
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 10-02983-55**

# Combined Assessment Program Review of the VA North Texas Health Care System Dallas, Texas

**January 12, 2011**

**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 crime awareness briefings 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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# Glossary

| | |
|---|---|
| C&P | credentialing and privileging |
| CAP | Combined Assessment Program |
| CBOC | community based outpatient clinic |
| CCU | critical care unit |
| CHF | congestive heart failure |
| CLC | community living center |
| COC | coordination of care |
| CNH | contract nursing home |
| CPRS | Computerized Patient Record System |
| ED | emergency department |
| EOC | environment of care |
| FTE | full-time employee equivalents |
| FY | fiscal year |
| IC | infection control |
| ICU | intensive care unit |
| JC | Joint Commission |
| MDRO | multidrug-resistant organisms |
| MH | mental health |
| MICU | medical intensive care unit |
| OEF | Operation Enduring Freedom |
| OIF | Operation Iraqi Freedom |
| OIG | Office of Inspector General |
| OSHA | Occupational Safety and Health Administration |
| PR | peer review |
| PRRTP | Psychosocial Residential Rehabilitation Treatment Program |
| SCI | spinal cord injury |
| SOP | standard operating procedure |
| QM | quality management |
| UM | utilization management |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary: Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, TX

**Review Purpose:** The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of October 18, 2010.

**Review Results:** The review covered seven activities. We made no recommendations in the following activities:

- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishments included the development of an electronic medical records review database adopted by 20 Veterans Health Administration (VHA) facilities and the facility's first place Fiscal Year 2010 Systems Redesign Champion award for Inpatient Systems Redesign.

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Ensure that all peer reviews are completed within the 120-day timeframe or have an extension requested that is approved in writing by the Director. Require that unauthenticated documentation is monitored in accordance with VHA policy.

*Environment of Care:* Conduct a comprehensive risk assessment to address examination tables and sharps containers throughout the facility, and correct identified deficiencies.

*Coordination of Care:* Document advance directive notification, and document advance care planning using approved progress note titles.

*Management of Multidrug-Resistant Organisms:* Ensure that infection strategies education is provided to patients infected or colonized with multidrug-resistant organisms and their families and that the education is documented.

*Management of Test Results:* Ensure that normal results are communicated to patients within the specified timeframe.

## Comments

The VISN and Interim Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. 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

# Objectives and Scope

## Objectives

**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 crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

## Scope

**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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through October 18, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program*

*Review of the VA North Texas Health Care System, Dallas, Texas,* Report No. 06-03482-86, February 26, 2007). We identified two repeat findings in QM.

During this review, we also presented crime awareness briefings for 660 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.

# Reported Accomplishments

## Electronic Medical Records Review Database

In 2009, staff developed a new database to evaluate and audit medical records for completeness. The facility is required to evaluate 75 medical records per month, and each has numerous areas for review. In order to meet regulatory requirements for auditing, staff developed an electronic database that automates the reporting process.

Reports are generated informing providers of opportunities for improvement and omissions in the medical record. Staff members from every service complete medical record reviews, and the information is used by facility managers to improve quality and ensure completeness.

The database was presented to other VHA facilities on a national Health Information Management conference call as a best practice. To date, 20 other facilities have adopted this database.

## VHA Systems Redesign Award

The facility received the first place FY 2010 Systems Redesign Champion Award for Inpatient Systems Redesign. This award was the result of improvements made to the management of patient movement from the inpatient to outpatient care setting. Managing how patients move throughout the facility is an essential part of providing timely, quality care.

Managers implemented daily patient flow huddle meetings on the inpatient units, developed a discharge center, and redesigned the patient transfer process. Patients are assigned discharge appointments, which allows for discharges to be distributed throughout the day. Managers

improved the process of transferring patients into and out of the Dallas campus, which has decreased the lengths of stays for patients hospitalized on the medical/surgical units and the ICUs. As a result of the changes, managers are able to optimize the efficiency of facility resources to expeditiously accommodate patient needs.

These system redesign efforts improved quality and access to care for patients and resulted in a significant cost avoidance of $35 million from 2009 through FY 2010.

# Results

## Review Activities With Recommendations

### QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. Senior managers were very supportive of QM program activities. However, we identified the following areas that needed improvement.

PR. Once the need for a PR is determined, VHA requires that the final review be completed within 120 days or that an extension be requested from and approved in writing by the facility's Director.[1] We reviewed the FY 2010 PR database and noted that 2 (2 percent) of 93 final PRs exceeded the 120-day timeframe and that extensions had not been requested or approved. This is a repeat finding from our previous CAP review.

Medical Records Review. VHA requires that the ongoing medical records review process monitors unauthenticated, electronic documentation.[2] The following documentation must be monitored: (1) lack of notes for outpatient encounters[3] that exist in VHA information systems; (2) unsigned and/or un-cosigned progress notes, addenda, discharge summaries, and operative reports; and (3) unsigned orders. Unsigned electronic documentation cannot be viewed by other clinicians. We found that the required documentation was not monitored on a consistent

[1] VHA Directive, 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[3] An encounter is a professional contact between a patient and a practitioner.

basis and that no data existed regarding the lack of notes for outpatient encounters. With regards to operative reports and post-operative notes, this is a repeat finding from our previous CAP review.

**Recommendations**

**1.** We recommended that all PRs be completed within the 120-day timeframe or have an extension requested that is approved in writing by the facility's Director.

**2.** We recommended that unauthenticated documentation be monitored in accordance with VHA policy.

## EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

At the Dallas campus, we inspected the SCI, MH, OEF/OIF, and Primary Care 3 and 4 clinics; radiology; the ED; the CLC; and the SCI, 7A Medicine, 6C Acute Care, MICU, CCU, and MH units. At the Bonham campus, we inspected the primary care, MH, dental, and specialty clinics; the CLC; and radiology. Both campuses maintained a generally clean and safe environment. We reviewed employee training records for bloodborne pathogens and radiation safety and determined that there was overall compliance with required training. However, we identified the following conditions that needed improvement.

IC. VHA facilities must employ infection prevention and control activities. At the Dallas campus, eight examination tables located in two primary care clinics had torn and cracked surfaces. Examination tables with compromised surfaces may present an IC risk to patients.

Sharps Containers. OSHA requires that containers for needles and other sharp objects are secured, not overfilled, easily accessible, puncture resistant, and leak proof. At the Bonham campus, there were two unsecured containers and three wall-mounted containers that were not easily accessible to all staff.

**Recommendation**

**3.** We recommended that a comprehensive risk assessment be conducted to address examination tables and sharps containers throughout the facility and that identified deficiencies be corrected.

## COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification Documentation. VHA requires that patients be given written notification stating their right to accept or refuse medical treatment, to designate a health care agent, and to document their treatment preferences in an advance directive.[4] We reviewed 10 patients' medical records and found that only 1 (10 percent) had notification documented. The facility is revising their progress note template to incorporate advance directive notification.

Advance Care Planning Progress Note Titles. VHA requires that staff use specific progress note titles when documenting advance care planning discussions with patients.[5] However, the facility's local policy conflicted with this requirement. While we were onsite, managers revised the local policy to include only approved progress note titles.

**Recommendation**

**4.** We recommended that staff document advance directive notification and document advance care planning using approved progress note titles.

## Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected the SCI and medicine units at the Dallas campus and the CLC at the Bonham campus, and we interviewed five employees. We identified no deficits in either the inspections or staff interviews. We reviewed 42 employee MDRO training records and determined that 41 (98 percent) had documentation of required training. However, we identified the following area that needed improvement.

[4] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[5] VHA Handbook 1004.02.

Patient/Family Education. The JC requires that patients infected or colonized[6] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of personal protective equipment. We reviewed 17 medical records and found that 16 (94 percent) of the records did not have documented evidence of MDRO education.

**Recommendation**

**5.** We recommended that infection strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

## Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[7]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following area that needed improvement.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[8] We reviewed the medical records of 20 patients who had normal results and found that only 13 (65 percent) contained documented evidence that the facility had communicated the results to the patients.

**Recommendation**

**6.** We recommended that normal results be communicated to patients within the specified timeframe.

# Review Activities Without Recommendations

## Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared,

[6] Colonization is the presence of bacteria in the body without causing clinical infection.
[7] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[8] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

transported, and administered the medications. We made no recommendations.

**Physician C&P**

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

# Comments

The VISN and Interim Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 16–20 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

| Facility Profile[9] | | |
|---|---|---|
| **Type of Organization** | Tertiary care medical center | |
| **Complexity Level** | 1a | |
| **VISN** | 17 | |
| **CBOCs** | Bridgeport, TX<br>Denton, TX<br>Granbury, TX<br>Greenville, TX<br>Paris, TX<br>Sherman, TX | |
| **Veteran Population in Catchment Area** | Approximately 490,000 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including PRRTP** | 308 | |
| • **CLC** | 196 | |
| • **Domiciliary** | 306 | |
| **Medical School Affiliation(s)** | University of Texas Southwestern Medical School at Dallas<br>Baylor College of Dentistry<br>University of North Texas Health Science Center<br>Texas Woman's University<br>University of Texas at Arlington<br>Texas Tech University | |
| • **Number of Residents** | Approximately 780 | |
| | **Current FY (through August 2010)** | **Prior FY (2009)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $722.9 | $688 |
| • **Medical Care Expenditures** | $635 | $680 |
| **Total Medical Care FTE** | 3,594.1 | 3,592.6 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 101,587 | 103,504 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 60,877 | 76,201 |
| o **CLC/Nursing Home Care Unit** | 51,713 | 64,283 |
| **Hospital Discharges** | 9,499 | 11,700 |
| **Total Average Daily Census (including all bed types)** | 621.5 | 650.4 |
| **Cumulative Occupancy Rate** | 74.06% | 77.71% |
| **Outpatient Visits** | 1,177,475 | 1,177,605 |

[9] All data provided by facility management.

| Follow-Up on Previous Recommendations | | | |
|---|---|---|---|
| **Recommendations** | **Current Status of Corrective Actions Taken** | **In Compliance Y/N** | **Repeat Recommendation? Y/N** |
| **QM Program** | | | |
| 1. Ensure that a comprehensive, effective QM program capable of identifying and resolving quality and patient safety issues is constructed at the facility. The following deficient program areas were identified: | | | |
| • QM oversight | Committee structure and processes were realigned to provide effective oversight of QM activities. | Y | N |
| • Mortality review and analysis | The mortality review process was revised, and mortality reviews are being conducted and analyzed in a timely manner. | Y | N |
| • Patient safety | Root cause analyses are being conducted in accordance with VHA policy, and required actions have been completed for the patient safety alerts. | Y | N |
| • Data tracking, trending, analysis, and reporting | Data is consistently collected, trended, analyzed, and discussed in committees; corrective actions are developed, implemented, and monitored for effectiveness. | Y | N |

| Recommendations | Current Status of Corrective Actions Taken | In Compliance Y/N | Repeat Recommendation? Y/N |
|---|---|---|---|
| • PR | With the exception of the completion of the final review of PR cases within the 120-day timeframe, the PR process is in compliance with VHA policy. | N | Y (see pages 3 and 4) |
| • Adverse event disclosure | Clinical disclosure of adverse events is in compliance with VHA policy. | Y | N |
| • Operative reports | For FY 2010, there is a high volume of delinquent operative reports and brief post-operative progress notes. | N | Y (see pages 3 and 4) |
| 2. Officially appoint and train the UM physician advisor. | A UM physician advisor has been appointed, trained, and certified in accordance with VHA policy. | Y | N |
| **CNH Program** | | | |
| 3. Ensure CNH Program nurses visit veterans in contract nursing facilities and document veterans' medical records as required. | Each veteran in a CNH is visited every 30 days by a social worker or nurse. The visits must be documented in CPRS within 48 hours. The CNH Program Coordinator conducts monthly audits to monitor compliance rates. This information is reviewed by the CNH Review Team monthly, the Community Nursing Home Advisory Committee quarterly, and the Quality Council monthly. | Y | N |

| Recommendations | Current Status of Corrective Actions Taken | In Compliance Y/N | Repeat Recommendation? Y/N |
|---|---|---|---|
| 4. Ensure CNH Program staff increase monitoring of contract nursing facilities not meeting quality or exclusion criteria and document the rationale(s) for contract renewal. | Each CNH is reviewed annually by the CNH Review Team and the CNH Oversight Committee. This review considers the family member, website information, information from the CNH nurse and social worker, and satisfaction with the care.<br><br>If a facility does not meet exclusionary criteria and its contract is renewed, the reasons are clearly documented. These facilities are placed on an action plan, and targeted action items are reviewed during meetings until the actions have been resolved. | Y | N |
| 5. Ensure CNH Program staff enter the appropriate range of billing codes for facility visits. | CNH Program nurses and social workers were trained on November 28, 2006, and again on April 27, 2010. The CNH Program Coordinator reviews billing codes during a monthly random audit. This information is reviewed by the CNH Review Team monthly and the CNH Oversight Committee quarterly. | Y | N |

| Recommendations | Current Status of Corrective Actions Taken | In Compliance Y/N | Repeat Recommendation? Y/N |
|---|---|---|---|
| 6. Ensure CNH Program staff follow standard procedures when using a Government vehicle. | CNH staff have been trained on appropriate use of Government vehicles. For staff assigned to the facility motor pool, the trip ticket system was converted to a travel log. Each employee is assigned a vehicle and must complete the log for each trip. This information is provided to Engineering Service monthly.<br><br>Staff assigned to the Bonham motor pool complete a trip ticket requesting a vehicle. They are assigned a vehicle for that trip. After a trip, staff provide individual trip tickets to Engineering Service | Y | N |
| **CBOCs** | | | |
| 7. Timely implement CPRS at all CBOCs. | All CBOCs have T-1 lines at the clinics; thus, all clinics are now paperless. | Y | N |
| 8. Ensure CBOC staff properly secure veterans' medical information. | All CBOCs are paperless since all sites now have T-1 capabilities. | Y | N |
| 9. Require designated facility staff to review the contractor's annual report for all appropriate performance elements. | Contractor annual reports are evaluated as part of the contract renewal process. Modifications are sent to the clinics for clarification. | Y | N |

| Recommendations | Current Status of Corrective Actions Taken | In Compliance Y/N | Repeat Recommendation? Y/N |
|---|---|---|---|
| 10. Require designated facility inspection team members to follow up on inspection deficiencies and assure completion of corrective actions. | QM nursing staff utilize an inspection form to record deficiencies, which are tracked in a database until completion. | Y | N |
| **Cardiac Catheterization** | | | |
| 11. Require staff to complete informed consents for cardiac catheterization procedures consistent with VHA policy**.** | Informed consent completion is monitored weekly through the leadership dashboard. Catheterization laboratory audits demonstrate 100 percent compliance. | Y | N |

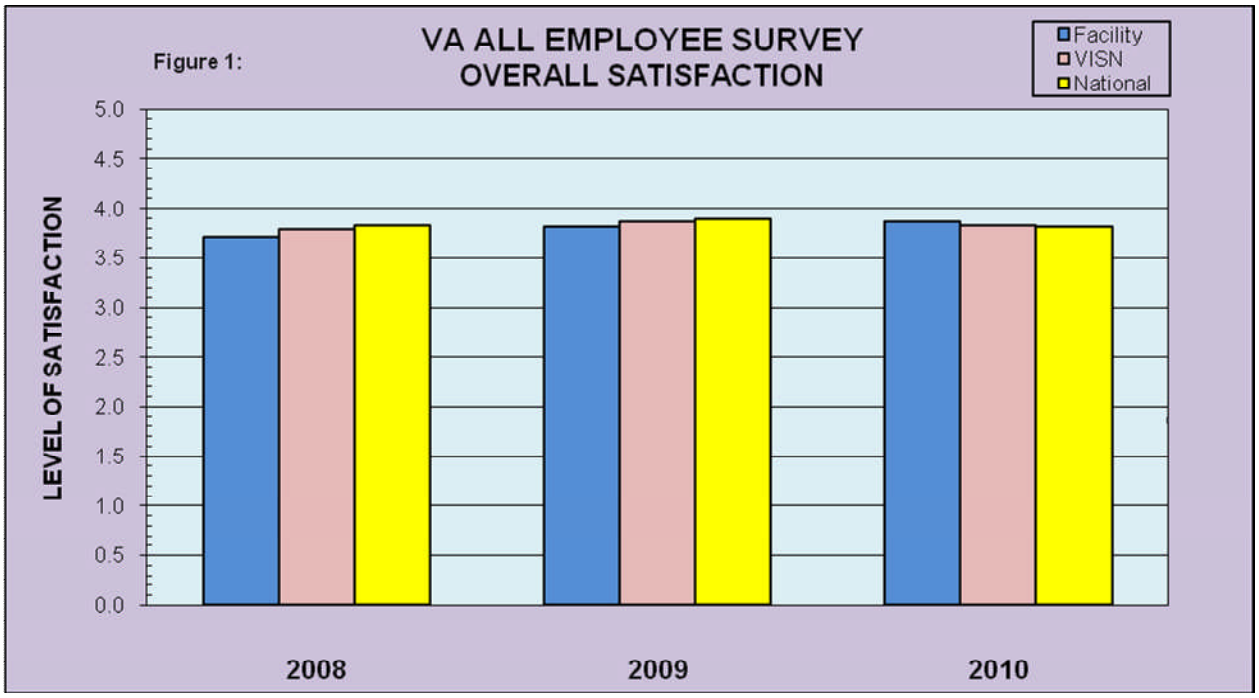
# VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

**Table 1**

| | FY 2010 (inpatient target = 64, outpatient target = 56) | | | | | |
|---|---|---|---|---|---|---|
| | Inpatient Score Quarter 1 | Inpatient Score Quarter 2 | Inpatient Score Quarter 3 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 | Outpatient Score Quarter 3 |
| Facility | 41.9 | 47.3 | 58.1 | 38.7 | 49.3 | 46.2 |
| VISN | 52.1 | 56.0 | 61.8 | 46.1 | 50.5 | 48.4 |
| VHA | 63.3 | 63.9 | 64.5 | 54.7 | 55.2 | 54.8 |

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



# Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[10] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | CHF | Pneumonia | Heart Attack | CHF | Pneumonia |
| Facility | 13.65 | 10.13 | 14.81 | 22.13 | 24.21 | 15.77 |
| VHA | 13.31 | 9.73 | 15.08 | 20.57 | 21.71 | 15.85 |

[10] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** December 14, 2010

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

**Subject:** **CAP Review of the VA North Texas Health Care System, Dallas, TX**

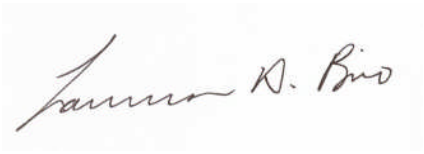
**To:** Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (VHA CO 10B5 Staff)

1. Attached is the response from the VA North Texas Health Care System to the draft report from the Combined Assessment Program Review conducted at the facility October 18th–22nd, 2010.

2. The medical center carefully reviewed all items identified as opportunities for improvement and has concurred with all recommendations. The Network also concurs with the recommendations contained in the report.

3. If you have any questions or need additional information, please contact Judy Finley, VISN 17 QMO, at (817) 385-3761.



Lawrence A. Brio

# Interim Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** December 14, 2010

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

**Subject:** **CAP Review of the VA North Texas Health Care System, Dallas, TX**

**To:** Director, VA Heart of Texas Health Care Network (10N17)

1. We appreciate the opportunity to review the draft report of the Combined Assessment Program Review completed October 18th–22nd, 2010 for the VA North Texas Health Care System in Dallas, Texas.

2. Attached you will find actions for each recommendation. Several of the actions have already been initiated.

3. We would like to extend our appreciation to the entire Office of Inspector General Team who was consultative, professional and provided excellent feedback to our staff. We appreciate their thorough review and the opportunity to further improve the quality care we provide to our Veterans every day.

Shirley M. Bealer

Shirley M. Bealer

# Comments to Office of Inspector General's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that all PRs be completed within the 120-day timeframe or have an extension requested that is approved in writing by the facility's Director.

**Concur**

**Target date for completion:** March 31, 2011

VA North Texas Health Care System (VANTHCS) Clinical Quality Management, Risk Management Section finalized an electronic tracking tool to effectively identify significant deadlines including 120-day PR events. This tool is currently being fully utilized to manage PR timelines.

For three months, the Director of Corporate Quality Management and Customer Service will conduct monthly reviews of the Risk Management tracking tool to validate 100% compliance with prescribed PR 120-day deadlines and completion of extension requests.

**Recommendation 2.** We recommended that unauthenticated documentation be monitored in accordance with VHA policy.

**Concur**

**Target date for completion:** June 30, 2011

In accordance with VHA policy, the Health Information Management Section is collating weekly medical record reports and identifying unauthenticated documentation deficiencies. This data is provided to the Chief of Staff's Office, Health Information Management Committee and Service level leadership for tracking and timely resolution. By June 30, 2011, the Chief of Staff's Office will validate that unauthenticated documentation deficiencies have reduced to 20% or lower.

**Recommendation 3.** We recommended that a comprehensive risk assessment be conducted to address examination tables and sharps containers throughout the facility and that identified deficiencies be corrected.

**Concur**

**Target date for completion:** February 28, 2011

VANTHCS completed an extensive risk analysis identifying examination tables requiring replacement and sharps containers necessitating relocation. The Chief, Engineering Service will validate 100% replacement of identified examination tables. The Bonham Quality Manager Specialist will validate 100% relocation of identified sharps containers.

**Recommendation 4.** We recommended that staff document advance directive notification and document advance care planning using approved progress note titles.

**Concur**

**Target date for completion:** April 29, 2011

Computerized Patient Record System (CPRS) documentation tools were updated to reflect VHA Handbook 1004.02 requirements. The Director of Corporate Quality Management and Customer Service will conduct audits of 30 patients, monthly for four months, to confirm that 95% of advanced care planning notification and documentation has been completed.

**Recommendation 5.** We recommended that infection strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

**Concur**

**Target date for completion:** April 29, 2011

CPRS documentation tools were revised to record MDRO patient education. As of November 16, 2010, nursing staff received education regarding MDRO documentation requirements. The Director of Corporate Quality Management and Customer Service will conduct audits of 30 isolation patients, monthly for four months, to confirm that 95% of MDRO patient education is documented.

**Recommendation 6.** We recommended that normal results be communicated to patients within the specified timeframe.

**Concur**

**Target date for completion:** August 31, 2011

VANTHCS addressed this recommendation with a systems redesign approach. The redesign will encompass these improvements:

- Formulate healthcare system policy to meet Directive 2009-019
- Develop laboratory results communication tools
- Refine methods and resources needed to implement redesigned processes
- Implement redesigned processes and communications tools

- From June 1st through August 31, 2011, the Director of Corporate Quality Management and Customer Service will conduct monthly audits of 40 patients with normal test results to validate 90% compliance with facility's guidelines addressing communication of normal test results.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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| **Report Preparation** | Produced under the direction of Verena Briley-Hudson, MN, RN<br>Director, Chicago Office of Healthcare Inspections |

# Report Distribution

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U.S. House of Representatives: Joe Barton, Dan Boren, Michael Burgess, Bill Flores, Louie Gohmert, Kay Granger, Ralph M. Hall, Jeb Hensarling, Eddie Bernice Johnson, Sam Johnson, Kenny Marchant, Randy Neugebauer, Pete Sessions, Mac Thornberry

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