Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Review of Alleged Institutional Mistreatment / Mismanagement of Geriatrics and Extended Care Patients VA Medical Center Coatesville, Pennsylvania

Report No. 06-00008-237 **September 29, 2006**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The purpose of this inspection was to determine the validity of multiple allegations pertaining to patient care issues in the Geriatrics and Extended Care Service (G&ECS) of the Coatesville, PA VA Medical Center. These allegations included alleged unanticipated deaths, patient abuse, privacy violations, and poor quality of care. In all, over 100 separate allegations were made by the complainant; we grouped them by category as follows:

Unanticipated Patient Deaths. We concluded that while patient deaths during the time period in question were not necessarily expected, the patients in question had compromised medical conditions. The deaths were not unanticipated and were not the result of poor care.

Patient Abuse. We found that instances of patient abuse had occurred in the past on the units in question. However, appropriate corrective actions had been taken to address this critical problem, and we found no current evidence of patient abuse.

Communication. There were multiple complaints alleging communication problems and patient privacy violations. Management has already taken action to improve communications; we found no evidence of patient privacy violations.

Staff Competencies. We concluded that unit staff had the appropriate competencies to treat patients admitted to, and cared for by, the G&ECS.

Environment of Care. We concluded that the G&ECS environment of care is clean and sanitary and that food and beverages served are not out of date. We concluded that there were delays for equipment repairs, but medical center managers have taken actions that have reduced these delays.

Information Technology Issues. We substantiated the allegation that the content of a signed medical record progress note can be altered by another individual, deleted, or made hidden to the end user. We concluded that this is an unacceptable electronic medical records vulnerability and patient safety issue. Upon further exploration, our concern is that the issue of inadequate compliance with the policy is system-wide in nature and not simply local.

Recommendation: We made a recommendation that the Under Secretary for Health should ensure that all Veterans Health Administration (VHA) medical facilities are in compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*. The Under Secretary concurred and submitted appropriate implementation plans. We will follow up on planned actions until they are completed.

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

TO: Director, Veterans Integrated Services Network 4 (10N4)
Director, Coatesville VA Medical Center (00)
Under Secretary for Health (10)

SUBJECT: Healthcare Inspection – Review of Alleged Institutional Mistreatment / Mismanagement of Geriatrics and Extended Care Patients, VA Medical Center, Coatesville, Pennsylvania.

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) received multiple allegations pertaining to patient care issues on the Geriatrics and Extended Care Service (G&ECS) of the Coatesville, PA, VA Medical Center (VAMC or medical center). These allegations were extensive and included alleged unanticipated deaths, patient abuse, patient privacy violations, inadequate communication with patient family members, poor quality of care, patient safety concerns, medical records documentation failures, medical records alterations, and an alleged unsatisfactory environment of care.

The purpose of this inspection was to determine the validity of these allegations.

Background

The medical center is a 533-bed specialty referral facility that provides treatment for substance abuse, post-traumatic stress disorder, chronic mental illness, homelessness, women's health, and dementia. On October 5, 2005, a complainant alleged to the VA OIG numerous deficiencies in patient care and medical center management. In all, over 100 allegations were made.

The overall themes of the allegations were those of alleged institutional mistreatment of patients and alleged deficiencies in patient care. They may be categorized as follows:

- Unanticipated Patient Deaths – The complainant alleged that there were over 40 unanticipated deaths that occurred on 2 of the medical center's G&EC Units over a 2–3 year period.

- Patient Abuse – The complainant alleged multiple instances of patient-on-patient assault and staff-on-patient assault. The complainant alleged that the medical center's Psychiatric Emergency Assistance Team was called inappropriately to force patients to take medications and that G&EC staff withheld privileges when patients refused to conform to unit policies. It was alleged that management did not intervene to stop patient abuse or support G&EC staff who attempted to report patient abuse.

- Communication Issues – There were multiple complaints alleging patient privacy violations. There were also allegations of poor communication by G&EC staff with patients and their families and between G&EC leadership and staff.

- Staff Competencies – It was alleged that some G&EC staff lacked necessary knowledge concerning patients' disease processes.

- Environment of Care Concerns – It was alleged that the G&EC unit was dirty, that there were deficiencies in infection control practices, that food and beverages served to patients were outdated, and that there were delays in equipment repair.

- Information Technology Issues – It was alleged that signed progress notes in the electronic medical record may be altered by individuals other than the note's original author. Such individuals may allegedly include cosigners. Further, it was alleged that medical center personnel with certain computer access privileges may delete from the electronic medical record a signed progress note or that they may hide it from the end user.

- Other Issues – It was alleged that G&EC employees are excessively loud during night shift. Also, it was alleged that a social worker had inappropriately committed patient funds without proper authorization.

Scope and Methodology

A review of each one of over a hundred allegations was beyond the scope of this review and exceeded the resources available to OHI. However, analysis revealed common themes. The allegations were grouped and addressed in the context of the broad categories discussed above.

The allegation regarding a social worker inappropriately committing patient funds without proper authorization was reviewed by the OIG and referred to the VAMC for administrative action. VAMC managers took appropriate action; we do not discuss this issue further.

On October 31, 2005, we conducted a telephone interview with the complainant in order to clarify the initial written allegations received by OIG. On November 3, we interviewed the complainant in person to further clarify the multiple allegations.

On December 12, at 5:30 a.m., we made an unannounced site visit to the medical center. We inspected the two long-term care units in question. We also interviewed staff and patients and reviewed medical records. Over the next 3 days, we made additional unannounced visits to the units, conducted interviews with patients, patients' family members, and staff. We interviewed medical staff responsible for maintaining the Information Security/Computerized Patient Record System (IS/CPRS). We obtained copies of the business rules regarding IS/CPRS and we conducted a test of CPRS to assist in determining whether the information technology allegations were valid.

On January 5, 2006, two healthcare inspectors interviewed the former Director for G&ECS who had been in that position during the time the majority of the complainant's alleged incidents occurred.

On January 8–11, we conducted a second site visit. We started the site visit on a Sunday, in order to optimize the availability of patient family members for interview and to inspect the units in question on a weekend day. During this second site visit, we interviewed additional staff. We also reviewed multiple documents, including personnel records, administrative investigation reports, root cause analyses reports, medical records, long-term care meeting minutes, unit and facility policies and procedures, and a December 2005 surveillance tape that showed an instance of staff-on-patient abuse.

The inspection was conducted in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Findings and Conclusions

1. Allegation: Unanticipated Patient Deaths

This allegation was not substantiated.

The complainant provided the names of 40 patients who died on the 2 long-term-units during a 3-year period, alleging that a number of the deaths seemed unanticipated by staff. The complainant related some of these deaths to a flu epidemic in 2003 and suggested that some of these deaths may have occurred due to poor care.

OHI nurses and a physician reviewed the medical records of all 40 of the named patients. We found that the average age of these patients was 80 years; most had do-not-resuscitate orders; and all had complex medical conditions. We found no indication that patients' deaths resulted from poor care, inappropriate care, or from foul play.

We confirmed that there had been a flu outbreak in 2003 and that seven patients on the two long-term-care units in question had died in this time period. We found that at the time of the outbreak, medical center clinicians took appropriate infection control actions. One of these was a patient quarantine on both units in an attempt to limit exposure.

Overall, we found that several deaths that were attributable to flu in elderly, compromised patients; other patient deaths, while not necessarily expected at precisely the time of occurrence, were not unanticipated.

Conclusions and Discussion Regarding: Unanticipated Patient Deaths

We concluded that while all patient deaths on the G&ES units during the time period in question were not necessarily expected at the time of occurrence, the patients in question had compromised medical conditions and death was not unanticipated. Several deaths did occur as a result of a flu outbreak. We concluded that the complainant was correct in identifying inpatient deaths and in relating some of these deaths to a flu epidemic in 2003. However, the larger context of the allegation—that either the flu deaths or others were due to poor care—does not have merit.

2. Allegation: Patient Abuse

The allegation of past patient abuse on long-term-care units at the medical center is substantiated. However, we did not substantiate the implication that medical center managers allowed abuse to continue unchecked or uninvestigated.

The complainant gave us a list of names of patients who had allegedly been abused and the names of medical center staff allegedly involved in this abuse. The complainant told us that medical center staff did not properly intervene when patients were abusing other patients.

The complainant alleged that due to staffing issues there was diminished staff supervision and accountability. The complainant alleged that staff yelled at, cursed, and threatened patients if they refused to take their medication(s) or be cooperative. The complainant alleged that patient privileges were withheld for minor unit rule infractions and that patients were not dressed appropriately for prevailing weather. The complainant further alleged that several patients suffered head injuries as a result of patient-on-patient assaults and alleged prejudicial actions by certain staff.

We found that in August 2002, medical center managers became aware that a culture of abuse existed on the units in question. They took actions to change this culture. An Administrative Board of Inquiry was conducted to review incidents of alleged patient abuse and the following actions were taken:

- Some staff were fired and other staff were reassigned**.**

- One staff member was arrested because of observed patient abuse.
- Increased professional staff were employed, including a social worker, psychologist, and a geropsychiatrist.
- Staff supervision lines were restructured. Existing staff on the units had to reapply for their positions.
- Both units were remodeled, and surveillance cameras were installed in order to improve the monitoring of patients and staff.
- All staff were required to attend "Culture Change" lectures that centered on the appropriate relationship between caregiver and the patient.

During our inspection, we interviewed numerous patient family members and unit staff to assess the current unit culture. Patient family members told us that they were pleased with the care their family members were receiving. Many felt that the ambience on the remodeled units was homelike and quiet. Having open visiting hours was appreciated, and many felt that communication with staff had improved. We were told that staff were now encouraging family members to attend regularly scheduled patient treatment meetings.

We interviewed both new staff and staff who were employed on the units when the documented instances of patient abuse had occurred. Generally, staff told us that the culture on the units had improved. They told us that new unit management teams were more responsive to their needs and included staff in decisions regarding patient care and unit policies. They felt the culture of the units was patient-centered and emphasized both patient and staff safety.

We did not observe any incidents of patient abuse during our multiple visits—including unannounced visits—to the units. We reviewed patient incident reports from fiscal year 2003 through February 2006 and found six reports of alleged patient abuse. Medical center managers had reviewed all six incidents; they took appropriate corrective actions in each to include suspensions, terminations, and removal from patient care.

We were shown a surveillance tape that showed a possible incident of staff-on-patient abuse. Managers had reported this incident to the local police, removed the employee from direct patient care, and conducted a Board of Inquiry.

Conclusions and Discussion Regarding: Patient Abuse

While we concluded that instances of patient abuse had occurred in the past on the units in question, appropriate corrective actions had been taken to address this critical problem. We concluded that at present, processes are in place to detect, report, and address

potential incidents of patient abuse; we found no evidence that a pattern of patient abuse is occurring presently.

3. Allegation: Communication Issues

We substantiated several of the complainant's allegations concerning poor communication.

The complainant alleged that staff violated patients' privacy rights, alleging that medical center staff discussed patient's private information (behaviors and diagnoses) in front of other patients and gave copies of patients' treatment plans to family members without proper authorization. The complainant alleged that staff wrote derogatory descriptions of patients in the medical records and did not document all medications that patients received. The complainant also alleged that patient family members were excluded from patient treatment meetings and were prevented from visiting patients.

We substantiated that some staff used inappropriate language in the patient's medical records. However, medical center mangers were aware of this issue and had taken appropriate corrective actions against the involved staff. We also found that in 2003 some family members were not invited to attend patient treatment planning meetings and at times were not allowed on the unit to visit the patients. However, the new culture on the units is to encourage family members to attend treatment planning meetings and to promote open visitation.

While we substantiated that staff gave copies of patient treatment plans to family members, we did not substantiate the implication that it was a violation of the patients' privacy rights. It is not a privacy violation to give copies of treatment plans to family members who participated in the patient treatment meeting during which the plan was developed, as was the situation in the instances that came to our attention.

Conclusions and Discussion Regarding: Communication Issues

We were unable to substantiate or refute whether staff in the past discussed patient's private information inappropriately or failed to document all medications that patients received due to the lapse in time from the alleged actions.

4. Allegation: Staff Competencies

We did not substantiate the allegation that unit staff was not competent to treat their patients.

The complainant alleged that staff lacked sufficient knowledge regarding dementia to give effective care to patients in the G&EC unit. Specifically, it was alleged that many G&EC staff were not able to recognize symptoms of co-morbid medical conditions that

should then be communicated to a registered nurse or physician; therefore, patients did not always receive the appropriate treatment.

An OHI physician who is a Board-certified geropsychiatrist and two OHI registered nurses reviewed the medical records of patients from several sources: a list provided by the complainant, cases noted in Pharmacy and Therapeutics Committee meeting minutes, and patient incident reports. We did not find any evidence of medical conditions that went undiagnosed or untreated. We also reviewed the credentialing and privileging files of unit staff and found that they had appropriate training and credentials for their assigned duties.

With regard to the general issue of staff competencies, the medical center's Chief Nurse Executive told us that over the last 3 years, the units had frequent turnovers in management. This had a negative impact on the consistency and quality of unit leadership and accountability of unit staff. The unit managers at the time of our inspection have been in place for approximately 6 months; senior managers, unit staff, and patient family members all reported their overall perceptions that patient care and staff morale have significantly improved.

Conclusions and Discussion Regarding: Staff Competences

Overall, we concluded that unit staff had the appropriate competencies to treat patients admitted to, and cared for by, the two units in question.

5. Allegation: Environment of Care

We substantiated that there were delays for equipment repairs. We did not substantiate that the two G&EC units in question were dirty. We could neither substantiate nor refute that patients were served outdated food and beverages in the past, but we did not substantiate that patients were served outdated food and beverages at present.

The complainant alleged long delays for equipment repairs. We reviewed the equipment work orders for both units for the last year. The medical center goal is to have all equipment repair orders completed within 30 days. However, we found several work orders that showed delays of 60 to 90 days. Medical center managers were aware of this problem and provided documentation to support improved timeliness for equipment repairs over the last year.

The complainant also alleged that the units were dirty. Specifically, it was alleged that furniture was not routinely and appropriately cleaned and that bathrooms were generally dirty with a foul odor.

We inspected both units multiple times on all shifts. Our inspections were both unannounced and announced, on weekdays and weekends. We also interviewed

housekeeping managers and staff and reviewed their training records. Our inspection revealed the units to be clean and sanitary. The units were generally free of foul odors. Housekeeping training records contained documentation that the cleaning staff had received required training.

With regard to the allegation that outdated food and beverages were served to patients, we interviewed dieticians and inspected refrigerators and patient trays for outdated food and beverages. We did not find any outdated food or beverages in the refrigerators or on patient trays. We also observed that dietary workers checked refrigerators on both units for expiration dates every shift.

Conclusions and Discussion Regarding: Environment of Care

We concluded that the unit environment of care is clean and sanitary, and that food and beverages served are not out of date. We concluded that there were delays for equipment repairs and that medical center managers have taken actions that have reduced these delays.

6. Allegation: Information Technology Issues

We substantiated the allegation that the content of a signed medical record progress note can be altered by another individual, such as a cosigner. We also substantiated that personnel with certain computer access privileges can delete a signed progress note or make it hidden to the end user.

The complainant alleged that a required cosigner deleted or had deleted numerous lines of a progress note after the complainant had signed it. At the other VA medical centers where the complainant had worked, the complainant reported that if a required cosigner had changes to signed reports, the cosigner affixed an addendum with the information, leaving the original report as written.

We reviewed Veterans Health Administration (VHA) and medical center information technology policies and interviewed Information Resource Management Service staff. We found that the problem described above by the complainant was indeed valid; it had also been recognized at both local and national VA levels. We learned a communication (a software patch) had been sent from the VHA Office of Information (OI) on October 20, 2004, to all VAMCs; it addressed a number of issues relating to the editing of signed documents. The patch stated that "the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed."

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. We found that the medical center had business rules that were in clear violation of VHA policy as follows:

1. An uncosigned progress note may be edited by a clinical coordinator.
2. An uncosigned progress note may be edited by a PC Team A leader.
3. An uncosigned progress note may be edited by a physician leader.
4. An uncosigned progress note may be edited by a Chief, Medical Information Service.

The patch directed medical center managers to remove business rules that allow expected cosigners to edit signed and uncosigned documents.

Due to the seriousness of this situation, in January 2006 the OIG initiated a formal inquiry to VHA. In response to this inquiry, VHA's OI completed an analysis of business rules on this topic at 122 VA medical centers in order to determine whether non-sanctioned employees (anyone other than the Privacy Officer) had the ability to edit signed medical documents. According to a memorandum to the OIG from VHA's Chief Information Officer, OI reviewed a total of 2,947 business rules for the 122 facilities. OI found that 37 percent of the 122 VAMCs had not deleted the business rules described above as directed by the patch. OI additionally told OIG, "…[E]vidence exists that facilities have created local business rules that permit personnel other than the Privacy Act Officer to edit a document in a signed state."[1] OI recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the facility's Privacy Officer.

Conclusions and Discussion Regarding: Information Technology Issues

We substantiated the allegation that the content of a signed medical record progress note could be altered by another individual, such as a cosigner, and concluded that this is system vulnerability ripe for exploitation or malfeasance. We also substantiated that personnel at the medical center with certain computer access privileges could delete a signed progress note or make it hidden to the end user. We concluded that this is an unacceptable electronic medical records vulnerability and patient safety issue.

The relevant policy that addresses the issues surrounding basic procedures for managing the patient health record is contained in VHA Handbook 1907.1, *Health Information Management and Health Records*. Upon further exploration, our concern from the findings at the Coatesville VAMC is that the issue of inadequate compliance with the policy is system-wide in nature and not simply local.

[1] Department of Veterans Affairs Memorandum dated April 3, 2006, from the VHA Chief Information Officer to the Director, Management Review Service, through the VHA Chief of Staff, sent to OIG by fax April 4, 2006.

Recommendation

The Under Secretary for Health should ensure that all VHA medical facilities are in compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*.

Under Secretary for Health Comments

The Under Secretary for Health concurred with all findings. With regard to the recommendation for managing patient health records, VHA concurred, with consideration of the following actions having been taken:

1. Coatesville VAMC's Business Rules #2 & #3 (see page 9) were removed at the time of the investigation.
2. Coatesville VAMC's Business Rules #1 & #4 (see page 9) have been removed and were replaced by: "An UNCOSIGNED PROGRESS NOTE may only be edited by the PRIVACY ACT OFFICER, or Designee. The Privacy Act Officer approves the designation of the Clinical Applications Coordinators to the User Class of Privacy Act Officer for the sole purpose of changing the cosigner of an uncosigned note."
3. If a note needs to be altered this does not occur without the approval of the Privacy Officer per VHA Handbook 1907.1 (reference page 27, (3) "No edit or alteration of any documentation after manual or electronic signature has been completed can occur without approval of HIM professional or Privacy Officer").

Office of Inspector General Comments

The Under Secretary for Health agreed with the findings and recommendation and provided acceptable implementation plans. (See Appendixes A and B, pages 11–19 for the complete text.) We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR, M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: AUG 7 2006

From: Under Secretary for Health (10)

Subj: OIG Draft Report: **Healthcare Inspection: Review of Alleged Institutional Mistreatment/Mismanagement of Mental Health Patients, Department of Veterans' Affairs Medical Center, Coatesville, PA** (Report No. 2006-00008-HI-0182) EDMS 356501

To: Assistant Inspector General for Healthcare Inspections (54)

1. I concur with the recommendation made in this report that I ensure that all VHA medical facilities are in compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, reflecting your finding at Coatesville of an electronic medical records vulnerability that permits non-sanctioned employees to potentially edit signed medical documents. At my direction, VHA's Office of Information (OI) conducted its own systemwide review, and further confirmed the weakness, which resulted from business rules that were released in July 1997 as part of the Veterans Health Information Systems and Technology Architecture (VistA) software. As you report, this situation is in violation of requirements contained in VHA Handbook 1907.1. Once alerted, VHA took immediate steps to rectify the problem.

2. Attached is a June 7, 2006 memorandum from the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to the VISN Directors requiring that all medical facilities remove the unacceptable business rules from their VistA systems within seven business days of the date of the memorandum. In order to verify facility compliance with this requirement, OI instituted quarterly extracts of business rules supporting the software packages in question. The initial July 20, 2006 extract showed improvement, with only 16 facilities still remaining out of compliance. On July 25, 2006, OI provided the DUSHOM a summary of extract results, including a list of the non-compliant facilities and reasons for their non-compliance. In addition, OI summarized the status of planned software changes to VistA that will also address identified concerns. I am attaching a copy of the July 26, 2006, OI memorandum for your review. Follow-up communication was immediately made with the non-compliant facilities and the network offices currently report that all have subsequently removed the business rules. To verify full systemwide compliance, OI will apply another software extract within the next two weeks, and quarterly thereafter, to target potential lapses by any facility.

3. Your findings have identified an important corrective opportunity that VHA is actively addressing. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

Jonathan B. Perlin, MD, PhD, MSHA, FACP

Appendix B

Department of Veterans Affairs

Memorandum

Date: JUN 07 2006

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Editing of Signed Medical Documents by Non-Sanctioned VAMC Employees

To: VHA VISN Directors (10N1-10N23)

1. In response to a December 2005 inquiry from the Office of Inspector General (OIG), the Veterans Health Administration (VHA) Office of Information (OI) conducted an investigation and found that some Department of Veterans Affairs (VA) Medical Centers (VAMCs) were granting non-sanctioned employees the ability to edit signed medical documents. This capability was made possible by business rules that had been released in July 1997 as part of Veterans Health Information Systems and Technology Architecture (VistA) software, Authorization and Subscription Utility (ASU) v1.0 and Text Integration Utility (TIU) v1.0.

2. VAMCs that have business rules in place that allow the editing of signed documents are in direct violation of VHA Handbook 1907.1, Health Information Management (HIM) and Health Records. This is an area of concern to the OIG and to this office. Specifically, paragraph 7f (3) states, "No edit or alteration of any documentation after manual or electronic signature has been completed can occur without approval of the HIM professional or Privacy Officer." The handbook further describes the processes to be followed to request edit or alteration of a document and the roles within the VAMC responsible for carrying out the action.

3. Software functionality must provide an audit trail and/or a method of retaining both the edited and original of a signed document before editing by anyone other than the Privacy Officer or designee can be allowed. Current VistA software does not provide an audit record for an edited electronic note after initial signature. On October 20, 2004, OI issued informational patch USR*1*26, requiring all VAMC facilities to manually delete certain business rules, which were originally exported with the software. The business rules that *must be deleted* include:

An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by An EXPECTED COSIGNER
An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by A CLINICAL SERVICE CHIEF
An UNCOSIGNED (CLASS) PROGRESS NOTE may be EDITED by An EXPECTED COSIGNER
An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be EDITED by A PROVIDER who is also An EXPECTED COSIGNER

An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be EDITED by A CLINICAL SERVICE CHIEF

4. Upon request of the OIG, an OI extraction of document business rules with an action of 'EDITED' and status of 'UNCOSIGNED', 'COMPLETED', 'AMENDED', or 'RETRACTED' from all VAMC VistA databases found 44 facilities (see attached listing), or approximately 35%, had not completed the instructions provided with the VistA patch USR*1*126 to manually remove the originally exported business rules.

5. OI has recommended stricter software controls within the USR application, such that business rules with the action of 'EDITED' and status of 'UNCOSIGNED', 'COMPLETED', 'AMENDED', or 'RETRACTED' be explicitly restricted to the user class of 'PRIVACY ACT OFFICER'. In addition, OI is researching how to alter current software to allow editing by expected co-signers while maintaining the original document and providing mechanisms to change expected cosigner, date/time of note, and clinic location without edit access to the text body of a clinical document.

6. All VAMCs are required to take immediate action to remove the unacceptable business rules from their VistA systems. Removal of rules should be completed within seven business days of the date of this memorandum. OI will extract document business rules from all VAMC VistA databases on July 1, 2006 and quarterly thereafter. Results will be shared with VISN Directors and other appropriate officials.

7. If you or members of your staff have questions please contact Linda Nugent, Director of the VHA HIM program, at 765-629-2330.

William J. Feeley

William F. Feeley, MSW, FACHE

cc: VHA VISN Administrative Representatives (10N1-10N23)

Attachment

Appendix C

Department of Veterans Affairs

Memorandum

Date: JUL 26 2006

From: VHA Chief Information Officer (19)

Subj: Update on Quarterly Data Extract and Software Changes to Prevent Non-Sanctioned S from Editing Signed Medical Documents

To: Deputy Under Secretary for Health for Operations and Management (10N)
Director, Management Review Service (10B5)

1. The Veterans Health Administration (VHA) Deputy Under Secretary for Health for Operations and Management tasked the Office of Information (OI) to institute quarterly extracts from the Veterans Health Information Systems and Technology Architecture (VistA) database and make software changes to ensure Department of Veterans Affairs (VA) Medical Centers (VAMCs) compliance with VHA Handbook 1907.1, Health Information Management (HIM) and Health Records. Some VAMCs had granted non-sanctioned employees the ability to edit signed medical documents. This memorandum outlines the results of the first quarterly extract and provides an update on the planned software changes to VistA.

2. OI scheduled the first quarterly extract of business rules supporting the Authorization and Subscription Utility (ASU) v1.0 and Text Integration Utility (TIU) v1.0 software packages from all VistA databases on July 1, 2006. The first quarterly extract, however, was delayed until July 20, 2006 due to configuration issues with the Veterans Integrated Service Network (VISN) 20 database. The extraction included those business rules with an action of 'EDITED' and status of 'UNCOSIGNED', 'COMPLETED', 'AMENDED', or 'RETRACTED. The first quarterly extract was refined to provide conclusive data for discharge summaries.

3. The July 20, 2006 extract showed improvement, with only 16 VistA databases still remaining out of compliance. It should be noted that the initial memorandum to the field cited 44 databases out of compliance, but the initial extract had actually identified 51 non-compliant databases that would have been listed had the extract been able to better identify discharge summary rules. Attached is a listing of the original 44 VistA databases, the additional seven databases that should have been identified, and the 16 databases still out of compliance, as well as the reasons for their non-compliance.

4. The software modifications approved in July 2006 permit editing by expected co-signers, maintain the original document, and provide mechanisms to change expected cosigner, date/time of note, and clinic location without edit access to the text body of a clinical document. Installing these modifications will be addressed in two phases:

Phase 1 - Modify the current functionality to allow editing of assigned expected co-signer by a clinical application coordinator or designee while restricting access to the original note text. The work for this effort is scheduled to begin August 1, 2006.

Phase 2 - Modify current functionality to provide expected co-signers a means to invoke a copy function of the current signed note, storing the note as originally written while creating an audit trail of the person that edited the note and the date the editing was done. Once completed, the expected co-signer will be allowed to edit the text of the signed note using appropriate document business rules. This work is planned to start in January 2007 and will be delivered in connection with CPRS v28.

5. The next extraction will take place on or immediately before October 1, 2006. If you need additional information about this process or these results, please contact Linda B. Nugent, Director, VHA Health Information Management, at 765-629-2330 or Jeanie Scott, OI Patient Safety Officer, at 518-449-0692.

Craig B. Luigart

cc: VHA VISN Administrative Representatives (10N1-10N23)

Attachments

7/7/06 Memorandum – Original Listing of 44 VAMC Facilities with non-compliant Clinical Documents and Progress Notes Business Rules

VAMC STATION#	Facility Name
358	Manila
460	Wilmington
463	Anchorage
503	Altoona
509	Augusta
515	Battle Creek
516	Bay Pines
519	West Texas HCS
521	Birmingham
526	Bronx
529	Butler
531	Boise
534	Charleston
538	Chillicothe
540	Clarksburg
544	Columbia, SC
550	Illianna HCS Danville
561	East Orange
583	Indianapolis
586	Jackson, MS
596	Lexington
598	Little Rock
608	Manchester
610	Northern Illinios HCS
614	Memphis
619	Montgomery
626	Nashville
635	Oklahoma City
636	Omaha
640	Palo Alto
642	Philadelphia
646	Pittsburgh
648	Portland
654	Reno
655	Saginaw
660	SLC
662	San Fran
671	Kerrville
672	San Juan
674	Temple
676	Tomah
687	Walla Walla
689	West Haven
695	Milwaukee

7/7/06 Memorandum – Original Listing of 44 VAMC Facilities with non-compliant Clinical Documents and Progress Notes Business Rules, additionally 7 facilities (**) with Discharge Summary Business Rules

VAMC STATION#	Facility Name
358	Manila
436	VA Montana HCS **
460	Wilmington
463	Anchorage
503	Altoona
504	Amarillo VAMC **
509	Augusta
515	Battle Creek
516	Bay Pines
518	Bedford VAMC **
521	Birmingham
526	Bronx
529	Butler
531	Boise
534	Charleston
538	Chillicothe
540	Clarksburg
544	Columbia, SC
550	Illianna HCS Danville
561	East Orange
583	Indianapolis
586	Jackson, MS
596	Lexington
598	Little Rock
605	Loma Linda VAMC **
608	Manchester
610	Northern Illinois HCS
614	Memphis
619	Montgomery
623	Muskogee VAMC **
626	Nashville
635	Oklahoma City
636	Omaha
640	Palo Alto
642	Philadelphia
646	Pittsburgh
648	Portland
649	Prescott VAMC **
654	Reno
655	Saginaw
660	SLC
662	San Fran
671	Kerrville
672	San Juan
674	Temple
676	Tomah
687	Walla Walla
689	West Haven
693	Wilkes Barre VAMC **
695	Milwaukee

Results of first quarterly extract – 16 Facilities remain non-compliant with USR*1*26 instructions to delete business rules exported with VistA Text Integration Utility v1.0 software.

STATION_NO	Station Name	Rules Remaining:	Clinical Document	Progress Note	Discharge Summary
358	Manila OPC		X		
436	VA Montana HCS				X
463	Anchorage VAMC		X	X	
504	Amarillo VAMC				X
518	Bedford VAMC				X
531	Boise VAMC		X	X	
583	Indianapolis VAMC		X		
605	Loma Linda VAMC				X
614	Memphis VAMC				X
623	Muskogee VAMC				X
642	Philadelphia VAMC				X
648	Portland VAMC			X	X
649	Prescott VAMC				X
674	Central Texas HCS		X		
689	Connecticut HCS		X	X	X
693	Wilkes Barre VAMC				X

Appendix D

OIG Contact and Staff Acknowledgments

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Acknowledgments	Nelson Miranda, Director Randall Snow, Associate Director Donna Giroux Carol Torczon

Appendix E

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