including nursing home patients, was 211. Outpatient workload totaled 360,537 visits.

Objectives and Scope

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

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

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following four areas and activities:

- EMR Business Rules.
- EOC.

- Patient Satisfaction.
- QM.

The review covered medical center operations for FY 2007 and FY 2008 through November 8, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Durham, North Carolina,* Report No. 05-00029-127, April 22, 2005). The medical center had corrected all findings related to health care from our prior CAP review.

We also followed up on recommendations from a report by VHA's Office of the Medical Inspector (OMI), (*Final Report: Review of Complaint Regarding the Quality of Medical Care*, *Durham, North Carolina*, November 5, 2004). In that report, the OMI made recommendations to improve communication, interdisciplinary treatment planning, support to caregivers, and bereavement services for family members. We reviewed the documentation of the follow-up from the medical center and found improvement actions to be acceptable. We consider all OMI recommendations closed.

During this review, we also presented fraud and integrity awareness training for 684 employees. This training covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine if: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal

and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed the self-assessment completed by QM staff regarding compliance with QM requirements. We also evaluated documents related to the functioning of the Executive Committee of the Governing Body, as well as other relevant QM documents and committee minutes.

The QM program was generally effective in its oversight of the quality of care provided at the medical center, and managers supported QM efforts. Credentialing and privileging, patient complaints, national patient safety goals, utilization management, blood products usage, operative and other procedures, resuscitation and outcomes, restraints and seclusion, and system redesign/patient flow were monitored effectively. However, we identified several program areas that needed strengthening.

Mortality Review. The mortality evaluation process did not comply with VHA Directive 2005-056, *Mortality Assessment,* issued December 1, 2005. We determined that mortality data:

- Did not include all required elements, such as provider, unit, and shift.
- Was not analyzed or graphed on a regular basis to identify unusual trends.

While some mortality data was reported annually to the Clinical Executive Board (CEB), this did not provide an opportunity to identify trends on a regular basis throughout the year. Since mortality data did not include all necessary elements and was not routinely evaluated and discussed, managers could miss opportunities to improve quality of care and patient safety.

Peer Review. The peer review process did not comply with VHA Directive 2004-054, *Peer Review for Quality Management*, issued September 29, 2004*.* Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline within 45 days, with subsequent Peer Review Committee (PRC) evaluation and concurrence with the findings within 120 days. We evaluated peer review

activities conducted during FY 2007 and identified the following issues:

- The peer review database identified 43 completed peer review cases. We found that 11 initial peer reviews (25 percent) were not completed within the 45-day timeframe and that 23 peer reviews (53 percent) were not reviewed by the PRC within the 120-day timeframe.
- PRC minutes did not reflect discussions and rationales for peer review level changes.
- There was no formal process to consider provider comments prior to the assignment of Level 2 or Level 3[2] to peer review findings.
- Quarterly tracking of peer review data did not include recommendations, action items, or follow-up resulting from completed peer reviews.
- Trending and analysis of data was not regularly presented to the PRC or CEB.
- The PRC did not refer system/process issues identified during peer review to appropriate QM staff.

Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. Peer reviews and data evaluation should be conducted in accordance with policy to ensure that providers perform according to accepted community standards and that improvement actions are taken when indicated.

Adverse Event Disclosure. The medical center did not comply with VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, issued October 27, 2005. The medical center had not evaluated all events that could potentially require institutional disclosure. Institutional disclosure is a formal process that is completed when serious injury, death, or potential legal liability are involved. During FY 2007, QM staff identified and completed appropriate institutional disclosure on four cases. However, we identified three additional cases that should have been evaluated for possible institutional disclosure but were not. Without adequate evaluation of events that potentially require

[2] Level 2 – Most experienced, competent practitioners might have managed the case differently; Level 3 – Most experienced practitioners would have managed the case differently.

disclosure, managers could not be assured that patients were provided with information needed to make decisions.

Root Cause Analyses. We found that elements of the RCA process did not comply with VHA guidelines. RCAs are designed to identify and resolve the root cause of system and/or process deficiencies involved in an actual or potential adverse event. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, issued January 30, 2002, requires that RCAs be conducted within 45 days of the medical center's identification of need and that feedback be provided to the event reporter on the actions taken. Additionally, the handbook requires implementation of action plans designed to prevent future occurrences of similar events.

For the 22 individual RCAs conducted for events occurring in FY 2007, we found that:

- Eight did not contain evidence that all recommended actions were tracked to completion; in some cases, actions were not completed by the due dates.
- Eleven did not include the signatures of the team members to indicate their concurrence with the findings and recommendations contained in the final report.
- Fourteen were not completed within the 45-day requirement.
- Sixteen did not include feedback to the event reporter on the actions taken.

In addition, the required aggregate review of medication events was not completed during FY 2007. Without an adequate RCA process, managers could not be assured that patient safety events were properly evaluated or that corrective actions were implemented.

Medical Record Review. We found that the medical record reviews conducted by Health Information Management staff did not comply with VHA requirements. The electronic medical record system allows copying and pasting of text, but VHA policy states that these functions should be used with caution. VHA Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, requires medical centers to monitor copying and pasting as part of the ongoing medical record review process. Routine copying and pasting of text can result in confusing and

misleading medical information that could negatively impact patient care. Without adequate medical record reviews, managers could not be assured that electronic functions were being appropriately used at the medical center.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires the mortality review process to comply with VHA policy.

The VISN and Medical Center Directors concurred with the findings and the recommendation and provided acceptable improvement plans. The medical center enhanced trending, analysis, and reporting of mortality data by incorporating all required review elements into reports and increasing the frequency of data reporting to the CEB. We will follow up on planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires the peer review process to comply with VHA policy.

The VISN and Medical Center Directors concurred with the findings and the recommendation and provided acceptable improvement plans. Actions taken to strengthen the peer review process include education of key staff regarding the importance of timely reporting and completion of peer reviews, modification of tracking tools, increased meeting frequency of the Protected Peer Review Committee (PPRC), and improved documentation of PPRC activities and deliberations. In addition, the medical center established a Risk Management Committee to facilitate communication across key patient safety processes to help ensure appropriate evaluation of patient incidents and issues. We will follow up on planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires the adverse event disclosure process to comply with VHA policy.

The VISN and Medical Center Directors concurred with the findings and the recommendation and provided acceptable improvement plans. Actions taken include establishing a Risk Management Committee responsible for identifying and considering cases for possible institutional disclosure, enhancing patient safety and peer review logs, and modifying local policy to require evaluation of all Level 3 peer

reviews for possible disclosure. We will follow up on planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires the RCA process to be completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and the recommendation and provided acceptable improvement plans. The RCA process has been strengthened by improving the tracking and documentation of recommended actions and feedback to the reporter, ensuring team member concurrence with RCA findings, chartering the required medication aggregate RCA, and establishing a Risk Management Committee to ensure that all patient incidents and issues have been appropriately evaluated. We will follow up on planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires medical record reviews to be completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and the recommendation and provided acceptable improvement plans. The medical center established a task force that evaluated current medical record review processes. The task force subsequently implemented actions, which include educating staff on copy and paste requirements and formalizing and expanding medical record monitoring activities. We will follow up on planned actions until they are completed.

Electronic Medical Record Business Rules

Business rules define which groups or individuals are allowed to edit or delete documentation in EMRs. The health record, as defined in VHA Handbook 1907.01, includes both the electronic and paper medical records. It includes items, such as physician orders, progress notes, and examination and test results. In general, once notes are signed, they should not be altered.

On October 20, 2004, the VHA Office of Information (OI) sent guidance to all medical centers to assure that business rules complied with VHA regulations. The guidance cautioned that, “The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed.” In January 2006, the OIG

identified a facility where progress notes could be improperly altered and recommended that VHA address the issue on a national basis. On June 7, 2006, VHA issued a memorandum to VISN Directors instructing all VA medical centers to comply with the guidance sent in October 2004.

During our review, we found that the medical center had one business rule that allowed the deletion of a note by someone other than the author. Staff took action to remove the business rule while we were onsite.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with VHA Handbook 1907.01 and the October 2004 OI guidance related to EMRs.

The VISN and Medical Center Directors concurred with the findings and the recommendation and provided acceptable improvement plans. Medical center staff removed the identified business rule and documented plans to maintain an effective system to monitor compliance with VHA guidance. We will follow up on planned actions until they are completed.

Review Activities Without Recommendations

Environment of Care

VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet VHA, Occupational Safety and Health Administration, and Joint Commission[3] standards. To evaluate the medical center's EOC, we inspected patient care areas for cleanliness, safety, infection control (IC) processes, and general maintenance.

We inspected occupied and unoccupied patient rooms, bathrooms, and areas where medications were stored on the nursing home units and on the inpatient units (medicine, surgery, psychiatry). We also inspected emergency carts and unit supply rooms in these areas. We found that guidelines were met, and risk assessments complied with VHA and Joint Commission standards.

[3] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

We evaluated the IC program to determine compliance with VHA directives that require data collection and analysis to improve performance and reduce risk of infections. The IC program monitored, trended, analyzed, and reported data to senior management for implementation of quality improvements.

We noted that Environmental Management Service switched from a double bucket mopping system to a microfiber mopping system. This system reduces the need to frequently change cleaning solutions. The mopping pads are soaked in a cleaning solution, and a new pad is used to clean each patient room. As soiled mop pads are never returned to the cleaning solution, the chance of cross contamination is limited. In addition, the microfiber mops leave less water on the floor, reducing the likelihood of slips and falls.

The medical center maintained a generally clean and safe environment. We made no recommendations.

Patient Satisfaction

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service dimensions, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients.

The purpose of this review was to assess the extent that VHA medical centers use SHEP data to improve patient care, treatment, and services. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Medical centers are expected to address areas in which they are underperforming.

The graphs on the next page show the medical center's performance in relation to national and VISN performance for FY 2006 through the 3rd quarter of FY 2007. Figure 1 shows the medical center's SHEP performance measure (PM) results for inpatients. The medical center met or exceeded the established target in all 7 quarters of available data. Figure 2 shows the medical center's SHEP PM results for outpatients. The medical center did not meet the established target for the last 7 quarters.

Figure 1:

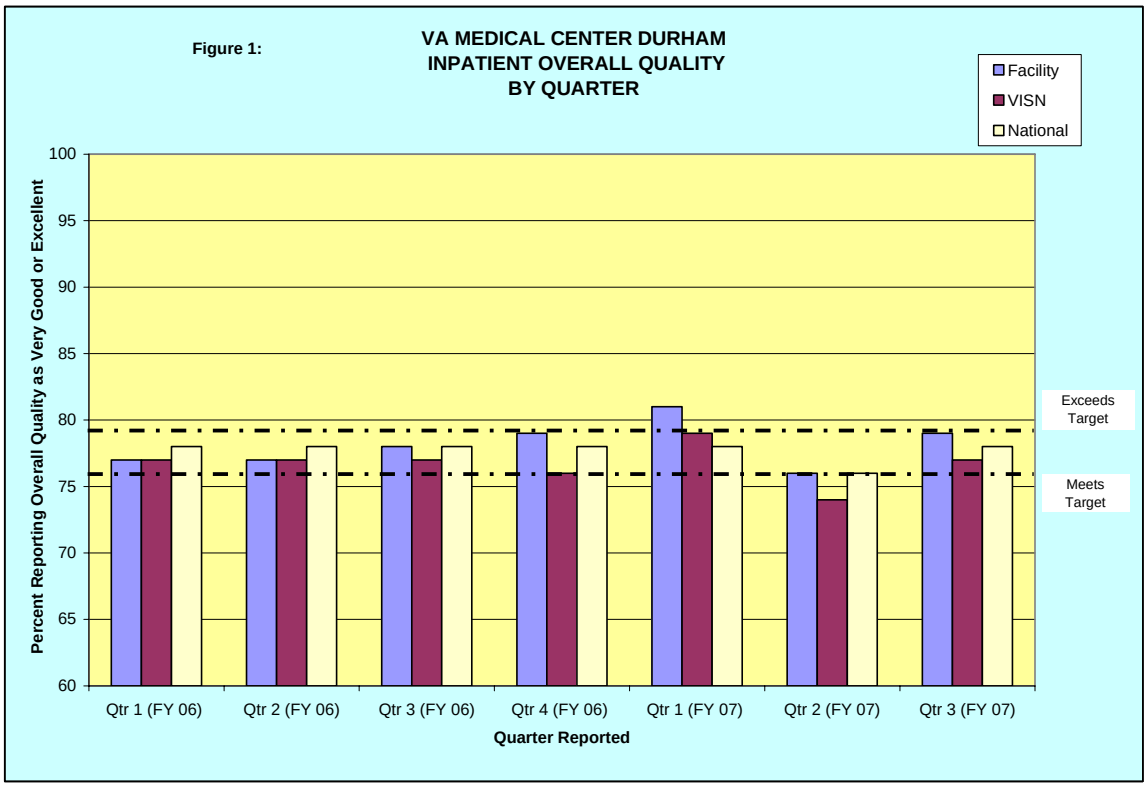
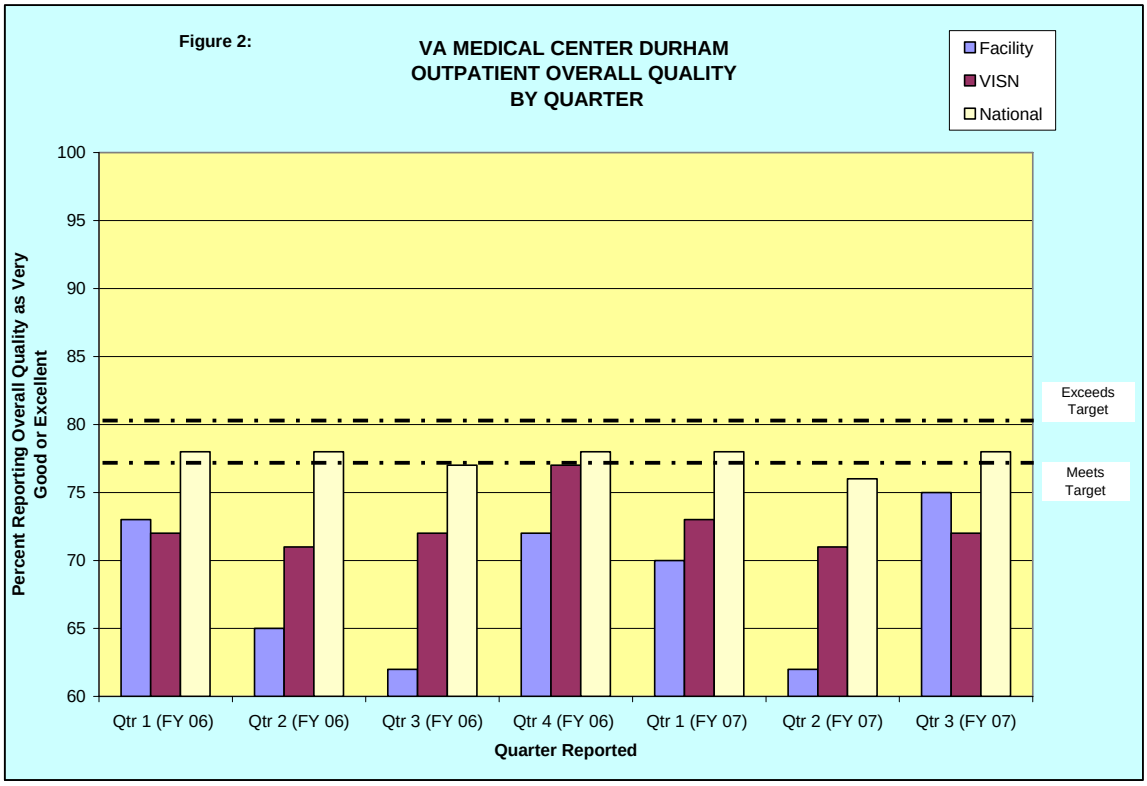


Figure 2:



The medical center's Patient Satisfaction Committee (PSC) has oversight and coordination responsibility for customer service activities. In addition, individual services develop action plans to address service level deficiencies. Because the medical center was underperforming in several outpatient dimensions, the PSC recommended improvement actions. Managers instituted initiatives to improve access to parking, the physical environment, pharmacy timeliness, and satisfaction with CBOC services. While insufficient time has passed to determine the ultimate effectiveness of these actions, substantial improvement was noted from the 2nd to the 3rd quarter of FY 2007. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 3, 2007

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Combined Assessment Program Review of the VA Medical Center, Durham, North Carolina**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Office (10B5)

The Network Office, VISN 6, agrees with the Medical Center Director's corrective action plan.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 3, 2007

From: Director, VA Medical Center, Durham, NC (558/00)

Subject: **Combined Assessment Program Review of the VA Medical Center, Durham, North Carolina**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

The Durham VA Medical Center concurs with the findings of the OIG and has attached a corrective action plan.

(original signed by:)

RALPH T. GIGLIOTTI, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires the mortality review process to comply with VHA policy.

Concur

December 3, 2007

The Quality Management Service has conducted a review of current practice related to mortality review and analysis. Mortality data are currently collected monthly, including all required elements (date of death, ward, day of week, shift, time of death, care team and attending physician), and reported to the Medical Records Committee. Analysis and trended data are reported annually to the Clinical Executive Board (CEB). Since this analysis did not include all elements of data being collected, graphs of each of these elements are available and have been added to the annual Mortality Review report to CEB. Further opportunity to identify trends on a more frequent basis throughout the year was identified; therefore, the program has been strengthened to provide analysis of trended data every other month to CEB.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires the peer review process to comply with VHA policy.

Concur

December 17, 2007

The Chief of Staff has taken a number of actions to ensure the peer review process is in compliance with VHA Directive 2004-054, *Peer Review for Quality Management.* A meeting was held with Clinical Service Chiefs on November 15, 2007, and Service QM Coordinators on November 19, 2007, to stress the importance of timely reporting of occurrences and completion of peer reviews. MS Excel spreadsheet was modified to include built in formulas, which enhance tracking timeliness. Reminders will be sent to peer reviewer prior to due dates (e.g., 21, 30 days). Protected Peer Review Committee (PRRC) meetings have been

changed to monthly rather than bi-monthly to facilitate more timely reviews by committee. Data from completed peer reviews are trended and analyzed bi-monthly by the PPRC and reported to the Clinical Executive Board (CEB) bi-monthly. Tracking includes recommendations, open action items, and follow-up. Documentation of discussions regarding changes to peer review levels is included in PPRC minutes. Prior to assignment of Level, the provider is formally invited to attend the PPRC and discuss the case or submit written feedback for committee consideration. The PPRC is exploring the feasibility and potential use of an Electronic Peer Review process. In addition, a Risk Management Committee has been established. This committee is chaired by the Quality Manager and includes the Risk Manager, Patient Safety Manager, Peer Review Coordinator, and the Chief of Staff as Physician Advisor. The Risk Management, Patient Safety, and Peer Review logs have been modified to provide a means to cross check that all patient incidents/issues have been appropriately evaluated.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the disclosure process to comply with VHA policy.

Concur

November 20, 2007

A Risk Management Committee has been established. This committee is chaired by the Quality Manager and includes the Risk Manager, Patient Safety Manager, Peer Review Coordinator, and the Chief of Staff as Physician Advisor. This committee is charged with the responsibility of identifying and considering cases for possible institutional disclosure. The Risk Management, Patient Safety, and Peer Review logs have been modified to provide a means to cross check that all patient incidents/issues have been appropriately evaluated. Medical Center Memorandum 558-07-5.129, *Peer Review for Quality Management*, has been modified to require all Level 3 Peer Reviews be evaluated for possible disclosure.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires the RCA process to be completed in accordance with VHA policy.

Concur

December 31, 2007

Durham VAMC has reviewed the RCA process and has taken the following actions to strengthen this aspect of the Patient Safety Program.

A. RCA actions are tracked using the built-in reports in the VA NCPS SPOT database. Actions due are identified 1 month in advance of their due date, and the responsible individual is sent a reminder. Once the response individual provides the data required by the outcome measure for each action or documentation of completed action items, it is posted in SPOT, and that action item is closed out. When all Actions Items are complete, the RCA is closed out as completed.

Pending and completed actions are included in the Safety Committee Minutes and reported through these minutes to the Environment of Care Committee on a monthly basis. Additionally, the Patient Safety Manager meets with the Director at a minimum of once per month, and RCA Actions are discussed during that meeting. The initiation of posting of the status of Action items in SPOT was initiated in July 2007. Overdue measures and completed measures have been updated and will continue to be monitored in SPOT as indicated above.

B. Signatures for the 11 RCAs identified by the OIG Team as missing have been obtained. Signature by the team members will be documented in Paragraph 22 of the RCAs for all future RCAs prior to obtaining the concurrence of the Director.

C. Timeliness of the RCA process, including documentation of Feedback to the reporter required in Paragraph 17 of the RCA, will be tracked using the following tracking tool.

ROOT CAUSE ANALYSIS TIME-LINE TRACKING TOOL			
RCA# _____	Team Leader: _____		
EVENT	**TARGET DAY**	**TARGET DATE**	**ACTUAL DATE**
	C=Charter Date		
Facilitator meets with team leader/Initiates JIT training	C+2		
First team meeting/complete JIT training	C+4		
Complete initial understanding of event AND assignment of member duties (inc literature reviews)	C+7		
List of interviews, etc accomplished	C+10		
Complete interviews, etc	C+17		
Complete final understanding of event. Review findings from literature, etc	C+20		
Root cause/contributing factors identified	C+23		
RCA outcomes and plan completed. Feedback from reporter obtained.	C+25		
RCA form completed with RCA team member signatures	C+28		
Final report delivered circulated to ELT for comment	C+29		
RCA presented to Director for concurrence	C+30		
RCA Transmitted to NCPS	C+45		

D. An Aggregate Medications RCA has been chartered and will be completed by December 31, 2007, for incidents occuring in the First and Second Quarter of Fiscal Year 2007.

E. A Risk Management Committee has been established. This committee is chaired by the Quality Manager and includes the Risk Manager, Patient Safety Manager, Peer Review Coordinator, and the Chief of Staff as Physician Advisor. The Risk Management, Patient Safety, and Peer Review logs have been modified to provide a means to cross check that all patient incidents/issues have been appropriately evaluated.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires medical record reviews to be completed in accordance with VHA policy.

Concur

February 4, 2008

Durham VAMC established a task force to review VHA Handbook 1907.1, *Health Information Management and Health Records*, to evaluate our monitoring and reporting system, and to develop a plan with timelines to achieve full compliance with the copy and paste monitoring requirements. This task force found that Durham VA policy (MCM 6.10, *Health Information Management*) clearly defines conditions where copy and paste is appropriate and requirements for education of staff. Education is being provided as required. A risk assessment has been conducted and areas of high risk have been identified. Monitoring is currently conducted in one of these high risk areas. This monitoring will be formalized, documented, and expanded to include all high-risk areas by December 19, 2007. Medical Records Committee (MRC) has added monitoring of copy and paste to their monthly reviews and will analyze 1st quarter data January 16, 2008. MRC report will be evaluated by Clinical Executive Board February 4, 2008.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with VHA Handbook 1907.01 and the October 2004 OI guidance.

Concur

November 9, 2007

Business rules define which groups or individuals are allowed to edit or delete documentation in the Electronic Medical Record. Once notes are signed they should not be altered. During the OIG review, one business rule was found that allowed the “deletion” of a progress note by someone other than the author. Although the language in this nationally released

rule used the term “delete,” the action taken is actually “retraction.” These notes were never edited and were fully recoverable by our Privacy Officer; Chief, HIMS; and Risk Manager. After discussion with the OIG Team and consultation with their expert in Washington during the site visit, the business rule was removed. Durham VA has in place and will continue to maintain an effective system to implement and monitor compliance with VHA Office of Information guidance.

OIG Contact and Staff Acknowledgments

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