Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-02987-78

Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center Richmond, Virginia

January 31, 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
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
EOC	environment of care
facility	Hunter Holmes McGuire VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
ICU	intensive care unit
JC	Joint Commission
MDRO	multidrug-resistant organism
MEC	Medical Executive Committee
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	patient information
PPE	personal protective equipment
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RCA	root cause analysis
SOPs	standard operating procedures
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA

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 three activities:

- Coordination of Care
- Medication Management
- Quality Management

The facility's reported accomplishments were winning the Carey Award for performance achievement, making community living center improvements, and improving patient flow and access.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Ensure all designated staff complete annual N95 respirator fit testing, and document the training. Strengthen processes to ensure confidential patient information is secured.

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

Management of Test Results: Consistently communicate normal test results within the specified timeframe.

Physician Credentialing and Privileging: Ensure that privileges appropriately indicate the setting where they may be practiced and that results of Focused Professional Practice Evaluation are reported to the Medical Executive Committee.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program 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

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

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 Hunter Holmes McGuire VA Medical Center, Richmond, Virginia,* Report No. 07-01753-07,

October 16, 2007). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 274 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

Carey Achievement Award

The facility received the 2010 Robert W. Carey Award for Performance Achievement for efforts made to improve the capabilities of the facility and the effectiveness of patient care and for the creation of a learning organization. By focusing on process improvement and performance excellence, the facility improved its Carey application score by 125 points from 2009 to 2010.

CLC Improvements

The facility embraced cultural transformation in the CLC by adding a mural and an electric fireplace in the dining room. In the day room, staff created a 1950s soda shop complete with a red and white soda counter and a jukebox, and they hold ice cream socials every Friday. In addition, staff added a dementia engagement nook where residents can safely engage in a variety of supervised activities.

Patient Flow and Access

Participation in the Facility Flow Collaborative is evidenced by strong core metrics. Building on this foundation, the facility expanded surgical briefings for all surgical sub-specialties to include a huddle with SPD personnel 2 days prior to a scheduled procedure. This has enhanced efficiency and safety and reduced surgical cancellations.

Results

Review Activities With Recommendations

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.

We inspected the emergency department; primary care clinics; behavioral health; one of the CLC units; the medical

ICU; the telemetry unit; the surgical unit; two construction sites; and the radiology department, which includes nuclear medicine. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Infection Control. OSHA requires that designated employees be fit tested annually if the facility uses respirators. We reviewed 25 employee training records and determined that only 13 (52 percent) of the employees had the required annual fit testing.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential PI to be secured. We found several areas in the facility with unsecured PI. Five office doors were open and contained unlocked computers or documents with confidential PI in plain view.

Recommendations

1. We recommended that all designated employees complete annual N95 respirator fit testing and that the training be documented.

2. We recommended strengthening processes to ensure that confidential PI is secured.

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 hospice, general medicine and oncology, and spinal cord injury and disorder units and one CLC unit, and we interviewed 10 employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of PPE.[1] We reviewed 40 medical records and found that 18 (45 percent) of the records did not have documented evidence of MDRO education.

[1] Colonization is the presence of bacteria in the body without causing clinical infection.

Recommendation

3. We recommended that infection prevention 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.[2]

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.[3] We reviewed the medical records of 20 patients who had normal results and found that only 12 (60 percent) of the 20 records contained documented evidence that the facility had communicated the results to the patients.

Recommendation

4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

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 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

Physician Privileges. VHA requires that when a facility grants a physician privileges to practice, the facility must determine whether the privileges should be restricted to specific care settings (such as the surgery suite, the ICU, or an outpatient clinic) and grant the privileges accordingly.[4] Of the 15 C&P files we reviewed, 11 documented the granting of specialized privileges; however, specific care settings had not been appropriately identified. For example, a surgeon

[2] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.
[3] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[4] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

had been granted specialized surgical privileges, which required staffing and equipment support, in several settings, including the outpatient clinic.

FPPE. VHA requires that an FPPE be initiated for all physicians who have been newly hired or have added new privileges and that results be reported to the MEC.[5] The two newly hired physicians whose profiles we reviewed had FPPEs implemented; however, the results were not reported to the MEC.

Recommendation

5. We recommended that privileges appropriately indicate the setting where they may be practiced and that results of FPPE be reported to the MEC.

Review Activities Without Recommendations

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 40 patients' medical records and determined that the facility generally met requirements in these areas. We made no 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, transported, and administered the medications. We made no 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. The QM program was generally compliant with

[5] VHA Handbook 1100.19.

requirements, and senior managers supported the program. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 13–16, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[6]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	6	
CBOCs	Fredericksburg, VA Charlottesville, VA Emporia, VA	
Veteran Population in Catchment Area	209,073	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	311	
• **CLC/Nursing Home Care Unit**	98 (includes 10 palliative care beds)	
• **Other**	N/A	
Medical School Affiliation(s)	Virginia Commonwealth University	
• **Number of Residents**	562	
	FY 2010 (through June 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$342	$331
• **Medical Care Expenditures**	$259	$331
Total Medical Care FTE	2,204	2,176
Workload:		
• **Number of Station Level Unique Patients**	41,459	43,290
• **Inpatient Days of Care:**		
o **Acute Care**	49,702	61,738
o **CLC/Nursing Home Care Unit**	20,297	27,807
Hospital Discharges	5,895	7,074
Total Average Daily Census (including all bed types)	258	245
Cumulative Occupancy Rate	63%	60%
Outpatient Visits	353,593	444,721

[6] 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**
Documentation of Intraoperative Clinical Information			
1. Allow only authorized staff with appropriate clinical privileges or scope of practice to document clinical information in patient medical records.	Clerical staff no longer enter clinical data. All clinical information is entered by a clinical provider.	Y	N
2. Ensure that the accuracy of intraoperative clinical information is monitored.	All records from the 3rd quarter of FY 2007 have been reviewed for discrepancies between the nursing intraoperative report and the anesthesia record. At the time of the CAP survey in June 2007, approximately 50 percent of the records required corrections. For the first 2 quarters, the rate was 8 percent. External Peer Review Package reviews revealed no discrepancies in subsequent quarters. Nursing and anesthesia no longer enter the same information, so there cannot be discrepancies. Anesthesia enters their data (antibiotic timing), and nursing enters theirs.	Y	N
QM			
3. Ensure that the signed informed consents are obtained for outpatient surgical procedures.	iMED consents are available in outpatient clinics. Monitoring for consents shows compliance with use of iMED.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
4. Ensure full compliance with medication reconciliation requirements.	Medication reconciliation has been added to all admission, discharge, and transfer templates as well as many outpatient clinic templates. Compliance is not consistent month to month and varies by service.	Y	N
5**.** Ensure that peer reviews and RCAs are completed within the required periods.	RCA completion is tracked and reported to leadership, the VISN, and the National Center for Patient Safety. Completion has been timely since the 1st quarter of FY 2008. Peer reviews are tracked by spreadsheet and reported to the MEC and the VISN. The 120-day completion has been met for at least the last 6 quarters. Initial peer review in 45 days is not 100 percent but has been greater than 90 percent. In the 2nd quarter of FY 2010, 110 reviews were done of which 106 were done within 45 days.	Y	N
EOC			
6. Take appropriate action regarding employees who inaccurately documented defibrillator testing.	Appropriate action was taken with employees involved in this incident. Nursing assures accurate documentation is a part of competency training.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
7. Ensure that all defibrillators are tested as required by local policy.	All nurses have been instructed on the defibrillator check procedures and documentation requirements. The code-cart documentation sheet was changed to require specific documentation of the defibrillator check and the test strip. All staff will be trained and competency assessed biannually. Nurse manager's monitoring shows compliance with the new requirements.	Y	N

VHA Satisfaction Surveys

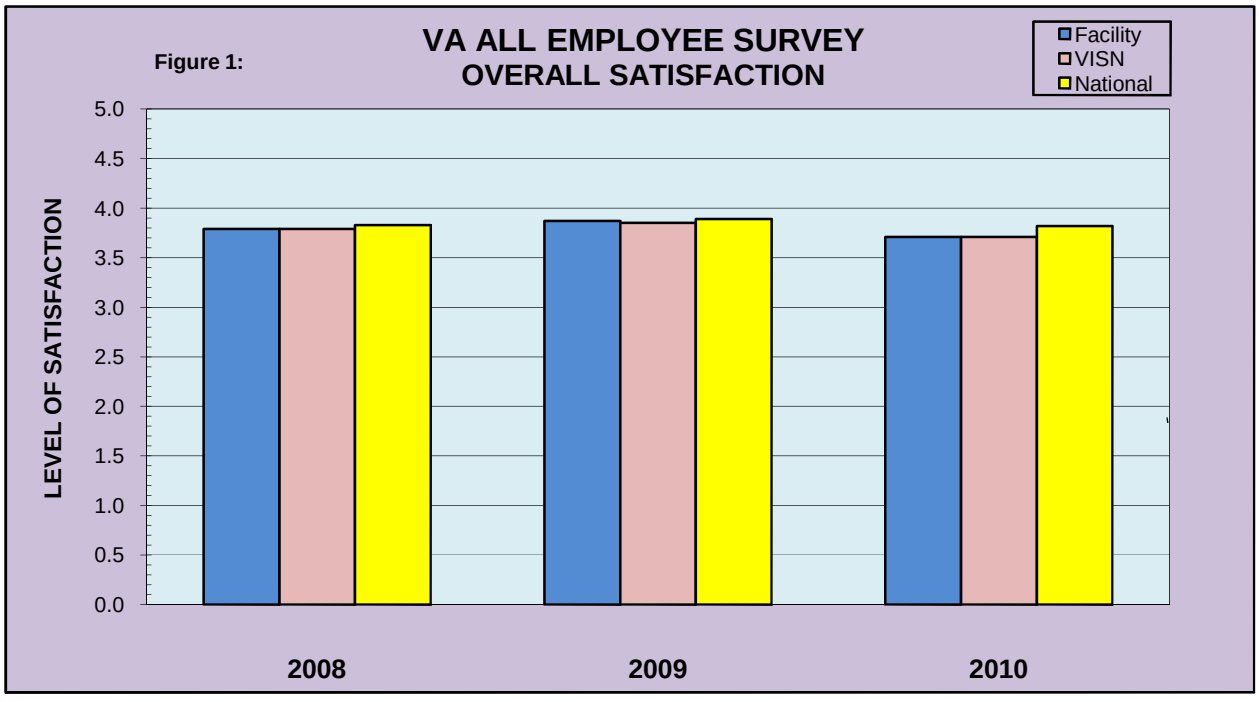
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

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	53.7	62.2	59.8	56.1	57.7	60.6
VISN	59.9	65.7	61.5	50.7	50.9	52.2
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.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[7] 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	14.91	10.07	16.07	20.97	23.27	16.68
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[7] 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 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: January 7, 2011

From: Director, Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA**

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

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

1. Thank you for the opportunity to respond.

2. The Hunter Holmes McGuire VA Medical Center, Richmond, VA concurs with the findings and has provided specific corrective actions for each recommendation.

3. If further information is required, please contact Charles Sepich, FACHE, Director, Richmond VA Medical Center at (804) 675-5500.

(original signed by:)
DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 6, 2011

From: Director, Hunter Holmes McGuire VA Medical Center (652/00)

Subject: **CAP Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA**

To: Director, Mid-Atlantic Health Care Network (10N6)

This memo serves to acknowledge receipt and review of the draft CAP Report for the program review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia. Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please do not hesitate to contact R. C. Polatty, MD, Chief of Quality Management at 804-675-5756.

(original signed by:)
CHARLES SEPICH, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that all designated employees complete annual N95 respirator fit testing and that the training be documented.

Concur.

A master roster of required positions has been created and reviewed by Infection Control and Safety. This master roster will serve as a tracking mechanism for annual reviews. Safety is performing mass fit testing and documentation utilizing opportunities which include the following: Flu Clinic Blitz, New Employee Orientation, individual clinical units on a schedule, and Medical Grand Rounds. The status will be reported quarterly to the Environment of Care Committee and the Infection Control Committee with a goal of ≥ 95% compliance with ongoing monitoring after that.

Target date: May 31, 2011.

Recommendation 2. We recommended strengthening processes to ensure that confidential PI is secured.

Concur.

Medical team rooms and others with PI have new locks and codes will be distributed to staff for use to secure information. The ACOS of Education has established a spreadsheet that will be used by service line resident coordinators to ensure the distribution of resident workroom lock codes. The spreadsheet will reflect the primary contact and other information that will be useful to the hospital's residents and attendings for accountability. Environment of Care Rounds, tracer activity, and the Privacy Officer will survey for information or computers that are unsecured and inform leadership for immediate correction.

The weekly newsletter and electronic message boards will also be used to re-educate staff on the importance of proper privacy practices.

Target date: March 31, 2011

Recommendation 3. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur.

Epidemiology has developed educational materials and trained nursing staff on their use to educate patients and families on MDRO. There is an order entered on admission for education and a template has been made for nursing documentation of education in CPRS. Documentation has begun and is ongoing. Documentation of education is being will be monitored and reported monthly to the Quality Executive Board.

Target Date: March 31, 2011

Recommendation 4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur.

All clinical services will develop a process to notify patients of test results within 14 days of availability unless the criticality of the result demands more immediate action. Per our bylaws, this may be done by face to face visit, phone encounter, or letter. The letter template used successfully by Primary Care has been made available to all services to adapt for their results. Services will review records monthly to ensure compliance and report to the Medical Executive Board.

Target Date: March 31, 2011

Recommendation 5. We recommended that privileges appropriately indicate the setting where they may be practiced and that results of FPPE be reported to the MEC.

Concur.

A tracking process for reporting FPPE's has been developed. FPPE's were reported to the Medical Professional Standards Board since November 2010 and will continue to be reported there and documented in minutes. Site specific privileging forms are being developed for each service and will be used with new and recurring privileges once forms are developed and approved by the Medical Executive Board.

Target Date: April 30, 2011

OIG Contact and Staff Acknowledgments

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