Department of Veterans Affairs
Office of Inspector General

Review of Environment of Care and Part-Time Physician Time and Attendance at the Louis Stokes VA Medical Center, Cleveland, Ohio

Report No. 04-02145-11 **October 29, 2004**

VA Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network 10 (10N10)

SUBJECT: Review of Environment of Care and Part-Time Physician Time and Attendance at the Louis Stokes VA Medical Center, Cleveland, Ohio

Introduction

On April 14 and 15, 2004, the Office of Inspector General (OIG) conducted a review at the Louis Stokes VA Medical Center, Cleveland, OH. Our purpose was to review alleged deficiencies in the environment of care, quality of patient care, resident supervision, and physician time and attendance reported during an April 8, 2004, national television broadcast of *Primetime*.[1]

This report addresses the results of our review of environment of care and time and attendance issues. Our review of the quality of patient care, resident supervision, and time and attendance practices specific to the surgeon who was the subject of the *Primetime* broadcast continues, and the findings will be discussed in a separate report.

Specifically, *Primetime* reported finding filthy bathrooms with what appeared to be human excrement on the floors, supply cabinets in disarray with dirty linens mixed in with clean supplies, dried blood on examination tables, overflowing bio-hazardous waste containers, and surgical delays caused by nonfunctioning equipment used to sterilize surgical instruments (autoclaves). Additionally, *Primetime* reported that medical center employees said that some physicians never reported to work, and *Primetime* reporters observed one surgeon at his home during his scheduled tour of duty at the medical center.

The medical center consists of two inpatient campuses located in Cleveland and Brecksville, Ohio, and is part of Veterans Integrated Service Network (VISN) 10. The Cleveland campus, known as the Wade Park Division, is a tertiary care hospital. The Brecksville campus, known as the Brecksville Division, is an extended care center. Both divisions also offer primary care services. In addition, the medical center provides care at 12 community-based outpatient clinics throughout northern Ohio.

[1] *Primetime* is an ABC television news program.

Results

Issue 1: Environment of Care

General housekeeping could be improved at both divisions. We did not find all of the conditions cited in the *Primetime* broadcast, but we found specific areas requiring management attention.

Environment of Care–Wade Park Division. Inpatient wards on 6B (Spinal Cord Injury) and 5B (Medical/Surgical, Geriatrics, Neurology, and Rehabilitation) were renovated in September 2003 and were generally clean, bright, nicely decorated, and well furnished. Patient rooms and bathrooms were clean. However, we found unsecured patient information and hazardous cleaning products on the wards and an unsecured medication cart.

Inpatient wards on the third and fourth floors (Wards 41, 42, 44, and the Medical Intensive Care and Cardiac Care Units) had not been renovated and were not as cosmetically pleasing. Medical center managers told us that there were plans to renovate these areas during Fiscal Year 2005. On Ward 31 (Inpatient Psychiatry), the nurse call system was not operational, the electrical access panel on the day room wall was not secured, and the clean linen room was in disarray. However, clean linens were not mixed with dirty linens or supplies as reported in the *Primetime* broadcast. A washing machine was leaking, posing a safety risk. On the three medical units located on the fourth floor, we found uncovered dirty linen receptacles, an unsecured medication cart, and unsecured hazardous cleaning products and sharps (needles, scissors, etc.).

Conditions in the Hemodialysis Unit were unacceptable. The unit is scheduled to be moved to a new location early in 2005. However, efforts should be made to improve conditions in the existing unit until it is vacated. General housekeeping in this area was poor (e.g. dirty floors, dust accumulation on horizontal surfaces, and dusty ventilation system covers). We found standing water on the floor in a room where chemical tanks are cleaned and stored, and we could not distinguish clean supplies from dirty supplies. Dirty towels were lying on top of water tanks, and areas behind the water tanks were dirty. Additionally, an eyewash station needed repair and had no inspection tag. The Occupational Safety and Health Administration (OSHA) recommends that eyewash stations be inspected weekly, but we could not determine when it was last inspected. The Administrative Officer to the Chief of Staff told us that daily inspections of the Hemodialysis Unit would begin immediately and the unacceptable conditions we identified would be corrected.

Our interview with the operating room nurse manager revealed that one of the four autoclaves in the operating room was not working. It was removed from service before our visit and replaced with a new one. At the time of our visit, all four autoclaves were operational.

Environment of Care–Brecksville Division. Two nursing home care units that we inspected had been renovated and were generally clean. Both units had adequate lighting and furnishings. Patients appeared well-groomed and comfortable. However, we noted some opportunities for improvement:

- Rolling bases on equipment such as intravenous poles needed cleaning.
- Shower and commode chairs were damaged and could cause injury or present risk of infection. They needed to be inspected for damage and replaced as appropriate.
- Pillows, mattresses, and bed sheets needed to be inspected and replaced as appropriate.
- Items were stored on storage rooms floors instead of on pallets as required by VA regulations. However, we found no evidence that clean and contaminated items were stored together.

We did not observe soiled examination tables or overflowing bio-hazardous waste containers as reported during the *Primetime* broadcast. Housekeeping employees told us that containers may have appeared to be overflowing because, at the time of the media's visit, they were required to stockpile cleaning supplies. This occurred because of the uncertainty of the budget and the need to ensure they did not run out of cleaning supplies.

Patient and Employee Satisfaction. We interviewed 36 patients. Thirty-two of the 36 (89 percent) patients rated the quality of care as good or better, said they would recommend the medical center to an eligible family member or friend, and rated the cleanliness of the medical center as good or better.

We also interviewed 35 employees. All of the employees interviewed rated the quality of patient care as good or better. Thirty-two of the 35 (91 percent) employees said they would receive their care at the medical center if they were eligible, and 33 (94 percent) employees rated the cleanliness of the medical center as good or better.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director: (a) corrects all environmental deficiencies; (b) maintains the Hemodialysis Unit in a clean, orderly, and safe condition for patients and employees; and (c) repairs the eyewash station and ensures the station is inspected weekly as recommended by OSHA.

The VISN and Medical Center Directors agreed with the findings and recommendations and stated that the Medical Center Associate Director was conducting environment of care and patient safety rounds in all patient care areas. Since April 2004, all inpatient units have undergone four inspections covering all three shifts (day, evening, and night). All areas were inspected for information security and privacy, cleaning product safety,

medication cart security, and overall cleanliness, including the medication, treatment, and patient rooms. In addition, the necessary repairs and improvements were made to the Hemodialysis Unit and the eyewash station. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Issue 2: Part-Time Physician Time and Attendance

Medical center managers have not fully implemented time and attendance controls necessary to ensure part-time physicians meet their VA employment obligations. The medical center was cited for ineffective time and attendance controls in a previous OIG report (*Follow-up of the Veterans Health Administration's Part-Time Physician Time and Attendance Audit*, Report Number 03-02520-85, February 18, 2004).

Current Review. On April 14 (Wednesday) and April 15 (Thursday), 2004, we reviewed part-time physician attendance at the Wade Park Division and found that most part-time physicians were on duty as required by their scheduled tours. Since 4 of the 73 (5 percent) part-time physicians scheduled for duty were not on duty, approved leave, or authorized absence, we concluded they were potentially not meeting their VA employment obligations. Specifically, we found that:

- Two part-time physicians were not on duty as required because they claimed to have changed their tours of duty. One physician was scheduled for 5 non-core hours[2] (8:00 AM to 1:00 PM) on Wednesday, April 14. According to the physician, he has worked on Thursdays instead of Wednesdays since July 2003 and had submitted the appropriate request to change his tour of duty. However, Medical Service staff could not find the physician's request for the change. Veterans Health Administration (VHA) Directive 2003-001 (Time and Attendance for Part-Time Physicians) allows part-time physicians to modify their tours of duty before or during the pay period consistent with patient care requirements. However, modifications are to be approved by the employee's supervisor in advance (except in medical emergencies) and communicated to the appropriate timekeeper as soon as possible. During our unannounced review on the morning of April 15 (Thursday), we observed the physician working in the pulmonary clinic.

  The second physician was scheduled for 5 non-core hours (1:00 PM to 6:00 PM) on April 15. According to the physician, he works on Saturdays instead of Thursdays but had not submitted a request to change his tour of duty schedule. The physician's Subsidiary Time and Attendance Report–Part Time Physicians (VA form 4-5631a) showed the physician claimed hours worked on Saturday but did not claim hours worked on Thursday.

[2] Core hours are the times in the biweekly pay period when the physician must be present, unless granted an appropriate form of leave or excused absence.

- One part-time physician was at a University Hospitals Health System facility at the time of our review. The physician was scheduled for 7 non-core hours (9:00 AM to 4:00 PM) on April 14. We found that he had conducted a coronary angioplasty at the medical center from approximately 8:30 AM to 9:00 AM on that day, and then left to attend a non-VA related cardiac catheterization conference at the University Hospitals Health System facility. He did not return to the medical center that day.
- One part-time physician, who was not at the medical center during our review, works at the VA medical center for 2.5 hours every Monday, even though his tour of duty shows his schedule as 5 hours on Monday (12:00 PM to 5:00 PM) and 5 hours on Wednesdays (8:00 AM to 1:00 PM). The physician also worked extended hours for 2 months (November 2003 and January 2004) to serve as an attending physician for resident training. VHA Handbook 5011 (Hours of Duty and Leave) requires timekeeping documents to reflect actual hours worked by employees.

Prior Review. On August 12, 2003, we conducted an unannounced follow-up review at 15 VA medical facilities (including the Louis Stokes VA Medical Center) to reassess time and attendance practices of part-time physicians. In our February 2004 follow-up report, we reported that 9 of the 48 (19 percent) part-time physicians scheduled for duty at the Wade Park Division were not on duty, approved leave, or authorized absence at the time of our review.

None of the nine part-time physicians in our follow-up report were among the four identified during this review. However, the circumstances of their absences were similar. For example, during both reviews we found that the medical center paid a physician every pay period, even though the physician generally worked only at the medical center for 2 months of the year to serve as an attending physician for resident training.

We recommended in our follow-up report, and the former Under Secretary for Health agreed, to require that VISN and medical facility directors ensure part-time physicians receive written approval before taking leave or changing their tours of duty. We also recommended that oversight procedures, detailed in VHA Directive 2003-001 to ensure part-time physicians fulfill their employment obligations to VA, be implemented. The VISN and Medical Center Directors need to ensure that these recommended controls are in place and operating as intended.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director: (a) takes appropriate actions against the four physicians we found were not on duty as required by their scheduled tours of duty and (b) implements controls needed to ensure that all part-time physicians are meeting their VA employment obligations.

The VISN and Medical Center Directors agreed with the findings and recommendations and stated that appropriate actions were taken against the four physicians who were not found on duty and controls were implemented to ensure all part-time physicians meet

their VA obligations. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Conclusion

Although there were opportunities to improve general housekeeping at both divisions, we did not find the conditions to be as egregious as cited in the *Primetime* broadcast. The Hemodialysis Unit at the Wade Park Division is scheduled to be moved to a new location early in 2005. However, efforts needed to be made to improve conditions in the existing area. Most patients and employees from both divisions indicated high levels of satisfaction with the quality of care and with the facilities' cleanliness.

Medical center managers had not fully implemented time and attendance controls recommended in our February 2004 follow-up report. Although most part-time physicians were on duty as required by their scheduled tours, 4 of the 73 (5 percent) part-time physicians scheduled for duty were not on duty, approved leave, or authorized absence under circumstances similar to those we identified during our follow-up report.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See pages 7–11 for the full text of the Directors' comments). We will follow up on the implementation of recommended improvement actions until they are completed.

(*original signed by:)*

MICHAEL L. STALEY
Assistant Inspector General for Auditing

(original signed by:)

JOHN D. DAIGH, JR., MD, CPA
Assistant Inspector General
for Healthcare Inspections

Appendixes:

A – VISN 10 Director Comments
B – Medical Center Director Comments
C – OIG Contact and Staff Acknowledgments
D – Report Distribution

Appendix A

VISN 10 Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 7, 2004

From: Network Director, VISN 10
VA Healthcare System of Ohio (10N10)

Subject: Review of Environment of Care and Part-Time Physician Time and Attendance at the Louis Stokes VA Medical Center, Cleveland, Ohio

To: Assistant Inspector General for Auditing (52)

I have reviewed Cleveland's response to the above review and agree with their recommendations and the actions taken.

(original signed by:)
CLYDE L. PARKIS

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 3, 2004

From: Director, Louis Stokes VA Medical Center, Cleveland, Ohio (541/00)

Subject: **Review of Environment of Care and Part-Time Physician Time and Attendance at the Louis Stokes VA Medical Center, Cleveland, Ohio**

To: Assistant Inspector General for Auditing (52)

1. Please see the Louis Stokes Cleveland VA Medical Center response to the Review of Environment of Care and Part-Time and Attendance conducted on April 14 and 15, 2004.

2. If you have any questions or need additional information, please contact Grace A. Rotter, RN, Quality Manager at (216) 231-3456.

(original signed by:)
WILLIAM D. MONTAGUE
Medical Center Director

Attachment

Appendix B

Medical Center Director Comments

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. We recommended that the VISN Director ensure that the Medical Center Director: (a) corrects all environmental deficiencies; (b) maintains the Hemodialysis Unit in a clean, orderly, and safe condition for patients and employees; and (c) repairs the eyewash station and ensures the station is inspected weekly as recommended by OSHA.

Concur **Target Completion Date:** June 30, 2004

a) The Associate Director is conducting Environment of Care/Patient Safety rounds in all patient care areas. Since April 2004, all inpatient units have undergone four inspections covering all three shifts (day, evening, and night). All areas are inspected for information security/privacy, cleaning product safety, medication cart security, and overall cleanliness including the medication, treatment and patient rooms.

- Privacy screens were installed on all monitors that can be viewed by visitors or patients.
- Medication room shelves were replaced.
- Obtained new linen hampers with covers.

b) Hemodialysis Unit:

- Floors behind large water tanks in the tech room were steam cleaned and skim coated in low areas to eliminate standing water.
- Reorganized and secured tools/equipment in both the main unit and tech room.
- Ceiling tiles were replaced.
- Walls painted.

Appendix B

Medical Center Director Comments

- Area is being inspected weekly pending the opening of the new Dialysis Unit in early 2005.

c) Eyewash station:

- The missing faucet cover was replaced on April 17, 2004.
- Engineering inspected the eyewash station and determined it to be fully functional.
- Hemodialysis Safety Representative is conducting weekly inspections.
- Environment of Care Team is inspecting eyewash station during all rounds.

Recommended Improvement Action(s) 2. We recommended that the VISN Director ensure that the Medical Center Director: (a) takes appropriate actions against the four physicians we found were not on duty as required by their scheduled tours of duty; and (b) implement controls needed to ensure that all part-time physicians are meeting their VA obligations.

Concur **Target Completion Date:** May 30, 2004

a) Actions taken against the four physicians who were found not on duty:

- All four physicians received counseling regarding the procedure for changing their tour of duty.
- One physician's tour of duty was changed to reflect new clinic responsibilities.
- Two physicians were placed on fee-basis consultant status.

b) Controls to ensure all part-time physicians are meeting their VA obligations:

- In April 2004, the Chief of Staff held meetings with the Senior Medical Staff leaders at University affiliate.

Appendix B

Medical Center Director Comments

- On April 21, 2004, the Chief of Staff instructed the members of the Medical Executive Council to emphasize the requirements regarding physician time and attendance as outlined in VHA Directive 2003-001 and the Memorandum from the Acting Undersecretary for Health, Jonathan Perlin, MD dated April 2004.
- Effective April 22, 2004, the Medical Center Director and Chiefs of Staff performance contracts now requires full compliance with mandates for part-time physicians' time and attendance.
- On May 30, 2004, a new GS12 coordinator was assigned to oversee the part-time physician time and attendance monitoring program.

Since April, three additional external teams (System-wide Ongoing Assessment and Review Strategy team, OIG Combined Assessment Program review team and the VISN 10 Oversight Team) have conducted assessments of this program and reported no deficiencies in controls or monitoring process.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	William Withrow, (816) 426-7100
Acknowledgments	Dennis Capps
	Paula Chapman
	Terrye Hall
	Henry Mendala
	Katherine Owens
	Carla Reid
	Larry Reinkemeyer

Appendix D

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Appendix D

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