Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03298-80

Combined Assessment Program Review of the Charlie Norwood VA Medical Center Augusta, Georgia

February 2, 2010

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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Table of Contents

Executive Summary

Introduction

During the week of November 2–6, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Charlie Norwood VA Medical Center (the medical center), Augusta, 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 225 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 made recommendations in all of the activities reviewed. For these activities, the medical center needed to ensure compliance with Veterans Health Administration (VHA) policies and other external standards related to:

- Environment of Care (EOC).
- QM.
- Physician Credentialing and Privileging (C&P).
- Medication Management.
- Magnetic Resonance Imaging (MRI) Safety.
- Contracted/Agency Registered Nurses.
- Coordination of Care (COC).
- Medical Center Policies.

This report was prepared under the direction of Susan Zarter, 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 16–23, 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 two-division facility located in Augusta, GA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics in Athens, GA, and Aiken, SC. The medical center is part of VISN 7 and serves a veteran population of about 101,000 throughout east central Georgia and west central South Carolina.

Programs. The medical center provides medicine, surgery, mental health (MH), rehabilitation medicine, and spinal cord injury services. It has 278 hospital beds, 60 domiciliary beds, and 132 community living center (CLC) beds.

Affiliations and Research. The medical center is affiliated with the Medical College of Georgia and with 44 other academic institutions. Training is provided for 87 medical and dental residents and for students in allied health disciplines programs such as audiology, laboratory technology, nursing, pharmacy, radiology, and physician assistant. In fiscal year (FY) 2009, the medical center's research program had 61 projects and a budget of $2.4 million. Important areas of research included stem cell, MH, and spinal cord injury.

Resources. In FY 2009, medical care expenditures totaled $327 million. The FY 2010 medical care budget is currently funded under a continuing resolution. FY 2009 staffing was 2,177 full-time employee equivalents (FTE), including 117 physician and 430 nursing FTE.

Workload. In FY 2009, the medical center treated 40,609 unique patients and provided 83,715 inpatient days in the hospital and 40,655 inpatient days in the CLC units. The inpatient care workload totaled 7,054 discharges, and the average daily census, including CLC residents, was 340. Outpatient workload totaled 391,883 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:

- Contracted/Agency Registered Nurses.
- COC.
- EOC.
- Medical Center Policies.
- Medication Management.
- MRI Safety.
- Physician C&P.
- QM.

The review covered medical center operations for FY 2009 and FY 2010 through November 6, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Review of the Augusta VA Medical Center, Augusta, Georgia*, Report No. 06-02107-43, December 15, 2006.) During our follow-up review, we found that the medical center had implemented appropriate actions to address all recommendations in our prior CAP report.

During this review, we also presented fraud and integrity awareness briefings for 225 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.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine if VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, National Fire Protection Association, and Joint Commission (JC) standards.

We inspected the medical/surgical (4A and 6A), locked MH (2F and 2G), spinal cord injury (1GE and 1GF), critical care, and CLC (1D and 3C) units; the emergency department; and two primary care (B and C) clinics. Overall, the medical center maintained a generally clean environment. During our tour, we identified several conditions, including two recapped needles on a cart; non-functioning patient call bells; an expired, opened multi-dose medication vial; and an open, undated medication vial. The medical center corrected these deficiencies while we were onsite. Therefore, we made no recommendations related to these findings. However, we identified the following conditions that needed improvement.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. We found two unlocked and unattended computers on the critical care unit. One computer displayed private patient information, which was visible to unauthorized individuals.

MH Environmental Safety. VHA[1] mandates that staff identify and correct environmental hazards on locked MH units that represent a threat to suicidal patients. We identified the following hazards during our tour.

[1] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 31, 2009.

- Over-the-head, elbow-type hinges at the entry doors.
- Protruding thermostats in the corridor.
- Protruding door alarm bell.
- Loop of encased wire not securely affixed and flush to the wall.
- Exposed sink plumbing in the dining rooms.
- Patient pay phones with 29-inch cords.
- Blind spots in the dayrooms and quiet rooms.
- Wall-mounted call bell cord in patient bathroom not breakaway or within reach in the event of a patient fall.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires sensitive patient information to be secured.

The VISN and Medical Center Directors agreed with the finding and recommendation. Automated Data Processing Application Coordinators (ADPACs) will conduct weekly computer and information security checks, and Information Security Officers will check for information security and privacy compliance during environmental rounds. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires the correction of environmental hazards on the locked MH units.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center will conduct an environmental assessment of the locked MH units and will address identified issues. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for 9 of the 12 program activities reviewed. However, we identified the following conditions that needed improvement.

Peer Review Committee. VHA regulations[2] require the Peer Review Committee (PRC) to document: (a) referrals to appropriate leadership when a deficiency of care was due to a system issue, (b) monitoring of follow-up actions through closure, (c) all discussions held with a provider prior to the assignment of a Level 2 or Level 3 peer review finding, and (d) feedback by the provider's supervisor on non-punitive actions implemented. PRC minutes did not include the documentation of all required committee activities.

Medical Record Committee. VHA regulations[3] require the Medical Record Committee (MRC) to monitor the results of qualitative point of care reviews. PI monitoring should include the use of the copy and paste functions in the Computerized Patient Record System (CPRS). In addition, medical center policy states that the MRC should meet bimonthly. MRC minutes did not contain trended data or regular reports of qualitative point of care reviews and did not evaluate the appropriate use of the copy and paste functions in CPRS. Also, the MRC met only three times in FY 2009.

Cardiopulmonary Resuscitation and Its Outcomes. The JC requires the collection of data on resuscitation outcomes to identify opportunities for improvement in the delivery of quality care, treatment, and services. In addition, VHA regulations[4] require that each medical center have a mechanism in place to ensure that designated staff members maintain cardiopulmonary resuscitation (CPR) certification. Medical center managers monitored physician compliance with CPR certification requirements. However, the medical center did not collect PI data on resuscitation events and outcomes and did not have a process in place to monitor compliance with CPR certifications for non-physician staff.

[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[4] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires the PRC to document all required committee activities.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center will ensure that PRC minutes reflect all required committee activities. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires the MRC to meet bimonthly, as required, and to document PI activities.

The VISN and Medical Center Directors agreed with the findings and recommendation. The MRC met in December 2009 and will continue bimonthly meetings. PI activities will be initiated, and results will be documented in the minutes. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires the collection of PI data on resuscitation events and the implementation of a tracking system to ensure that designated staff members have CPR certification.

The VISN and Medical Center Directors agreed with the findings and recommendation. The CPR Committee will review and analyze data on resuscitation events. Responsibility for tracking CPR certification has been reassigned, and a process change will be implemented. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[5] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed the C&P files and profiles of 12 physicians who were granted either initial privileges or renewal of privileges

[5] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

in the past 12 months. We found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

Focused Professional Practice Evaluation. Focused Professional Practice Evaluation (FPPE) is a process whereby the medical center evaluates the privilege-specific competence of a physician (such as a newly hired physician) who does not have documented evidence of competently performing the requested privileges. FPPE should be considered at the time of initial appointment. We found that the C&P files and profiles for two of the four newly hired and privileged physicians did not contain evidence of FPPE.

Ongoing Professional Practice Evaluation. Ongoing Professional Practice Evaluation (OPPE) is a process that reevaluates privilege-specific competence for all existing privileged physicians. Although VHA requires a thorough, written plan that includes specialty or service-specific competency criteria, the medical center's draft plan did not contain this information. In addition, five of the eight physician profiles did not contain adequate supporting evidence of OPPE data for the 2-year period prior to reprivileging. For example, privileges were granted for procedures such as bone marrow biopsy, joint aspiration, and subclavian catheter insertions without supporting volume and complication PI monitors.

We also found that the medical center's Professional Standards Board (PSB) meeting minutes did not reflect detailed discussion of physicians' PI data prior to reprivileging.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that FPPE, OPPE, provider profiles, and the granting of privileges are in compliance with VHA requirements.

The VISN and Medical Center Directors agreed with the findings and recommendation. The Medical Staff Office will track FPPE and submit completed forms to the PSB. OPPE data on provider performance will be collected and sent to service chiefs for review. PSB meeting minutes will include detailed discussions of PI data. The implementation plans

are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes in the medical/surgical, MH, and CLC units.

We found that the medical center had a designated Bar Code Medication Administration (BCMA) Program Coordinator who had appropriately identified and addressed problems. However, we identified the following areas that needed improvement.

Pain Medication Effectiveness Documentation. Medical center policy requires that nurses document PRN (as needed) pain medication effectiveness within 4 hours after administration. We reviewed the medical records of 30 patients who received a total of 87 doses of pain medications. Only 31 (36 percent) of the 87 doses had effectiveness documented within the timeframe specified by medical center policy.

Monthly Medication Reviews. Accreditation standards require that a pharmacist review each CLC patient's medications monthly to identify any problems, such as interactions or duplications. We reviewed the medical records of 10 veterans who had resided in the CLC units for at least 12 months. We found that all 10 records were missing one or more monthly medication reviews.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document PRN pain medication effectiveness within the timeframe specified by medical center policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. Charge nurses will monitor PRN pain medication effectiveness documentation compliance on each tour, and the BCMA Program Coordinator will provide a weekly report to the medical center's Director. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that pharmacists consistently document CLC monthly medication reviews.

The VISN and Medical Center Directors agreed with the finding and recommendation. Managers updated the clinical pharmacy functions standard operating procedure to ensure that pharmacists conduct and document monthly CLC medication reviews. Additionally, the pharmacy supervisor will conduct random CLC chart audits. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined patient medical records and staff training records, reviewed relevant policies, and interviewed key staff. We determined that the medical center had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by the JC. Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and MRI staff, and the patient had access to a push-button call system while in the scanner. However, we identified the following areas that needed improvement.

Patient Screening. The JC recommends that trained staff screen patients for metal devices, tattoos, or other contraindicated objects. Medical center policy requires screening to be completed by the ordering provider and an MRI staff member. We reviewed the medical records of patients who underwent MRI studies during July 2009 and found that physician screening was not documented in 2 (20 percent) of the 10 patient records. Additionally, we found no evidence that MRI staff completed screenings.

Informed Consent for High-Risk Patients. Medical center policy requires that patients sign consent forms before receiving contrast media for an MRI. We reviewed the medical records of patients who underwent MRI studies with

contrast media during July 2009 and found no evidence of signed consents for 4 of the 5 patients.

MRI Safety Education. The JC recommends that annual safety education be provided to all staff who may enter the MRI area, including housekeepers and police officers. We reviewed selected training records and found that two of the six MRI staff members and five of the six non-MRI staff members did not have documentation of safety education.

Security and Safety. The JC recommends that Zones 3 (control room) and 4 (MRI magnet room) be restricted to appropriately screened patients and trained staff. MRI suite design guidelines published by the American College of Radiology recommend that Zone 3 function as an anteroom to Zone 4. However, the medical center's MRI suite (designed over 10 years ago), has Zone 4's access door abutting a commonly used, high-traffic hallway. In addition, MRI staff tended to leave the doors to Zones 3 and 4 ajar. Thus, unauthorized staff or patients could intentionally or inadvertently enter Zones 3 and 4.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that MRI screenings are completed and documented in the medical record.

The VISN and Medical Center Directors agreed with the findings and recommendation. MRI staff will document completed screening in CPRS, and staff will conduct continuous monitoring to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that informed consents for contrast media are completed and documented in the medical record.

The VISN and Medical Center Directors agreed with the finding and recommendation. MRI contrast media informed consents will be documented electronically. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that all employees who may enter the MRI area receive safety education.

The VISN and Medical Center Directors agreed with the finding and recommendation. Safety education will be provided to appropriate staff. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director takes action to restrict access to Zones 3 and 4 in the MRI area.

The VISN and Medical Center Directors agreed with the findings and recommendation. MRI staff will restrict access to Zones 3 and 4. The corrective actions are acceptable, and we consider this recommendation closed.

Contracted/Agency Registered Nurses

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

Training. VHA requires several training courses for staff as well as contracted/agency registered nurses.[6] We found that privacy training was not completed by 2 (20 percent) of the 10 contracted/agency registered nurses, yet these nurses had access to private patient information.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires that contracted/agency registered nurses complete mandatory training.

The VISN and Medical Center Directors agreed with the finding and recommendation. Prior to appointment, Human Resources will verify that contracted/agency registered nurses have completed the two required pre-employment

[6] VHA Directive 2007-026, *Mandatory and Required Training for VHA Employees*, September 17, 2007.

training modules. Additional required training will be completed during orientation. Since the medical center does not currently have any contracted/agency registered nurses, we consider this recommendation closed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the medical records of 19 patients transferred within the facility and found that 3 (16 percent) of the 19 records did not contain the documentation required by medical center policy. Managers agreed with our finding and will monitor completion of documentation to ensure compliance. Therefore, we made no recommendation for this finding.

We reviewed the medical records of five patients recently discharged from the locked MH units. We found documentation that patients received information about accessing emergency MH care and that they were given MH clinic appointments within 2 weeks of discharge. We also found documentation that MH providers either arranged for follow-up appointments or contacted the patients by phone within 7 days of discharge. However, we identified the following area that needed improvement.

Discharge Information. Consistency between patient discharge instructions and discharge summaries facilitates continuity of care. We reviewed the medical records of 23 patients discharged in August and September 2009. We determined that 7 (30 percent) of the 23 records reflected medication inconsistencies between the discharge instructions and discharge summaries.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires that discharge summaries and discharge instructions are consistent.

The VISN and Medical Center Directors agreed with the finding and recommendation. Discharge summaries will automatically be populated with all active prescriptions. Managers will conduct continuous monitoring to ensure

consistency between discharge summaries and discharge instructions. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Center Policies

Medical center policies provide staff with current guidance on areas such as standards of care, procedures, and professional expectations. The medical center did not ensure that policies were current and available to staff and did not have an effective process to review and update polices prior to expiration.

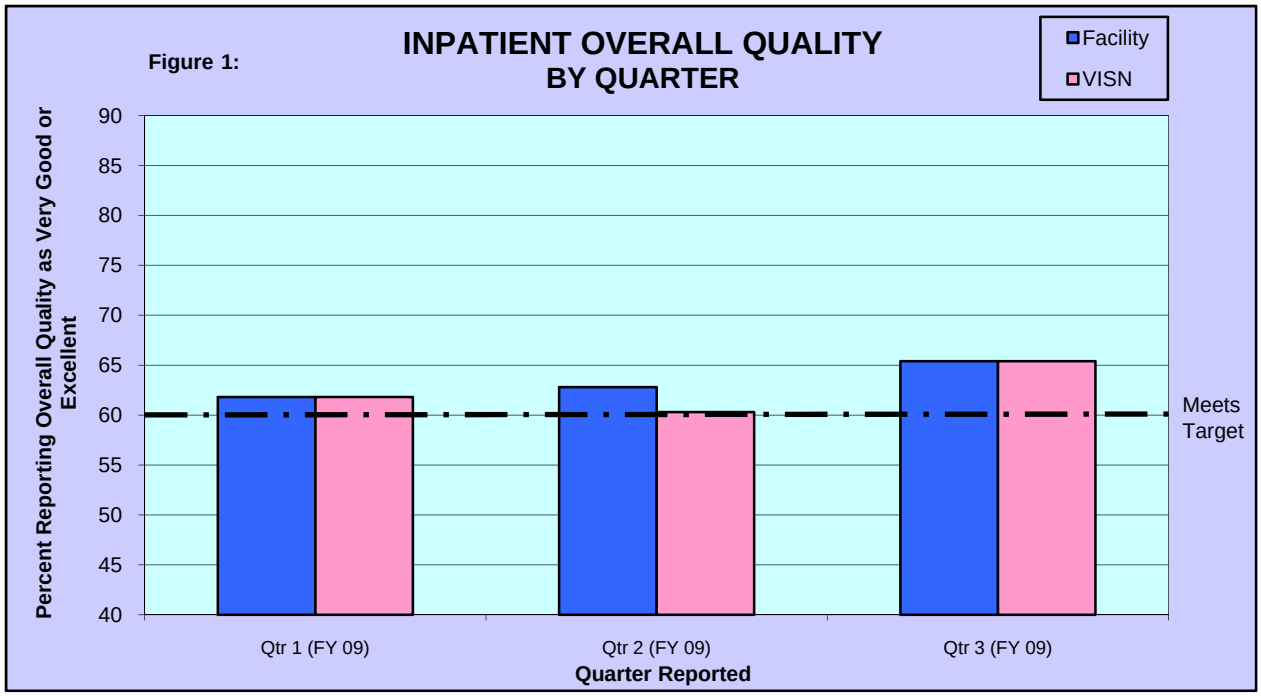
Recommendation 15 We recommended that the VISN Director ensure that the Medical Center Director develops a process to ensure that policies are current and available to staff.

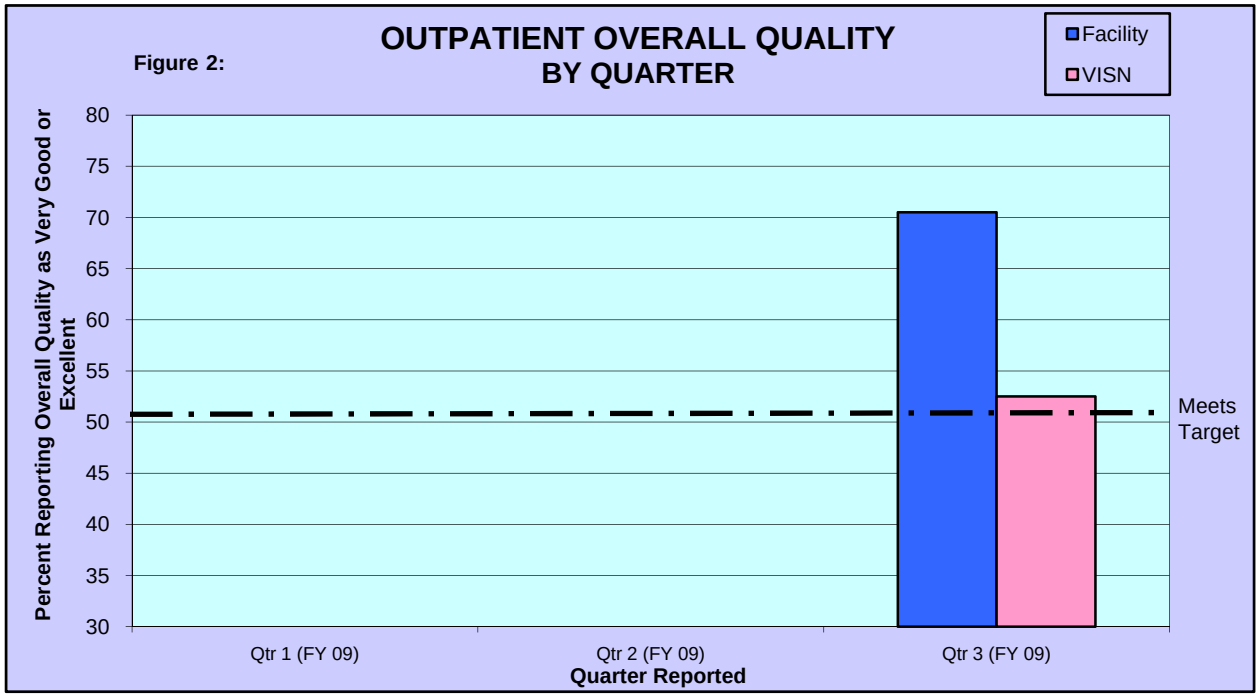
The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center is updating and reformatting all policies to ensure that they are current and accurate. In addition, staff will be given notice when a policy is due for revision. Policies are now available on the medical center's intranet home page. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–3 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[7] The target scores are noted on the graphs.

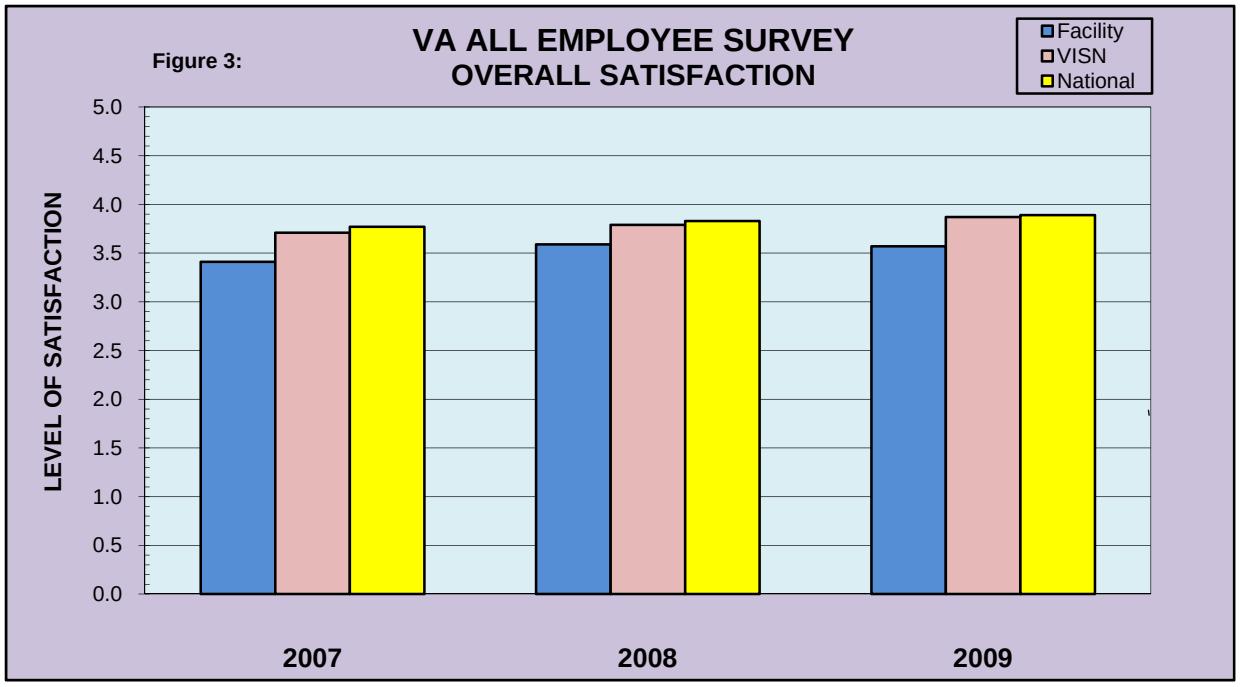
[7] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.





Employees are surveyed annually. Figure 3 on the next page shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3:


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 20, 2010

From: Director, VA Southeast Network (10N7)

Subject: **Combined Assessment Program Review of the Charlie Norwood VA Medical Center, Augusta, Georgia**

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

Director, Management Review Service (10B5)

I have reviewed and concur with the recommendations and responses from the Charlie Norwood VA Medical Center, Augusta, Georgia.

(original signed by:)
Lawrence A. Biro

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 13, 2010

From: Director, Charlie Norwood VA Medical Center (509/00)

Subject: **Combined Assessment Program Review of the Charlie Norwood VA Medical Center, Augusta, Georgia**

To: Director, VA Southeast Network (10N7)

1. The recommendations made during the Office of Inspector General Combined Assessment Program Review conducted November 2–6, 2009, have been reviewed, and corrective action plans have been implemented.

2. Our appreciation is extended to the entire OIG-CAP Team led by Mrs. Susan Zarter. Every member of the team was consultative and professional and provided excellent feedback to our staff.

3. If you have any questions, please contact Ellen W. Harbeson, QM Coordinator at 706-823-2286.

(*original signed by:*)
Rebecca J. Wiley

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 sensitive patient information to be secured.

Concur:

Employees are required to complete Information Security Awareness and Rules of Behavior Training and sign the Rules of Behavior prior to being granted computer access and annually. The protection of sensitive (PHI/PII) is discussed in training and statements concerning the Rules of Behavior are signed by every employee with computer access. In addition to the training and Rules of Behavior, employees are reminded continually of the importance of logging off the computer and protecting sensitive information via all staff messages distributed in Outlook and Vista. Reminders are also published in the Communiqué. The ADPACs are required to complete a weekly computer security check of their areas for information security and privacy violations which includes checking for unattended PCs and appropriate handling of sensitive information. The Information Security Officers also participate in the Environmental Rounds checking for information security and privacy violations. Violators are reported to their service line managers and/or supervisors for appropriate action. These actions will be implemented by January 2010.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires the correction of environmental hazards on the locked MH units.

Concur:

Identified environmental hazards on locked MH units will be appropriately addressed and corrected. An assessment of this area will be performed, and the current issues will be addressed accordingly by April 2010.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the PRC to document all required committee activities.

Concur:

The minutes of the Peer Review Committee will appropriately reflect all required committee activities including those areas noted as many deficient, particularly the participation of the individual practitioner in the discussion of Level 2 and Level 3 reviews and the referral, follow-up, and closure of any systems problems identified by the Peer Review Committee beginning with the March 2010 minutes.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires the MRC to meet bimonthly, as required, and to document PI activities.

Concur:

We concur with the findings of the Office of the Inspector General. The MRC met on December 3, 2009, and will continue with bimonthly meetings. Performance Improvement activities will include: recruiting, training, and retraining of reviewers; updating the review tool; identified issues will be followed-up until compliance/closure and documented in the committee minutes.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires the collection of PI data on resuscitation events and the implementation of a tracking system to ensure that designated staff members have CPR certification.

Concur:

Resuscitation events are initially reviewed by Nursing Management immediately following the event. Additional reviews are conducted by members of the CPR Committee the next business day. The CPR Committee membership and responsibilities were redesigned in December 2009. These changes also included tracking, trending, and analysis of the data by the CPR Committee and data input into the IPEC database by the Associate Nurse Executive for Critical Care. Responsibility for tracking CPR certification dates was reassigned to Hospital and Nursing Education and this process change will be completed February 1, 2010.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that FPPE, OPPE, provider profiles, and the granting of privileges are in compliance with VHA requirements.

Concur:

FPPE. The Professional Standards Board (PSB) established a 90-day FPPE period for all new appointments. The Medical Staff Office (MSO) continues to receive completed FPPE forms which document FPPE

completion; FPPEs are discussed at PSB and filed appropriately. The MSO Coordinator has sent out reminders to evaluators with outstanding FPPEs. Follow-ups are made in 30-day increments until FPPE(s) are complete.

The MSO has developed a better tracking procedure for FPPE evaluations. Upon confirmation from Human Resources that the new provider has completed in-processing, a FPPE notification is sent to the Service or Section Chief. A Copy of the FPPE is maintained in the MSO until the original completed evaluation is received; a 60-day reminder is set to remind the evaluator of the impending FPPE due date.

OPPE. The MSO has identified new resources for OPPE documentation (productivity reports, monthly EPRP fall-out data, patient complaints/complement data, attending evaluations). The MSO office continues to search for and identify resources for documenting provider performance. OPPE data from the Service Lines, along with data collected by the MSO, will be reviewed. In addition, the MSO will include OPPE data with re-privileging file(s) sent to the service chief for review. A revised OPPE plan documents how providers are competent in 6 areas; the service chief will complete the OPPE plan based on the documentation obtain during the period.

Meeting Minutes. PSB meeting minutes now reflect detailed discussions of the committee, including specific discussions with references and supervisors. Beginning in March 2010, minutes will include the information used to determine the provider(s) competency and how the FPPE will be performed.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document PRN pain medication effectiveness within the timeframe specified by medical center policy.

Concur:

In December 2009, a new functional statement was written for the BCMA Coordinator, and she was reassigned to Nursing Education with direct reporting to the Nurse Executive. One hundred percent of her workload was designated for BCMA issues related to tracking, trending, and education with a special emphasis placed on PRN pain effectiveness. The BCMA policy was also revised to improve clarity of timeframes in December 2009, and this information was disseminated to staff. The BCMA Coordinator monitors adherence to documentation compliance on a regular basis. Charge Nurses monitor the documentation compliance each tour, Nurse Managers and Clinical Nurse Leaders oversee this process, and the BCMA Coordinator also oversees and reinforces the

correct process. PRN pain effectiveness has been added to the Clinical Nurse Leaders performance contracts, effective January 2010. Effective February 2010, the BCMA Coordinator will provide weekly PRN pain effectiveness reports to the Director.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that pharmacists consistently document CLC monthly medication reviews.

Concur:

To ensure that the pharmacists consistently document CLC monthly medication reviews:
(1) The pharmacist will utilize the RAI/MDS assessment calendar to catch patient movement and admissions to decrease likelihood a resident's chart is overlooked during the month.
(2) The pharmacist will review inpatient rosters for all CLC units on a weekly basis to look for newly admitted residents or residents who have moved to another unit to ensure the record is reviewed at least once during the month.
(3) The Pharmacy SOP 114-58-04 Clinical Pharmacy Functions Uptown has been updated.
(4) The Uptown pharmacy supervisor will conduct a random audit of CLC charts on a monthly basis for at least 3 months to ensure charts are being reviewed consistently. No less than 10 resident charts will be audited and each CLC unit will be represented. This currently includes: 1C UD, 1D UC, 2B UD and 3C UD. The results of the audit will be reported to the Chief, Pharmacy.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that MRI screenings are completed and documented in the medical record.

Concur:

MRI Screenings are performed on all patients being examined in the MRI Suite. The MRI Staff will document completed screening in CPRS regularly. Continuous monitoring will occur to ensure compliance with documentation requirements.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that informed consents for contrast media are completed and documented in the medical record.

Concur:

Informed consents for MRI contrast media are completed and documented via I-Med as of November 2, 2009.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that all employees who may enter the MRI area receive safety education.

Concur:

MRI safety education is required for all employees who may enter the MRI area on annual basis. Safety education is provided by Steve Knapp PhD, Radiation Safety Officer, and Wayne Hadley, MRI supervisor. A DVD presentation will provide 1.5 Hours of safety education for the following employees: Facility Management Service, Nursing and MRI staff by February 2010.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director takes action to restrict access to Zones 3 and 4 in the MRI area.

Concur:

Access to Zones 3 and 4 in MRI Suite is restricted to patient care only. MRI staff has received specific instructions to restrict access to Zones 3 and 4 to patient care activity only. Unauthorized staff and patients are restricted from entering Zones 3 and 4 as of November 2, 2009.

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director requires that contracted/agency registered nurses complete mandatory training.

Concur:

Currently there are no RN agency contracts in place, but this process will be implemented upon initiation of any new contracts. Process improvements, effective December 2009, include that HR will verify that the two required pre-employment training modules are completed prior to appointment. Nursing Education will ensure that additional required training is completed during designated orientation, and Nurse Managers will verify completion of all required training prior to scheduling the registered nurse. Completed.

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that discharge summaries and discharge instructions are consistent.

Concur:

The discharge instruction sheet is automatically populated with active prescriptions, and these should be identical to what is on the dictated discharge summary; unfortunately with dictation, some omissions did

occur. We will take action to enable the discharge summary to be automatically populated with all active prescriptions. Further, we will have an ongoing review to ensure that these lists are accurate and the two documents and any other paperwork given to the patient are congruent and if any issues are seen, a rudimentary educational plan will be developed for the relevant services. This will be completed by March 2010.

Recommendation 15. We recommended that the VISN Director ensure that the Medical Center Director develops a process to ensure that policies are current and available to staff.

Concur:

Attention has been given to the process of updating all medical center policies. All policies are now being updated and reformatted to ensure that they are all current and accurate. Staff will now receive notice one month prior to any policy being up for revision so that necessary action can be taken. Policies are now available and accessible to all staff via the medical center's intranet home page.

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