Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Resident Supervision Issues
VA North Texas Health Care System
Dallas, Texas

Report No. 09-02024-222 **September 21, 2009**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The purpose of the review was to determine the validity of allegations regarding resident supervision and attending physicians' presence at the VA North Texas Health Care System (the system). The complainant alleged:

- Widespread false documentation of resident supervision,
- Contractual obligations not fulfilled by the University of Texas Southwestern Medical Center at Dallas (the university), and
- Attending physician's (attending) absence during a Code Blue event.

We did not substantiate the allegation of widespread false documentation of resident supervision. We found that a resident failed to document the correct attending name in one medical record in 2007.

We did not substantiate the allegation that the university failed to meet its contractual obligations. We found that attendings provided adequate resident supervision and surgical care services. Although we substantiated the allegation that an attending was not present during the Code Blue (cardiorespiratory arrest), we found that the patient was managed appropriately and that the attending was available by phone.

During the course of our review, we found that system staff failed to consistently document discharge summaries in the medical record, as required. We recommended that the system comply with VHA policy regarding documentation of discharge summaries. The Veterans Integrated Service Network and System Directors agreed with the findings and recommendation and provided an acceptable action plan. Since the system had already addressed the issue identified in the recommendation, we consider this recommendation closed.

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

TO: Director, Veterans Integrated Service Network 17

SUBJECT: Healthcare Inspection – Alleged Resident Supervision Issues, VA North Texas Health Care System, Dallas, Texas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections received allegations of false documentation by resident physicians (residents) and inadequate attending physicians' (attendings) presence at the VA North Texas Health Care System (the system), Dallas, TX. The purpose of this review was to determine whether the allegations had merit.

Background

The system, which is part of Veterans Integrated Service Network (VISN) 17, is a tertiary care facility in Dallas, TX. It provides a broad range of services. Surgical specialty care is provided by attendings and residents affiliated with the University of Texas Southwestern Medical Center at Dallas (the university). The system supported 671 residents and medical students during the 2008 academic year. The residents rotate between the university and the system, providing care for VA patients under the direct supervision of attendings.

Veterans Health Administration (VHA) resident supervision policy is detailed in a handbook that establishes requirements for attending involvement in the care provided by residents and documentation of that involvement.[1] Documentation of supervision must be entered into the medical record by the attending or reflected within the resident progress note. The physical presence of the attending is required in the following patient settings: (a) outpatient clinic; (b) emergency department; (c) operating room (OR), and (d) specialty non-OR (e.g., cardiac catheterization laboratory, angiography suite) procedure areas.

[1] VHA Handbook 1400.1, *Resident Supervision*, July 27, 2005.

The system's critical care services for surgical patients are carried out in the 15-bed surgical intensive care unit (SICU), where care management and resident supervision are provided by intensivists[2] from two university groups of contract physicians with surgery and anesthesia expertise. The services alternate attending responsibilities on a weekly basis. Timesheets are maintained to validate that contracted services are provided.

In April 2009, a complainant contacted the VA OIG Hotline. Allegations included false documentation of resident supervision in 2007 and inadequate performance of SICU attending responsibilities. The complainant alleged that:

- There is widespread false documentation of attending presence even when the attending is not at the bedside or in the hospital.
- System managers said that the VA is not entitled to a monetary refund because despite problematic documentation, the university has met its contractual obligations.
- An SICU attending did not fulfill responsibilities during an SICU Code Blue (cardiorespiratory arrest) event.

Scope and Methodology

We interviewed the complainant prior to a site visit conducted June 30–July 1, 2009. We interviewed system senior leaders, physician managers, administrators, attendings, residents, and nurse managers. We reviewed medical records and facility documents, including policies, meeting minutes, call schedules, time and attendance records, contract agreement with the university, and various reports. We also reviewed VHA policies and procedures.

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

Inspection Results

Issue 1: Widespread Resident Supervision Documentation Issues

We did not substantiate the allegation of widespread false documentation of resident supervision in the medical record.

For the one medical record entry in 2007, we confirmed that a resident incorrectly documented attending involvement. The wrong attending was named in the progress note, and neither the attending nor the resident entered an addendum to correct the

[2] Intensivists are physicians trained in critical care medicine.

information. The complainant did not provide additional documentation or information to support the allegation that thousands of patient records were falsely documented.

System physician managers agreed that discrepancies in the medical record must be corrected as soon as the error is known and that this was the responsibility of the resident as well as the attending. Physician managers stated that it is emphasized during new resident orientation that resident supervision information in the medical record must be accurate. The residents we interviewed confirmed this information.

We reviewed the medical records of 29 patients who were admitted to the SICU during the 2nd quarter of fiscal year (FY) 2009. We found documentation of resident supervision to be correct and adequate and to correlate with the timesheets of the attendings. We determined that residents correctly reflected attending involvement in the medical record.

Issue 2: Contractual Obligations

We did not substantiate the allegation that the university failed to meet its contractual obligations. We found that attendings provided adequate resident supervision and surgical care services.

We reviewed the contract related to SICU attending responsibilities and resident supervision. We determined that the provision of 1.0 full-time employee equivalent hours of critical care surgical services by the university was satisfied for the 6-month timeframe reviewed. We examined the "Alternate Hire – Time Record" and the "VA Intensive Care Unit Call Schedule for the 2nd and 3rd Quarters of FY 2009." We found evidence of contract physician coverage for the SICU and resident supervision, as stipulated in contract agreements between the system and the university. We also reviewed the system's admission and discharge oversight monitors for resident supervision. The monitors documented compliance with VHA resident supervision requirements. We determined that contract attendings provided the required SICU coverage.

Issue 3: Attending Presence During Code Blue

We substantiated the allegation that the attending was not present during the Code Blue event.

The assigned SICU attending had appropriately documented in the time record that he was away from the system at the time of the Code Blue. There was no requirement for the attending to be physically present in the unit to fulfill resident supervision responsibilities. The residents we interviewed confirmed that attendings are generally available by phone for consultations. During this code, the attending spoke with the resident by phone and did not return to the system because two other attendings (from Medicine and Anesthesia) were already present and managing the patient. Resuscitation was successful, but the patient expired the following day due to factors unrelated to the

Code Blue. The SICU Medical Director stated that the presence of the SICU attending during the Code Blue would not have changed the ultimate outcome for the patient. The Chief of Surgery confirmed this information. Based on our review of the patient's medical record, we determined that the patient was managed appropriately.

Issue 4: Discharge Summaries

We identified an additional issue that required management attention. VHA policy requires that a discharge summary be documented within 24 hours of death.[3]

We reviewed the medical records of 15 SICU patients who died January 1–March 31, 2009. We noted appropriate death notes, but discharge summaries were missing in 5 (33 percent) of the 15 records. We brought this deficiency to the attention of physician managers who agreed that a discharge summary must be completed when there is a patient discharge or death. By the end of our onsite visit, three of the five discharge summaries had been documented. The remaining two discharge summaries were awaiting transcription. We recommended that system managers ensure compliance with VHA policy regarding documentation of discharge summaries.

Conclusions

We did not substantiate widespread false documentation of resident supervision. We found one instance in 2007 where a resident documented the name of an incorrect attending in the medical record. We did not substantiate that the university failed to meet contractual obligations. The contract attendings provided adequate resident supervision and surgical care services. Although we substantiated that an SICU attending was not present during a Code Blue event, we determined that the patient was managed appropriately. We found that the system needed to comply with VHA discharge summary documentation requirements.

[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the System Director complies with VHA policy regarding discharge summary documentation requirements.

Comments

The VISN and System Directors agreed with the findings and recommendation and provided acceptable corrective actions. (See Appendixes A and B, pages 6–9, for the full text of the Directors' comments.) Since the system has already implemented actions to address the findings, we consider this recommendation closed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 31, 2009

From: Director, VA Heart of Texas Network (10N17)

Subject: Healthcare Inspection – Alleged Resident Supervision Issues, VA North Texas Health Care System, Dallas, Texas

To: Associate Director, Los Angeles Regional Office of Healthcare Inspections (54LA)

Thru: Director, Management Review Service (10B5)

I concur with the response by the Medical Center Director and with the recommendation for improvement identified in the report.

(*original signed by:)*
Timothy P. Shea, FACHE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 31, 2009

From: Director, VA North Texas Health Care System (549/00)

Subject: Healthcare Inspection – Alleged Resident Supervision Issues, VA North Texas Health Care System, Dallas, Texas

To: Associate Director, Los Angeles Regional Office of Healthcare Inspections

We concur with OIG's findings and recommendation. Please note that the five discharge summaries that were found to be missing during the OIG's review for patients who died from January 1, 2009–March 31, 2009, have been transcribed and placed in the patients' medical records.

Attached is our response to the OIG's recommendation.

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

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

Recommendation 1. We recommended that the VISN Director ensure that the System Director complies with VHA policy regarding discharge summary documentation requirements.

Concur

A reminder notice was sent to all VA North Texas Health Care System (VANTHCS) surgeons on VHA's policy regarding documentation of discharge summaries when there is a patient discharge or death. In addition, VANTHCS has re-trained all residents on the policy and will continue to train all future incoming residents on this policy to ensure compliance.

Quality Management will conduct chart audits of all deaths that occur in the ICU to determine if documentation of discharge summaries is completed with 24 hours of death. This data will be collected and analyzed quarterly and reported to the Executive Committee of the Medical Staff (ECMS) as a recurring agenda item. Minutes from the ECMS will be submitted to the VISN 17 Office to monitor and ensure compliance with the VHA Policy concerning documentation of discharge summaries within 24 hours of death.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, RN, MA Director, Denver and Los Angeles Regional Offices of Healthcare Inspections (213) 253-2677 ext. 4936
	Daisy Arugay, Coordinator Mary Toy, Team Leader

Appendix D

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