DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia

HEALTHCARE INSPECTION | REPORT #20-01480-31 | DECEMBER 16, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia, to assess allegations from an anonymous complainant that deficiencies in care coordination between facility staff and remote telemedicine intensive care unit (tele-ICU) staff resulted in deaths, injuries, or poor outcomes for patients in the critical care unit (CCU) after general surgery residents (residents) were withdrawn.[1] The complaint provided names of six patients allegedly affected.[2] The residents, who were supervised by attending physicians (surgical intensivists) had been available to assess and care for patients during business hours as well as off-hours and weekends.[3] The complaint further alleged that the "decision to keep the surgical program running with tele-ICU services without housestaff has been cavalier."[4]

The OIG confirmed that the residents were withdrawn. Prior to July 2019, residents from Augusta University were available at the facility to provide care to patients, including during off-hours, as the facility participated with Augusta University in the provision of graduate medical education training. In July 2019, Augusta University decided to no longer place residents at the facility, in part because of decreased clinical learning opportunities.[5] In the absence of on-site residents who were no longer available during off-hours and weekends, surgical intensivists (who were on-call but not on-site) relied on CCU nursing staff and remote tele-ICU staff to assess patients and relay patient care information.

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[1] VA. *About the VISN 10 Tele-ICU Program*. https://dvagov.sharepoint.com/sites/VHAV10Councils/Home/HS/CriticalCare/teleicu/SitePages/Home.aspx. (The website was accessed April 8, 2020; this is an internal site not publicly accessible.) Veterans Integrated Service Network 10 offers tele-ICU services, which includes "a bidirectional audiovisual technology uniting bedside ICU providers with remotely located critical care intensivists." Beginning in 2014, the facility affiliated with the VISN 10 Tele-ICU Program. Specific tele-ICU services were outlined in a Memorandum of Understanding and a Telehealth Service Agreement. Tele-ICU staff support facility staff remotely, and do not replace bedside staff. Accreditation Council For Graduate Medical Education, *About Us*. https://www.acgme.org/Portals/0/PDFs/ACGME_Website_Guide.pdf?ver=2016-03-24-134312-827. (The website was accessed on September 10, 2020.) Residents are fully licensed physicians who are in a graduate medical education program designed to provide clinical training and experience in a particular specialty or subspecialty.

[2] The records of one of the six patients was reviewed and addressed by the OIG in a previous report and was not reviewed again in this report.

[3] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. An attending physician is a supervising practitioner. The handbook was in effect during the time frame of the events discussed in this report; it was rescinded and replaced by VHA Directive *Supervision of Physicians, Dental, Optometry, Chiropractic, and Podiatry Residents* in November 2019. The 2019 directive contains the same or similar language related to supervising and attending physicians. Within the context of facility residents, attending physicians were surgical intensivists.

[4] The OIG interpreted *housestaff* to be synonymous with residents and *cavalier* to mean irresponsible.

[5] Department of Surgery, Augusta University. *Surgical Clinical Care and Education at the Charlie Norwood Veterans Administration: A Future of Shared Excellence,* January 2018.

The OIG substantiated that there were deficiencies in care coordination between facility staff and tele-ICU staff. The OIG evaluated the electronic health records of the patients submitted as examples to support the allegations and was unable to determine that withdrawal of the residents and care coordination deficiencies resulted in deaths, injuries, or poor outcomes.

The OIG found that communication between CCU and tele-ICU staff was sometimes challenging. During interviews with the OIG, CCU staff noted

- Tele-ICU was not often utilized and interactions with tele-ICU staff were not initiated because the use of tele-ICU was disruptive;
- Tele-ICU staff had advised that tele-ICU patient alarms activated two to three minutes after CCU patient alarms, which caused concern with delayed response to patients' deteriorations; and
- There was frustration with the tele-ICU service when tele-ICU staff made recommendations about patient care but were not physically present in a patient's room.

In addition, the facility policy for the on-call process did not provide specific guidance on procedures between the CCU and tele-ICU.

The OIG determined that a combination of misunderstanding of the tele-ICU program and a lack of CCU staff engagement with tele-ICU staff to assist with the direct co-management of monitored patients contributed to a challenging relationship and an impaired communication process.

While the OIG did not consider the facility's decision to continue the surgical program after the residents were withdrawn to be cavalier, the OIG identified that facility leaders were aware of the potential of the withdrawal of surgery residents but did not take actions to ensure that effective processes were in place should they withdraw. Leaders were not proactive in developing, disseminating, and ensuring the effectiveness of algorithms for surgical intensivists and nursing staff to address the care of post-operative patients in the CCU, including communication between facility and tele-ICU staff about the co-management of the CCU patients. [6]

During the inspection, the OIG found challenges that limited the efficiency and effectiveness of the tele-ICU process including noncompliance with requirements outlined in the Memorandum of Understanding and Telehealth Service Agreement between the facility and the tele-ICU regarding

[6] UMass Memorial Medical Center, *Surgical Intensivist*. https://www.umassmemorialhealthcare.org/umass-memorial-medical-center/services-treatments/critical-care/what-intensivist. (The website was accessed on September 10, 2020.) Surgical intensivists are physicians who provide care for critically ill patients and have advanced training and experience in treating this complex type of patient.

- Quality management review processes;
- Equipment and technical issues; and
- Orientation and competency training of CCU and tele-ICU staff.

Deficient quality management processes included reporting and evaluating patient safety events, as well as conducting and participating in peer reviews. Facility staff and tele-ICU staff did not report, and therefore, patient safety staff did not evaluate, tele-ICU patient safety events, nor did facility staff and tele-ICU staff conduct or participate in peer reviews as required.

According to the Telehealth Service Agreement, facility CCU staff must enter an electronic work order to report tele-ICU equipment problems noted at the facility to allow for addressing and tracking of malfunctioning equipment and technical issues. Facility staff did not identify and address tele-ICU equipment and technical issues as required.

The OIG concluded that deficient orientation and competency training of CCU and facility support staff contributed to a lack of knowledge regarding which provider should be notified when concern for a CCU patient's condition arose. Within the context of a patient care setting, miscommunication has the potential for poor outcomes.

The OIG made six recommendations to the Facility Director related to communication and coordination between facility and tele-ICU staff, on-call processes, a written plan outlining medicine and surgery staff responsibilities, patient safety reporting training, quality review collaboration processes, and orientation and competency training. The OIG made two recommendations to the Veterans Integrated Service Network 10 Tele-ICU Medical Director related to patient safety reporting training, patient care review processes training, and coordination of patient care reviews with facility staff.

Comments

Directors for Veterans Integrated Service Networks 7 and 10 as well as Facility and Telemedicine Intensive Care Unit Directors concurred with the recommendations and provided acceptable action plans (see appendixes B, C, D and E). The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

CCU	Critical Care Unit
EHR	electronic health record
ICU	intensive care unit
MOU	Memorandum of Understanding
OIG	Office of Inspector General
tele-ICU	telemedicine intensive care unit
TSA	Telehealth Service Agreement
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia, to assess allegations from an anonymous complainant that deficiencies in care coordination between facility staff and remote telemedicine intensive care unit (tele-ICU) staff resulted in deaths, injuries, or poor outcomes for patients in the critical care unit (CCU) after general surgery residents (residents) were withdrawn.[1] The residents, who were supervised by attending physicians (surgical intensivists) had been available to assess and care for patients during business hours as well as off-hours and weekends.[2] The complaint further alleged that the "decision to keep the surgical program running with tele-ICU services without housestaff has been cavalier."[3]

The facility, part of Veterans Integrated Service Network (VISN) 7, is a two-division medical center providing tertiary care in medicine, surgery, neurology, psychiatry, rehabilitation medicine, and spinal cord injury. The Veterans Health Administration (VHA) classifies the facility as level 1a–highest complexity.[4] From October 1, 2018, through September 30, 2019, the facility served 46,350 patients and had a total of 407 hospital operating beds, including 215 inpatient, 60 domiciliary, and 132 community living center beds. The facility has sharing agreements with Eisenhower Army Medical Center at Fort Gordon, Georgia, and is affiliated with Augusta University.

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[1] VA. *About the VISN 10 Tele-ICU Program*. https://dvagov.sharepoint.com/sites/VHAV10Councils/Home/HS/CriticalCare/teleicu/SitePages/Home.aspx. (The website was accessed April 8, 2020; this is an internal site not accessible to the public.) Veterans Integrated Service Network (VISN) 10 offers tele- intensive care unit (ICU) services, which includes "a bidirectional audiovisual technology uniting bedside ICU providers with remotely located critical care intensivists." Beginning in 2014, the facility affiliated with the VISN 10 Tele-ICU Program. Specific tele-ICU services were outlined in a Memorandum of Understanding and a Telehealth Service Agreement. Tele-ICU staff support facility staff remotely, and do not replace bedside staff. Accreditation Council For Graduate Medical Education, *About Us*. https://www.acgme.org/Portals/0/PDFs/ACGME_Website_Guide.pdf?ver=2016-03-24-134312-827. (The website was accessed on September 10, 2020.) Residents are fully licensed physicians who are in a graduate medical education program designed to provide clinical training and experience in a particular specialty or subspecialty.

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[3] The OIG interpreted *housestaff* to be synonymous with residents and *cavalier* to mean irresponsible.

[4] VHA facilities are categorized into one of five groups from most complex to least complex. The highest complexity, 1a facilities, have a high volume of patients, high-risk patients (based on severity of illnesses/diagnoses), the most complex clinical programs, and large research and teaching programs. http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (The website was accessed on November 14, 2019.)

The facility's CCU includes 10 intensive care unit beds and nine stepdown beds. Placement in an intensive care unit (ICU) bed allows monitoring and treatment of seriously ill medical and surgical patients using special medical equipment and services. Medical and surgical patients placed in a stepdown bed require less than intensive care but more than general inpatient care.[5]

The facility's invasive procedure complexity is designated "Inpatient Complex" by VHA based upon the capability of the facility related to the infrastructure and the complexity of surgical procedures performed.[6]

Specifically, VHA requires that Inpatient Complex facilities have

- Dedicated 24 hours a day, 7 days a week (24/7) critical care service coverage with daily multidisciplinary rounds;
- Specialized technology and board-certified specialists, as applicable, for approved invasive programs;
- Thoracic and vascular surgical consultants available 24/7 within 15 minutes by phone and on-site within 60 minutes;
- A formal call schedule for general surgery and specialty service attending physicians;
- ICU intensivist coverage on-site during day shifts and on-call during off-hours;[7]
- ICU intensivists available on-call within 15 minutes by phone and on-site within 60 minutes; and
- An ICU intensivist available within 15 minutes by phone and on-site within 60 minutes to supplement care and treatment when off-hours coverage is provided by tele-ICU.[8]

VHA inpatient telemedicine began in 2012. The VHA Tele-ICU Program, is currently affiliated with 37 different VHA facilities, including the facility, and provides remote monitoring services to nearly 25 percent of all VHA ICU beds.[9] Tele-ICU staff support facility staff, but do not

[5] Facility Policy Memorandum 03-17-34, *Admission and Discharge Criteria: Step Down Unit*, May 24, 2017.

[6] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting*, May 13, 2019, amended February 11, 2020. The 2020 amendments included updates related to infrastructure requirements for VA medical facilities performing invasive procedures in any clinical setting and established multiple levels of Invasive Procedure Complexity designations related to performing the most basic outpatient invasive procedure in the clinic to the most complex surgical procedures in an operating room.

[7] The OIG defined off-hours as 7:00 p.m.–7:00 a.m. Monday through Thursday and all day on weekends beginning on Friday at 7:00 p.m. through 7:00 a.m. Monday and holidays.

[8] VHA Directive 1220(1).

[9] VA. *About the VISN 10 Tele-ICU Program*. https://dvagov.sharepoint.com/sites/VHAV10Councils/Home/HS/CriticalCare/teleicu/SitePages/Home.aspx. (The website was accessed April 8, 2020; this is an internal site not accessible to the public.) The VISN 10 tele-ICU, part of the VHA Tele-ICU Program, covers 18 different VA facilities.

replace existing services or bedside staff who are the primary care team and have ultimate authority for patient treatment decisions.

Tele-ICU services have been provided to the facility by the VISN 10 Tele-ICU Program since 2014 through a Memorandum of Understanding (MOU).[10] Services included tele-ICU critical care nurse monitoring of facility patients 24/7 and tele-ICU physician monitoring in the evenings from 4:00 p.m. until 7:00 a.m. the following day. Tele-ICU physicians also provided coverage over weekends and holidays beginning at 4:00 p.m. before the weekend or holiday and ending at 7:00 a.m. following a weekend or holiday. Tele-ICU physicians assisted with the direct co-management of monitored patients when facility physicians were not readily available to assess or assist patients, for example, during off-hours.

Prior to July 1, 2019, the facility had on-site off-hour CCU general surgery coverage provided by Augusta University residents, with tele-ICU staff as backup. Tele-ICU leaders employed the following processes to provide continuity of care and obtain change of shift information on CCU patients:

- Tele-ICU staff used a report board to communicate which patients met certain acuity criteria and required follow up.
- Tele-ICU staff huddled at 7:00 a.m. and 7:00 p.m. and signed out the high acuity patients.[11]
- Tele-ICU staff accessed data through the patient electronic health record (EHR).

Beginning on July 1, 2019, after the loss of the on-site residents, tele-ICU staff became the off-hour coverage for CCU post-operative general, vascular, and thoracic surgical patients. On-site backup coverage was provided by the facility on-call surgical intensivist and surgeon. In response, the following processes were added to provide continuity of care and obtain change of shift information on CCU patients:

- Tele-ICU staff received a patient status report from the post-operative patient's anesthesiologist or surgeon upon the patient's arrival from the operating room.[12]

[10] The January 2017 *Memorandum of Understanding for Telehealth Credentialing and Privileging (MOU)* entered into by the VISN 10 Tele-ICU and the facility defines the expectations of both parties with regard to credentialing and privileging of providers in the provision of tele-ICU service delivery. The MOU required the execution of a Telehealth Service Agreement that specified business and technical details of teleconsultative and telemedicine operations. In accordance with this requirement, the VISN 10 Tele-ICU and the facility entered into a Telehealth Service Agreement that defined the responsibilities and procedures involved in establishing and operating a telehealth service between them.

[11] Institute for Healthcare Improvement, *Huddles*. http://www.ihi.org/resources/Pages/Tools/Huddles.aspx. (The website was accessed on November 17, 2020.) "A short, stand-up meeting—10 minutes or less—that is typically used once at the start of each work day in a clinical setting."

[12] A red button on the wall (the eLert button) in patient rooms was available for CCU nurses, physicians, and staff to use to communicate with tele-ICU staff.

- Tele-ICU staff received a telephone call from facility surgical intensivists, before leaving for the day, with an update on all patients in the CCU.

Prior OIG Reports

On May 12, 2020, the OIG published *Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia*.[13] The report outlined noncompliant practices and other deficits that contributed to adverse patient events and clinical outcomes. Due to the lack of consistent documentation, the OIG was unable to determine whether insufficient nurse staffing contributed to many of the patient events outlined in the allegations. The OIG made six recommendations related to compliance with VHA and facility requirements for pressure injury prevention and management including nursing documentation; processes for cardiac monitoring and tele-ICU services; evaluation of the circumstances surrounding the respiratory care for a patient; processes for securing sitters; and CCU nursing staff assignment practices. Four recommendations remained open as of November 24, 2020.

On July 11, 2019, the OIG published *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*.[14] The report outlined facility challenges including leadership and staffing deficits, quality of care failures, leaders' failures to take action, and other concerns including nursing competencies, staffing, hiring, and long-term problems in the emergency department. The OIG did not substantiate most of the allegations related to CCU-specific policies and patient care failures; however, the OIG confirmed that CCU nurse staffing could be problematic, and that communication about, and understanding of, certain policies was inadequate. The OIG also confirmed poor nursing morale in several areas, which interviewees attributed to inadequate nurse staffing levels, guidance, and accountability. The OIG made 27 recommendations, several of which concerned CCU nurse staffing and related issues. Three remained open as of November 24, 2020. Specifically, the OIG recommended that CCU staffing decisions include contingencies for staff absences; efforts to recruit and hire for CCU nurse vacancies be continued and that, until optimal staffing was attained, alternate methods consistently be available to meet patient care needs; and that unexcused nursing absences be addressed.

Allegations

In mid-December 2019, the OIG received anonymous allegations that deficiencies in care coordination between facility staff and tele-ICU staff resulted in deaths, injuries, or poor outcomes for post-operative patients in the CCU after on-site residents who had provided

[13] VA OIG, *Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia, Report* No. 19-08296-118, May 12, 2020.

[14] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia,* Report No. 19-00497-161, July 11, 2019.

coverage for surgical patients after hours and on the weekend were withdrawn. The allegations included the names of six patients with care concerns. In addition, the allegations cited that leaders' "decision to keep the surgical program running with tele-ICU services without housestaff has been cavalier."[15]

One of the patients was reviewed and addressed during a prior OIG inspection; the OIG substantiated that the patient developed a life-threatening arrhythmia that was unwitnessed and not responded to timely. It was determined the facility adequately addressed consideration of an institutional disclosure based on the circumstances surrounding the patient's cardiac arrest.[16]

The initial allegations also included general concerns about the facility's inability to cover specialties including cardiology, imaging, hematology, respiratory, neurosurgery, and nephrology; demoralized nursing staff calling in sick; and noted deficiencies in the respiratory therapy department that have gone unaddressed; and the unsafe practice of the CCU charge nurse being assigned to care for patients. These or similar concerns were addressed in previous OIG reports; therefore, the OIG did not address those issues in this report.[17]

During the inspection, the OIG noted possible deficiencies with the integration of the tele-ICU into the facility's quality management processes that are discussed in section 3—noncompliance with MOU and Telehealth Service Agreement (TSA) requirements.

Scope and Methodology

The OIG initiated the inspection on March 9, 2020, and conducted the inspection remotely due to the COVID-19 pandemic.

The OIG interviewed the VISN 7 Chief Surgical Consultant, the facility's Director, Associate Director for Patient Care Services, Chief of Staff, Associate Director, Deputy Chief of Staff, Associate Chief of Staff for Education and Affiliations, Chief of Surgery, Chief of CCU, CCU Nurse Manager, Chief of Biomedical Engineering, Chief of Quality Management, Patient Safety Manager, Clinical Risk Manager, and relevant facility staff with knowledge of the issues. The OIG also interviewed the tele-ICU's Associate Medical Director, Operations Director, Chief Health Informatics Officer, Patient Safety Coordinator, Systems Administrator, and relevant tele-ICU staff with knowledge of the issues.

The OIG reviewed relevant VHA directives and facility policies, the facility's tele-ICU MOU and TSA, guidelines, protocols, algorithms, CCU training and competency files, and other

[15] The OIG interpreted *housestaff* to be synonymous with residents and *cavalier* to mean irresponsible.

[16] VA OIG Report No. 19-08296-118.

[17] VA OIG Report No. 19-00497-161; VA OIG Report No. 19-08296-118.

documents pertinent to the on-call issues. The OIG reviewed EHRs of five patients for time frames relevant to each patient's care.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, § 7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Deficiencies in CCU and Tele-ICU Patient Care Processes

The OIG substantiated that there were deficiencies in care coordination between facility staff and tele-ICU staff after the residents were withdrawn. However, the OIG was unable to determine that the withdrawal of the residents and the care coordination deficiencies resulted in deaths, injuries, or poor outcomes in the five patients identified in the allegations.

Results of OIG's EHR Reviews

The OIG was unable to clarify specifics of the anonymously submitted allegations. Therefore, the OIG evaluated the EHRs of the five patients submitted as examples to support the allegations:

- Two of the five patients were deceased. The OIG review found that the patients' deaths were due to multiple co-morbidities and clinically challenging post-operative complications.

The OIG found that none of the three remaining cases had poor outcomes related to the allegations:

- A patient in the CCU had an arterial line to monitor blood pressure and vital signs.[18] The arterial line was not consistently functional, so the tele-ICU physician instructed the CCU nurse to begin taking manual blood pressure checks. A decision was made later that morning to maintain the arterial line for another day to facilitate drawing blood for laboratory tests. The following day, the arterial line was discontinued and the patient was discharged home.
- A post-operative patient had an episode of difficulty breathing and became unresponsive while in the CCU, which was treated by insertion of a breathing tube. The following day the patient was more awake and alert, and tolerated removal of the breathing tube. Tele-ICU staff continued to assist with the patient's care during the following evening while the patient resumed use of a continuous positive airway pressure machine for breathing. The patient did well and was transferred to the general medical floor and discharged from the hospital six days later.
- A patient allegedly had a cardiac arrest in the CCU. The OIG found that the patient experienced the cardiac arrest on a general medicine/surgery floor prior to transfer to the CCU.

[18] Albert Dahan, Dirk Engberts, and Marieke Niesters, "Arterial Line Placement: Safety First," *Anesthesiology* 124, no. 3 (March 2016): 528-529. Arterial lines are used to closely monitor blood pressure and heart function in critically ill patients.

Facility CCU and Tele-ICU Communication Issues

The OIG was told during interviews with facility CCU staff that the relationship between the CCU and tele-ICU staff was contentious at times.

VHA policy does not require 24/7 on-site surgical physicians such as residents.[19] In a news article, VA recognized that "As part of the overall telehealth program, eICU [tele-ICU] enables a co-located team of trained critical care physicians and nurses to remotely monitor patients in the ICU regardless of patient location."[20] The article also discussed VHA plans to expand and improve the tele-critical care program.

CCU staff nurses stated during interviews that the tele-ICU was not often utilized and interactions with tele-ICU staff were not initiated because the use of tele-ICU was disruptive. CCU staff also reported that tele-ICU staff had advised that tele-ICU patient alarms activated two to three minutes after CCU patient alarms, which caused concern with delayed response to patients' deteriorations. A facility physician stated during an OIG interview that monitoring a patient for deterioration was "very hard to do it [*sic*] from a camera." CCU staff also stated there was frustration with the tele-ICU service when tele-ICU staff made recommendations about patient care but were not physically present in a patient's room. The OIG was told that CCU nursing staff were unaware of tele-ICU staff credentials, experience, or background, and CCU staff did not know tele-ICU staff critical care expertise when providing care for a CCU patient. CCU staff were not aware of any policy that identified criteria for a tele-ICU evaluation versus an in-person evaluation of a patient or when to call the tele-ICU physician.

The tele-ICU service planned a March 2020 site visit to the facility to discuss process improvements but the visit was postponed due to travel restrictions related to the COVID-19 pandemic. Planned topics of discussion included

- Improved integration of the facility CCU with tele-ICU (a 2020 goal of the tele-ICU service),
- Barriers to tele-ICU integration,
- Aspects of tele-ICU that are working well,
- Areas for improvement, and
- Fostering of more team building.

During interviews, the OIG found that communication between CCU and tele-ICU staff was sometimes challenging. The OIG determined that a combination of misunderstanding of the

[19] VHA Directive 1220(1).

[20] Fierce Healthcare, *VA inks 10-year, $100M deal with Philips for remote critical care services*, www.fiercehealthcare.com/tech/va-inks-10-year-100m-deal-philips-for-remote-critical-care-services, Heather Landi, July 8, 2020. (The website was accessed on July 9, 2020).

tele-ICU program and a lack of CCU staff engagement with tele-ICU staff to assist with the direct co-management of monitored patients contributed to a challenging relationship and an impaired communication process.

Although the tele-ICU TSA included the facility's responsibility to ensure CCU physicians' and healthcare staff's orientation to tele-ICU service and technology, there was no evidence to support that orientation was provided. Orientation and training may have resolved some of the deficiencies causing the contentious and challenging environment between the CCU and tele-ICU staff (see discussion of orientation and training in section 3).

Deficient Surgical On-Call Processes

The Facility Director issued an on-call policy in February 2019; however, it did not specifically address CCU and tele-ICU processes.[21] When the facility initiated tele-ICU in 2014, surgical off-hours coverage was provided by Augusta University residents. During an OIG interview, a tele-ICU associate director stated that prior to the withdrawal of surgical residents by Augusta University, tele-ICU provided assistance as needed to the residents and stated, "the first call is always going to go to residents for in-house [on-site], and we're kind of the backup for emergencies as well as staffing issues." During an OIG interview, a facility surgical intensivist stated that loss of Augusta University surgical residents created a void of off-hours coverage and, until that point, surgical intensivists rarely used tele-ICU services.

Before and after the withdrawal of the surgical residents, the facility had surgical on-call schedules and disseminated the instructions and expectations of the surgical on-call process to all relevant staff. However, facility CCU and tele-ICU staff had a mixed understanding of on-call expectations and requirements. A surgical intensivist told the OIG that whether to call the surgical intensivist or the tele-ICU physician, or both, was nurse dependent. For example, the OIG found that a patient in their 50s with a history of breathing problems, high blood pressure, and alcohol use disorder was admitted for abdominal cancer surgery in late 2019.[22] Post-operatively the patient was admitted to the CCU with tele-ICU support.

Early the next morning, the tele-ICU physician was contacted by a CCU nurse after the patient passed a bloody stool. The nurse notified the tele-ICU physician that the patient's hemoglobin had dropped significantly from the prior day. The tele-ICU physician advised the nurse and documented in the EHR that, "I am a tele-provider and cannot visually assess what was passed," recommended the nurse contact the on-call surgeon, and ordered a hemoglobin test be repeated later that morning. The nurse spoke with other CCU staff and was told that since the tele-ICU physician had been notified and a repeat hemoglobin was ordered, there was little else that could be done. The tele-ICU physician documented in the EHR, "Notified by bedside ICU RN

[21] Facility Policy 6025, *On Call Staff Guidelines*, February 15, 2019.

[22] The OIG uses the singular form of they (their) in this instance for patient privacy purposes.

[registered nurse], tele-ICU is only coverage for SICU [surgical intensive care unit]." The patient had clinical decline while in the CCU that necessitated multiple physician interventions. The patient died four days after the surgery. The OIG found that the patient's tele-ICU physician was not aware of any policy that provided guidance to CCU staff or to the tele-ICU physician regarding when to contact the facility on-call surgeon.

The OIG also found that after the patient's death, the facility identified communication and coordination deficiencies between facility CCU staff and tele-ICU staff. As a result, the facility postponed elective general surgery cases for patients requiring post-operative admission to the CCU from December 17, 2019, through February 2, 2020.

During the six-week postponement, the facility developed CCU general surgery patient care algorithms to be followed by facility surgical intensivists and CCU staff for off-hours:

- A surgical intensivist algorithm formalized communication between facility physicians and tele-ICU physicians including a process to "sign out all surgery patients in the ICU and stepdown units to the tele-ICU intensivist."
- A CCU nursing staff algorithm formalized communication between CCU nursing staff, the facility's on-call surgical intensivist, and tele-ICU physicians related to patient care concerns or changes in condition. Communication between CCU nursing staff and the tele-ICU physician could be made via the eLert system or through a phone call to a designated number. Should CCU nursing staff contact the tele-ICU physician, they were to notify the on-call surgical intensivist, continue patient care, and document concerns, calls, and orders in the EHR.

General surgery post-operative CCU admissions resumed on February 3, 2020.

Although the OIG did not substantiate the allegations related to the five patients, the OIG identified the need to improve facility and tele-ICU processes such as the integration of the facility CCU with tele-ICU. The tele-ICU TSA delegated responsibility to the facility to ensure CCU physicians and healthcare staff were oriented to the tele-ICU service and technology. As noted above, orientation may have resolved some of the deficiencies leading to a contentious and challenging environment between the CCU and tele-ICU staff. In addition, the OIG found that the facility-wide policy for the on-call process did not provide guidance on processes between the CCU and tele-ICU. The facility was not proactive in establishing CCU on-call protocols until after the death of a CCU surgical patient.

2. Facility Leaders' Lack of Proactive Planning

While the OIG did not consider the facility's decision to continue the surgical program after the residents were withdrawn to be cavalier, the OIG identified that facility leaders were aware of

the potential of the withdrawal of the residents but did not take actions to ensure that effective processes were in place should they withdraw.[23]

At the end of June 2019, facility leaders were made aware that Augusta University would no longer be providing residents to work at the facility starting July 1, 2019. Facility leaders were unable to prevent or delay withdrawal of the residents. The acting Chief of Surgery requested that all surgical division directors describe the impact of the loss of residents to facility surgical services. The acting Chief of Surgery sent an interim CCU coverage plan to the CCU medical director that specifically stated the following:

1. Any patient admitted to the ICU or SDU [CCU] will have admission orders written by the admitting service. The case will be reviewed with the covering surgical intensivist upon admission. The Intensivist will be first call on these patients until 7 p.m.
2. At 7 p.m. the Surgical intensivist will sign out to Tele-ICU.
3. After 7 p.m. to 7 a.m., Tele-ICU will be first notification for nursing, respiratory therapy questions. Specific post-operative surgical questions will be referred to the ICU service. For major changes in the patient, the Surgical intensivist will be called as well.

The acting Chief of Surgery also emailed the surgical staff with a change in coverage due to the loss of the residents that

> For the next 2 weeks or until further notice our approach for these services include
>
> 1. Reschedule any patient that would require an inpatient stay after surgery,
> 2. Any patient that is admitted to the ED [emergency department] requiring or likely to require emergency surgery should be transferred,
> 3. For any inpatient that should require emergency surgery for these specialties should be transferred,
> 4. Consultation regarding a patient in the ED or inpatient should be directed to that Attending on-call.

VHA requires a written plan for addressing the responsibilities of medicine and surgery staff in the care of post-operative patients in the CCU.[24] The OIG requested the required written plans addressing responsibilities for post-operative patients in the CCU that were in place after

[23] As noted above, the OIG interpreted *housestaff* to be synonymous with residents and *cavalier* to mean irresponsible.

[24] VHA Directive 1220(1).

January 1, 2019. The OIG was provided email correspondence as well as copies of the algorithms indicating dissemination of the algorithms to CCU staff on January 31, 2020, but there was no written plan specifically addressing the care of post-operative patients in the CCU.

As noted above, after the death of a patient in late 2019, facility leaders postponed all elective surgical cases that required post-operative admission to the CCU. During the postponement of elective surgeries, CCU leaders developed separate nursing and physician algorithms for the care of post-operative patients during off-hours that were emailed to CCU physicians and nursing staff. On February 3, 2020, the facility resumed elective surgeries that required patients to be admitted to the CCU for post-operative care.

CCU leaders told the OIG that there was not a direct method to assess the effectiveness of the algorithms. CCU leaders relied on verbal feedback from CCU nursing staff and surgeons and stated that there were no reported problems of dissatisfaction with the algorithms or problems with communications regarding the care of post-operative patients in the CCU.

Therefore, the OIG reviewed the care of post-operative CCU patients in the 90 days following implementation of the algorithms to assess their effectiveness. The OIG reviewed the EHRs of two CCU post-operative patients whose names were provided by the facility and found that nursing staff were not following the algorithm to contact and to document the contact with the facility on-call surgical intensivist when tele-ICU physicians were contacted about a patient. Upon a review of CCU staff training records, the OIG confirmed that staff had received training on the newly developed algorithms between January 31, 2020, and February 14, 2020.

While the OIG did not consider the facility's decision to continue the surgical program without the residents as cavalier, the OIG determined that facility leaders were aware of the potential of surgery residents leaving but did not take actions to ensure that effective processes were in place, and failed to be proactive in developing, disseminating, and ensuring effectiveness of the nursing and surgical intensivists' algorithms.

3. Noncompliance with Certain MOU and TSA Requirements

During the course of the inspection, the OIG found challenges that limited the efficiency and effectiveness of the tele-ICU process including noncompliance with the requirements outlined in the MOU and TSA regarding quality management review processes, equipment and technical issues, and orientation and competency training of CCU and tele-ICU staff.[25]

[25] 38 U.S.C. § 5705(a) (2020). Confidentiality of Medical Quality Assurance Records provides in pertinent part, "[r]ecords and documents created by the Department as part of a medical quality-assurance program…are confidential and privileged[.]" The issues discussed in this report relate to procedures and processes and not the substance of the reviews.

Quality Management Processes

The OIG determined that the tele-ICU was not integrated into required facility quality management processes. The OIG found that facility staff and tele-ICU staff were not collaborating as required regarding potential events necessitating further evaluation and determination of action. The deficient quality management processes included reporting and evaluating patient safety events and conducting and participating in peer reviews.[26]

Patient Safety

The OIG found that facility staff and tele-ICU staff did not report, and therefore patient safety staff did not evaluate, tele-ICU patient safety events. Through tele-ICU staff interviews, the OIG noted instances which revealed a lack of knowledge or understanding regarding the patient safety reporting process and the expectation to collaborate between the facility and tele-ICU staff. During an interview, facility patient safety staff told the OIG they had not been involved in any meetings regarding CCU patient safety since the Augusta University residents left the facility on July 1, 2019.

VHA requires staff to report adverse events, close calls, sentinel events, and any unsafe conditions to patient safety managers.[27] Examples of reportable patient safety events include "untoward" incidents, inadvertent treatments, and procedural errors.[28] The TSA provides the expectations for reporting all tele-ICU incidents leading to serious adverse events or outcomes, to include the tele-ICU and the facility patient safety staff.[29] Further, the TSA and MOU require processes to ensure collaboration between the facility and tele-ICU patient safety staff, such as including tele-ICU staff in related reviews and in communications and committees.[30]

The TSA further indicated that CCU staff must notify the tele-ICU leaders of any quality of care concerns, including adverse events, immediately or the next business day. Tele-ICU staff will include any information received from the facility in tele-ICU quality reviews or staff evaluations.[31] Tele-ICU staff must utilize the Joint Patient Safety Reporting system to report incidences related to patient safety. The facility must work with the designated tele-ICU patient

[26] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[27] The Joint Commission Resources. "Special Report: Suicide Prevention in Health Care Settings," *Joint Commission Perspectives* 2017 Nov; 37(11):1 and 3–7; A sentinel event is a patient safety event that occurs to a patient and results in any of the following: death, permanent harm, or severe temporary harm and intervention required to sustain life. They are called sentinel because they signal the need for immediate investigation and response.

[28] VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011.

[29] MOU for Tele-ICU Services, January 10, 2017; TSA, February 7, 2019.

[30] TSA, February 7, 2019.

[31] TSA, February 7, 2019.

safety coordinator to add tele-ICU staff to the facility's reporting system to allow tele-ICU staff to report and review incidents.[32]

The facility's Patient Safety Manager told the OIG of being unaware of the CCU incidents in the original allegations, including post-operative CCU patient issues, tele-ICU physicians not having access to the facility surgical on-call schedule, and tele-ICU equipment failures in the CCU.

Tele-ICU staff stated that they had never been asked to participate in patient safety reviews when an adverse event was experienced by a CCU patient. During interviews, tele-ICU staff stated they were unaware of how to report patient safety events through the facility's Joint Patient Safety Reporting system.

Reporting issues through correct channels such as the Joint Patient Safety Reporting system makes it possible to identify quality of care and other patient safety concerns to enable early intervention and may prevent additional adverse patient events.

Peer Review

The OIG found that the facility and tele-ICU did not conduct or participate in peer reviews as required. Clinical events are referred for peer review, when appropriate or required, for quality assurance and practice improvement.[33]

VHA requires that specific clinical events, such as a patient death related to hospitalization, have peer review(s) completed; other clinical events such as post-operative complications and unaddressed test results should be considered for peer review.[34] Tele-ICU staff are required by the MOU to either conduct protected peer reviews of applicable incidents and include members from the facility, or facility staff may conduct their own review. In either case, facility and tele-ICU staff must share with each other the results of any review(s) conducted.[35]

Facility quality management staff told the OIG they did not include and were unclear if tele-ICU staff could be included as part of the facility peer review process. Tele-ICU staff stated they have not been asked to participate in quality reviews for tele-ICU patients.[36]

Protected peer review enables the facility and the tele-ICU service to identify staff who may need additional training or oversight, thereby improving quality of care. When these reviews are

[32] TSA, February 7, 2019.

[33] VHA Directive 1190.

[34] VHA Directive 1190.

[35] MOU for Tele-ICU Services, January 10, 2017.

[36] VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activity That Can Generate Confidential Documents*, November 7, 2008. Morbidity and mortality reviews are quality management activities that are "clinical discussions about the care provided to individual patients who died or experienced complications." VHA Directive 1190.

not conducted and not shared between the facility and tele-ICU staff, the risk for patient adverse clinical outcomes may be increased.

Malfunctioning Equipment and Technical Issues

The OIG determined that the facility did not identify and address tele-ICU equipment and technical issues as required. According to the TSA, the facility CCU staff are required to enter an electronic work order to report tele-ICU equipment problems.[37]

During interviews, CCU nurses told the OIG of technical issues including tele-ICU monitoring equipment failures and CCU room telemonitor camera malfunctions. Facility biomedical staff confirmed that the tele-ICU monitoring equipment required "a lot of time" maintaining and keeping the equipment operational, due to the age of the equipment. Facility biomedical staff indicated that notifications of tele-ICU equipment issues came by email or call instead of the required work order, but biomedical staff responded no matter the method of notification. The OIG determined that the lack of reporting via work order did not allow for tracking of malfunctioning equipment and technical issues.

The tele-ICU biomedical staff provided information on 94 tele-ICU equipment-related work orders that occurred in 2019. Facility staff response times ranged from same day to 155 days after submission of the work order, with an average of 14 days to resolution. The reported equipment issues were related to lack of audio and video capability between facility and tele-ICU staff, or monitoring equipment completely off-line. In March 2020, facility staff determined that tele-ICU equipment, including hardware such as cameras, speakers, and computers, needed to be replaced and were expected to be included in a consolidated VISN purchase. New tele-ICU equipment was ordered and installation was expected for the first week of December 2020.

According to the CCU nurse manager, if the tele-ICU equipment was not working in patients' rooms, the expectation was that the room would not be used. If a patient was in the room at the time of the tele-ICU equipment malfunctions, the patient would be transferred to a room with functional equipment. However, this expectation was not always met. For example, while a patient was in the CCU, EHR documentation noted that the tele-ICU camera was off-line; however, the patient remained in that room for the next 17 hours. At that time, CCU staff reported that the patient was having difficulty breathing to the tele-ICU physician, who noted the inability to see the patient on the camera or review the patient's heart rhythm due to "technical problems." The patient was moved to a room with functioning tele-ICU equipment and was intubated shortly thereafter. While it is unclear if the equipment issues contributed to the patient's deterioration, the lack of properly functioning equipment and CCU staff not moving the patient to a room with functional tele-ICU equipment posed a patient safety concern.

[37] TSA, February 7, 2019.

During interviews, CCU staff reported an effective method for ensuring tele-ICU equipment was functional had not been developed. In March 2020, the CCU implemented a formalized CCU daily tele-ICU equipment check procedure to ensure tele-ICU equipment was functional at the beginning of each 12-hour shift. The procedure required the CCU charge nurse or designee verification that each room's red alert button, audio, and camera functioned properly, and that tele-ICU staff could visualize patient data for occupied rooms. The OIG reviewed selected documentation of tele-ICU equipment checks for four weeks between April 5, 2020, and July 11, 2020. The OIG determined that the facility followed the procedure to ensure equipment functionality during the time frame under review.

Patient safety and bed utilization can be improved by ensuring that tele-ICU monitoring equipment is operational prior to patients being admitted to a room. Unless staff have a process to identify when tele-ICU equipment is not functional and know and follow the steps to report the issue, patients may be in rooms without functioning tele-ICU equipment, placing them at increased risk for adverse clinical outcomes.

Orientation and Competency

The OIG found that CCU and facility support staff were not oriented nor were they provided with competency training in the use of tele-ICU as required.

The MOU required the facility to ensure competencies of staff supporting the delivery of tele-ICU services.[38] The TSA required facility-based CCU new staff orientation to tele-ICU services and technology, to include simulated patient scenarios after the initial orientation provided by tele-ICU staff.

Prior to July 1, 2019, the facility had general policies and procedures to contact on-call staff during regular and off-hours. The OIG learned during interviews that because on-site residents had previously been used for off-hour coverage, not all CCU and tele-ICU staff had been trained on the call schedule and processes for who to call if they were concerned about the condition of a patient. To evaluate CCU training on tele-ICU, the OIG reviewed training and competency records of CCU nurses hired from November 1, 2019, through June 30, 2020, and found no evidence of facility-based tele-ICU orientation, competency, and training.

The lack of orientation and routine training of the call schedule and tele-ICU processes may have contributed to CCU staff not knowing how or who to call if there was a concern for a patient's condition, which can lead to miscommunication and poor patient outcomes.

[38] MOU for Tele-ICU Services January 10, 2017; TSA, February 7, 2019.

Conclusion

The OIG substantiated that there were deficiencies in care coordination between facility staff and tele-ICU staff after the residents were withdrawn in July 2019. The OIG was unable to determine that the withdrawal of the residents and care coordination deficiencies resulted in deaths, injuries, or poor outcomes after a review of the EHRs of five patients submitted as examples to support the allegations.

The OIG found that communication between CCU and tele-ICU staff was sometimes challenging and contributed to a combination of misunderstanding of the tele-ICU program and a lack of CCU staff engagement with tele-ICU staff to assist with the direct co-management of monitored patients. In addition, the facility policy for the on-call process did not provide guidance on specific processes between the CCU and tele-ICU staff.

While the OIG did not consider the facility's decision to continue the surgical program after the residents were withdrawn to be cavalier, the OIG identified that facility leaders were aware of the potential of the withdrawal of the residents but did not take actions to ensure that effective processes were in place should they withdraw. Facility leaders were aware of the potential withdrawal of the residents but did not take actions to ensure that effective processes were in place and failed to be proactive in developing, disseminating, and ensuring effectiveness of algorithms to address post-operative patient care in the CCU.

During the course of the inspection, the OIG found challenges that limited the efficiency and effectiveness of tele-ICU processes. The challenges included noncompliance with the requirements outlined in the MOU and TSA regarding quality management review processes, equipment and technical issues, and orientation and competency training of CCU and tele-ICU staff. Facility staff and tele-ICU staff did not collaborate as required regarding potential events requiring further evaluation and determination of action. The deficient quality management processes included reporting and evaluating patient safety events and conducting and participating in peer reviews. Facility staff and tele-ICU staff also did not report, and therefore patient safety staff did not evaluate, tele-ICU patient safety events, and did not conduct or participate in patient care reviews as required. Facility staff did not identify and address tele-ICU equipment and technical issues as required, to allow for addressing and tracking of malfunctioning equipment and technical issues. Further, CCU and facility support staff were not oriented nor were they provided competency training in the use of tele-ICU as required, which could lead to miscommunication and potential poor patient outcomes.

Recommendations 1–8

1. The Charlie Norwood VA Medical Center Director evaluates the effectiveness of the current algorithms for critical care unit nurses and surgical intensivists involving post-operative patients and communication with tele-intensive care unit staff during off-hours, and takes action as indicated.
2. The Charlie Norwood VA Medical Center Director confirms the current on-call policy is evaluated and modified as appropriate to include specific telemedicine intensive care unit processes.
3. The Charlie Norwood VA Medical Center Director ensures development of a written plan to address responsibilities of medicine and surgery staff caring for post-operative patients in the Critical Care Unit.
4. The Charlie Norwood VA Medical Center Director requires critical care unit staff receive training on patient safety reporting and review processes, and monitors compliance.
5. The Charlie Norwood VA Medical Center Director ensures the coordination between the facility quality management and telemedicine intensive care unit staff on required patient care reviews, and evaluates compliance.
6. The Charlie Norwood VA Medical Center Director requires that current and new critical care unit staff receive telemedicine intensive care unit initial orientation and competency training, and monitors compliance.
7. The Veterans Integrated Service Network 10 Telemedicine Intensive Care Unit Program Medical Director requires telemedicine intensive care unit staff training on patient safety reporting and patient care review processes, and monitors compliance.
8. The Veterans Integrated Service Network 10 Telemedicine Intensive Care Unit Program Medical Director ensures the telemedicine intensive care unit and facility quality management staff coordinate on required patient care reviews, and evaluates compliance.

Appendix A: Timeline of Events

Table A.1. October 2014–May 2020 Timeline of Events

Date:	Event
October 27, 2014	Start of tele-ICU support for facility CCU.
July 1, 2019	General surgery residents from Augusta University withdrawn from facility. Transition coverage plan for general, vascular, and thoracic surgical patients after the withdrawal of Augusta University general surgery residents.
Late 2019	Death of a post-operative patient in CCU.
December 17, 2019	All surgical cases requiring a CCU bed post-operatively are postponed.
January 31, 2020	Dissemination of algorithms for CCU surgical intensivists and nursing staff for the care of post-operative patients in the CCU. Initiated training of CCU nursing staff on algorithm.
February 3, 2020	All surgical cases requiring a CCU bed post-operatively are resumed.
May 26, 2020	OIG review of facility-provided post-operative patients' EHR for compliance with CCU nursing care algorithm.

Source: OIG compilation of facility and tele-ICU documents.

Appendix B: VISN 7 Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 12, 2020

From: Interim Director, VA Southeast Network (10N7)

Subj: Healthcare Inspection— Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia

To: Director, Office of Healthcare Inspections (54RR)

Executive in Charge, Office of the Under Secretary for Health (10)

Director, GAO/OIG Accountability Liaison (VHA 10 EG GOAL Action)

1. I have had the opportunity to review the Healthcare Inspection - Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia.
2. VISN 7 and Charlie Norwood VA Medical Center submits the attached status update providing justification and documentation to recommendation numbers 1 through 6. I concur with the Augusta VA Medical Center's action plan and ongoing implementation for recommendations 1 through 6 and request for closure of recommendations 1, 2, 4, and 6.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by*:)

Joe D. Battle
Interim Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 29, 2020

From: Medical Center Director, Charlie Norwood VA Medical Center (509/00)

Subj: Healthcare Inspection—Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia

To: Interim Director, VA Southeast Network (10N7)

1. In response to the VA Office of Inspector General (OIG) Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia, we concur with the recommendations.
2. Augusta VA Medical Center submits the attached status update providing justification and documentation to recommendation numbers 1 through 6. I concur with the Augusta VA Medical Center's action plan and ongoing implementation for recommendations 1 through 6 and request for closure of recommendations 1, 2, 4, and 6.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information please contact the Acting Chief, Quality Management at 706-733-0188.

(*Original signed by*:)

Robin E. Jackson, Ph.D.
Medical Center Director

Facility Director Response

Recommendation 1

The Charlie Norwood VA Medical Center Director evaluates the effectiveness of the current algorithms for critical care unit nurses and surgical intensivists involving post-operative patients and communication with tele-intensive care unit staff during off-hours, and takes action as indicated.

Concur.

Target date for completion: December 15, 2020

Director Comments

The current algorithms for critical care unit nurses and surgical intensivists involving postoperative patients and communication with tele-intensive care unit staff during off-hours: Is in-place, and effective.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Charlie Norwood VA Medical Center Director confirms the current on-call policy is evaluated and modified as appropriate to include specific telemedicine intensive care unit processes.

Concur.

Target date for completion: December 15, 2020

Director Comments

The current on-call process for the CNVAMC [Charlie Norwood VA Medical Center] is encoded in an electronic system for identification of responsible staff. This process is updated and modified as appropriate. There is a process for notification to the appropriate Telemedicine on call staff notification.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The Charlie Norwood VA Medical Center Director ensures development of a written plan to address responsibilities of medicine and surgery staff caring for post-operative patients in the Critical Care Unit.

Concur.

Target date for completion: November 13, 2020

Director Comments

The Director will task the Chief of Critical Care to develop a written SOP [standard operating procedure] to address responsibilities of medicine and surgery staff caring for postoperative patients in the critical care unit.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 4

The Charlie Norwood VA Medical Center Director requires critical care unit staff receive training on patient safety reporting and review processes, and monitors compliance.

Concur.

Target date for completion: December 15, 2020

Director Comments

The Director will task the Chief Critical Care and Critical Care Nurse Manager to review the process for assigning training on patient safety reporting and compliance monitoring.

The Critical Care Nurse Manager ensured registered nursing staff received training on patient safety reporting and reviewed process and monitored compliance. Within staff meeting minutes dated for September 2020 discussion was held regarding JPSR (the why & how to place them).

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 5

The Charlie Norwood VA Medical Center Director ensures the coordination between the facility quality management and telemedicine intensive care unit staff on required patient care reviews and evaluates compliance.

Concur.

Target date for completion: January 1, 2021

Director Comments

The Director will task the Chief of Quality Management to ensure that all patient reviews by telemedicine intensive care unit staff will be reported in QSVI [Quality Safety Value Innovation] on a biannual basis.

Recommendation 6

The Charlie Norwood VA Medical Center Director requires that current and new critical care unit staff receive telemedicine intensive care unit initial orientation and competency training, and monitors compliance.

Concur.

Target date for completion: December 15, 2020

Director Comments

The Director will task the Chief, Critical Care and Critical Care Nurse Manager to ensure all critical care staff receive telemedicine intensive care unit orientation and competency training.

The Critical Care Nurse Manager ensured that all newly hired Registered Nurse completed the initial competencies used for 100% of the Registered Nurses. This was updated in April 2020 to include Tele Intensive care Unit competency training for all new hires during initial Registered Nurse orientation phase in Critical Care Unit (CCU).

Tele Intensive Care Unit TMS training was conducted in the Critical Care Unit this year (CY 2020).

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Appendix D: VISN 10 Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 15, 2020

From: Network Director, Veterans Integrated Service Network (10N10)

Subj: Healthcare Inspection—Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia

To: Executive in Charge, Office of the Under Secretary for Health (10)

1. I have reviewed and concur with the response for the Healthcare Inspection – Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia.

2. The facility will ensure that the corrective action plans are implemented with continued oversight.

(*Original signed by*:)

RimaAnn O. Nelson
Network Director VISN 10

Appendix E: Telemedicine Intensive Care Unit Medical Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 15, 2020

From: Acting Medical Director, VISN 10 Telemedicine Intensive Care Unit (539/111)

Subj: Healthcare Inspection— Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia

To: Director, Veterans Integrated Service Network (10N10)

1. I have reviewed and concur with Recommendations 7-8 as outlined in the Healthcare Inspection— Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia

2. Please find attached the comments and actions to be taken in response to the recommendations in the report.

(*Original signed by*:)

Amy M. Rohs, MD
Acting Medical Director, VISN 10 Telemedicine Intensive Care Unit

VISN 10 Telemedicine Intensive Care Unit Medical Director Response

Recommendation 7

The Veterans Integrated Service Network 10 Telemedicine Intensive Care Unit Program Medical Director requires telemedicine intensive care unit staff training on patient safety reporting and patient care review processes, and monitors compliance.

Concur.

Target date for completion: March 31, 2021.

Director Comments

The existing nursing competency for patient safety reporting in the Joint Patient Safety Reporting system (JPSR) is being expanded into a comprehensive standard operating procedure (SOP) that outlines the reporting process for VISN 10 Tele Critical Care East staff. This SOP will be readily accessible and utilized to provide refresher training to all VISN 10 Tele Critical Care East clinical staff. The SOP will also be used to provide this training during orientation and annually via a competency education review. Progress with implementation of this action and monitoring of compliance will be reported to the VISN 10 Specialty Care Subcommittee.

Recommendation 8

The Veterans Integrated Service Network 10 Telemedicine Intensive Care Unit Program Medical Director ensures the telemedicine intensive care unit and facility quality management staff coordinate on required patient care reviews and evaluates compliance.

Concur.

Target date for completion: March 31, 2021.

Director Comments

The VISN 10 Tele Critical Care East leadership team actively works to maintain and improve relationships with quality management staff and Intensive Care Unit leadership at facilities where Tele Critical Care services are provided. This is accomplished via site visits and open communication amongst leadership teams. Dialogue between the VISN 10 Tele Critical Care East Acting Medical director and the Charlie Norwood VAMC ICU Medical Director has already been initiated.

The VISN 10 Tele Critical Care East leadership team will meet with the facility quality management staff to ensure bidirectional process understanding for the performance of required patient care reviews. In addition, VISN 10 Tele Critical Care East and Charlie Norwood VAMC

ICU leadership will meet virtually to discuss and potentially plan bidirectional team building between the two programs to enhance communication and understanding of workflows and processes. Progress with implementation of these actions and monitoring of compliance will be reported to the VISN 10 Specialty Care Subcommittee.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Toni Woodard, BS, Director Gail Bozzelli, RN Erin Butler, LCSW Danette Johnson, DO Katherine Auerswald, MD Eileen Keenan, MSN, RN Kara McDowell, BSN, RN Daphney Morris, MSN, RN Glenn Schubert, MPH
Other Contributors	Nicholas DiTondo, BA Kathy Gudgell, JD, RN Jeanne Martin, PharmD Chastity Osborn, DNP, RN Dawn Rubin, JD Natalie Sadow, MBA

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