Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Carl Vinson VA Medical Center Dublin, Georgia

Report No. 07-00795-99 **March 14, 2007**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of February 12, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Carl Vinson VA Medical Center (the medical center), Dublin, Georgia. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 128 employees. In addition, we followed up on selected recommendations from the previous CAP review of the medical center. The medical center is part of Veterans Integrated Service Network (VISN) 7.

Results of Review

The CAP review covered six operational activities. The medical center was in compliance with selected standards at the Macon Community Based Outpatient Clinic (CBOC).

We identified conditions in five areas that needed management attention and made the following recommendations:

- Improve QM oversight, reporting, and timeliness.
- Develop a comprehensive patient satisfaction program.
- Assure staff comply with policies regarding defibrillator testing and contact isolation.
- Review and update medical center policies before they expire.
- Assure that business rules governing electronic medical records (EMRs) comply with Veterans Health Administration (VHA) policy.

Comments

The Acting VISN and Acting Medical Center Directors concurred with the CAP review findings and recommendations. They discussed findings and corrective actions with medical center managers and all VISN 7 sites on a conference call held February 15, 2007, and provided us with acceptable improvement plans. The Acting VISN Director will monitor compliance. (See pages 11–16 for the full text of the Directors' comments.) We will follow up on planned improvement actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The medical center provides primary and secondary care and is designated as a Veterans Rural Access Hospital. Outpatient care is also provided at two CBOCs located in Macon and Albany, Georgia. Additionally, the medical center operates a weekly clinic at the Georgia War Veterans Home in Milledgeville, Georgia. The medical center is part of VISN 7 and serves a veteran population of about 128,250 in a primary service area that includes 52 counties in Georgia.

Programs. The medical center provides medical, surgical, mental health, and rehabilitative services. The medical center has 34 hospital beds, 161 nursing home beds, and 145 domiciliary beds.

Affiliations and Research. The medical center has 21 active affiliations with medical schools and universities and 3 affiliations with technical colleges. Approximately 190 students receive medical and allied health training at the medical center each year. Although the medical center has affiliations for students, it does not offer a formal resident physicians' training program.

Resources. In fiscal year (FY) 2006, medical care expenditures totaled $76.7 million. The FY 2007 medical care budget is $82.7 million. FY 2006 staffing totaled 740 full-time equivalent employees (FTE), including 36.4 physician and 125.8 nursing FTE.

Workload. In FY 2006, the medical center treated 26,711 unique patients. The medical center provided 10,546 inpatient days of care in the hospital, 52,318 inpatient days of care in the Nursing Home Care Unit (NHCU), and 42,578 days of care in the domiciliary. The inpatient care workload totaled 1,485 discharges, with an additional 259 NHCU discharges and 537 domiciliary discharges. The average daily census was 28.9 for the hospital, 143.3 for the NHCU, and 116.7 for the domiciliary. The outpatient workload was 143,023 visits.

Services for Military Personnel Returning from Iraq and Afghanistan. The medical center offers a comprehensive program of services to military personnel returning from duty in Iraq and Afghanistan that includes case management for outpatient and inpatient care. A designated medical center employee coordinates referrals from military treatment facilities for active duty personnel and acts as an advocate and liaison for returning combat veterans entering the VA system. The medical center offers diagnostic, treatment, and rehabilitation services for combat-related illnesses and injuries. The State of Georgia has had approximately 3,998 active duty military personnel deployed to Iraq or Afghanistan. Through its outreach efforts, the medical center has enrolled 2,155 returning veterans, including 1,740 male veterans and 415 female veterans, for VA care.

Objectives and Scope of the Combined Assessment Program Review

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 facilities focusing on patient care and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of QM and patient care administration. QM is the process of monitoring the quality of care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. In addition, we conducted follow-up on selected aspects of our previous CAP review (*Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia,* Report No. 04-03028-49, December 13, 2004).

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered selected aspects of the following six programs and activities:

CBOC	Medical Center Memoranda
EMR Business Rules	Patient Satisfaction
Environment of Care (EOC)	QM

The review covered medical center operations for FYs 2005, 2006, and 2007 through February 15, 2007, and was completed in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Opportunities for Improvement

Quality Management – Oversight, Reporting, and Timeliness Needed Improvement

The purposes of this review were to determine if (a) the medical center had a comprehensive, effective QM Program designed to monitor patient care activities and coordinate improvement efforts and (b) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations.

Conditions Needing Improvement. During our review, we found that some QM oversight and reporting functions were not completed consistently, accurately, or timely, as follows:

Committee and QM Program Oversight and Reporting. Documentation of committee oversight activities did not reflect quality oversight in important patient care and performance-related areas. The Medical Executive Committee (MEC), the Quality Leadership Team (QLT), and the Executive Leadership Team (ELT) provide oversight and monitoring of clinical, administrative, and performance improvement (PI) activities.

- *MEC:* From January 2006 through January 2007, the MEC met six times rather than monthly and did not review mandatory reports on a quarterly basis, as required. During this period, the MEC reviewed medical record and infection control reports twice and pharmacy and therapeutic minutes and blood usage review reports once. Additionally, the meeting minutes did not reflect review of operative and other invasive procedures or peer review results. Since the MEC did not meet as often as required to address areas under its purview and did not review all mandatory reports when meetings were convened, managers could not be assured that clinical activities were properly coordinated and actions or recommendations by subordinate committees were reviewed. This condition was also noted in our 2004 report.

- *QLT:* From January through December 2006, the QLT did not review utilization review or cardiopulmonary resuscitation performance reports, as required. The QLT reviewed utilization review data for the 1st, 3rd, and 4th quarters of FY 2006, but the minutes did not reflect analysis, conclusions, or actions to be taken based on the reports. This condition was also noted in our 2004 report.

- *ELT:* The ELT minutes did not reflect review of PI activities or the MEC and QLT minutes, as required by policy.

- *QM:* Overall, the QM Program did not provide the necessary comparisons, data analysis, or reporting to oversight committees for review and action. We found that the reports for cardiopulmonary resuscitation, utilization review, blood usage, operative and other procedures, and restraint usage did not always include clear data presentation, analysis, comparisons, or recommendations. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires data analysis to identify patterns and trends and determine variability or unacceptable levels of performance. Medical center policy requires reporting of data to responsible medical center oversight committees for review, analysis, and action, as appropriate. Without appropriate data management and follow-up activities, managers could not be assured that patient care and patient safety processes were functioning effectively or that PI activities were initiated, when indicated.

  QM Program managers have initiated a process to enhance committee minutes and reports to ensure they reflect data analysis, opportunities for improvement, and recommendations for consideration by the responsible oversight committees.

Timeliness of Root Cause Analyses. None of the 15 root cause analyses (RCAs) (9 individual and 6 aggregate) completed during FY 2006 and the 1st quarter FY 2007 met the 45-day requirement for completion. Several of the RCAs were completed 5 months after their due dates. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, specifies evaluation and reporting requirements for potential and actual adverse events. Corrective actions should be promptly implemented to prevent future occurrences of similar events.

The VISN and the National Center for Patient Safety had oversight responsibility but had not addressed the RCA delays. Without timely completion of RCAs, managers could not be assured that corrective actions were promptly initiated.

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*. Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care, with subsequent Peer Review Committee (PRC) evaluation and concurrence with the findings. Once the need for peer review is determined, VHA requires initial reviews to be completed within 45 days and PRC discussions to occur within 120 days. We reviewed the one peer review conducted in FY 2006 (initiated in March 2006) and did not find any evidence that the PRC met and discussed the findings.

Peer reviews should be conducted in accordance with policy to ensure that corrective actions to improve patient care are promptly initiated and that providers perform according to accepted community standards.

Recommended Improvement Action 1. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that:

a. Oversight committees review and analyze data to identify opportunities for improvement.
b. QM Program managers develop an effective mechanism to analyze and report performance data to oversight committees.
c. RCAs are completed on all appropriate cases within 45 days.
d. Peer reviews are completed and discussed at the PRC within 120 days.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that: (1) staff will be trained on data analysis, and a matrix will be developed to ensure regular reporting at committee meetings; (2) staff will receive refresher training on RCA requirements and the QLT will monitor RCAs to ensure completion within the established timeframes; and (3) PRC members will receive refresher training on completing peer reviews within 120 days. We will follow up on the planned actions until they are completed.

Patient Satisfaction – Program Improvements Are Needed

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. Patients answer multiple questions for each service area, and those answers comprise the total score for that area. VHA relies on the analyses and interpretations of the survey data for making administrative and clinical decisions for improving the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients treated and 76 percent of inpatients discharged during a specified date range will report their experiences as Very Good or Excellent. Medical centers are expected to address areas in which they are underperforming. The following graphs show the medical center's performance in relation to national and VISN performance.

Carl Vinson VA Medical Center Outpatient SHEP Results
Q4 FY 2006

Facility Name	Facility No.	Bed section	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	**National**	**All Bed Sections**	**81.35**	**78.9**	**89.9**	**67.92**	**65.97**	**75.95**	**83.43**	**74.66**	**70.11**	******
VISN 7	Overall	ALL	82	79.4	89.1	70.4	67.6	76	82.3	74.6	70.4	**
VAMC	557	ALL	83.1	84.3	87.6	69	65.5	74.7	82.3	72.9	64.1	**

Legend: ** Less than 30 respondents

Carl Vinson VA Medical Center Inpatient SHEP Results
Q3 & Q4 FY 2006

Facility Name	Facility Number	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	**National**	**81.1**	**77.9**	**94.7**	**72.8**	**83.1**	**75.6**	**81.9**	**65.9**	**81.4**	**80.7**	**84.4**
VISN 7	Overall	76.8	76.6	92.3	71.1	81.9	74.5	78.1	68	79.3	81	84.3
VAMC OPC Clinic – Overall	557	73.8	64.9	84.3	63.6	74.5	68	76.9	63.8	75	87	74.2
- VAMC OPC	557	70.8	72.1	82.2	64	74.4	67.5	**	64.5	75.2	88	72.6
- Macon CBOC	557GA	79.2	44.8	90.8	58.5	72.8	67.3	82.2	**	69.7	81.3	73.1
- Albany CBOC	557GB	87.5	43.4	91.2	68.5	77.2	73.3	69.6	**	81.1	**	87

Legend: ** Less than 30 respondents

Conditions Needing Improvement. The medical center's SHEP Coordinator completed comparative analyses of SHEP scores from FYs 2004, 2005, and 2006 and communicated this information to appropriate managers and staff in various forums. The report shows that many of the medical center's SHEP scores met or exceeded VISN or national averages in FY 2006. However, we found that some deficient SHEP scores dated back to FY 2004, yet corrective actions were not initiated until recently. We were told that the previous SHEP Coordinator was unable to perform his SHEP duties while functioning as a patient advocate, since he considered SHEP a lower priority. The medical center's current SHEP Coordinator was assigned in February 2006 and has taken action to improve communication, education, documentation, and outcome monitoring related to SHEP. However, we found the program is still in the developmental stages, as follows:

- Aggregated information was not broken down in a manner that would allow service chiefs to focus attention on service-specific issues or problems.
- Service chiefs were not required to submit action plans to improve scores in their areas.
- In some instances, actions were taken but were not documented.
- Many actions were implemented so recently (November and December 2006) that outcomes were not yet available.

Recommended Improvement Action 2. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director develops a comprehensive SHEP Program that includes specific action planning and follow-up of improvement actions and their effectiveness.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendation and reported that service line managers will receive service-specific SHEP information and will submit action plans to the Quadrad[1] on an ongoing basis. SHEP results will also be discussed at the Communication and Customer Service Council and QLT meetings. We will follow up on the planned actions until they are completed.

Environment of Care – The Medical Center Was Clean and Well Maintained, but Some Improvements Were Needed

VHA requires that healthcare facilities have a comprehensive EOC Program that complies with VHA policy, Occupational Safety and Health Administration regulations, and JCAHO standards. We inspected 12 clinical areas for cleanliness, safety, infection control, and general maintenance. We also followed up on EOC concerns cited during the medical center's EOC rounds and found that those issues were resolved. Our inspection revealed that the medical center maintained a clean and safe environment, secured medications, and regularly monitored infection rates. However, we identified two conditions requiring management attention.

Conditions Needing Improvement. A nurse documented that she had checked the defibrillator on a long term care unit on February 6, 2007; however, the paper test strip still in the defibrillator showed testing on February 5 and February 7. Defibrillators are life-saving equipment that must be maintained in operational order at all times. Untested defibrillators could be malfunctioning, which could result in negative patient outcomes.

In addition, we found that medical center staff did not always document isolation precautions taken for patients with Methicillin Resistant Staphylococcus Aureus (MRSA). The medical center policy requires patients with MRSA to be placed on contact isolation in private rooms or in rooms with other MRSA positive patients. We reviewed the medical records of 19 patients with MRSA who were admitted during the 3rd and 4th quarters of FY 2006 and the 1st quarter of FY 2007. We found that only five medical records contained documentation that patients were placed on appropriate precautions. The Infection Control Coordinator (ICC) told us that physicians do not always order isolation, and nurses do not always document room changes and other precautions; however, we were assured that MRSA positive patients were properly managed. The medical center's low infection rate supported the ICC's statement.

Recommended Improvement Action 3. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that:

a. Defibrillators are tested according to policy and that results are appropriately documented and monitored.

[1] The Director, Associate Director, Associate Director for Patient/Nursing Services, and the Chief of Staff, the four senior managers at the medical center.

b. Appropriate action is taken regarding the nurse who improperly documented the defibrillator testing.

c. Staff document isolation precautions for the appropriate management of MRSA and other drug-resistant organisms.

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendations and reported that defibrillator testing requirements will be reviewed with appropriate staff. In addition, action has been taken regarding the nurse who improperly documented the testing on February 6. As a reminder, managers forwarded the MRSA policy to appropriate staff, and QM will monitor compliance and report to the MEC. We will follow up on the planned actions until they are completed.

Medical Center Memoranda – Many Policies Were Expired

Condition Needing Improvement. In December 2006, the medical center had 36 policies related to patient care and medical staff functions that had expired; some of them had expired in July 2004. Since December however, 13 policies were reissued; at the time of our site visit, there were 23 expired policies. Medical center policies provide clinicians and clinical support staff with current guidance on areas, such as standards of care, facility programs and services, and professional and committee expectations. Availability of current policies increases the likelihood that staff members will provide consistent care and services.

Recommended Improvement Action 4. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires that all policies be reviewed and updated prior to expiration, as needed.

The Acting VISN and Acting Medical Center Directors agreed with the finding and recommendation and reported that the expired policies are in draft and are being circulated for concurrence. In addition, timely reissue of policies will be accomplished through an automated notification process, and responsible staff will be held accountable. We will follow up on the planned actions until they are completed.

Electronic Medical Record Business Rules – Business Rules Should Comply with VHA Policy

Business rules define which groups or individuals are allowed to edit or delete documentation in electronic medical records. On October 20, 2004, the VHA Office of Information (OI) sent software informational patch USR *1*26 to all medical centers with instructions to assure that business rules complied with VHA regulations. The guidance cautioned that, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." In January 2006, the OIG identified a facility in the Northeast where progress notes could be improperly altered and recommended that VHA address the issue on a national basis. On

June 7, 2006, VHA issued a memorandum to VISN directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

Condition Needing Improvement. During our review, we found that the medical center had several business rules that allowed editing or amending of progress notes by users other than the author or allowed retraction or deletion of notes by staff other than the Privacy Officer or designee. These business rules required modification or removal. Medical center staff took action to edit and remove these business rules while we were onsite.

Recommended Improvement Action 5. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director requires continued compliance with VHA Handbook 1907.1, *Health Information Management and Health Records,* and the October 2004 OI guidance.

The Acting VISN and Acting Medical Center Directors agreed with the finding and recommendation and reported that the Clinical Applications Coordinator will meet with Health Information Management Service staff to coordinate future changes to the business rules to ensure compliance with VHA policy. We will follow up on the planned actions until they are completed.

Other Area Reviewed

Community Based Outpatient Clinic – Macon Clinic Operations Met Selected Standards

The purpose of this review was to assess CBOC operations and delivery of health care services. CBOCs were designed to improve veterans' access to care by offering primary care in local communities, while delivering the same standard of care as the parent facility. The Macon CBOC, located about 60 miles from the medical center, was staffed by a combination of VA and contract employees and served 6,149 veterans in FY 2006.

We reviewed Macon CBOC policies, performance documents, and provider credentialing and privileging (C&P) files. We conducted an EOC inspection to assess compliance with environmental standards. To determine if patients received the same standard of care, we compared the management of patients receiving warfarin[2] at the parent facility with those receiving warfarin at the Macon CBOC. We also interviewed 10 patients about their perceptions of care.

We found that Macon CBOC providers' C&P files contained appropriate background screening and professional practice documentation. Clinical staff were certified in basic life support and educated in and knowledgeable about rendering emergency care. The

[2] Medication used to prevent blood clots.

CBOC's emergency management plan was current, and the facility was clean and well maintained. Macon CBOC met JCAHO, Health Insurance Portability and Accountability Act, and Life Safety requirements.

Patients on warfarin received the same standard of care at the Macon CBOC as patients at the parent facility. A pharmacist managed the warfarin clinic at the parent facility, and a registered nurse, with a pharmacist's oversight, managed patients on warfarin at the Macon CBOC. Patient education regarding warfarin use and side effects was conducted by providers at both the parent facility and the CBOC. Patients at both sites were given the same toll-free telephone number to call if they had problems or concerns related to their medication. The patients we interviewed reported being satisfied with their care.

Appendix A

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 16, 2007

From: Acting Director, VA Southeast Network (10N7)

Subject: **Draft Report** – Combined Assessment Program Review, Carl Vinson VA Medical Center, Dublin, Georgia – Project Number 2007-00795-HI-0269

To: Assistant Inspector General, Office of Healthcare Inspections (54)

Thru: Director, Management Review Service (10B5)

I agree with comments submitted by the Acting Medical Center Director and the corrective actions outlined in her response.

If you have any questions, please contact my office at (678) 924-5718.

(original signed by:)

Thomas A. Cappello, MPH, FACHE

Appendix B

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 15, 2007

From: Acting Director, Carl Vinson VA Medical Center (557/00)

Subject: **Draft Report** – Combined Assessment Program Review, Carl Vinson VA Medical Center, Dublin, Georgia – Project Number 2007-00795-HI-0269

To: Acting Director, VA Southeast Network (10N7)

Attached are our corrective actions to findings from the OIG Site Visit held February 12-15, 2007.

The employees of the Carl Vinson VA Medical Center provide outstanding care and services to our veterans each and every day. The review indicated several areas that require additional attention, and we look forward to implementing our corrective actions.

I am proud of the employees who contribute to our success each day in Dublin, Georgia. Our veterans deserve the best.

(original signed by:)
Kelly O. Duke

Acting Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires that:

a. Oversight committees review and analyze data to identify opportunities for improvement.
b. QM Program managers develop an effective mechanism to analyze and report performance data to oversight committees.
c. RCAs are completed on all appropriate cases within 45 days.
d. Peer reviews are completed and discussed at the PRC within 120 days.

Concur **Target Completion Date:** 2/28/2007

a. & b. A matrix will be developed to provide a schedule to review and analyze data regarding opportunities for improvement. The matrix will be used to establish agenda for all meetings. Responsible management officials will receive refresher training emphasizing the need to review performance improvement data and other pertinent information for oversight committee meetings.

c. A timeline for completing RCAs will be developed and discussed with all employees trained to conduct RCAs. Future charters will contain timelines with completion dates of 30 days. The Quality Leadership Team (QLT) will monitor timeliness of RCAs.

d. Refresher training will be conducted for Peer Review Committee members to ensure timely review of completed peer reviews. Responsible management officials will be held accountable for the 120 day timeline.

The Acting Network Director discussed findings and corrective actions with VAMC Dublin and all VISN 7 sites on a conference call held February 15, 2007. Acting Network Director will monitor compliance.

Recommended Improvement Action 2. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director develops a comprehensive SHEP program that includes specific action planning and follow-up of improvement actions and their effectiveness.

Concur **Target Completion Date:** 2/28/2007

Service Line Managers will receive specific information from SHEP surveys in order to identify problem areas in their departments.

Actions Plans identifying corrective action will be forwarded to Quadrad for review by February 28, 2007.

Service line specific information and action plans will continue with future SHEP surveys.

SHEP survey results will be discussed at Communication & Customer Service Council (CCSC) and Quality Leadership Team (QLT).

Recommended Improvement Action 3. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires that:

a. Defibrillators are tested according to policy and that results are appropriately documented and monitored.

b. Appropriate action is taken regarding the nurse who improperly documented the defibrillator testing.

c. Staff document isolation precautions for the appropriate management of MRSA and other drug resistant organisms.

Concur **Target Completion Date:** 2/15/2007

a. Information was forwarded to all nurse managers for review by staff with signature verification to ensure appropriate staff training.

b. Appropriate action taken regarding nurse who improperly documented the defibrillation testing.

c. Medical Center Memorandum 00-138, Methicillin Resistant Staphyplococcus Aureus (MRSA), was forwarded to all appropriate staff to be reviewed with signature verification. Quality Management staff will monitor compliance and report to Medical Executive Committee (MEC).

Acting Network Director discussed findings and corrective actions with VAMC Dublin and all VISN 7 sites on a conference call held February 15, 2007. Acting Network Director will monitor compliance.

Recommended Improvement Action 4. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires that all policies be reviewed and updated prior to expiration, as needed.

Concur **Target Completion Date:** 2/16/2007

The Medical Center Memoranda (MCMs) identified during the OIG visit are now in draft format being cirdulated for hospital-wide concurrence.

The overall issue of timely completion of MCMs will be corrected by automating the notification process for MCMs expiring. Responsible management officials will be notified via Task Manager in Outlook 60 days prior to the MCM expiration date.

Appropriate action will be taken with responsible management officials if MCMs are not completed timely.

Acting Network Director discussed findings and corrective actions with VAMC Dublin and all VISN 7 sites on a conference call held February 15, 2007. Acting Network Director will monitor compliance.

Recommended Improvement Action 5. We recommend that the Acting VISN Director ensure that the Acting Medical Center Director requires continued compliance with VHA Handbook 1907.1, *Health Information Management and Health Records,* and the October 2004 OI guidance.

Concur **Target Completion Date:** 2/14/2007

Medical Center staff took immediate action to correct findings during OIG visit.

Clinical Applications Coordinator will meet with Health Information Management Services (HIMS) to coordinate future changes (additions or deletions) for Business Rules to ensure compliance with VHA Handbook 1907.1, Health Information Management and Health Records, and the October 2004 OI guidance.

Acting Network Director discussed findings and corrective actions with VAMC Dublin and all VISN 7 sites on a conference call held February 15, 2007. Acting Network Director will monitor compliance.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5962
Acknowledgments	Toni Woodard, Healthcare Inspections Team Leader Bertha Clarke Darlene Perkins Sue Zarter

Appendix D

Report Distribution

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