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**Administrative Case Closure
Administrative Investigative Board
Atlanta VA Medical Center
2006-03056-HI-0410**

The Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to review the Atlanta VA Medical Center's (medical center) response to recommendations made by an Administrative Investigative Board (AIB) regarding allegations of improper conduct involving Registered Nurses (RN) and Master Social Workers (MSW) activities in the oversight of the Community Nursing Home (CNH) program.

Background

The purpose of the AIB was to investigate allegations of improper conduct at the medical center in the oversight of the CNH program. More specifically, during the OIG Combined Assessment Program (CAP) review May 2006, employees at three contracted community nursing homes stated that they were not aware of VA RNs or social workers visiting patients every 30 days as required in VA Handbook 1143.2.

Scope and Methodology

Our OIG CAP inspection included interviews with the CNH Coordinator, Chief of Geriatrics and Extended Care and Rehabilitation Service Line, and members of the CNH Oversight Committee. During the CAP review, we also conducted site visits to CNHs involved in this case and reviewed related documents, such as policies and procedures, medical record audits, and the medical center's June 16, 2006, AIB report that made nine recommendations

Results of AIB Recommendations

Issue 1: Based on the employee's actions, an RN was referred to Human Resources for appropriate disciplinary actions.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2. As a result of personnel review for the CNH program, additional staff have been hired, transferred in house, or re-trained to provide appropriate quality of care.

Issue 2: Revised CNH protocols must be received at all CNHs by May 30, 2006.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2.

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Issue 3: Geriatrics Service Line must establish accountability and oversight of the CNH program by adding random monthly audits of 10 percent of progress notes.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2. Monthly audits are reviewed by Chief, Geriatrics and Extended Care and Rehabilitation Service Line and the CNH Oversight Committee.

Issue 4: Contract quality assurance personnel must review and ensure CNHs compliance with VA contract agreements.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2.

Issue 5: CNH policies must be revised and distributed to contracted CNHs to include expectations regarding procedures for visiting facilities, communication among staff, and content and timeliness of progress notes by August 11, 2006.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2. The deadline of August 11, 2006 was met, and staff verbalized an understanding of the revisions to the policy.

Issue 6: By June 29, 2006, CNH team must establish weekly meetings to discuss patient progress and ensure follow up on identified issues.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2. Weekly meetings are clinically oriented to improve outcomes of veterans' care. However, there is limited documentation of these meetings. Future plans include improving the documentation process in this area.

Issue 7: CNH staff, including backup coverage, are required to have thorough education and training by August 30, 2006.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2. Adequate evidence of education and training has been established.

Issue 8: Medical center must establish a policy on medical record documentation (cutting and pasting) by August 14, 2006.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2. Medical Center Memorandum 16-23, Copying, Pasting, and Template Use in the

Electronic Medical Record, was published September 5, 2006. Staff participated in the creation of this memorandum and are currently being trained on the final published guidelines.

Issue 9: Contingency plans, including coverage for CNH program staffing, must be established by August 30, 2006.

The medical center implemented an effective action plan which met the recommendation of the AIB and concurred with VHA Handbook 1143.2. A written contingency plan for nurse staffing exists. The contingency plan for social worker coverage is not written but is clearly understood by the CNH program staff.

Conclusion

All recommendations from the AIB were followed up in a timely manner by medical center managers, and action plans were implemented to meet the intent of the AIB recommendations and VHA Handbook 1143.2. The medical center has taken action to improve documentation of weekly meetings and to improve oversight as related to the CNH program.

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