Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03089-116

Combined Assessment Program Review of the Atlanta VA Medical Center Decatur, Georgia

April 27, 2009

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 February 2–6, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Atlanta VA Medical Center (the medical center), Decatur, GA. 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 382 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 7.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- Women's Health Initiative.
- Emergency Department (ED) Annex.
- Community Living Center (CLC) Remembrance Celebration.

We made recommendations in six of the activities reviewed. For these activities, the medical center needed to:

- Complete all peer reviews within the required timeframe.
- Include documentation of peer review follow-up actions in committee minutes.
- Consistently report peer review data to the Executive Committee of the Medical Staff (ECMS).
- Conduct and document institutional and clinical disclosures in accordance with Veterans Health Administration (VHA) and local policy.
- Collect relevant practitioner-specific data for use in privileging decisions.
- Complete safety plans for all patients at high risk for suicide and monitor the documentation of those plans.
- Consistently verify and document licensure of all registered nurses (RNs).
- Consistently complete intra-facility transfer documentation, as required by local policy.
- Consistently complete discharge documentation, as required by local policy.

- Ensure that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.
- Ensure that ED staff complete inter-facility transfer documentation, as required by VHA and local policy.

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

- Environment of Care (EOC).
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Dorothy Duncan, Associate Director, and Jennifer Kubiak, Healthcare Inspector, Kansas City 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 15–22, 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 Decatur, GA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics (CBOCs) in East Point, Smyrna, Oakwood, Lawrenceville, and Stockbridge, GA, and at two outreach clinics in Decatur and Rome, GA. The medical center is part of VISN 7 and serves a veteran population of about 451,000 throughout 48 counties in Georgia.

Programs. The medical center provides a full range of inpatient and outpatient care, including primary, specialty, acute, and extended care services. Currently, the medical center has 153 operating hospital beds and 100 operating CLC beds.[1]

Affiliations and Research. The medical center is affiliated with Emory University's School of Medicine and provides training for 125 medical residents in 33 training programs. The medical center also has active affiliation agreements with 34 other schools to provide training in various other health care disciplines. In fiscal year (FY) 2008, the medical center research program had 503 projects and a budget of $32.3 million. Important areas of research included infectious diseases, traumatic brain injury, low vision, oncology, and pulmonary diseases.

Resources. In FY 2008, medical care expenditures totaled $386.4 million. The FY 2009 medical care budget is $410.6 million. FY 2008 staffing was 2,260 full-time employee equivalents (FTE), including 220 physician and 559 nursing FTE.

Workload. In FY 2008, the medical center treated 67,321 unique patients and provided 50,228 inpatient days in the hospital and 30,860 inpatient days in the CLC. The inpatient care workload totaled 6,080 discharges, and the average daily censuses for the hospital and the CLC were 137 and 84, respectively. Outpatient workload totaled 681,629 visits.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

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:

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/Urgent Care (E/UC) Operations.
- EOC.
- Medication Management.
- QM.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through February 5, 2009, 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 Atlanta VA Medical Center, Atlanta, Georgia,* Report No. 06-01571-231, September 29, 2006). The medical

center had corrected all findings related to health care from the prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 382 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 Strengths

Women's Health Initiative

In an effort to improve medication safety, a quality improvement team identified the need to consistently screen age appropriate women veterans for pregnancy and breastfeeding. The screen is now part of the template for documentation of medication reconciliation and patient assessment. If the screen is positive, a consult is sent to the women's wellness program, and a warning flag is generated in the computerized medical record system. Women's wellness staff review the flags monthly and make any appropriate changes.

Emergency Department Annex

The medical center created a separate area for mental health (MH) patients who require emergency treatment. The annex has its own entrance and is staffed by MH providers 24 hours per day, 7 days per week. As a result, the medical emergency room is less crowded. Also, MH patients are treated in a more therapeutic environment and are ensured immediate access to practitioners who are aware of their unique needs.

Community Living Center Remembrance Celebration

This dignified celebration was designed to pay respect to and honor veterans after their death. CLC nursing staff drape the veteran's body with the American flag, and "taps" is played. Family members, significant others, and CLC residents are invited to attend the celebration. After the flag is folded, it is sent to the funeral home and presented to the family on the day of the funeral.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 11 of the 14 program activities reviewed. We identified three areas that needed improvement.

Peer Review. Peer reviews were not completed within the 120-day timeframe, as required by VHA and local policy.[2] During FY 2008, timely completion of peer reviews ranged from 56 to 80 percent. Medical center staff developed action plans, and results from the 1st quarter of FY 2009 showed improvement. However, we will monitor reports from future quarters to ensure continued improvement.

Follow-up on recommendations made by the Peer Review Committee (PRC) was not documented in subsequent committee minutes. PRC minutes identified several recommendations for action throughout the year, but documentation of the status of these recommendations was not present. During our review, QM staff were able to provide us with current status and proof of actions taken. However, this information was not readily available to committee members.

Additionally, peer review data were not consistently reported to the ECMS for communication of aggregate peer review data to medical staff leadership. According to local policy, the PRC is responsible for providing quarterly reports to the ECMS for identification of trends in care. We reviewed 4 quarters of ECMS minutes and were unable to find peer review reports for the 3rd quarter of FY 2008. We were told that because providers were not completing peer

[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

reviews within 120 days, there had been delays in compiling data for the ECMS. As a result, 3rd quarter data was missed and never reported.

Adverse Event Disclosure. The medical center did not consistently document disclosure of adverse events, as required by VHA and local policy.[3] Local policy requires that disclosure be a routine part of the response to a harmful or potentially harmful event and be documented in the patient's medical record using a VHA-mandated template.

We reviewed five medical records containing events that required institutional disclosure. In one of the five records, we found no documentation of disclosure. The medical center did not maintain a log of clinical disclosures. To obtain our clinical disclosure sample, we randomly selected two records from among PRC cases that should have been clinically disclosed based on the PRC's conclusions. Staff agreed that these cases should have been disclosed but were unable to provide the required medical record documentation.

Credentialing and Privileging. Service chiefs did not consistently collect and utilize appropriate quality data to evaluate physician performance for granting and renewing clinical privileges, as required by VHA.[4] We reviewed 13 physician profiles and found that 9 (69 percent) did not have relevant practitioner-specific data to support renewal of clinical privileges. Of the six services represented in our sample, two provided meaningful data while the other four only collected data related to workload, which gave little insight into the quality of care. Also, local policy requires that an ongoing, professional practice evaluation that includes specific measures be used to continuously evaluate a practitioner's professional performance. Not all services collected specific measures.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that all peer reviews are completed within the required timeframe.

[3] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.
[4] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that PRC minutes include documentation of follow-up actions.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires consistent reporting of peer review data to the ECMS.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that all institutional and clinical disclosures are conducted and documented in accordance with VHA and local policy.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical services collect relevant practitioner-specific data for use in privileging decisions.

The VISN and Medical Center Directors concurred with our findings and recommendations. The process for tracking peer review completion has been revised. The Risk Manager is now responsible for ensuring that PRC actions are competed and recorded in committee minutes. Quarterly peer review reports have been added to the standing agenda for the ECMS. The Risk Manager will ensure that all events requiring institutional disclosure are disclosed and documented. QM analysts have implemented a clinical disclosure database and will ensure that events are disclosed and documented. Service line managers collect data and complete competency assessment forms. A spreadsheet detailing data used in the provider review process has been developed for the Professional Standards Board. We find these action plans appropriate and will follow up on reported implementation actions to ensure completion.

Suicide Prevention Program

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at the medical center and at any very large CBOCs, and we evaluated whether SPCs fulfilled all required functions.[5] Also, we verified whether

[5] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled. None of the medical center's CBOCs met this criterion.

medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs), documented safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.[6]

We interviewed the medical center SPC and the QM liaison for MH. We reviewed pertinent policies and the medical records of seven medical center patients and three CBOC patients determined to be at risk for suicide. The medical center SPC and two associate SPCs follow patients at the CBOCs. The SPC had entered Category II PRFs in all 10 medical records, and there was documented collaboration between the SPC and MH providers. We found that the suicide prevention program was generally effective; however, we identified one area that needed improvement.

Safety Plan Documentation. VHA regulations require that all medical records of patients at high risk for suicide contain a documented safety plan.[7] The SPC, in coordination with other MH providers, had developed a safety plan template for the electronic medical record that included fields for meaningful, individualized information. However, only 3 (30 percent) of the 10 records that we reviewed included the required template. MH providers needed to complete the required safety plans in a timely manner for all patients at high risk for suicide.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that safety plans for all patients at high risk for suicide be completed and that documentation of those plans be monitored.

The VISN and Medical Center Directors concurred with our findings and recommendation. The SPC will now review all patients added to the high-risk list to ensure that they have the templated safety plan completed within 7 days. The SPC will also ensure that plans are updated prior to discharge. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

[6] A Category II PRF is an alert mechanism that is displayed prominently in medical records.
[7] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We reviewed documents for several required components, including licensure, training, and competencies. Also, we reviewed 10 files of contracted/agency personnel who worked at the medical center within the past year and identified one area that needed improvement.

Licensure. The medical center did not utilize the same process for verification of licensure for contracted RNs that they used for full-time staff RNs. Full-time staff RNs provide their nursing licenses to Human Resources (HR) for verification, and HR staff document the dates of verification and expiration. Nursing management verifies contracted RNs' licensure via internet nursing board websites. However, 5 (50 percent) of the 10 contracted RNs' files did not have documentation of current licensure. During our inspection, nursing verified that all contracted RNs had current licensure.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that medical center staff consistently verify and document licensure of all RNs.

The VISN and Medical Center Directors concurred with our findings and recommendation. Documentation of license verification has been added to the contract RN tracking spreadsheet. The process for contract RN licensure verification is now consistent with the process used for staff RNs. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, transfers, and discharges were coordinated appropriately and met VHA requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 24 inpatients that had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes. We identified two areas that needed improvement.

Transfer Documentation. We found that 7 (29 percent) of 24 intra-facility transfers did not have the required medical record documentation specified by local policy. None of the seven included the required nursing documentation, and one of the seven did not include the required physician documentation.

Discharge Documentation. We found that 11 (46 percent) of 24 medical records did not have patient discharge instructions that were consistent with the patient discharge summary. Additionally, nurses had not documented the locally required discharge education in 2 (8 percent) of the 24 records.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete intra-facility transfer documentation, as required by local policy.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete discharge documentation, as required by local policy.

The VISN and Medical Center Directors concurred with our findings and recommendations. Processes have been implemented to monitor compliance with documentation of inter-facility transfers and discharges. We find these action plans appropriate and will follow up on reported implementation actions to ensure completion.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the inpatient medical and surgical units, the intensive care units (ICUs), and the CLC. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers prior to medication administration. We identified one area that needed improvement.

Documentation of Pain Medication Effectiveness. Nurses did not consistently document the effectiveness of pain

medications in accordance with local policy requirements. We reviewed the Bar Code Medication Administration records of 46 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. Nurses documented pain medication effectiveness within the required timeframe of 4 hours for only 164 (58 percent) of the 284 doses of pain medication.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. Nursing Service has implemented a process to ensure timely documentation of pain medication effectiveness. Nurse managers are monitoring for compliance. We find these action plans appropriate and will follow up on reported implementation actions to ensure completion.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility E/UC operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's ED for cleanliness and safety.

The ED is located within the main hospital building and is open 24 hours per day, 7 days per week. The emergency services provided are within the medical center's patient care capabilities.

We reviewed medical records of patients who presented in the ED with acute mental health conditions, and in all cases, we found that staff managed the patients' care appropriately. We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. We also found that managers had appropriately documented nurse competencies.

We determined that the ED complied with VHA operational standards, including staffing guidelines, cleanliness, and competency. However, one area needed improvement.

Inter-Facility Transfers. ED staff did not document specific inter-facility transfer data, as required by VHA and local policy.[8] The movement of acutely ill patients from one institution to another exposes them to risks. Failing to transfer patients may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately to assure maximum patient safety and to comply with the intent of the Emergency Medical Treatment and Labor Act.

None of the medical records we reviewed contained all the required documentation elements. During onsite interviews, ED staff identified their local inter-facility transfer policy, and they provided paper forms that contained all required documentation elements. However, staff did not consistently complete the forms. We were told that there are plans to develop an electronic inter-facility transfer template.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete inter-facility transfer documentation, as required by VHA and local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. Staff have implemented VHA's electronic transfer template, and compliance is being monitored. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected infection control (IC) standards and maintained a clean and safe health care environment. Medical centers are required to establish a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

[8] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

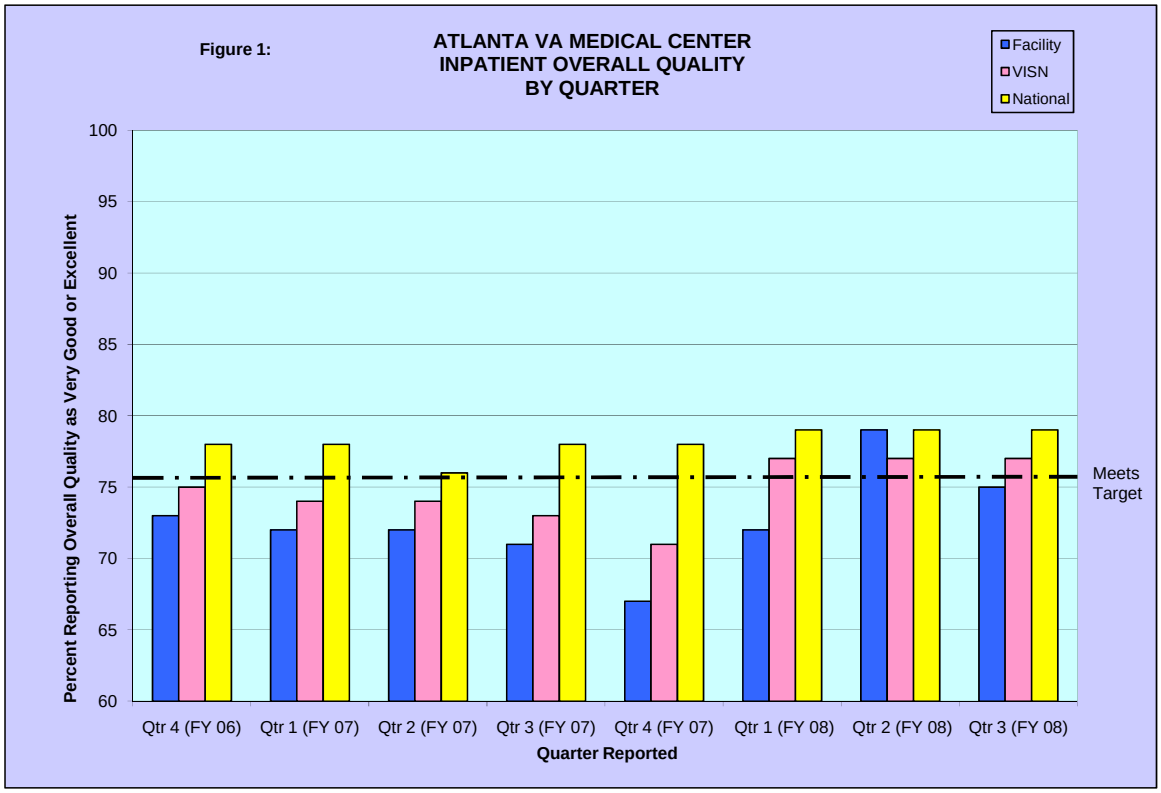
We evaluated the IC program to determine compliance with VHA directives that require management to collect and analyze data to improve performance. IC staff appropriately monitored, trended, analyzed, and reported infection data to clinicians for implementation of quality improvements to reduce infection risks for patients and staff.

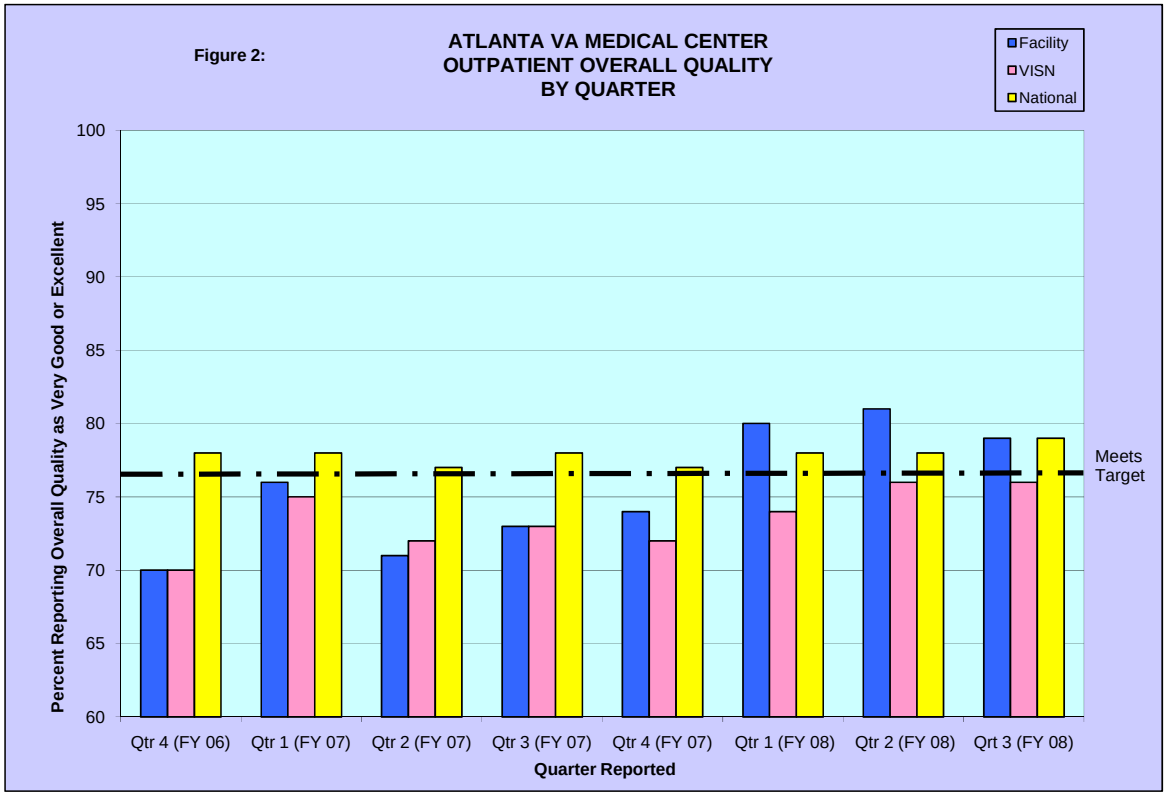
We conducted onsite inspections of ambulatory care areas, all medical and surgical inpatient units, the MH unit, both CLC units, the telemetry unit, the dialysis unit, and all ICUs. We also inspected the laboratory. We found that the medical center maintained a generally clean and safe environment. Nurse managers on the inpatient units expressed high satisfaction with the responsiveness of the housekeeping staff. Safety guidelines were met, and risk assessments complied with VHA standards. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 4th quarter of FY 2006 and ending with the 3rd quarter of FY 2008. Figures 1 and 2 on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.





The medical center scored above the 76 percent target in 1 of the last 8 quarters of available data for inpatient overall

quality; it scored above the 77 percent target in 3 of the last 8 quarters of available data for outpatient overall quality. The medical center's Director shared SHEP data with staff, service chiefs, and patients. All data were analyzed, action plans were appropriate, and actions were taken. Improvements in both inpatient and outpatient scores are now evident; therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 24, 2009

From: Director, VA Southeast Network (10N7)

Subject: **Combined Assessment Program Review of the Atlanta VA Medical Center, Decatur, Georgia**

To: Director, Kansas City Healthcare Inspections Division (54KC)

Director, Management Review Service (10B5)

I have reviewed and concur with the recommendations and responses from the Atlanta VA Medical Center.

(original signed by:)

Lawrence A. Biro

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 23, 2009

From: Director, Atlanta VA Medical Center (508/00)

Subject: **Combined Assessment Program Review of the Atlanta VA Medical Center, Decatur, Georgia**

To: Director, VA Southeast Network (10N7)

I concur with the findings/recommendations presented in the Atlanta VA Medical Center OIG CAP review. Actions taken as a result of these findings are attached.

(original signed by:)

James A. Clark, MPA

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 that all peer reviews are completed within the required timeframe.

Concur

In January 2009 the process for tracking peer review completion was revised to provide a chain of responsibility notification for peer reviews that is activated prior to the peer review due date to ensure timeliness of completion. Since October 2008, all peer reviews have been timely for both the 45-day initial review and the 120-day Peer Review Committee review timeframes (25 of 25 Peer Reviews meeting the 45 and 120 thresholds).

Target Date: Completed 1/20/09. Although the process was strengthened by adding the chain of responsibility notification on January 20, 2009, tracking has demonstrated 100% peer reviews completed timely since October 2008. Ongoing monitoring is in place.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that PRC minutes include documentation of follow-up actions.

Concur

A worksheet was developed within the Peer Review database to track Peer Review Committee recommendations and follow-up responsibility. Follow-up actions are forwarded to the responsible staff by the Risk Manager with a 30-day completion target. The Risk Manager ensures actions are completed and recorded in the next Peer Review Committee meeting minutes. The process redesign was implemented on 2/10/09. There has been one meeting of the Peer Review Committee since implementation, and all follow-up actions were documented in the committee minutes. Ongoing monitoring is in place.

Target Date: Completed 2/10/09.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires consistent reporting of peer review data to the ECMS.

Concur

A reporting schedule has been established for Peer Review quarterly reporting to the Executive Committee of the Medical Staff (ECMS) that allows reporting of peer review once the peer reviews initiated in the quarter have been closed (i.e., reviewed by the Peer Review Committee). The reporting schedule was developed on 2/10/09 and provided to the ECMS Committee organizer as a standing agenda for the ECMS presentation May, August, November, and February.

Target Date: Completed 2/10/09.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that all institutional and clinical disclosures are conducted and documented in accordance with VHA and local policy.

Concur

A process was implemented on 2/17/09 whereby the Risk Manager ensures that all reported incidents requiring an institutional disclosure, the disclosure occurs and is properly documented in the computerized medical record. The A Clinical Disclosure database was developed. The Quality Management Analysts began a process of notifying the clinical provider when review of incidents and or occurrences reveal the need for clinical disclosure. The QM Analyst will ensure the clinical disclosure occurs and is documented in the computerized record. Since 2/17/09, there have been three incidents requiring disclosure with all conducted and documented appropriately.

Target Date: Completed 2/17/09. Ongoing monitoring is in place.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical services collect relevant practitioner-specific data for use in privileging decisions.

Concur

The Service Line Manager collects data and completes a competency assessment sheet for presentation to the Professional Standards Board. The raw data is not maintained in the Credentialing area. During the OIG review, raw data from one Service Line was available and found to be in compliance. At the time of the OIG review the Service Line Manager and Section Chief were not physically available to provide their raw data. The

raw data was located in a protected area because it contained patient information from chart reviews. Since the OIG review, the two individuals have given access to other key personnel in the service to ensure it will be available when requested.

The Manager/Section Chief of each department determines on-going monitoring. Departments tailor competency assessment forms to meet department activities. For example, Endocrinology Section conducts chart reviews for total thyroid ultrasound reports done or supervised, addresses and documents appropriate aspects of ultrasound, thyroid biopsies done or supervised, addresses diabetes preventive are in comprehensive manner (lipids, HTN, eye exam, foot exam, glycemic control, ASA). The Section reviews resident supervision, complaints/dissatisfaction from patients, effective communication with physicians and other clinic staff, compliments from staff/patients, appropriately uses facility resources for patient care, delinquent medical records, signed charts within 24 hours, co-signed trainee notes within 24 hours, completed consults within 24 hours. Triggers are assigned for each activity. Other areas reviewed are: compliance issues, CME hours, involvement in malpractice suits, adverse actions, voluntary/mandatory reduction of privileges, reports to the NPDB and FSMB, and completed perception surveys that were distributed to the supporting clinical staff that interact with the provider.

In addition to on-going monitoring by the departments, the Professional Standards Board reviews documentation supplied by the provider indicating the number of procedures performed during the rating period and reviews the clinical activity report obtained from the primary practice location of the provider. This information is reviewed by the committee members and compared with the privilege request to determine if the provider has actively utilized the procedure during the review period.

Tracers conducted during 2008 identified the activity of on-going monitoring with various departments. Departments reviewed were collecting data to support privilege request. Tracers of on-going monitoring are part of the Periodic Performance Review for Medical Staff activities and will continue throughout 2009-2010.

Additional improvements include the development of a master spreadsheet detailing the raw data used in the review process of each provider for sharing with the Professional Standards Board.

Target Date: April 23, 2009.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that safety plans for all patients at high risk for suicide be completed and that documentation of those plans be monitored.

Concur

The Suicide Prevention Coordinator (SPC) was in the process of reviewing and ensuring that safety plans for high risk patients included all of the required elements outlined in the October Suicide Prevention training. Although many of the notes contained the required elements in the electronic progress notes or scanned document, the documentation was not in a uniform template. A new note title and template, with all the required elements, was fully implemented 2/28/09. By 2/28/09, all current high risk patients had been reviewed by the SPC with the new template initiated on any patient identified as not having a safety plan containing all of the required elements. A process was implemented on 2/28/09 for the SPC to review all patients newly added to the high risk list to ensure that they have the templated safety plan completed within 7 days. Additionally, all patients being discharged from the high risk protocol are reviewed by the SPC to ensure the safety plan is updated prior to discharge. Ongoing monitoring results reveal 100% compliance for all patients newly placed on the high risk list. The results of this monitor is presented monthly at the Service Line Clinical Operations Committee and quarterly to the SL Performance Improvement Council.

Target Date: Completed 2/28/09. Ongoing monitoring is in place.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that staff consistently verify and document licensure of all RNs.

Concur

All nurses both contract and VA staff have initial verification of licensure via the Vet Pro system. All contract nurse license expirations are provided to the office of the Associate Nurse Executive, Staffing/Resources where the information is placed in a computerized contract nurse tracking spreadsheet. The tracking spreadsheet is reviewed at the beginning of each month to identify each license that is due to expire that month. The online verification is checked to identify if the license has been renewed. If not, the agency is notified and the nurse is not permitted to work until the license is verified as renewed. Once verified, a copy of the verification of the license renewal is placed in the contract nurse folder. The date of license verification, date of printing of the verification, name of the staff member completing the verification and license expiration date is entered on the tracking spreadsheet. The Nurse Credentialing Coordinator completes an on-line verification as well; consistent with the practice for verifying Atlanta VA Medical Center nursing staff. Ongoing review by the Associate Nurse Executive, Staffing/Resources indicates 100% compliance with this process. Currently six licenses have been identified through this process for renewal prior to 3/31/09. Four have been verified

as renewed and two are pending. The agency has been notified of these pending renewals as per the process described above.

Target Date: Completed 2/6/09.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete intra-facility transfer documentation, as required by local policy.

Concur

On 2/17/09, a process was implemented whereby the Charge Nurse on the night tour monitors all intra facility transfers received on the unit for documentation of concurrence and/or addendum to the transfer reassessment progress note. Monitoring demonstrates 95% (95 of 100 intra facility transfers). Additionally, the Documentation Monitor was revised on 2/27/09 to include intra-facility transfer documentation and provide ongoing monitoring of compliance.

Target Date: Completed 2/17/09. Ongoing monitoring in place as above.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete discharge documentation, as required by local policy.

Concur

Service Chiefs will require attending physicians on the wards to oversight this process to ensure that discharge summaries are consistent with patient discharge instructions. The Chief of Staff has directed Service Chiefs to provide this guidance to inpatient attendings regarding their responsibility, and that compliance with this requirement be tracked as part of the evaluation process of ward attending staff.

Target Date: May 31, 2009.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

Concur

On 2/5/09, IT and the Clinical Applications Coordinator added a feature to BCMA which requires the nurse to document the PRN effectiveness pain score as well the reason for PRN administration. On 2/13/09, the Charge Nurse on all shifts began printing the PRN Effectiveness list every 3 hours, to ensure compliance with the policy for documentation of PRN

effectiveness. This report is also being used as a hand off tool when PRN effectiveness is pending during shift change. On 2/8/09, the BCMA Coordinator began providing daily BCMA PRN effectiveness reports to the Nurse Managers for follow-up. The BCMA PRN effectiveness report has demonstrated over 90% compliance (3209 of 3556 PRNs documented timely) with PRN effectiveness documentation within the timeframe of the policy since 3/1/09. Daily monitoring is continuing through March with weekly monitoring in April and then ongoing monthly BCMA PRN Effectiveness reports provided to the Nursing Leadership and Staff.

Target Date: Completed 2/8/09. Ongoing monitoring plan as above.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete inter-facility transfer documentation, as required by VHA and local policy.

Concur

The VHA computerized transfer form template and I-MED consent was implemented on 2/17/09. Utilization Management is currently monitoring all transfers to ensure inter facility transfer documentation, as required by local policy and VHA, is completed. Since 2/17/09, monitoring demonstrates 95% compliance (54 of 57 transfers).

Target Date: Completed 2/17/09. Ongoing monitoring is in place as above.

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