Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00035-191

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

June 10, 2011

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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
ECMS	Executive Committee of the Medical Staff
EOC	environment of care
facility	Durham VA Medical Center
FY	fiscal year
JC	Joint Commission
MDRO	multidrug-resistant organisms
MICU	medical intensive care unit
MRI	magnetic resonance imaging
NCPS	National Center for Patient Safety
OIG	Office of Inspector General
PII	personally identifiable information
PPE	personal protective equipment
PR	peer review
PSCI	Patient Safety Center of Inquiry
QM	quality management
RCA	root cause analysis
SICU	surgical intensive care unit
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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Executive Summary: Combined Assessment Program Review of the Durham VA Medical Center, Durham, NC

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of March 7, 2011.

Review Results: The review covered seven activities. We made no recommendations in the following three activities:

- Medication Management
- Physician Credentialing and Privileging
- Quality Management

The facility's reported accomplishments were its receipt of the Gold Cornerstone Award for quality and improvements in National Patient Safety Goals and the establishment of a Patient Safety Center of Inquiry.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Secure confidential personally identifiable information in the community living center unit inspected.

Management of Test Results: Revise the local policy addressing communication of critical pathology test results to include all Veterans Health Administration requirements, and monitor compliance. Consistently communicate normal radiology test results to patients within the specified timeframe, and monitor documentation of communication for compliance.

Coordination of Care: Provide and document advance directive notification. Ensure staff provide diet education to patients discharged with special diet orders, and document the education.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to patients infected or colonized with multidrug-resistant organisms and their families, and document it.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through March 7, 2011, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Medical Center, Durham, North Carolina,* Report No. 07-03443-46, December 19, 2007). The facility

provided sufficient proof that it had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 595 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.

Reported Accomplishments

PSCI

The PSCI is an inter-professional team of health care providers, human factors engineers, and business experts who work to improve the safety, reliability, and quality of medical care provided to patients in perioperative environments. One of the highlights of this program is the simulation laboratory that allows the facility to test investigational ideas and products without patient risk and prior to large capital investment. The lessons learned in process modeling, predictive capacity of simulation, and implementation science might be of immense value to quality and safety efforts throughout VHA. Those who have observed the PSCI Code Response Team training sessions agree that they are witnessing a culture changing for the better, and clinical staff feel more empowered. Additionally, revitalized leaders are assuming greater ownership of code results.

Patient Safety Program

The facility received high praise for its culture of safety during the NCPS site visit and received the Gold Cornerstone Award in FY 2010 for the quality of its RCA work and process improvements in anticoagulation therapy, critical results, MDRO, and medication reconciliation, all of which are National Patient Safety Goals.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the emergency department, a primary care clinic, behavioral health, one of the CLC units, the SICU, two mixed medical-surgical units, the MRI suite, radiation oncology, and the radiology department (which includes nuclear medicine). The facility maintained a generally clean and safe environment. However, we identified the following condition that needed improvement.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential PII to be secured. The CLC unit we inspected is being remodeled. Charts with some paper records containing PII were present in a small office that was previously located behind the CLC nurses' station. As part of the remodeling, the nurses' station was removed. The office with the charts is now more accessible to the public, and the door to the office does not have a locking mechanism. The charts containing PII could not be secured when staff was not present in the area.

Recommendation

1. We recommended that processes be strengthened to ensure that confidential PII in the CLC unit we inspected is secured.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[1]

We interviewed facility managers, and we reviewed facility policies and procedures and patient medical records. We identified the following areas that needed improvement.

Policy. VHA requires that facilities develop a written policy regarding communication of test results from diagnostic clinicians to ordering providers.[2] This policy must define the acceptable length of time between the availability of critical tests, values, or results and receipt by the responsible provider. Local policy was unclear regarding the timeframe for reporting critical pathology results. Additionally, local policy requires that the pathologist who identifies the critical result call the provider and document that call in VistA. We found that critical pathology results were not communicated to providers by phone.

[1] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.
[2] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[3] We reviewed the medical records of 10 patients who had normal radiology results and found that only 4 of the 10 records contained documented evidence that providers had communicated the results to the patients.

Recommendations

2. We recommended that local policy addressing communication of critical pathology test results be revised to include all VHA requirements and that communication of critical pathology results to patients be monitored for compliance with local policy.

3. We recommended that normal radiology test results be consistently communicated to patients within the specified timeframe and that documentation of communication be monitored for compliance.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification. VHA requires that patients be given written notification stating their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance directive.[4] We found evidence of notification in only 4 of the 10 records we reviewed.

Discharge Instructions. VHA requires that upon discharge from the facility, providers include information regarding medications, diet, activity level, and follow-up appointments in instructions to patients.[5] In addition, The JC requires that clinicians provide patients with written discharge instructions.

We reviewed the medical records of 14 discharged patients; 9 patients had special diet orders. Only six of the nine

[3] VHA Directive 2009-019.
[4] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

records with special diet orders contained documented evidence that diet education was provided prior to discharge.

Recommendations

4. We recommended that processes be strengthened to ensure that staff provide and document advance directive notification.

5. We recommended that processes be strengthened to ensure that staff provide diet education to patients discharged with special diets and document the education.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected the MICU and medical unit (7A) and interviewed employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[6] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of PPE. We reviewed 16 medical records and found that only 9 of the records had documented evidence of MDRO education.

Recommendation

6. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

[6] Colonization is the presence of bacteria in the body without causing clinical infection.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. The QM program was generally compliant with requirements, and senior managers supported the program. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 12–17, for the full text of the Directors' comments.) We consider Recommendation 1 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[7]		
Type of Organization	Tertiary medical center	
Complexity Level	1A	
VISN	6	
Community Based Outpatient Clinics	Raleigh, NC Greenville, NC Morehead City, NC	
Veteran Population in Catchment Area	199,937 projected	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	123 Total - 48 surgery - 75 medicine	
• **CLC/Nursing Home Care Unit**	120 (includes 10 hospice)	
• **Other**	28 psychiatry	
Medical School Affiliation(s)	Duke University The University of North Carolina at Chapel Hill East Carolina University	
• **Number of Residents**	325 rotating residents	
	FY 2011 (through November 2010)	**FY 2010**
Resources (in millions):		
• **Total Medical Care Budget**	$338	$350
• **Medical Care Expenditures**	$81	$350
Total Medical Care Full-Time Employee Equivalents	2,054.6	1,987.5
Workload:		
• **Number of Station Level Unique Patients**	30,574	53,661
• **Inpatient Days of Care:**		
o **Acute Care**	28,935	44,931
o **CLC/Nursing Home Care Unit**	14,199	34,143
Hospital Discharges	1,053	6,638
Total Average Daily Census (including all bed types)	194	217
Cumulative Occupancy Rate (in percent)	71.6	80
Outpatient Visits	86,213	507,595

[7] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Ensure the mortality review process complies with VHA policy.	All deaths are monitored for the required elements, trended by risk management monthly, and reported to the ECMS quarterly.	Y	N
2. Ensure the PR process complies with VHA policy.	PRs have been completed within required timeframes, and quarterly reports were submitted as required. Providers who are assigned a level II or III PR are notified of this decision and given a chance to respond to the PR Committee.	Y	N
3. Ensure the adverse event disclosure process complies with VHA policy.	Processes have been designed to ensure that the adverse event process complies with VHA policy.	Y	N
4. Ensure the RCA process is completed in accordance with VHA policy.	RCAs are meeting VHA timeliness standards, and processes are in place to ensure compliance with VHA policy.	Y	N
5. Ensure medical record reviews are completed in accordance with VHA policy.	Facility policy was updated to include copy/paste requirements. The Medical Record Review Committee conducts quarterly reviews.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Electronic Medical Record Business Rules			
6. Require continued compliance with VHA Handbook 1907.01 and the October 2004 Office of Information guidance related to electronic medical records.	Policy is in place, and the October 4, 2004, Computerized Patient Record System informational patch was installed.	Y	N

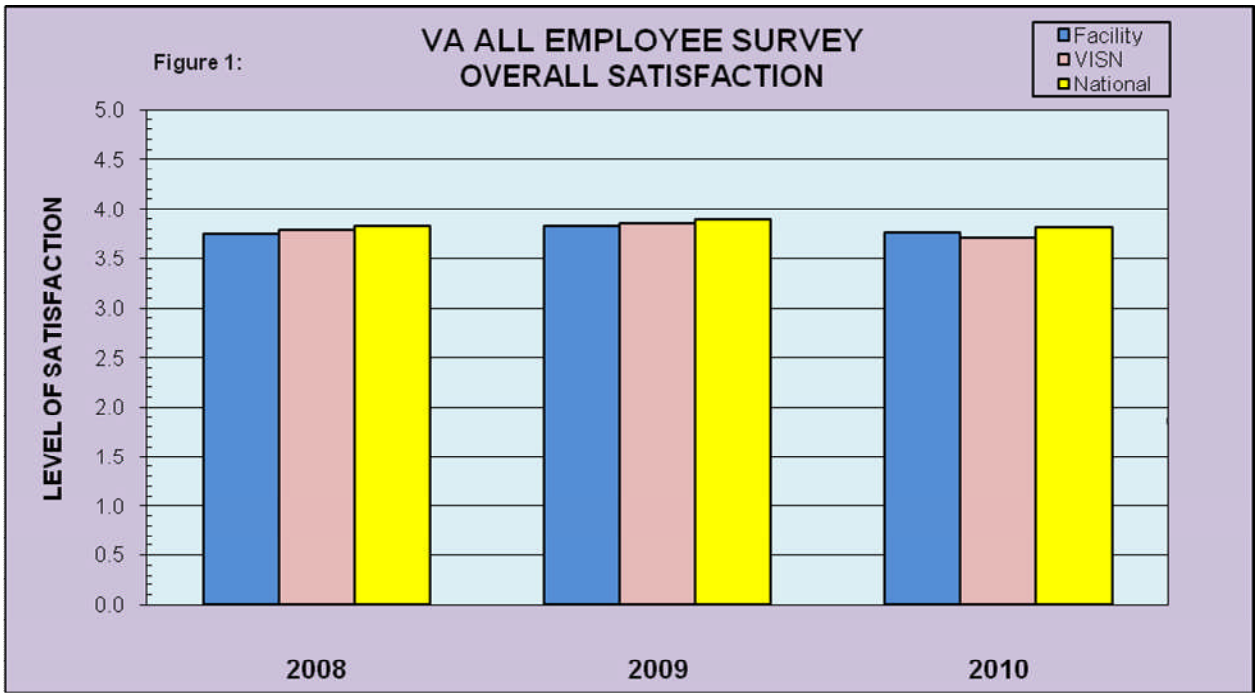
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	66.5	71.4	68.8	61.9	47.1	50.5	49.4	42.6
VISN	59.9	65.7	61.5	62.4	50.7	50.9	52.2	46.5
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[8] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	14.54	9.55	17.04	20.82	21.79	13.77
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[8] Congestive heart failure (CHF) is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 23, 2011

From: Network Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subject: **CAP Review of the Durham VA Medical Center, Durham, NC**

To: Director, Washington DC Office of Healthcare Inspections (54DC)

Director, Management Review Service (VHA CO 10B5 Staff)

1. The attached subject report is forwarded for your review and further action. I have reviewed the responses and concur with the facility's recommendations.

2. Please contact Ralph Gigliotti, Director, Durham VA Medical Center, at 919-286-6903l, if you have any further questions.

(original signed by Augustin A. Davila for:)

DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 6, 2011

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

Subject: **CAP Review of the Durham VA Medical Center, Durham, NC**

To: Director, VA Mid-Atlantic Health Care Network

This memo serves to acknowledge receipt and review of the draft CAP Report for the program review of the Durham VA Medical Center, Durham, North Carolina. Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please do not hesitate to contact Jane Penny, MSN, CPHQ, Chief of Quality Management at 919-286-0411 ext 6970.

(original signed by:)
Ralph T. Gigliotti, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that confidential PII in the CLC unit we inspected is secured.

Concur

The protection of Personal Identifying Information (PII) was addressed with CLC leadership and the Privacy Officer. A risk assessment was conducted and a decision was made to remove the unsecured PII from the nurse's workroom N1029 where it was found and to secure it in a locked storage cabinet in the medication cart parking area of CLC 1. The CLC 1 Nurse Manager monitors the security of PII and presence of the key during daily rounds. This service is also on the EOC Rounds schedule, internal tracer schedule, and random audits are conducted by the Privacy Officer.

Completed: April 27, 2011

Recommendation 2. We recommended that local policy addressing communication of critical pathology test results be revised to include all VHA requirements and that communication of critical pathology results to patients be monitored for compliance with local policy.

Concur

Working collaboratively, Patient Safety, Pathology and Laboratory Medicine Service (P&LMS), and Laboratory Quality Improvement, revised the Medical Center Memorandum (MCM) 555-11-113.9 COMMUNICATING PATHOLOGY AND LABORATORY MEDICINE TEST RESULTS, ensuring the incorporation of all VHA Directive 2009-019 requirements for reporting pathology results to providers in a timely manner. The revised MCM distinctively identifies new anatomic pathology diagnostic testing results as requiring confirmation that those results are communicated to the requesting provider. This MCM also makes the distinction that these results are not critical values or results that require immediate intervention by the provider. The revised MCM clarifies that provider notification of new anatomic pathology diagnoses of malignancy are made within 5 days of the diagnosis and describes the process for reporting and recording provider notification in VISTA/ CPRS. Communication of new anatomic pathology results is monitored and reported quarterly to the Patient Safety/Risk Management Committee and the Executive Committee of the Medical Staff.

Target Date of Completion: May 31, 2011

Recommendation 3. We recommended that normal radiology test results be consistently communicated to patients within the specified timeframe and that documentation of communication be monitored for compliance.

Concur

The Chief of Staff educated the Clinical Service Chiefs and the Executive Committee of the Medical Staff during the April 2011 meeting regarding the requirements in VHA Directive 2009-019, ORDERING AND REPORTING TEST RESULTS, dated March 24, 2009. All Clinical Service Chiefs were tasked to develop a process to notify patients and document communication of diagnostic test results within 14 days of the availability of the results. In accordance with Medical Center Memorandum 558-11-114.1, RADIOLOGY CRITICAL TEST AND CRITICAL RESULTS REPORTING, communication of test results to patients may be accomplished in person, by telephone, in writing, or secure messaging when available. The template letters used successfully by Ambulatory Care and Medicine Service to notify patients in writing are available to all services to modify as needed. Service Chiefs will review medical records monthly for compliance and report finding to the Durham Leadership Board through the Quality Council.

Target Date for Completion: June 30, 2011

Recommendation 4. We recommended that processes be strengthened to ensure that staff provide and document advance directive notification

Concur

HAS leadership, HIMS Chief/Medical Records Committee Co-Chair, Integrated Ethics Coordinator, Chief of Social Work, Nursing QA Representative, and the Physician Representative to the Medical Records Committee reviewed the strengths and opportunities identified during this visit. A decision was made by the Medical Records Committee to modify the Conditions of Admission form to indicate that an Advanced Directive notification and information pamphlet was received by the patient. A completed Conditions of Admission must include (1) the veteran and the admitting individual's signatures on the form; or (2) documentation of the patient's inability to sign due to his/her medical condition, and no family member/guardian was available to sign the form for the veteran. HAS is now scanning the Conditions of Admission into the electronic medical record. HAS implemented daily monitoring of admissions from the previous day to ensure Conditions of Admission documentation is completed and scanned. Results of monitoring will be reported monthly to the Quality Council.

Target Completion Date: June 30, 2011

Recommendation 5. We recommended that processes be strengthened to ensure that staff provide diet education to patients discharged with special diets and document the education.

Concur

Nursing, Nutrition & Food Services (NFS), Medicine, MH and Surgery reviewed the strengths and opportunities identified during the Coordination of Care visit. The processes were strengthened to ensure staff provide diet education to patients discharged with special diets and document the education. No Concentrated Sweets (Diabetic) and Low Cholesterol/Sodium (Cardiac) diet scripts were placed in the Surgical and Medical Services Discharge Instructions Templates in March. Additional categories of diet scripts are developed whenever a need is identified. NFS also provides diet education for inpatients on consult and/or by patient request. Referrals to Nutrition Clinic are recommended for patients interested in more diet education. A Nutrition Screen has also now been added as a mandatory field on the Nursing Admission Assessment to facilitate discharge planning. Nursing Education through the Clinical Professional Practice Committee (CPPC) addressed the issue of providing and documenting patient education with acknowledgement of the patient and/or family members understanding. Each CPPC member was tasked to provide this information and educate the staff on their units. Nursing chart reviews will be done for diet education beginning May 2011 for discharged patients and diet education is being monitored until a minimum 90% compliance is achieved. Numerator: # of patients with diet education, Denominator: # of charts reviewed with special dietary needs. Results of monitoring are reported up to the Nursing Executive Coordinating Council and corrective actions taken as needed.

Target Completion Date: June 30, 2011

Recommendation 6. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur

Nursing, Clinical Informatics, MDRO Prevention Coordinator (MPC), and the Veteran Health Education Coordinator collaborated as a sub-group of CPPC to address the need to improve documentation of MDRO education provided to patients infected or colonized with MDRO. This includes education for their families and related documentation in CPRS. Revisions were made to various nursing templates to facilitate documentation of MDRO education which included additions for MDROs other than MRSA (C diff, ESBL, VRE, etc.). The revised nursing templates were submitted to CPPC for approval on May 4, 2011. Revisions were accepted. Training on the revised templates will be provided to all nursing units by 5/16. Clinical Informatics will place revised templates into the live CPRS accounts by 5/18.

Nursing will conduct random chart reviews of MDRO education in June for a period of 5 days. This chart review will be conducted on all discharged patients during this period who were MDRO+ during admission, reviewing revised templates for the presence of education on MDRO prevention strategies. Numerator: # of patients with MDRO education, Denominator: # of MDRO+ charts reviewed. CPPC requested follow-up monitoring for MDRO Education documentation by the Nursing PI Committee on a

monthly basis through the end of FY11. The target is ≥ 90% compliance by the end of June 2011.

Target Completion Date: June 30, 2011

OIG Contact and Staff Acknowledgments

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