Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-01753-07

Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center Richmond, Virginia

October 16, 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 June 11–15, 2007, the OIG conducted a CAP review of the Hunter Holmes McGuire VA Medical Center (the medical center). 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 251 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strength:

- Adverse Event Disclosure Process.

We made recommendations in three of the activities reviewed. For the activities of documentation of intraoperative clinical information, QM, and environment of care (EOC), the medical center needed to:

- Allow only authorized staff with appropriate clinical privileges or scope of practice to document clinical information in patient medical records.
- Monitor accuracy of documentation of intraoperative clinical information.
- Ensure that signed informed consents are obtained for outpatient surgical procedures.
- Achieve full compliance with medication reconciliation requirements.
- Require that peer reviews and root cause analyses (RCAs) are completed within the required timeframes.
- Take appropriate action regarding employees who inaccurately documented defibrillator testing.
- Ensure defibrillators are tested, as required.

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

- Computerized Patient Record System (CPRS) Business Rules.

- Fredericksburg Community Based Outpatient Clinic (CBOC).
- Patient Satisfaction.
- Scope of Practice for Unlicensed Physicians Conducting Research on Human Subjects.
- Surgical Care Improvement Project (SCIP).

This report was prepared under the direction of Christa Sisterhen, Associate 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 14–18, 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 Richmond, VA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at one CBOC in Fredericksburg, VA. The medical center is part of VISN 6 and serves a veteran population of about 200,000 throughout central and southern Virginia and northern North Carolina.

Programs. The medical center provides medical, surgical, mental health, substance abuse, geriatric, rehabilitation, neurology, spinal cord injury, dental, and hospice health services. The medical center has 329 hospital beds and 98 nursing home beds.

Affiliations and Research. The medical center is affiliated with Virginia Commonwealth University and provides training for 136.5 medical residents. In fiscal year (FY) 2006, the medical center research program had 265 projects and a budget of $6.5 million. Important areas of research include hepatitis C, diabetes and lipid disorders, molecular oncology, and regulation of bile acids and biliary cholesterol. The medical center also participates in the Defense and Veterans Brain Injury Center polytrauma research program.

Resources. In FY 2006, medical care expenditures totaled $258.6 million. The FY 2007 medical care budget is $266.3 million. FY 2006 staffing was 1,792.6 full-time employee equivalents (FTE), including 138.1 physician and 690 nursing FTE.

Workload. In FY 2006, the medical center treated 40,231 unique patients and provided 62,397 inpatient days in the hospital and 28,988 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 7,006 discharges, and the average daily census, including nursing home patients, was 250.4. Outpatient workload totaled 391,989 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 eight activities:

- CPRS Business Rules.
- Documentation of Intraoperative Clinical Information.
- EOC.
- Fredericksburg CBOC.
- Patient Satisfaction.
- QM.
- SCIP.
- Scope of Practice for Unlicensed Physicians Conducting Research on Human Subjects.

The review covered medical center operations for FY 2006 and FY 2007 through June 15, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA,* Report No. 04-02277-48, December 13, 2004).

During this review, we also presented fraud and integrity awareness briefings to 251 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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.

Organizational Strength

Adverse Event Disclosure Process

The medical center's adverse event disclosure process was comprehensive and well organized. The medical center formalized their adverse event disclosure process in 2004, prior to VHA Directive 2005-049, *Disclosure of Adverse Events to Patients,* issued October 27, 2005. VHA's directive requires that medical errors or harmful events be disclosed to patients and/or their families.

During the initial implementation of the medical center's adverse event disclosure process, providers received training on their role in clinical and institutional disclosure. Disclosure experts presented during medical center Grand Rounds, and "just-in-time" training assistance was provided when an adverse event occurred. When the need for disclosure is identified, the Risk Manager and the Associate Chief of Staff for QM immediately notify the Chief of Staff and Regional Counsel to discuss the event and determine the appropriate action. In addition, the Risk Manager meets with the clinical staff involved to provide an overview of what is expected in the disclosure process and arranges for them to review publications on disclosure and the "healing words" of apology.

As a result of the early efforts of medical center staff, we found that the disclosure process was efficient, effective, well integrated, and in compliance with all required elements of the directive; it met the intent of adverse event disclosure. We found that clinical staff members appropriately documented disclosure of adverse events in patients' medical records. The medical center's disclosure process assures managers that patients and/or their families are provided timely and accurate information when adverse events occur.

Results

Review Activities with Recommendations

Documentation of Intraoperative Clinical Information

We found that 16 of 30 (53 percent) medical records we examined for the SCIP review had a "Nurse Intraoperative Report" containing an improperly authored addendum by the Anesthesia Service clerk. These addenda documented clinical information and were not co-signed by clinical staff. Content of the addenda included, but was not limited to, additional

antibiotics administered but not previously documented, corrections to dosage, and additions of or corrections to the time of medication administration. Clinical information should only be entered into the medical record by authorized staff with the appropriate clinical privileges or scope of practice.

The Anesthesia Service clerk was responsible for reconciling the anesthesia records. We learned that the Chief of Anesthesia Service had instructed the clerk to correct identified discrepancies in the anesthesia portion of the Surgery Package (computer software used to collect intraoperative information). Although the corrected information was entered in the Surgery Package, it appeared as addenda to the "Nursing Intraoperative Reports" in CPRS. Nursing documentation required frequent correction; in the 12 months prior to our review, the Anesthesia Service clerk authored 2,800 addenda that documented corrections to clinical information contained in these notes.

Medical center managers acknowledged the need to clarify process issues and establish accountability regarding operating room (OR) documentation.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director allows only authorized staff with the appropriate clinical privileges or scope of practice to document clinical information in patient medical records.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director monitors accuracy of documentation of intraoperative clinical information.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. Medical center clinical staff are now required to enter their own data in patient medical records. A sample of nursing intraoperative notes and anesthesia flow sheets will be monitored until 100 percent accuracy is achieved. We will follow up on planned actions until they are completed.

Quality Management

The purposes of this review were to determine if the medical center (a) had a comprehensive and effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed committee minutes, documents

related to the functioning of the Quality Executive Board and Joint Leadership Council, and other relevant QM information.

The QM program was generally effective in providing oversight of the quality of patient care. Credentialing and privileging (C&P), mortality reviews, patient complaints, adverse event disclosure, utilization management, blood product usage reviews, operative procedure reviews, resuscitation outcomes, medical records, restraint and seclusion, patient flow, and advanced clinic access were monitored appropriately. However, we identified the following program areas that needed improvement:

Informed Consent. We found that the medical center did not always obtain signed informed consents for outpatient surgical procedures, as required by The Joint Commission;[1] VHA Directive 2004-028, *Ensuring Correct Surgery and Invasive Procedures*, issued June 25, 2004; and medical center policy. The medical center reported that signed informed consents were not obtained for 20 percent of the outpatient surgical procedures performed in the 1st quarter of FY 2006. The medical center did not continue to monitor performance in this area until April and May of 2007, when they reported 87 percent compliance. In addition, they had not developed an action plan to improve performance. Without signed informed consents, managers could not be assured that patients were properly informed of risks, benefits, and all of their health care options prior to outpatient surgical procedures.

Medication Reconciliation. We found that the medical center was not in compliance with The Joint Commission's requirement for medication reconciliation at admission and discharge. The intent of this Joint Commission patient safety goal is to ensure that patients and clinicians are aware of medication changes when a patient is transferred from one setting, service, provider, or level of care to another within or outside the medical center. The complete list of a patient's medications is compared (reconciled) with medications at the next level of care. On average, the medical center reported 68 percent compliance for admissions from January through April 2007, and 17 percent compliance with discharges from March through May 2007. The medical center acknowledged the importance of full compliance in this process and took corrective actions to improve performance. They developed templates that facilitated capture

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

of this information, but clinicians were not always documenting the medication reconciliation, as required. Without consistent documentation of medication reconciliation, managers could not be assured that safeguards were in place to prevent adverse medication events.

Timeliness of Peer Reviews and Root Cause Analyses. We found that the medical center did not always meet timeliness requirements for peer reviews and RCAs, as follows:

- Peer reviews were not always completed within 120 days, as required in VHA Directive 2004-054, *Peer Review for Quality Management*, issued September 29, 2004. We found that 11 of 30 peer reviews initiated between August 6, 2006, and April 16, 2007, were not completed within the 120-day requirement, and at the time of our review, 6 of those 30 cases remained pending longer than 160 days.

- RCAs were not always completed within 45 days of the medical center's identification of need, as required in VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, issued January 30, 2002. Of the 23 RCAs (11 individual and 12 aggregate) conducted for events occurring in FY 2006 through the 2nd quarter of FY 2007, we found that 18 were not completed within the 45-day requirement.

Without timely peer reviews and RCAs, managers could not be assured that quality improvement actions were promptly implemented to improve patient outcomes.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that signed informed consents are obtained for outpatient surgical procedures.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires full compliance with medication reconciliation requirements.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that peer reviews and RCAs are completed within the required timeframes.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. Medical center policy is being revised to clarify procedures requiring written informed consent, and staff will be

trained on the revised policy. Use of electronic consent templates will be expanded and monitored until 95 percent compliance is achieved. The medication reconciliation template was added to the admission, transfer, and discharge templates. Additional pharmacy staff were requested for medication reconciliation. Appropriate medical center managers will be notified when RCA team members are unable to meet completion deadlines. Peer reviews are being tracked for timeliness, and delinquencies will be reported to service chiefs and the Chief of Staff. Some actions will be referred to other committees to ensure closure within 120 days. We will follow up on planned actions until they are completed.

Environment of Care

VHA requires that health care facilities have a comprehensive EOC program that complies with VHA policy, Occupational Safety and Health Administration regulations, and Joint Commission standards. We inspected 19 clinical areas for cleanliness, safety, privacy, infection control, and general maintenance. We also followed up on EOC concerns cited in the previous CAP report and found those issues resolved.

Our inspection revealed that the medical center generally maintained a safe and clean environment and that infection control clinicians monitored exposures and infections appropriately. We noted some minor deficiencies during the inspection that were corrected before we left site. However, we identified a patient safety issue that required management attention.

Defibrillator test strips on two units did not agree with the signed defibrillator check sheets used by nursing staff. Defibrillators print a dated strip when the equipment is successfully tested. We found that on one unit, the defibrillator had not been tested on June 12, 2007, but nursing staff signed the defibrillator check sheet indicating that the test had been performed. On another unit, the defibrillator check sheet showed that nursing staff tested the defibrillator daily, yet the strip revealed that testing had not occurred for 4 consecutive days. Medical center policy requires daily defibrillator testing and documentation. Defibrillators are life saving equipment. Without appropriate testing, managers could not be assured that defibrillators would function properly in an emergency.

Recommendation 6 We recommended that the VISN Director require the Medical Center Director to take appropriate action regarding employees who inaccurately documented defibrillator testing.

Recommendation 7 We recommended that the VISN Director require the Medical Center Director to ensure that all defibrillators are tested, as required by local policy.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. Appropriate action was taken with responsible employees. The code cart checklist was changed, and responsible nursing staff received training on defibrillator check procedures and documentation. Nurse managers are monitoring compliance. All nursing staff will complete an additional competency verification of proper defibrillator checks. We will follow up on planned actions until they are completed.

Review Activities without Recommendations

Computerized Patient Record System Business Rules

Business rules define which groups or individuals are allowed to edit, amend, or delete documentation in electronic medical records. The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes the electronic and paper medical record. 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 software informational patch USR*1*26 to all medical centers with instructions 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 informational patch sent in October 2004.

We reviewed the medical center's business rules and found them to be in compliance with VHA policy. We made no recommendations.

Fredericksburg Community Based Outpatient Clinic

The purpose of this review was to assess CBOC operations and delivery of health care services. CBOCs were designed to improve veterans' access to care by offering primary care in local communities, while delivering the same standard of care as the parent facility. The Fredericksburg CBOC, located about 55 miles from the medical center, was staffed by VA employees and served 2,697 veterans in FY 2006.

We reviewed CBOC policies, performance documents, and provider C&P files, and conducted an EOC inspection to assess compliance with environmental standards. To determine if patients received the same standard of care, we compared the management of patients receiving warfarin at the parent facility with those receiving warfarin at the CBOC. We also interviewed five patients about their perceptions of care.

We found that the CBOC's emergency management plan was current, and staff were knowledgeable about rendering emergency care. CBOC providers' C&P files contained appropriate background screening and professional practice documentation. The facility was clean and well maintained and met Joint Commission, Health Insurance Portability and Accountability Act, and Life Safety requirements.

Patients on warfarin received the same standard of care at the CBOC as patients at the parent facility. Pharmacists managed the warfarin clinic at both the parent facility and the CBOC. The pharmacists conducted patient education on warfarin use and side effects and gave patients the same toll-free telephone number to call if they had problems or concerns. The patients we interviewed reported being satisfied with their care. 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 areas, including access to care, coordination of care, and courtesy. VHA relies on the analyses, interpretations, and delivery of the survey data for making administrative and clinical decisions to improve the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients treated and 76 percent of inpatients discharged during a specified date range will report 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.

Dates of survey reporting period: Qtrs. 3 and 4, FY 2006

Hunter Holmes McGuire VA Medical Center

INPATIENT SHEP RESULTS

	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.35	78.90	89.90	67.92	65.97	75.95	83.43	74.66	70.11	**
VISN	82.60	80.40	90.90	68.70	67.10	76.10	83.00	75.80	71.20	**
Medical Center	77.60	76.80	88.70	65.70	63.70	73.80	79.90	71.80	68.70	**

Dates of survey reporting period: Qtr. 4, FY 2006

Hunter Holmes McGuire VA Medical Center

OUTPATIENT SHEP RESULTS

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81.1	77.9	94.7	72.8	83.1	75.6	81.9	65.9	81.4	80.7	84.4
VISN	81.3	80.3	95.2	73.9	82.4	76.8	84.8	67.4	81.6	83.1	85.5
Outpatient Clinics-Overall	78.9	77.6	95.6	77.1	85.4	78.5	88.3	69.9	81.4	81.1	87.1
Richmond Outpatient Clinic	78.7	78.2	95.8	77.4	85.5	78.8	88.7	69.9	81.3	81.3	87.5
Fredericksburg CBOC	84	63.9	92.8	70.3	82.6	72.2	83.2	*	83	74.5	78.7

** Less than 30 Respondents*
"+" Results are Significantly Better than the National Average
"-" Results are Significantly Worse than the National Average

The medical center created a Customer Service Executive Board to serve as a catalyst for data driven, system-wide process change and organizational improvement related to customer service and patient satisfaction. The board meets monthly and reports to the Joint Leadership Council for review and approval of minutes and recommendations. Several areas for improvement have been identified in both inpatient and outpatient areas, and services have developed action plans to address deficiencies. To address patient dissatisfaction with outpatient pharmacy pick-up times, the medical center implemented use of "Quick Card" Waiting Time Surveys and enhanced patient education. Other examples of pharmacy improvement initiatives included stationing a volunteer in the pick-up area and providing coffee coupons to patients who have waited excessively for their prescriptions. To improve inpatient satisfaction, patients receive a follow-up call post discharge, and a visit to each patient at admission is being considered.

As the medical center was adequately addressing areas of lower patient satisfaction, we made no recommendations.

Scope of Practice for Unlicensed Physicians Conducting Research on Human Subjects

The purpose of this review was to determine whether research activities performed by unlicensed physicians constitute the practice of medicine.

In order to practice medicine in the United States, a medical school graduate must complete a residency training program in the United States. This requirement exists regardless of the skills, training, or experience of the graduate. Medical school graduates who cannot or do not complete an internship or residency in the United States are not eligible for licensure. If engaged in research activities, these individuals may function in certain roles, such as study coordinators or research assistants, but they cannot practice medicine. Activities traditionally considered to constitute the practice of medicine include performing invasive procedures, conducting physical examinations, and altering medications.

VHA Handbook 1200.5, *Requirements for the Protection of Human Subjects in Research*, issued July 15, 2003, requires the medical center Director to ensure that Institutional Review Board members and investigators conduct research in accordance with ethical standards and applicable regulations. As a result, unlicensed physicians operate under a scope of practice. "Scope of practice" is a term used to describe activities that may be performed by health care workers regardless of whether they are licensed independent health care providers.

The medical center identified one unlicensed physician assigned to four human subject research studies. We reviewed 36 patient medical records and determined that the scope of practice of the unlicensed physician was appropriate, and activities performed did not constitute the practice of medicine. We made no recommendations.

Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 30 patients who had surgery performed during the 2nd quarter of FY 2007. The review included medical records for each of the following surgical categories: (a) cardiac, (b) colorectal, (c) vascular, and (d) orthopedic (knee or hip replacement).

Inspectors evaluated the following VHA performance measure (PM) indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled blood glucose levels for cardiac surgery, which should be maintained below 200 milligrams/deciliter for the first 2 days post-operative. Elevated levels are associated with impaired bactericidal activity of the immune system.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. The table below shows the scores needed to receive fully satisfactory ratings and the medical center's most recent scores.

Performance Measure	Target PM Score	Medical Center Score
Antibiotic started timely	90 percent	89 percent
Antibiotic discontinued timely	87 percent	42 percent
Controlled blood glucose 2 days post-operative – cardiac surgery	90 percent	89 percent
Controlled body temperature – colorectal surgery	70 percent	39 percent

The medical center did not meet the target PM scores in any of the four indicators, but only two of the four were significantly below target. To improve performance in these measures, managers developed and implemented corrective action plans, monitored the efficacy of the actions, and communicated the results to staff.

To improve the timely discontinuation of antibiotics, the medical center developed order sets (standardized physician orders) that surgeons were required to use. The order sets included

timeframes for antibiotic administration, not to exceed 24 hours. An internal monitor as well as daily monitoring by the Chief of Surgery ensured compliance.

To bring patients' core temperatures up after surgery, warm blankets were placed on them while in the OR, and a warm blanket was placed on the bed before they were transferred from the OR table. In addition, the post-anesthesia care unit (PACU) added warm air blowers, recalibrated thermometers for accuracy, and used urinary catheter thermometers to provide more accurate temperatures. The PACU flow sheet was also revised to include "patient warming" on the check list.

Our review of 30 surgical cases showed that the medical center appropriately started and discontinued antibiotics or documented clinical reasons why this did not occur. Clinicians monitored blood glucose for the first 2 days post-operative for the patients who had cardiac surgery performed and controlled immediate post-operative body temperature for the patients who had colorectal surgery performed. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 27, 2007

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

Subject: **Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia**

To: Associate Director, Atlanta Healthcare Inspections Division (54AT)

Director, Management Review Office (10B5)

Attached please find the response to the draft CAP Report for the program review of the Hunter Holmes McGuire VA Medical Center, Richmond. The VISN concurs with the action plan submitted by the facility.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 27, 2007

From: Director, Richmond VA Medical Center (652/00)

Subject: **Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia**

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

This is to acknowledge receipt and review of the draft CAP report for Hunter Holmes McGuire VA Medical Center, Richmond, Virginia. Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact RC Polatty, MD, Interim ACOS/QM at 804-675-5756.

(original signed by:)

MICHAEL B. PHAUP

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 allows only authorized staff with the appropriate clinical privileges or scope of practice to document clinical information in patient medical records.

Concur

Clerical staff no longer enter clinical data. Clinical staff enter their own data.

[Completed: June 20, 2007]

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director monitors accuracy of documentation of intraoperative clinical information.

Concur.

Anesthesia program clerk will monitor 30 percent of cases for discrepancies in data entered between the nursing intraoperative note and the Anesthesia flow sheet. Monitoring will continue until 100 percent of records have no discrepancies.

[Target Completion Date: September 30, 2007]

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that signed informed consents are obtained for outpatient surgical procedures.

Concur.

Consents have been monitored throughout the time period in question by the Patient Safety Manager, the Medical Records Committee, and the reviewer for Residency supervision. Data thus far in FY 2007 for informed consents as part of Residency supervision shows 100 percent compliance. Certain minor bedside procedures were causes for outliers in other monitors. Medical Center Memorandum (MCM) 11-55, "Informed Consent for Major and Minor Procedures and Transfusions" is being revised to clarify which procedures do require written informed consent

and include a more detailed list of procedures. Staff education on the revised list will be given to all services. We will continue to expand the use of iMed consents and add procedures to each library as appropriate. Completed consents will be monitored for appropriate procedures and actions will be taken to ensure compliance is > 95 percent.

[Target Completion Date: August 15, 2007, for revised policy, September 30, 2007 for goal of > 95 percent compliance, with ongoing monitoring after that.]

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires full compliance with medication reconciliation requirements.

Concur.

The medication reconciliation template has been added to the admission, transfer, and discharge template. Service Chiefs have been notified to encourage use of these templates. Additional pharmacy FTEE were requested for medication reconciliation. Reviews for compliance occur monthly, and feedback is given to the providers and Clinical Service Chiefs.

[Target Completion Date: October 30, 2007]

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that peer reviews and RCAs are completed within the required timeframes.

Concur.

During FY 07, the medical center completed seven RCAs, with an average completion time of 47.5 days; this is compared to 61 days in FY 06. In FY 07, all aggregate RCAs were completed within 45 days. Service Chiefs and appropriate members of the Senior Management will be notified to facilitate timely completion of RCAs, if team members are unable to complete them in a timely manner.

Peer reviews are tracked for timeliness. Service Chiefs and the Chief of Staff will be notified of initial peer reviews not completed within 30 days to ensure the completion within 45 days. Actions relating to system issues will be referred to other committees and will be closed out to Peer Review Committee to ensure closure within 120 days.

[Target Completion Date: September 30, 2007]

Recommendation 6. We recommended that the VISN Director require the Medical Center Director to take appropriate action regarding employees who inaccurately documented defibrillator testing.

Concur.

Appropriate action was taken with employees involved in this incident regarding the requirement to accurately document defibrillator testing.

[Completed June 15, 2007]

Recommendation 7. We recommended that the VISN Director require the Medical Center Director to ensure that all defibrillators are tested as required by local policy.

Concur.

The code cart check list was changed to require specific documentation of the defibrillator check. Nursing staff responsible for defibrillator checks received training on defibrillator check procedures and documentation of the test. Nurse Managers are checking to ensure the new crash cart checklist is completed and test strips are run. All nursing staff will complete an additional competency verification of proper defibrillator checks this year.

[Target Completion Date: August 3, 2007]

OIG Contact and Staff Acknowledgments

Contact	Christa Sisterhen, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Contributors	Toni Woodard, Healthcare Inspector, Team Leader Thomas Bennett, Investigator Bertha Clarke, Healthcare Inspector David Griffith, Healthcare Inspector

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