Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-01730-14

Combined Assessment Program Review of the VA Maryland Health Care System Baltimore, Maryland

October 21, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is 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 May 18–22, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Maryland Health Care System (the system), Baltimore, MD. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 601 system employees. The system is part of Veterans Integrated Service Network (VISN) 5.

Results of the Review

The CAP review covered eight operational activities and one follow-up review area from the previous CAP review. We identified the following organizational strength and reported accomplishment:

- Pressure Ulcer/Wound Care Management.

We made recommendations in four of the activities reviewed and in the follow-up review area; one recommendation was repeat recommendation from the prior CAP report. For these activities and the follow-up review area, the system needed to:

- Notify providers who receive a Level II or III peer review of their opportunity to provide comments to the Peer Review Committee (PRC).
- Monitor root cause analysis (RCA) actions and report results to ensure that actions achieve the desired effects.
- Required designated staff to maintain cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) certification.
- Require the local policy to define actions to monitor current CPR and ACLS certification and actions to be taken when current certification is not maintained.
- Monitor the copy and paste functions in the electronic medical record.
- Require inter-facility transfer documentation to comply with Veterans Health Administration (VHA) policy.
- Protect patient privacy.
- Perform and document critical equipment monitoring.

- Screen all community living center (CLC) patients for tuberculosis (TB).
- Conduct and document ventilator circuit changes in accordance with system policy.
- Require all Multidisciplinary Safety Inspection Team (MSIT) members to receive the required environmental hazards training.
- Ensure that all utility room doors are locked.
- Require signage to comply with VHA policy and to facilitate access to health care.
- Require providers to document consultation review and, when appropriate, the reasons for the clinical decision to not implement consultation recommendations.
- Complete intra-facility transfer documentation in accordance with Joint Commission (JC) requirements.
- Require staff to complete discharge documentation to assure consistency and document patient receipt and understanding of discharge instructions.
- Ensure that responsible clinicians document breast cancer interdisciplinary treatment plans in the electronic medical record.

The system complied with selected standards in the following four activities:

- Contracted/Agency Registered Nurses.
- Medication Management.
- Patient Satisfaction.
- Suicide Prevention.

This report was prepared under the direction of Nelson Miranda, Director, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 19–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Profile

Organization. The system has two divisions located in Baltimore and Perry Point, MD, which provide major medical, surgical, inpatient, and outpatient care. Outpatient care is also provided at five community based outpatient clinics (CBOCs) in Cambridge, Fort Howard, Glen Burnie, Baltimore (Loch Raven), and Pocomoke City, MD. The system also operates an outpatient mental health clinic at Maryland Homeless Veterans, Inc., in Baltimore, MD. The system is part of VISN 5 and serves a veteran population of about 127,000 throughout the State of Maryland.

Programs. The system provides medical, surgical, mental health, long-term care, and home health services. It has 236 hospital beds and 275 CLC beds.[1]

Affiliations and Research. The system has academic affiliations with the University of Maryland's School of Medicine, Johns Hopkins University, and Coppin State University and supports almost 1,600 residents, interns, and students. In fiscal year (FY) 2008, the system's research program had 684 projects and a budget of $76 million dollars. Important areas of research included laboratory, rehabilitation, health services, lifestyle interventions of diet-induced weight loss, and physical function in obese older Americans.

Resources. In FY 2008, medical care expenditures totaled approximately $421 million. The FY 2009 medical care budget is more than $421 million. FY 2008 staffing was 2,800 full-time employee equivalents (FTE), including 85 physician and 705 nursing FTE.

Workload. In FY 2008, the system treated 51,229 unique patients and provided 68,210 inpatient days in the hospital and 85,930 inpatient days in the CLC. The inpatient care workload totaled 8,933 discharges of which 235 were CLC discharges. Outpatient workload totaled 597,776 visits.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

Objectives and Scope

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 facility operations, focusing on patient care administration 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 patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities and one follow-up review area:

- Breast Cancer Management.
- Contracted/Agency Registered Nurses.
- Coordination of Care.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention.

The review covered system operations for FY 2008 and FY 2009 through May 22, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Maryland Healthcare System, Baltimore, Maryland,* Report Number 06-01831-202,

September 11, 2006). We had a repeat Breast Cancer Management finding from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 601 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Pressure Ulcer/Wound Care Management

The system instituted multiple actions to reduce the incidence of hospital-acquired pressure ulcers (HAPU). An Interdisciplinary Wound Management Committee and three wound care nurses manage all actions related to HAPU. The committee instituted the following:

- Development of a wound care manual based on the National Pressure Ulcer Advisory Panel.
- Designation of unit-based skin liaison staff.
- Weekly wound care rounds.
- Unit-based wound care in-services.
- Mandatory training on web-based wound care learning modules for all nurses.
- Nurse initiated wound care consults.

Since implementation of the above, the incidence of HAPU within the system has been reduced to 1.4 percent. The national rate is 6.84 percent.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's Director and Chief of Staff, and we interviewed QM

personnel. We evaluated plans, policies, performance improvement data, and other relevant documents.

The system's QM program was generally effective, and senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. Appropriate review structures were in place for 8 out of the 14 program activities reviewed; however, we identified the following QM and risk management areas that needed improvement.

Peer Review. VHA regulations[2] require that providers who are assigned a Level II or III[3] peer review during the initial peer review process be notified and invited to submit written comments on the case during initial review. Providers who are assigned a Level II or III peer review after an initial review must be notified and invited to address the PRC in person or in writing. We reviewed all Level II and III peer reviews performed from October 1, 2008, to May 18, 2009, and found only one instance where a provider had submitted written comments. Also, we did not find any evidence in committee minutes or in the individual peer reviews that the individual whose care was under review was invited to provide comments on the initial review or the committee review.

RCA. The RCA process identifies the basic or contributing casual factors that underlie variations in performance. VHA regulations[4] require that serious adverse events be evaluated using the RCA process. Once corrective actions have been identified and initiated, follow-up needs to occur to ascertain that the corrective actions have had the intended effect.

We reviewed five RCAs and found that all were completed in a timely manner and that corrective actions had been identified and initiated. However, all five were closed after the initiation of the actions, and there was no documented evidence of follow-up or monitoring of the planned actions. We reviewed minutes from the Executive Performance

[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[3] Level I – Most experienced, competent practitioners would have managed the case in a similar manner. Level II – Most experienced, competent practitioners might have managed the case differently. Level III – Most experienced, competent practitioners would have managed the case differently.
[4] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

Improvement Committee and the Executive Committee of the Medical Staff and were unable to determine if the actions had the desired results.

Training. System policy defines which employees are required to maintain current ACLS and CPR certification. Respiratory therapists certified to perform out-of-operating room airway management are required to be certified in ACLS. We found that only 2 (13 percent) of the 16 respiratory therapists certified to perform out-of-operating room endotracheal intubation had the required ACLS certification. In addition, VHA policy[5] states that all police officers must have CPR and automated external defibrillator (AED) training. Four (8 percent) of the 50 police officers had expired CPR and AED certifications. We also found that the local policy did not define actions to track compliance and actions that would be taken if an individual failed to maintain certification.

Medical Record Reviews. VHA policy[6] requires that the system have a process for monitoring the copying and pasting of text in the electronic medical record. The system is also required to report violations. We found that local policy defines the rules for copying and pasting text; however, the system does not have a process to monitor these functions and report violations.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that the Chairman of the PRC formally notify providers who receive a Level II or III peer review in writing of their opportunity to provide comments on their case to the PRC.

The VISN and System Directors concurred with the findings and recommendation. The system has developed and implemented a form letter to notify providers of the process for providing their comments and/or appearing before the PRC. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that all RCA actions are monitored

[5] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[6] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

and that results are reported to ensure that actions achieve the desired effects.

The VISN and System Directors concurred with the findings and recommendation. The system will review and update the RCA reporting process. After corrective action implementation and initial follow-up, summary information will be sent to the appropriate committee for further monitoring and reporting. Patient Safety will ensure that all information collected meets the targeted compliance rate and that the assigned committee conducts and reports follow-up. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that designated staff maintain current CPR, ACLS, and AED certification.

The VISN and System Directors concurred with the findings and will review all facility policies to determine if the appropriate CPR, ACLS and AED certification is included for specific disciplines and that policies include disciplinary actions for non-compliance. In addition, each clinical service will be required to submit a plan for CPR, ACLS and AED ongoing monitoring, training and disciplinary actions. Implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that the local policy defines actions to monitor current CPR, ACLS, and AED certification and actions to be taken when current certification is not maintained.

The VISN and Facility Directors concurred with the findings and will review all policies and Standard Operating Procedures (SOP's) referencing CPR, ACLS, and AED certification to determine if the appropriate requirements are included and ensure that disciplinary actions for noncompliance are included as appropriate. Implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires monitoring of the copy and paste functions in the electronic medical record.

The VISN and System Directors concurred with the findings and recommendation. The system will review the existing policy and develop a methodology for obtaining baseline frequency of the copy and paste functions. Data will be reported through the Medical Records Committee, which will conduct ongoing monitoring. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility emergency/urgent care operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the system's emergency department (ED) and urgent care clinic (UCC) for cleanliness and safety.

The ED is located within the main hospital building at the Baltimore division, and the UCC is located at the Perry Point division. Both are open 24 hours per day, 7 days per week. The emergency services provided are within the system's capabilities.

We interviewed program managers and the transfer coordinator, and we reviewed documents, including competency files and credentialing and privileging folders. We also reviewed the medical records of patients who presented to the ED or UCC with acute mental health conditions. In all cases, we found that staff managed patients' care appropriately. We reviewed the ED and UCC nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources.

We determined that the UCC had adequate staffing during normal hours of operation but was only staffed from 6:30 p.m. to 7:30 a.m. by the on-call nurse and the on-call physician. Although UCCs are not designed to provide the full spectrum of emergency medical care, they are expected to provide initial stabilization of acute emergencies. If the UCC is open 24 hours per day, 7 days per week, it must be staffed appropriately, and the level of services provided must be congruent with the capabilities, capacity, and function of that UCC. To resolve this issue, managers decided to change UCC operating hours from 24 hours per day to 12 hours per day. Nursing Service developed an acceptable

action plan to staff the UCC until the operating hours can be officially changed. Therefore, we made no recommendation for this finding.

Additionally, we reviewed medical records of patients who received consults or were admitted to inpatients units. We found consults and admissions to be appropriate. However, we identified the following areas that needed management attention.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred from the ED to other medical facilities for care. Transfer documentation did not comply with VHA policy,[7] which requires the use of VA Form 10-2649A, "Inter-Facility Transfer Form," and/or the appropriate electronic medical record template note.

Patient Privacy. We found work stations in the ED with unprotected computers screens open to public view.

Equipment Monitoring. During our EOC tour of the ED, we found that the defibrillator checklist was signed, indicating that a nurse had completed the daily checks. However, when we reviewed the strip that is run as part of the check, we found the previous day's date.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that all inter-facility transfer documentation complies with VHA policy.

The VISN and System Directors concurred with the finding and recommendation. The Medical Records Committee will review the existing inter-facility transfer policy and documentation and ensure that the appropriate VA form and/or template note are included. ED direct care providers and nurses will be reminded to complete appropriate documentation when patients are sent to community facilities. The Medical Records Committee will monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires that patient privacy is protected.

[7] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

The VISN and System Directors concurred with the finding and recommendation. System staff will be reminded to preserve patient privacy. The Office of Education and Academic Affairs will determine whether staff have completed the required privacy training. Ongoing monitoring will occur. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that critical equipment monitoring is performed and documented.

The VISN and System Directors concurred with the findings and recommendation. Nursing staff will be reminded of the expectation to accurately and timely perform and document critical equipment monitoring. Ongoing tracers will monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the system maintained a clean, safe, and secure health care environment. The system is required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and external accreditation standards.

We conducted onsite inspections at the Loch Raven CLC; the inpatient behavioral health unit and the ambulatory care area at the Perry Point division; and all inpatient care units, the operating room, the medical intensive care unit (MICU), the inpatient behavioral health unit, and the dental clinic at the Baltimore division. Overall, we found the areas we inspected to be clean and well maintained. Managers expressed satisfaction with the housekeeping staff assigned to their areas. We identified the following conditions that required management attention.

Infectious Disease. We reviewed the CLC for EOC; the patient elopement system; and unique patient care issues, such as TB screening. The system's Geriatrics and Long-Term Care Committee recognizes the importance of identifying CLC residents as at risk for latent TB infection and requires screening for all patients admitted to the CLC. We

reviewed 10 CLC patient records. Four (40 percent) of the 10 patients did not have documented TB screening.

Ventilator Circuit Changes. The system's policy for ventilator circuit changes requires that a respiratory care practitioner (RCP) change the ventilator circuits at least every 7 days and more frequently if indicated. We inspected the MICU and asked the RCP responsible for ventilator-dependent patients the process for ventilator circuit changes. We also asked the RCP to demonstrate where it was documented that the circuits had been changed. The RCP was unaware of the required frequency for ventilator circuit changes, and ventilator circuit changes were not documented on the flow sheet or in the electronic medical record.

Inpatient Behavioral Health Unit. The MSIT is responsible for conducting EOC rounds to identify environmental hazards that represent a threat to suicidal patients. Training in environmental hazard identification and correction is required at orientation and annually. We found that the non-clinician members of the MSIT had not received this training.

Utility Rooms. Utility rooms throughout the system needed to be secured (locked) to prevent unauthorized access to cleaning products, hazardous waste, and equipment. We found that utility rooms were locked on several units but that they were not consistently locked throughout the system.

Signage. Standardized nomenclature is needed to ensure that patients seeking emergency care in any VHA facility can readily identify the appropriate location for such services. VHA policy[8] has directed that any department providing emergency services be designated as an ED and that all signage directing patients to this location display "Emergency Department." We found that the sign over the entrance door to the ED and smaller signs throughout the system read "Emergency Care Services." Also, there were no signs outside the building housing the UCC at the Perry Point division to direct patients seeking urgent care. System stairwell doors had signs to indicate the floor and what medical care was located there. However, when the doors are propped open, the signs are not visible. The system has a long-term plan to address the identified signage problems but needed to develop an interim action plan until the

[8] VHA Directive 2006-051, *Standards for Nomenclature and Operations in VHA Facility Emergency Departments*, September 15, 2006.

permanent solution is in place. While we were onsite, some of the signage issues were corrected.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that all CLC patients are screened for TB.

The VISN and System Directors concurred with the finding and recommendation. Infection Control will review a random sample of new and established CLC patients each quarter until compliance is achieved. The implementation plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 10 We recommended that the VISN Director ensure that the System Director requires that ventilator circuit changes are conducted and documented in accordance with system policy.

The VISN and System Directors concurred with the findings and recommendation. The Chief of Respiratory Therapy will review system policy with all respiratory therapists and will conduct follow-up to ensure appropriate documentation of ventilator circuit changes. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the VISN Director ensure that the System Director requires that all MSIT members receive the required environmental hazards training.

The VISN and System Directors concurred with the finding and recommendation. All MSIT members will be required to complete training in environmental hazard identification and correction by the end of the FY and annually thereafter. An audit of all MSIT training records will be conducted at the end of the FY to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the VISN Director ensure that the System Director requires that all utility room doors are locked.

The VISN and System Directors concurred with the finding and recommendation. A reminder will be issued to all units regarding the requirement to lock utility rooms to prevent

unauthorized access. Unit supervisors will conduct random checks to monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 13 We recommended that the VISN Director ensure that the System Director requires that signage complies with VHA policy and facilitates patients' and visitors' access to health care.

The VISN and System Directors concurred with the findings and recommendation. The system had previously recognized that new signage was needed and had implemented a long-term plan to address the issues through a recently funded contract. Interim plans to address OIG findings include moving stairwell door signs, replacing the large sign over the ED entrance with a temporary sign, covering smaller signs with temporary signage, and posting a temporary exterior sign for the UCC. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes. We identified the following areas that needed improvement.

Consultations. We found that 11 (65 percent) of 17 consultations had evidence that the provider who requested the consultation (or another provider on the team) received or reviewed the response from the consulted provider. Also, we found that 3 (27 percent) of the 11 patients who had recommendations resulting from their consultations did not have their recommendations implemented. Additionally, their providers had not documented any reasons for not implementing the recommendations.

Intra-Facility Transfers. Hand-off communication facilitates coordination of care and is a JC requirement. Nurse-to-nurse reporting facilitates continuity of care. We found that 9 (56 percent) of 16 intra-facility transfers had a documented nurse-to-nurse report. Also, we found that only

6 (43 percent) of the 14 transfers where there was a change of provider had documentation of notes or orders from sending physician to receiving provider.

Discharges. Congruency of patient discharge instructions and discharge summaries facilitates continuity of care. We compared information on 21 discharge summaries and the corresponding patient discharge instructions for consistency. Thirteen (62 percent) had the same discharge medications listed, 12 (57 percent) had the same diet recommendations, 9 (43 percent) had the same activity level recommendations, and 8 (38 percent) had documentation that the patient received a copy of the discharge instructions.

Recommendation 14 We recommended that the VISN Director ensure that the System Director requires providers to document the review of consultations and, when appropriate, the reasons for the clinical decision to not implement consultation recommendations.

The VISN and System Directors concurred with the findings and recommendation. All providers will be reminded to document their reviews of consultations. If the provider requesting the consult decides not to follow the consultant's recommendations, a progress note will be required. Compliance will be monitored. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 15 We recommended that the VISN Director ensure that the System Director requires staff to complete intra-facility transfer documentation in accordance with JC requirements.

The VISN and System Directors concurred with the findings and recommendation. The Medical Records Committee will review the existing policy and develop a policy that meets JC standards. Direct care providers and nurses will be reminded to complete intra-facility transfer documentation. The Medical Records Committee will monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 16 We recommended that the VISN Director ensure that the System Director requires staff to complete discharge documentation to assure consistency between discharge

summaries and discharge instructions and to document patient receipt and understanding of discharge instructions.

The VISN and System Directors concurred with the findings and recommendation. Providers will be reminded that discharge instructions and discharge summaries must be consistent and include documentation of patient receipt and understanding of the discharge instructions. Compliance will be monitored. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Breast Cancer Management

We followed up on recommendations from our prior CAP review. We had recommended that the system improve compliance with VHA's breast cancer screening performance measure and ensure that responsible clinicians document an interdisciplinary treatment plan in each patient's medical record. We determined that the corrective action plan was only partially implemented.

VHA breast cancer screening performance measures assess the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to optimal patient outcomes. While the system met the applicable screening measures, we identified the following area that continued to need improvement.

Interdisciplinary Treatment Plans. We found that interdisciplinary treatment plans were not consistently documented. We reviewed the electronic medical records of eight newly diagnosed breast cancer patients. We found that only three had appropriate interdisciplinary treatment plans documented. This was a repeat finding from our previous CAP review.

Recommendation 17 We recommended that the VISN Director ensure that the System Director requires that responsible clinicians document interdisciplinary treatment plans for breast cancer patients in the electronic medical record.

The VISN and System Directors concurred with the finding and recommendation. Women's Health Program staff members will notify all providers of the requirement to document an interdisciplinary treatment plan in the patient's medical record and will ensure completion of the plan. A random sample of medical records will be audited quarterly

for compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether registered nurses working in VHA facilities through contracts or temporary agencies met the same entry requirements as registered nurses hired as part of VHA facility staff. We reviewed documents for several required components, including licensure, training, and competencies. We found that system managers had appropriate processes in place and followed them consistently with all contracted/agency registered nurses selected for review. Also, the system has an electronic database that is used for monthly compliance audits. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the inpatient medical and surgical units and in the intensive care unit. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers prior to medication administration. We interviewed patients and specifically questioned them on the medication administration process; all were able to cite key elements of the patient identification process.

We reviewed the Bar Code Medication Administration records of 31 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication for a total of 189 doses. We found that nurses documented pain medication effectiveness within the local policy's required timeframe of 4 hours 91 percent of the time. We made no recommendations.

Patient Satisfaction

The purpose of this review was to assess the extent that VHA medical facilities used quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of

Quality and Performance within VHA is the analytical, methodological, and reporting staff for the Survey of Healthcare Experiences of Patients (SHEP). VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical facilities are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 1st quarter of FY 2007 and ending with the 4th quarter of FY 2008. Figures 1 and 2 below and on the next page show the system's SHEP performance measure results for inpatients and outpatients, respectively.

Figure 1:

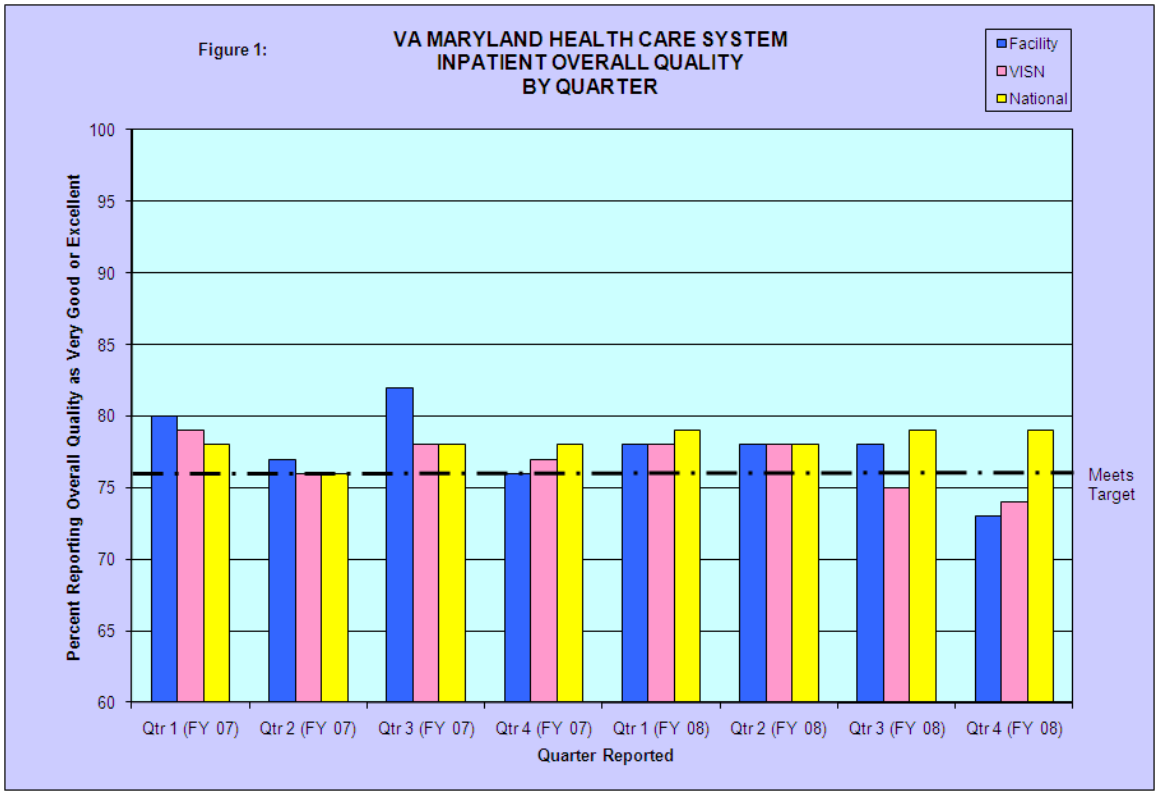
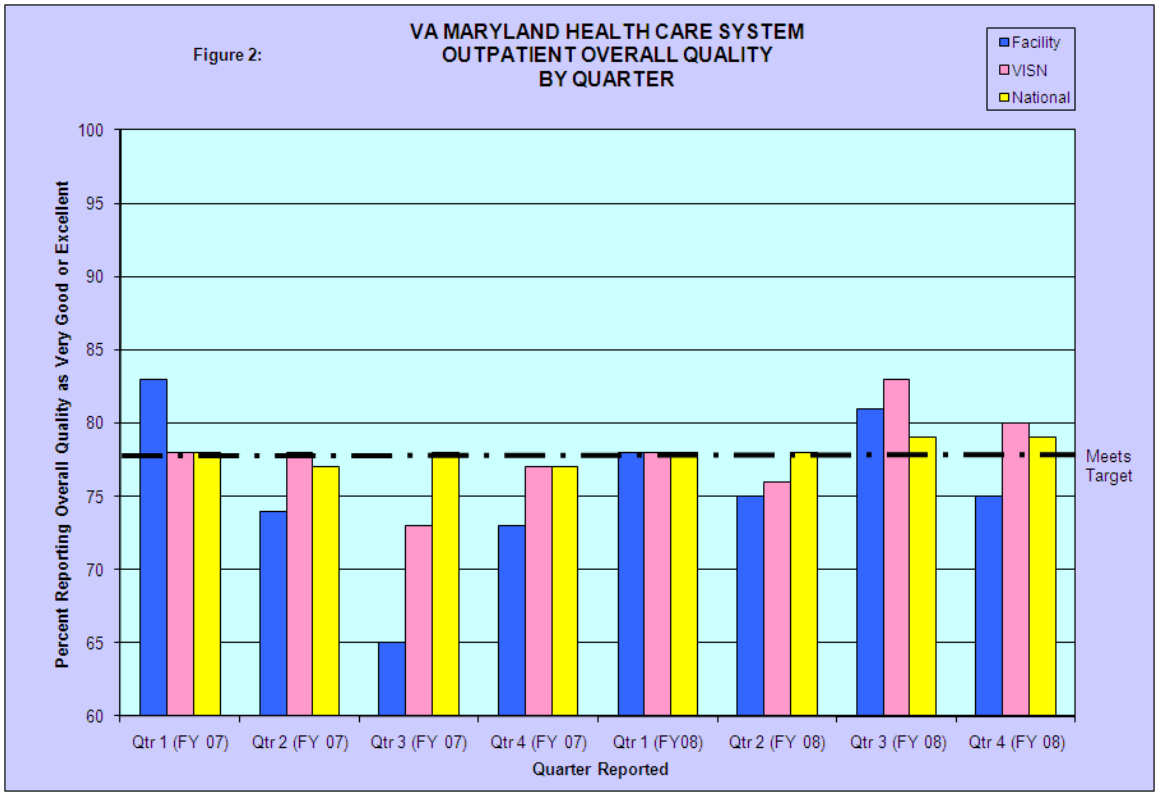


Figure 2:



The system's inpatient results met or exceeded the target in 7 of the 8 quarters reviewed. The system's outpatient results met or exceeded the target in 3 of the 8 quarters reviewed. Managers had analyzed survey results, identified opportunities for improvement, initiated an action plan, and evaluated the plan for effectiveness. Therefore, we made no recommendations.

Suicide Prevention

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs.[9] In addition, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[10] documented safety plans that addressed suicidality, and documented collaboration between mental health providers and SPCs.

We interviewed the system's SPCs, and we reviewed pertinent policies and the medical records of 12 system

[9] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[10] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

patients and one CBOC patient determined to be at risk for suicide. We found that senior managers had appropriately appointed the SPCs and that the SPCs fulfilled the required functions. We found that all 13 records reviewed contained PRFs, safety plans, and documented collaboration between mental health providers and SPCs. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 16, 2009

From: VISN Director

Subject: **Combined Assessment Program Review of the VA Maryland Health Care System, Baltimore, Maryland**

To: Director Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

1. I have reviewed the comments provided by the Medical Center Director, VA Maryland Health Care System, and I concur with the responses and proposed action plans to the 17 recommendations outlined in the report.

2. We appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

3. If further information is required, please contact Iris Pettigrew, RN, MS, ScD, CPHQ, Director of Performance Improvement and Accreditation, VA Maryland HCS, at (410) 605-7009.

(*original signed by:*)
SANFORD M. GARFUNKEL, FACHE

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 16, 2009

From: System Director

Subject: **Combined Assessment Program Review of the VA Maryland Health Care System, Baltimore, Maryland**

To: Network Director, VISN 5 (10N5)

1. Attached please find the VAMHCS responses and relevant action plan for the 17 recommendations from the Office of the Inspector General Combined Assessment Program Review conducted May 18–22, 2009.

2. We appreciate the professionalism demonstrated by your team and the consultative attitude during this review process.

3. If you have any questions regarding this report, please contact Iris E. Pettigrew, RN, MS, ScD, CPHQ, Director Performance Improvement and Accreditation, at 410-605-7009.

(original signed by:)
DENNIS SMITH

Comments to Office of Inspector General's Report

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

Corrected Information in Facility Profile (page I and 3 Draft Report):

Should be corrected to read: *During this review, we also presented fraud and integrity awareness briefings for 601 employees.*

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that the Chairman of the PRC formally notify providers who receive a Level II or III peer review in writing of their opportunity to provide comments on their case to the PRC.

Concur

A form letter has been developed and implemented that notifies providers whose care receives a Level II or III that includes the process for providing their comments and/or appearing before the Peer Review Committee.

Target Date: June 1, 2009 (**Completed**).

Perform two (2) quarterly reviews (post process identification to identify that process implemented and functional.

Target Date: February 2010.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that all RCA actions are monitored and that results are reported to ensure that actions achieve the desired effects.

Concur

The RCA reporting process will be reviewed/updated to assure that after implementation of a corrective action and the appropriate initial follow-up interval, the summary information will be sent, in writing, to the appropriate committee (PI Sub-council; or other standing committee) for further management and reporting. Patient Safety is responsible for ensuring that the information collected to date meets the targeted compliance rate prior to reassignment and the appropriate analysis and further tracking requirements are communicated to these committees.

Target Date: August 30, 2009.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that designated staff maintain current CPR, ACLS, and AED certification.

Concur

Review all policies and SOPs containing reference to CPR, ACLS, and AED certification requirements to determine if the appropriate certification is included for specific disciplines in specific areas and includes disciplinary action steps for noncompliance, as appropriate.

Target Date: October 15, 2009.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that the local policy defines actions to monitor current CPR, ACLS, and AED certification and actions to be taken when current certification is not maintained.

Concur

The VAMHCS Director's Office will have each clinical center/service submit to their office, their plan for ongoing monitoring of required CPR, ACLS, AED training and reporting of disciplinary actions for staff requiring certification who fail to obtain as prescribed by VAMHCS policy.

Target Date: November 30, 2009.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires monitoring of the copy and paste functions in the electronic medical record.

Concur

After review of existing policy, the Performance Improvement & Accreditation department in cooperation with the Medical Records Committee Chair will develop a methodology for obtaining the baseline frequency of copying and pasting.

Target Date: September 30, 2009.

The baseline data and methodology will be collected by PI and a report sent to the Medical Record Committee upon completion.

Target Date: November 30, 2009.

The Medical Record Committee will add this indicator to the Service Reviews for ongoing monitoring and reporting by service until a 90% compliance rate is achieved. **Implementation**

Target Date: December 15, 2009.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that all inter-facility transfer documentation complies with VHA policy.

Concur

The Medical Records Committee will review the existing inter-facility transfer policy and documentation and confirm that it includes the existing VA form 10-2649A, "Inter-Facility Transfer Form" and/or the appropriate template note.

Target Date: September 15, 2009.

The COS and CNE will send reminders to direct care providers/nurses in the ED concerning the importance of completing inter-facility transfer documentation using the template and/or guideline when patients are sent to community facilities from the VAHMCS.

Target Date: September 15, 2009.

The Medical Record Committee will add the use of the template/equivalent to the Service Reviews for ongoing monitoring and reporting by service until a 90% compliance rate is achieved. **Implementation**

Target Date: October 31, 2009.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that patient privacy is protected.

Concur

The ISO and Privacy Officer will reinforce to staff the importance of preserving patient privacy using of emails, posters and/or meeting with staff.

Target Date: August 31, 2009.

In cooperation with Education and Academic Affairs, the determination will be made whether 90% of staff have completed the required privacy training for FY09.

Target Date: October 31, 2009.

As part of ongoing tracers throughout the organization, checks for exposed computer screens with patient information will be noted and results given to unit/area managers.

Target Date: August 31, 2009.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that critical equipment monitoring is performed and documented.

Concur

The CNE will issue a reminder to all nursing staff concerning the importance and the expectation that all critical equipment monitoring must be performed and documented accurately and timely as indicated by established procedure.

As part of ongoing tracers throughout the organization, checks of logs to determine if critical equipment monitoring has been done timely and accurately will be noted and results given to unit/area managers.

Target Date: August 31, 2009.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that all CLC patients are screened for TB.

Concur

In order to ensure that the CLC patients who have a negative PPD or haven't had a PPD in the last 2 years are screened for TB at a level of 100% compliance, a representative random sample of new and established CLC patients will be reviewed for the current quarter and subsequent quarters by the Infection Control service until compliance achieved.

Target Date: October 31, 2009.

Recommendation 10. We recommended that the VISN Director ensure that the System Director requires that ventilator circuit changes are conducted and documented in accordance with system policy.

Concur

The Chief, Respiratory Therapy under the supervision of Chief, Pulmonary Services will review the VAMHCS policy (512-111MD-021) with all Respiratory Therapists (RT) emphasizing frequency of changing the ventilator circuits and the timely documentation.

Target Date: August 31, 2009.

The Chief, Respiratory Therapy (with validation from assigned PI Specialist) will conduct a follow-up check for each RT to assure that they are documenting, as appropriate.

Recommendation 11. We recommended that the VISN Director ensure that the System Director requires that all MSIT members receive the required environmental hazards training.

Concur

The Associate Director, Operations will issue a notice to all members of the VAMHCS Multidisciplinary Safety Inspection Team (Administrative Rounds Team) that they must complete training in environmental hazard identification and correction by the end of the fiscal year and then annually thereafter. Compliance may be satisfied with the completion of different educational forums including but not limited to "*Suicide Prevention Guide Training"* (SAVE) or Assessing the Environment for Suicide Risk in Inpatient Units (SOARS film available at http://soars.vssc.med.va.gov/MHVideo/default).

Target Date: August 31, 2009.

At the end of the fiscal year the Executive Assistant to the AD for Operations will determine from educational records that all members of the MSIT have received the annual training.

Target Date: October 31, 2009.

Recommendation 12. We recommended that the VISN Director ensure that the System Director requires that all utility room doors are locked.

Concur

The CNE and AD for Operations office will issue a reminder to all units that all dirty utility rooms must be locked to prevent unauthorized access and protect unauthorized persons from potential exposure to cleaning products, hazardous waste, or equipment. The area supervisors will be charged with determining compliance via random checks. This determination will also be added to the administrative rounds and environmental tracer checklist.

Target Date: September 30, 2009.

Recommendation 13. We recommended that the VISN Director ensure that the System Director requires that signage complies with VHA policy and facilitates patients' and visitors' access to health care.

Concur

The VAMHCS recognized that new signage was needed previously and implemented a long term plan to address the issues through a contract mechanism that has now been funded.

Target Date: December 30, 2009.

There are interim plans that have been developed to address the findings from the OIG visit.

Stairwell door signs are being moved to a more visible area until new signage arrives

Target Date: Completed.

Large sign over ED entrance door now has temporary insert with correct signage made by Medical Media

Target Date: Completed.

Smaller signs within the building are being replaced with temporary coverings displaying required signage

Target Date: August 15, 2009.

A temporary outside sign for the UCC is being produced and will be completed shortly and posted.

Target Date: August 15, 2009.

Recommendation 14. We recommended that the VISN Director ensure that the System Director requires providers to document the review of consultations and, when appropriate, the reasons for the clinical decision to not implement consultation recommendations.

The Chief of Staff Office will issue a reminder to all providers that there should be documentation of their review of the consultation, such as a signature or other evidence. If the requesting provider decides, as a clinical decision, to not implement consultation recommendations, a progress note is needed.

Target Date: August 31, 2009.

A random representative sample will be reviewed to determine if requesting provider acknowledgement is evident or if documentation is present for not implementing a consultation recommendation for the current quarter and subsequent quarters until 90% compliance is achieved.

Target Date: October 31, 2009.

Recommendation 15. We recommended that the VISN Director ensure that the System Director requires staff to complete intra-facility transfer documentation in accordance with JC requirements.

Concur

The Medical Records Committee/designee will review the existing intra-facility transfer process and documentation and develop a formal policy that includes the existing VAMHCS template. This task will include the determination of policy congruence with relevant Joint Commission standards.

Target Date: November 15, 2009.

The COS and CNE will send reminders to direct care providers/nurses concerning the importance of completing intra-facility transfer documentation using the template and/or guideline.

Target Date: August 30, 2009.

The Medical Record Committee will add this indicator to the Service Reviews for ongoing monitoring and reporting by service until 90% compliance is achieved. **Implementation**

Target Date: October 31, 2009.

Recommendation 16. We recommended that the VISN Director ensure that the System Director requires staff to complete discharge documentation to assure consistency between discharge summaries and discharge instructions and to document patient receipt and understanding of discharge instructions.

Concur

The Chief of Staff Office will issue a reminder to all providers that there must be consistent documentation between discharge summaries and discharge instructions, especially as related to current medications. Additionally, the use of the discharge instruction template or other format must include documentation of the patient's receipt of discharge instructions and their understanding must be documented.

Target Date: August 31, 2009.

A random representative sample will be reviewed to determine the level of compliance with the consistency of recommendations on the discharge summary and discharge instructions and if patient receipt and

understanding is documented for the current quarter and subsequent quarters until a 90% compliance rate achieved.

Target Date: November 15, 2009.

Recommendation 17. We recommended that the VISN Director ensure that the System Director requires that responsible clinicians document interdisciplinary treatment plans for breast cancer patients in the electronic medical record.

Concur

The Women's Health Program will have the primary responsibility for assuring that clinicians document an interdisciplinary treatment plan (IDT) in the patient's medical record. The IDT at a minimum will be the summation of the approach determined by the participating providers. Concurrence with the IDT approach will be noted by the additional signatures of the providers.

The Women's Health Program/Managed Care Clinical Center will inform all providers of this requirement.

Target Date: August 15, 2009.

Two (2) quarterly reviews will be conducted on a random sample of patients (not to exceed 30 per period) to determine compliance of at least 90 percent.

Target Date: February 28, 2010.

OIG Contact and Staff Acknowledgments

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