Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Cardiology Quality of Care Issues
Bay Pines VA Healthcare System
Bay Pines, Florida

Report No. 09-01699-184 **August 3, 2009**

VA Office of Inspector General
Washington, DC 20420

Executive Summary

The purpose of this review was to determine the validity of allegations regarding cardiology quality of care issues at the VA Medical Center in Bay Pines, Florida.

We did not substantiate the allegations that three registered nurses (RNs) in the pacemaker and heart failure clinics were instructed to perform pacemaker device checks and programming without having proper training. The RN hired for the pacemaker clinic had received training to do basic pacemaker checks, and a competence assessment and validation was completed by medical center Cardiology Section staff prior to the RN performing any independent pacemaker checks. Two RNs in the heart failure clinic were being cross-trained to assist with patient screening and evaluation for the pacemaker clinic, but their duties did not involve any pacemaker device checks.

We did not substantiate the allegation that RNs were given a deadline of 1 month to be trained in pacemaker device checks. A goal of 1 month was set for the pacemaker clinic RN to independently perform pacemaker battery checks after appropriate training and competence validation were completed.

We did not substantiate the allegation that not allowing pacemaker company representatives to do pacemaker device checks and programming compromised patient safety. We found that no untrained personnel were performing pacemaker checks. We made no recommendations.

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

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: Healthcare Inspection – Alleged Cardiology Quality of Care Issues, Bay Pines VA Healthcare System, Bay Pines, Florida

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations that untrained nurses are doing pacemaker checks and programming[1] at the VA Medical Center (the medical center) in Bay Pines, Florida.

Background

The medical center is part of the Bay Pines VA Healthcare System of Veterans Integrated Service Network (VISN) 8. It is a tertiary care facility which provides medical, surgical, mental health, long term care, and dental services for veterans in central Florida. Cardiology services include acute care and outpatient services, cardiac catheterizations, and pacemaker insertion and follow-up. Patients requiring further cardiac interventions are referred to another VA facility or, if the situation warrants, to the community.

The OIG received allegations, originally sent to the U.S. Office of Special Counsel, from an anonymous complainant who reported that:

- Three RNs [registered nurses] in the pacemaker and heart failure clinics were instructed to perform pacemaker device checks and programming without proper training.
- An RN specifically hired to assist the cardiology nurse practitioner [NP] was instructed to perform pacemaker device checks, although not trained in pacemaker devices.

[1] Pacemakers are devices that provide electrical stimulation to the heart, causing a heartbeat. They are placed under the skin, and with the proper equipment can be interrogated for function and settings, and reprogrammed if needed.

- The RNs were given a deadline of 1 month to complete training for pacemaker checks and programming.
- Pacemaker company representatives, who previously assisted with pacemaker checks, were told not to assist in the pacemaker clinic as only VA employees were to do the checks. Pacemaker company representatives were not allowed to stay until an adequate number of staff were trained, which left only one person to safely perform pacemaker checks and programming, compromising patient safety.

Scope and Methodology

We conducted a site visit at the medical center April 19, 2009. We interviewed the Chief and Assistant Chief of Cardiology (ACOC), the cardiology NP, and two cardiology clinic RNs. We reviewed pacemaker clinic visit schedules, local policies and procedures, and relevant Veterans Health Administration directives.

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

Inspection Results

Issue 1: Use of Untrained RNs

We did not substantiate the allegation that three RNs in the pacemaker and heart failure clinics were instructed to perform pacemaker device checks and programming without proper training. Prior to our site visit, an RN had been hired for the pacemaker clinic to assist with pacemaker device checks. Two RNs in the heart failure clinic were being cross-trained to assist with patient screening and evaluation for the pacemaker clinic, but their duties did not involve any pacemaker device checks. In an effort to ensure a consistent standard of care for veterans with pacemakers, the ACOC instituted the following changes within the department:

- A new RN joined the pacemaker clinic staff to assist with pacemaker checks. She received training provided by a pacemaker company, and Cardiology staff completed a competence assessment and validation prior to the RN performing any independent pacemaker checks.
- Recognizing that it takes time and experience to become proficient in all aspects of pacemaker device checks and programming, the ACOC limited the RN to doing battery checks only at the present time.

Issue 2: Training Deadline

We did not substantiate the allegation that RNs were given a deadline of 1 month to be trained in pacemaker device checks. Interviews with the ACOC and the pacemaker clinic

RN revealed that the RN was not required or expected to perform any duties she did not feel competent to do. During a departmental meeting, a goal of 1 month was set for the RN to independently perform pacemaker battery checks after appropriate training and competence validation were completed.

Issue 3: Use of Pacemaker Company Representatives

We did not substantiate the allegation that not allowing pacemaker company representatives to do pacemaker device checks and programming compromised patient safety. Previously, vendor representatives from pacemaker companies were performing some pacemaker checks and programming functions, and the cardiology NP was the only VA employee consistently performing pacemaker checks. Prior to our visit, the ACOC had requested that only VA Cardiology staff perform pacemaker checks. In an effort to reduce reliance on vendors, an additional RN was hired to assist with pacemaker checks. A review of clinic visit schedules from October 2008 through February 2009 did not reveal delays or cancelled clinics due to a lack of assistance from outside vendors. Cardiologists on staff are also able to perform pacemaker checks and programming functions if needed. There were no adverse events, and we found no quality management data indicating that patient safety had been compromised for patients with pacemakers.

Conclusions

We did not substantiate the allegations that untrained personnel were performing pacemaker device checks. We did not substantiate the allegation that a deadline of 1 month was imposed for the pacemaker clinic RN to be trained to do pacemaker checks. Instead, a goal of 1 month was set for the RN to begin performing basic pacemaker battery checks. We also did not substantiate the allegation that without pacemaker company representative participation, patient safety was compromised. We made no recommendations.

Comments

The VISN and System Directors concurred with our findings and conclusions. (See Appendixes A and B, pages 5 and 6 for the Directors comments).

(original signed by Dana Moore, Ph.D.,
Deputy Assistant Inspector General
for Healthcare Inspections for:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 17, 2009

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Healthcare Inspection – Alleged Cardiology Quality of Care Issues, Bay Pines VA Healthcare System, Bay Pines, Florida**

To: Associate Director, St. Petersburg Regional Office of Healthcare Inspections

I concur with the inspection results and conclusions.

Nevin M. Weaver

Nevin M. Weaver, FACHE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 10, 2009

From: System Director, Bay Pines VA Healthcare System (516/00)

Subject: **Healthcare Inspection – Alleged Cardiology Quality of Care Issues, Bay Pines VA Healthcare System, Bay Pines, Florida**

To: Director, VA Sunshine Healthcare Network (10N8)

I would like to take this opportunity to commend the OIG Healthcare Inspection Team for both their thoroughness and professionalism. I concur with the inspection results and conclusions.

WALLACE M. HOPKINS, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Carol Torczon, Associate Director St. Petersburg Office of Healthcare Inspections 727-395-2415
Acknowledgments	David Griffith

Appendix D

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