



Patient Died at New York VA Hospital After Alarm Was Ignored

by Charles Ornstein and Tracy Weber
ProPublica, May 15, 2012, 3:06 p.m.

Registered nurses at a Manhattan Veterans Affairs hospital failed to notice a patient had become disconnected from a cardiac monitor until after his heart had stopped and he could not be revived, according to a report Monday from the VA inspector general [1].

The incident from last June was the second such death at the hospital involving a patient connected to a monitor in a six-month period. The first, along with two earlier deaths at a Denver VA hospital, raised questions about nursing competency in the VA system, ProPublica reported last month [2].

The deaths also prompted a broader review of skills and training of VA nurses. Only half of 29 VA facilities surveyed by the inspector general in a recent report had adequately documented that their nurses had skills to perform their duties. Even though some nurses "did not demonstrate competency in one or more required skills," the government report [3] stated, there was no evidence of retraining.

Monday's report documents the June 2011 death of patient in his 80s at the Manhattan campus of the VA's New York Harbor Healthcare System. The man had undergone several heart procedures and needed to have his vital signs continuously monitored, the report said.

On his fifth day at the hospital, monitor records show that an alarm indicated a problem with the device or the patient. But there is no evidence nurses were aware of the alarm until the man was discovered unresponsive an hour and a half later. He was declared dead shortly afterward, the report said.



“The patient’s telemetry status was not effectively monitored at the time of his death due to a lack of awareness of the disconnected lead,” inspectors concluded.

Registered nurses assigned to telemetry units typically place cardiac leads, set parameters for the monitors tracking each patient, verify heart rhythms and take appropriate actions if there is an irregularity. They also enter progress notes and inform doctors of any changes.

Ironically, federal inspectors were in the hospital the same month to investigate the first death, which occurred in a different monitoring unit in January 2011.

During that investigation, the inspectors discovered nurses at the hospital didn't understand how the monitors even worked [1]. None of those interviewed could accurately explain what would happen if a patient became disconnected from a cardiac monitor.

Inspectors also found no evidence that the nurses' competence had been checked. Records showed that one of the patient's nurses had last received training on the monitors 13 years earlier, according the October 2011. The report recommended sweeping changes and retraining, which the hospital agreed to implement.

IG inspectors were not notified of the second death at the Manhattan facility until someone complained in November 2011, five months after the alarm was missed and the patient died.

The latest report does not recommend any additional changes or training at the hospital because “managers have made significant progress” after the first report.

In a response to the inspector general, the hospital acknowledged receipt of the report and said it concurred with the document. A spokeswoman for the VA in Washington didn’t immediately respond to our requests for comment.

-
1. <http://www.propublica.org/documents/item/356534-vaoig-nyc1.html>
 2. <http://www.propublica.org/article/va-nurses-scrutinized-after-patient-deaths-in-two-states>
 3. <http://www.propublica.org/documents/item/356535-vaoig-nursing-review.html>

What to Read Next

New Report Likely to Fuel Debate Over TSA Scanners

Pardon Attorney Torpedoes Plea for Presidential Mercy

How Does the FDA Monitor Your Medical Implants? It Doesn't, Really

Sponsored Links

2 Drugs FDA Recommends You Stay Away From (HealthCentral.com)

10 U.S. Cities With the Most Expensive Cost of Living (Kiplinger)

6 worst home fixes for the money (Bankrate.com)

The Best, Most Disgusting Reporting on Food Safety

American Pain Foundation Shuts Down as Senators Launch Investigation of Prescription Narcotics

Scott Walker Dominates, Labor Falters in Wisconsin Recall Primary (The Daily Beast)

Faces of Social Security: Rolf K. Fischer (AARP.org)

[What's this?]

© Copyright 2012 Pro Publica Inc.

Steal Our Stories

Unless otherwise noted, you can republish our stories for free if you follow these rules.





Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Summary Report

Evaluation of Registered Nurse Competency Processes in Veterans Health Administration Facilities

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: <http://www.va.gov/oig/contacts/hotline.asp>)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections completed an evaluation of registered nurse (RN) competency assessment and validation processes in Veterans Health Administration facilities. The purposes of the evaluation were to determine whether facilities: (1) established policy/process requirements for initial and ongoing RN competency assessment and validation, (2) addressed key components in competency assessment and validation documentation, (3) completed RN competency assessment and validation in accordance with local policy, and (4) identified actions to be taken when an individual cannot demonstrate competency.

Inspectors evaluated RN competency assessment and validation processes at 29 facilities during Combined Assessment Program reviews conducted from April 1–September 30, 2011.

Strong competency assessment and validation processes ensure that nursing staff are able to demonstrate the skills required to perform their assignments and that hospitals are able to identify and initiate appropriate actions when deficiencies are identified. We identified three areas where RN competency assessment and validation processes needed improvement. We recommended that the Under Secretary for Health establish specific RN competency assessment and validation requirements to ensure consistency among facilities. We also recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that:

- Competency validation documentation includes all elements required by Joint Commission standards and local policy.
- All competency documentation is present in competency folders and is current and validated.
- Appropriate actions are taken when competency expectations are not met.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health (10)

SUBJECT: Combined Assessment Program Summary Report – Evaluation of Registered Nurse Competency Processes in Veterans Health Administration Facilities

Purpose

The VA Office of Inspector General Office of Healthcare Inspections evaluated registered nurse (RN) competency assessment and validation processes in 29 Veterans Health Administration (VHA) facilities. The purposes of the evaluation were to determine whether facilities: (1) established policy/process requirements for initial and ongoing RN competency assessment and validation, (2) addressed key components in competency assessment and validation documentation, (3) completed RN competency assessment and validation in accordance with local policy, and (4) identified actions to be taken when an individual cannot demonstrate competency.

Background

The Joint Commission (JC) defines competence as the knowledge, skills, ability, and behaviors to perform a job correctly, skillfully, and appropriately. When an individual is not competent to perform his or her job, he or she lacks some of these characteristics and is more likely to make errors, misjudgments, and oversights, which can lead to serious consequences for others and the individual. A hospital cannot provide safe, reliable, and appropriate health care if its staff members are not competent.¹ Competency assessment and validation is the process of verifying an individual's ability to perform and to apply knowledge and skills. Core competencies, such as medication administration, are skills typically required for all RNs. Unit/position-specific competencies are skills unique to a particular area of patient care, such as an intensive care unit.

The JC requires that hospital staff are competent to perform their responsibilities. The JC's Elements of Performance include the following:

¹ Joint Commission Resources, *Assessing Hospital Staff Competence*, 2007.

- Staff competence is assessed and documented once every 3 years or more frequently as required by hospital policy or in accordance with law and regulation.
- The hospital uses assessment methods, such as test taking, return demonstration, or simulation, to determine the individual's competence in the skills being assessed.
- An individual with the education, background, experience, or knowledge related to the skills being reviewed assesses competence.
- Staff competence is initially assessed and documented as part of orientation.
- The hospital takes action when a staff member's competence does not meet expectations.

VHA implemented a high performance development model, which proposes that training, selection, and promotion of employees be based on a set of eight core competencies. However, this model does not specifically address methods for initial and ongoing competency assessment and validation for clinical staff.

Previous Office of Healthcare Inspections reviews have found RN competency assessment and validation to be areas with opportunities for improvement.

A healthcare inspection found that nursing staff were not competent in the use and understanding of telemetry monitoring equipment to ensure that the correct patient parameters were set and that alarms sounded when necessary to alert staff to potential problems.² One RN caring for a patient had not had telemetry use competency assessment and validation completed for 13 years despite facility annual competency requirements. We recommended that staff receive initial and refresher training on the telemetry monitoring system in accordance with VHA and facility policies.

A healthcare inspection found that lack of RN competency and training affected patient care on a telemetry unit.³ Even though managers were aware of skill deficiencies, the facility did not have an ongoing process to assess and validate cardiac monitoring competencies for RNs assigned to this unit. We recommended that all staff complete competency assessments for their specific positions and that training be provided as needed to maintain competency.

During Combined Assessment Program (CAP) reviews conducted from July 1, 2008–June 30, 2009, we evaluated whether emergency department/urgent care clinic (ED/UCC) staff had documentation of annual competency assessment and validation of ED/UCC-specific competencies and documentation of point-of-care testing competencies.⁴ Eleven (24 percent) of the 46 facilities evaluated did not meet VHA and

² *Healthcare Inspection – Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, New York*, Report No. 11-02545-15, October 27, 2011.

³ *Healthcare Inspection – Telemetry Monitoring Issues, VA Eastern Colorado Health Care System, Denver, Colorado*, Report No. 09-01047-69, January 21, 2010.

⁴ *Healthcare Inspection – Evaluation of Emergency Departments and Urgent Care Clinics in Veterans Health Administration Facilities*, Report No. 07-03165-139, April 28, 2010.

local competency requirements. We recommended that VHA ensure compliance with competency evaluations.

During CAP reviews conducted from January 1–December 31, 2009, we evaluated whether RNs working in VHA facilities through contracts or agencies had competencies evaluated prior to providing patient care.⁵ Of the 168 RN competency records reviewed, 32 (19 percent) did not have evidence of competency evaluation. We recommended that VHA ensure facilities evaluate contracted/agency RN competence prior to provision of patient care and annually thereafter.

Other Office of Healthcare Inspections reviews identified RN competency assessment and validation issues in dialysis, mental health, long-term care, spinal cord injury, endoscopy procedure areas, the operating room, and the cardiac catheterization laboratory and with reusable medical equipment. Additionally, we evaluated clinical staff competency assessment and validation during VA Community Based Outpatient Clinic reviews conducted from April–September 2011 and identified opportunities for improvement.

Scope and Methodology

We performed this review in conjunction with 29 CAP reviews of VHA medical facilities conducted from April 1–September 30, 2011. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). We interviewed nurse managers and reviewed documents, including facility self-assessments and fiscal year 2010 competency records.

We generated an individual CAP report for each facility. For this report, we analyzed the data from the individual facility CAP reviews to identify system-wide trends. We used 90 percent as the general level of expectation in the areas discussed.

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

Inspection Results

Issue 1: Competency Assessment and Validation Policies/Processes

The JC requires RN competency assessment and validation minimally every 3 years or more frequently if required by local policy or in accordance with law and regulation. Although all 29 facilities had policies/processes for RN competency assessment and validation, we identified inconsistencies among facilities for specific elements. For

⁵ *Healthcare Inspection – Evaluation of Contracted/Agency Registered Nurses in Veterans Health Administration Facilities*, Report No. 10-02288-193, July 15, 2010.

example, if defined, competency assessment and validation responsibility, methods, and documentation requirements were not consistently addressed or implemented.

We recommended that VHA establish specific RN competency assessment and validation requirements to ensure consistency among facilities.

Issue 2: Competency Assessment and Validation Documentation

At least three of The JC's Elements of Performance are fulfilled if facilities define competency assessment and validation documentation processes that include the dates of assessments, the methods used to determine competency, the names and signatures of the individuals (validators) performing assessments, and the signatures of the employees being assessed. We reviewed competency assessment and validation documentation for 349 RNs to determine whether core and unit/position-specific competency validation forms included key elements. Table 1 provides non-compliance results for these elements.

Table 1

Element	Validation Date	Method of Assessment	Validator Signature	Employee Signature
Core competency validation forms included:	75/349 (21%)	57/349 (16%)	86/349 (25%)	71/349 (20%)
Unit/position-specific validation forms included:	81/349 (23%)	75/349 (21%)	92/349 (26%)	74/349 (21%)

We reviewed core and unit/position-specific competency assessment and validation documentation for 349 RNs to determine whether competencies were present, completed, and validated in accordance with local policy. Table 2 below summarizes review elements and findings. RN competency documentation was not complete, current, and in compliance with local policy/process requirements at 15 of the 29 facilities.

Table 2

Element	Non-Compliance
Core and unit/position-specific competencies required by the facility were:	
• Present in folders/files	59/349 (17%)
• Completed for fiscal year 2010	65/349 (19%)
• Validated	100/349 (29%)

We recommended that competency validation documentation include all elements required by JC standards and local policy. We also recommended that all RN

competency documentation be present in competency folders and be current and validated.

Issue 3: Actions for Competency Deficiencies

The JC requires that hospitals take action when staff competence does not meet expectations. Fifty-eight (17 percent) of 349 RNs did not demonstrate competency in one or more required skills. We did not find documentation of actions taken to address the deficiencies for 24 (41 percent) of the 58 RNs.

We recommended that appropriate actions be taken when competency expectations are not met.

Conclusions

All 29 facilities had RN competency assessment and validation policies/processes in place. However, these policies/processes varied among VHA facilities and were not consistently followed. VHA could strengthen this process by defining RN competency assessment and validation requirements. Managers should encourage strong competency validation practices, such as documenting validation of each individual skill with dates and methods of assessment, validator signatures, and evidence of employee involvement. Competency assessment and validation processes must reflect the skills required to perform nursing assignments. Appropriate actions need to be taken when competency expectations are not met.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health establish specific RN competency assessment and validation requirements to ensure consistency among facilities.

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that competency validation documentation includes all elements required by JC standards and local policy.

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that all RN competency documentation is present in competency folders and is current and validated.

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that appropriate actions are taken when competency expectations are not met.

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are completed.



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

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 09, 2012

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Combined Assessment Program
Summary Report: Evaluation of Registered Nurse
Competency Processes in Veterans Health Administration
Facilities**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations.
2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

(original signed by:)

Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

OIG Draft Report, Combined Assessment Program Summary Report: Evaluation of Registered Nurse Competency Processes in Veterans Health Administration Facilities (*VA IQ TBD*)

Date of Draft Report: January 30, 2012

<u>Recommendations/ Actions</u>	<u>Status</u>	<u>Completion Date</u>
-------------------------------------	---------------	----------------------------

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health establish specific RN competency assessment and validation requirements to ensure consistency among facilities.

VHA Response

Concur

The Veterans Health Administration (VHA) has developed a VHA Nursing Handbook that is currently being processed for approval and distribution. The handbook establishes specific Registered Nurse (RN) competency assessment and validation requirements to ensure consistency among facilities.

In process	Handbook to be issued
	NLT
	December 31, 2012

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that competency validation documentation includes all elements required by JC standards and local policy.

VHA Response

Concur

The VHA Nursing Handbook will include the requirement that competency validation documentation includes all elements required by Joint Commission (JC) standards and local policy. VHA will require verification of competency validation documentation through an annual RN Competency Validation Report to be submitted through each Veterans Integrated Service Network (VISN) Quality Management Officer (QMO) to the Office of Nursing Services (ONS) for evaluation.

In process	Handbook to be issued NLT December 31, 2012
------------	---

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that all RN competency documentation is present in competency folders and is current and validated.

VHA Response

Concur

The VHA Nursing Handbook will include the requirement that Associate Directors for Patient Care Services/Chief Nurse Executives (ADPCS/NE) certify that all RN competency documentation is present in competency folders, and is current and validated. Compliance will be ensured via an RN Competency Validation Report to be submitted annually on October 1 through the VISN QMO to ONS for evaluation.

In addition, the ONS will work with their national nursing leadership field advisory group to develop a standardized competency assessment tool for use by ADPCS/NE and during random ONS reviews. This group will also develop standardized strategies to align competency reviews with annual performance reviews for all nursing staff.

In process	A standardized competency validation report, a competency assessment tool, and competency review strategies will be issued NLT August 31, 2012 Random field reviews to begin September 30, 2012
------------	--

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that appropriate actions are taken when competency expectations are not met.

VHA Response

Concur

VHA agrees that facilities must ensure that all nursing personnel have current, validated and documented competencies, and no nursing personnel will be allowed to perform procedures for which they have expired competencies until those competencies have been re-validated and documented. Local policy will dictate actions to be taken when validation of an individual's required competencies is not met. The Deputy Under Secretary for Health for Operations and Management will distribute a memorandum to VISNs requesting the development of local policy that appropriately establishes action for all levels of VISN and facility leadership to take when competency expectations are not met.

ONS will conduct random reviews during field-based visits to ensure compliance with this memorandum. Also, the VHA Nursing Handbook will address this issue as described previously in this response.

In process	Memorandum to be issued NLT May 30, 2012
	Random field reviews to begin September 30, 2012
	Handbook to be issued NLT December 31, 2012

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Carol Torczon, MSN, ACNP, Project Coordinator Annette Acosta, MN, RN Lisa Barnes, MSW Paula Chapman, CTRS Jennifer Christensen, DPM Audrey Collins-Mack, RN, MSA Myra Conway, RN Melanie Cool, MEd, LDN Kathy Gudgell, RN, JD Stephanie Hills, RN, MSN Gayle Karamanos, MS, PA-C Jennifer Kubiak, RN, MPH JoDean Marquez, RN, BSN James Seitz, RN, MBA Virginia Solana, RN, MA Mary Toy, RN, MSN Ann Ver Linden, RN, MBA Susan Zarter, RN, BSN

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
National Center for Patient Safety
Office of General Counsel
Office of Medical Inspector
VISN Directors (1–23)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

This report is available <http://www.va.gov/oig/publications/reports-list.asp>.



VA Nurses Scrutinized After Patient Deaths in Two States

by Tracy Weber and Charles Ornstein
ProPublica, April 30, 2012, 1:19 p.m.

After a patient died last year at a Veterans Affairs hospital in Manhattan, federal inspectors discovered nurses in his unit had a startling gap in their skills: They didn't understand how the monitors tracking vital signs worked.

None of the nurses interviewed could accurately explain what would happen if a patient became disconnected from a cardiac monitor — which allegedly occurred to the patient who died, according to an October 2011 report [1] from the U.S. Department of Veterans Affairs' inspector general.



(iStockPhoto)

The incident followed two deaths in the cardiac monitoring unit at a VA hospital in Denver [2] that raised similar questions about nurse competency.

Earlier this month, a broader review by the VA inspector general [3] of 29 VA facilities found only half had adequately documented that their nurses had the needed skills. Some nurses "did not demonstrate competency in one or more required skills," but there was no evidence of retraining, the report said.

An outside nursing expert who reviewed the reports at ProPublica's request called them "troubling" and said the fact that the lapses weren't caught and corrected "signified much broader problems."

The inspector general's findings reveal "a lack of oversight and adherence to accepted clinical and regulatory standards," said Jane Hirsch, a clinical professor emeritus at the University of California, San Francisco School of Nursing, who previously oversaw nursing at U.C. San Francisco Medical Center.

The April 20 IG report also noted that previous inspections had found nurse competency issues in "dialysis, mental health, long-term care, spinal cord injury, endoscopy procedure areas, the operating room and the cardiac catheterization laboratory and with reusable medical equipment."

In a response to the inspector general, the VA pledged to create uniform competency standards for its 152 hospitals and to ensure that evaluations of every nurse's skills are up-to-date. Nurses will not be able to work in areas in which they have not demonstrated competency.

A VA spokeswoman declined further comment.

Nurse competency has increasingly become an issue in medicine. Hospitals and clinics create their own procedures and tests for assessing the skills of nurses, but their adherence to these policies is spotty [4].

Outside regulators don't test individual nurses, but simply check if a sampling of the nurses' files have the appropriate paperwork certifying competency.

That's what VA's inspector general did for the April review. As such, officials acknowledged that they could not verify whether nurses at those hospitals, or others, are providing competent care.

"We did not look at actual care or actual competence," Julie Watrous, director of the inspector general's combined assessment program, which inspects each VA hospital every three years, told ProPublica.

Only half the 29 facilities included in the new report had complete nurse skill assessment records that met the hospitals' standards, inspectors found. Of the 349 nurses whose files were examined, paperwork showed that 58 lacked skills in at least one area. And for 24 in that group, there was no evidence that anything was done in response.

In an interview, however, the IG official who coordinated the report said she was generally pleased with the findings. Although both the VA and its hospitals had room to improve, she said, all of the hospitals had policies in place and at least some proof of skills in each nurse's file.

"We never found one single site or even person that didn't have at least components of competency assessment and validation," said Carol Torczon, associate director of the St. Petersburg, Fla., office of the inspector general. "Where we found the holes was in the paper process."

Torczon said she believed that the problems identified in Denver and New York were not reflective on the care generally provided by VA nurses in cardiac monitoring units.

Inspectors in the New York and Colorado cases said they could not definitely tie the deaths of the patients to their nurses' care. But they noted that their lack of training put patients at risk.

Registered nurses assigned to telemetry units typically place cardiac leads, set parameters for the monitors tracking each patient, verify heart rhythms and take appropriate actions if there is an irregularity. They also enter progress notes and inform doctors of any changes.

After the patient in New York died, inspectors quizzed nurses and a biomedical engineer about what would happen if a patient got disconnected. "According to some staff, a 'red alarm' would be triggered since a disconnected lead was considered critical," the report said, "whereas other staff told us that a disconnected lead would trigger a yellow alarm or that it would not trigger any alarm at all."

Inspectors also found no evidence that the nurses' competence had been checked. Records showed that one of the patient's nurses had last received training on the monitors 13 years earlier.

Two years earlier at a VA hospital in Denver, inspectors looked into the deaths of two patients on cardiac monitors. After the first death, the hospital gave nurses a basic test of their ability to interpret monitor readings: only one of 28 passed, according to a January 2010 report [2]. The nurse in charge when both patients died had never received specialized training in cardiac monitors.

Even after the second patient died in 2009, inspectors found "it was unclear who was responsible for telemetry training, and staff were not aware that policies had been updated."

Both facilities vowed extensive reforms in responses that were included in the IG reports.

Experts say up-to-date competency evaluations are important because they ensure that nurses, who provide the bulk of the frontline care in hospitals, have the skills for their position.

"It would appear that the old adage 'inspect what you expect' has most certainly not been taken very seriously in these environments," said Hirsch, who was chief nursing officer at UCSF Medical Center for nine years.

After reading the New York and Denver reports, Hirsch said her concern wasn't the incidents themselves as much as that the competency of the nurses hadn't been documented or evaluated in a long time.

Had she been in charge, the findings would have caused her "to be really nervous and want to jump on it immediately," she said.

-
1. <http://www.va.gov/oig/pubs/VAOIG-11-02545-15.pdf>
 2. <http://www.va.gov/oig/54/reports/VAOIG-09-01047-69.pdf>
 3. <http://www.va.gov/oig/pubs/VAOIG-12-00956-159.pdf>
 4. <http://www.propublica.org/series/nurses>

What to Read Next

The Champion of Painkillers

Law and Disorder Judge Hits New Orleans Cops with Harsh Sentences - ProPublica

Top MuckReads: Mosque Surveillance and Bain's Political Preferences

One Soldier's Progress Against Traumatic Brain Injury

No Forensic Background? No Problem

Sponsored Links

6 Signs You're Addicted to Facebook (CNBC)

JPMorgan's \$2 Billion Loss: 9 Who Stand to Gain (The Fiscal Times)

High cost of retiree health care (Bankrate.com)

2 Drugs FDA Recommends You Stay Away From (HealthCentral.com)

Derivatives May Still Endanger The Financial System (Forbes.com)

[What's this?]

© Copyright 2012 Pro Publica Inc.

Steal Our Stories

Unless otherwise noted, you can republish our stories for free if you follow these rules.





Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Telemetry Unit Deficiencies VA New York Harbor Healthcare System New York, New York

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: <http://www.va.gov/oig/contacts/hotline.asp>)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to determine the validity of an allegation regarding the quality of patient care on a telemetry unit at the Manhattan Campus of the New York Harbor Healthcare System, New York, NY. Specifically, the complainant alleged that a patient on the telemetry unit was not continuously monitored and the telemetry monitoring system displayed a disconnected telemetry lead. The complainant expressed concern that poor staffing and/or an equipment malfunction may have contributed to a lack of monitoring and the patient's death.

We could neither confirm nor refute the allegation that a patient on the telemetry unit was not continuously monitored due to a disconnected telemetry lead, malfunctioning monitoring equipment, or short staffing. The unit did not maintain sufficient documentation for us to determine if a telemetry lead became disconnected on the patient. We found that the telemetry equipment was functioning properly and that preventive maintenance was conducted in accordance with the manufacturer's specifications. Staffing on the night in question was consistent with the patient-to-nurse ratio that the system described as their usual practice based on industry standards.

However, our review did find that the unit had two system weaknesses that increased the risk of patients not being adequately monitored. Specifically, we found that medical record documentation by unit staff did not meet industry or facility requirements and that telemetry unit nursing and biomedical engineering staff were not trained to properly use the telemetry monitoring equipment.

To improve patient care and safety for telemetry patients, we recommended that the facility Director:

- Implement procedures to ensure that telemetry unit nursing staff comply with industry standards and system policies on charting and telemetry documentation to maintain a timely, complete, and accurate medical record for each patient.
- Ensure that telemetry unit nursing and biomedical engineering staff receive initial and refresher training on the telemetry monitoring system in accordance with Veterans Health Administration and facility policies.

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA New York Harbor Healthcare System (630/00)

SUBJECT: Healthcare Inspection—Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, New York

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of an allegation made by a complainant concerning quality of care for a patient in a telemetry unit at the Manhattan Campus, New York Harbor Healthcare System (the facility), New York, NY.

Background

VA New York Harbor Healthcare System

The facility is part of Veterans Integrated Service Network (VISN) 3 and comprises three campuses located in Manhattan, Brooklyn, and Queens. The Manhattan Campus has bed services in acute medicine, surgery, acute psychiatry, neurology, and rehabilitation medicine. The campus is the VISN 3 referral center for interventional cardiology, cardiac surgery, and neurosurgery.

The telemetry unit (the unit) is a 19-bed step down unit located in the main hospital at the Manhattan Campus. Patients who are hemodynamically stable¹ but still require continuous electrocardiogram (ECG) monitoring are admitted to the unit, including patients who have been transferred from the medical intensive care unit (MICU) and the cardiac care unit (CCU).

Allegation

In April 2011, a complainant contacted the OIG's Hotline Division and alleged that in January 2011, a patient on the telemetry unit was not continuously monitored and that, according to a registered nurse (RN), the telemetry monitoring system displayed a disconnected telemetry lead. The complainant expressed concern that poor staffing

¹ Hemodynamically stable indicates that the circulatory system is functioning well enough to provide adequate blood flow throughout the body.

and/or an equipment malfunction may have contributed to a lack of monitoring and the patient's death.

Overview of Telemetry Monitoring for Cardiac Patients

Telemetry monitoring provides a continuous ECG reading of the heart's electrical activity through external electrodes placed on the patient's body. Segments of the ECG data are automatically transmitted to a remote surveillance location. As the patient's electrical rhythms are transmitted, they are continuously analyzed according to parameters programmed into the device. Some segments, such as rapid and slow heart rates or other symptomatic episodes, will automatically trigger an audible alarm. Hospital staff who acknowledge the alarms and observe the telemetry data are able to respond to the patient and provide immediate care should emergencies arise. The telemetry monitoring equipment at the system triggers three types of audible alarms:

- **Red Alarm** is an audible critical alarm that is loud and continuous. It indicates the need to immediately check on a patient's status and vital signs.
- **Yellow Alarm** is a quieter and intermittent audible alarm that stops after several minutes. It indicates a temporary irregularity in the heart rate or rhythm that is not immediately critical.
- **Blue Alarm** is similar to the yellow alarm and indicates a problem with the system itself or an improperly connected, or disconnected, telemetry lead.

Facility Policy and Industry Standards

According to the facility protocol for telemetry monitoring, all telemetry unit patients must be hemodynamically stable.² Unstable patients and those with Acute Coronary Syndrome³ should be managed in an intensive care unit. The protocol also identifies criteria for initiating telemetry monitoring on patients with various cardiac conditions. In this case, the patient required monitoring of his heart rate because of atrial fibrillation with rapid ventricular response⁴ but did not have chest pain.

According to the protocol, RNs on the unit are required to perform the following telemetry monitoring and documentation procedures:

² New York Harbor Healthcare System (NYHHS) Policy No. 111-05, *Electrocardiographic Telemetry Monitoring Protocol*, November 2008.

³ Acute Coronary Syndrome is when the heart does not receive enough oxygen-rich blood, which can cause chest pain or a heart attack.

⁴ Atrial fibrillation with rapid ventricular response is an irregular heart rate that can cause inadequate blood circulation through the heart, resulting in pooling of blood and eventual clots that can lead to stroke.

- Connect the patient to the telemetry monitor using a modified central lead-1⁵ or a lead that best transmits the appropriate waveform.
- Set alarm parameters according to the individual patient's needs and/or the physician's specifications, and ensure that the alarm volume is loud enough to be heard at all times.
- Keep alarms on at all times.
- Obtain and attach a representative sample of ECG strips to the hard copy medical record every shift and when necessary to document any abnormality and interventions instituted.
- Report any abnormalities to the physician.
- Review the alarms each hour.
- Respond immediately to alarm activation, institute appropriate intervention, and notify the physician.

Standards published by the American Heart Association (AHA) advocate that each facility establish protocols to govern the roles and responsibilities at all staff levels regarding cardiac monitoring, documentation of ECG changes, periodic documentation that alarms are set appropriately, and response to emergency and nonemergency cardiac events.⁶

The AHA recommends that all staff assigned to telemetry units receive comprehensive training, including initial orientation followed by periodic competency evaluations, to ensure continued proficiency in critical elements of cardiac monitoring. AHA also recommends periodic reviews of unit protocols, training curricula, and competency levels to determine if staff and patient needs continue to be met. This analysis should include reviews of staff performance, critical events, and patient outcomes.

Scope and Methodology

We conducted a site visit from June 14 through 16, 2011. To address the allegation, we interviewed the complainant, staff physicians, the unit supervisor and nursing personnel, and other clinical and administrative staff. We reviewed relevant facility policies and procedures, nurse training records, preventive maintenance reports, quality management documents, and the medical record of the patient identified in the complaint. We visited the unit, the MICU, and the CCU and reviewed the functions of the telemetry equipment with nursing staff and a member of the biomedical engineering staff.

⁵ A modified central lead-I is the primary lead on a 3-lead telemetry monitoring system that is attached to the patient.

⁶ AHA Scientific Statement, *Practice Standards for Electrocardiographic Monitoring in Hospital Settings*, American Heart Association Science Advisory and Coordinating Committee, June 2004.

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

Case Summary

The patient was a man in his sixties with a history of 2-vessel coronary artery bypass graft surgery⁷ and mitral valve⁸ repair in 2007, high blood pressure, and atrial fibrillation. He presented to the emergency department in mid-January, 2011, with a chief complaint of shortness of breath on exertion for a duration of 2 weeks accompanied by weakness and fatigue. The emergency department admission assessment note indicated that the patient was oriented and denied any chest pain. His blood pressure was elevated, and the ECG showed the patient to be experiencing supraventricular tachycardia with a rapid ventricular response (endorsed as atrial flutter⁹ by a staff cardiologist's ECG report). The patient was treated with cardiac medications for ventricular rate control and transferred to the MICU for further management and monitoring.

The plan of care included monitoring of vital signs every 8 hours and heart rate and rhythm every hour. MICU nursing staff were to monitor vital signs and urine output, achieve full anticoagulation, continue outpatient medications, and institute cardiac monitoring (for ongoing assessment of heart rate control). Within 24 hours, (hospital day [HD] 2) the patient's heart rate was effectively rate controlled in the MICU. The MICU nursing progress note indicated no additional changes in the plan of care, and the patient was transferred at 7:30 p.m. to the CCU. Patients are transferred to the CCU, an area immediately adjacent to the MICU, when they still require close monitoring but at a less intense level than the MICU. A CCU physician's team note, written that same day, specified the plan of care was to schedule a cardiac ablation¹⁰ for the upcoming week in an attempt to more effectively control heart rate and to keep the patient in the hospital in the interim for ongoing anticoagulation, blood pressure control, monitoring, and observation.

On HD 3, the patient remained asymptomatic and was acceptably controlled as to heart rate. A resident physician ambulated the patient at 6:00 p.m., and, being clinically stable, the patient was transferred from the CCU to the telemetry unit, though he did have persisting significant blood pressure elevation.

The telemetry unit's nursing acceptance note documents the patient as arriving via wheelchair at 6:15 p.m. and being placed on a cardiac monitor showing him to be in

⁷ Coronary artery bypass graft surgery is a procedure to improve blood flow to heart tissue; it is most commonly performed by grafting a section of vein material to bypass an obstruction or narrowing of a coronary artery.

⁸ The mitral valve controls blood flow between the left upper and lower chambers of the heart.

⁹ Atrial flutter is a type of supraventricular tachycardia where the upper chambers of the heart beat abnormally fast and, when accompanied by a rapid ventricular response, the lower chambers also beat abnormally fast.

¹⁰ Cardiac ablation is a type of treatment for cardiac arrhythmias.

normal sinus rhythm¹¹ with occasional premature ventricular contractions,¹² a heart rate of 95 beats per minute, and persistent elevated blood pressure. The patient was also noted to be alert and oriented, having no chest pain, and ambulating independently. The plan of care was to include monitoring of vital signs every 8 hours and heart rate and rhythm every hour. A medicine resident physician's examination in the telemetry unit at 7:15 p.m. indicated the patient to be acceptably heart-rate controlled but with continuing high blood pressure readings ("uncontrolled at baseline"), and the physician's note expressed the intent to continue blood pressure control, anticoagulation, and plans for a "possible ablation" on HD 7.

At 7:30 p.m. on HD 3, the patient's nursing care was assumed by a new shift of nurses on the telemetry unit. The first chart entry made by the telemetry unit RN who had assumed responsibility for the patient at 7:30 p.m. was a transfer summary completed at 4:33 a.m. on HD 4, an hour after the patient was found unresponsive (that is, no nursing chart entries were made during the first 9 hours on this particular telemetry unit nursing shift).

The transfer summary included retrospective entries regarding the patient's condition from the previous evening. The note cited the patient as being on the telemetry monitor with normal sinus rhythm and a heart rate of 80 beats per minute as of 7:30 p.m. on HD 3. In addition, the note documented that the patient received his scheduled cardiac medication at 11:24 p.m. and had denied chest pain, dizziness, palpitations, or shortness of breath. The note chronicles that at 3:35 a.m. on HD 4, the patient was found unresponsive with no palpable pulse and with a blood pressure of 64/40 mmHg. At that time, staff initiated cardiopulmonary resuscitative measures and called a cardiac arrest response team to the unit.

Following resuscitative efforts, the patient was restored to a sinus bradycardia rhythm¹³ but with evidence of severe brain injury resulting from the cardiac arrest, as confirmed by a neurology resident physician. The patient was transferred back to the MICU at 4:45 a.m. on HD 4 and required ventilator support.

The period of unresponsiveness prior to the code is not determinable based on the limited nursing note documentation and the lack of telemetry data prior to the code. The patient's post-resuscitative severe brain injury, though, was associated with a poor prognosis and high mortality. According to an MICU nursing progress note, later on HD 4, the patient experienced a rapid drop in his blood pressure and heart rate, and a cardiac arrest response team was called at 2:15 p.m. Resuscitative efforts were unsuccessful, and the patient was pronounced dead at 2:35 p.m. on HD 4.

¹¹ Sinus rhythm is the normal beating of the heart as measured by an ECG.

¹² Premature ventricular contractions occur when the heartbeat is initiated by a site in the heart's lower chambers rather than its normal initiation site in the sinus node.

¹³ A sinus bradycardia rhythm is a regular but slow heart rate beating 60 beats a minute or less.

Inspection Results

We could neither confirm nor refute the allegation that in mid-January 2011, a patient on the telemetry unit was not continuously monitored due to a disconnected telemetry lead, malfunctioning monitoring equipment, or short staffing.

Disconnected Telemetry Lead. The telemetry unit did not maintain sufficient documentation for us to determine if a telemetry lead became disconnected on the patient. According to the patient's medical record, he was transferred from the CCU to the telemetry unit on HD 3 at 6:15 p.m. and placed on a telemetry monitor. A nursing transfer note written by an MICU RN at 4:45 a.m. on HD 4, after the patient was transferred back to the MICU, indicates that on HD 3, a telemetry RN checked on the patient at 7:30 p.m. According to the note, the patient was on the telemetry monitor at 7:31 p.m., which is supported by a unit report generated by the telemetry monitoring system.

We found no additional documentation in the patient's medical record, such as nurse progress notes or copies of telemetry monitor print-outs, or in unit monitoring records to verify if the patient continued to be on the telemetry monitor. We did find a telemetry observation record for HD 4, which indicated that nursing staff reviewed telemetry monitor alarms every hour. However, the telemetry observation record was not patient specific and did not reflect if any alarms had occurred. Furthermore, facility staff could not provide us this record for HD 3.

Malfunctioning Equipment. During our discussion with the complainant, the complainant referenced an ECG report in the patient's medical record indicating poor data quality, which may affect interpretation. The complainant expressed concern that this indicated some type of malfunction with the telemetry monitoring equipment. Based on our inspection of the equipment with a facility biomedical engineer and our review of applicable biomedical engineering records, we found that the equipment was functioning properly and that preventive maintenance was conducted in accordance with the manufacturer's specifications. We also found that an ECG was performed on the patient after the cardiac arrest on HD 4. Although the ECG report did indicate poor data quality, this is an indication that the equipment is functioning properly and informs the user that there is a presence of an artifactual signal, such as electrical interference from wall outlets, cell phones, muscle tremors, or patient movement.¹⁴ The presence of artifactual signal was not a significant finding in this case and did not, in any way, affect the patient's clinical outcome.

Short Staffing. According to facility nurse managers, the telemetry unit should have a patient-to-RN staffing ratio of 5:1. Although the facility does not have a policy explicitly requiring this staffing, the nurse managers told us that it is consistent with guidance from

¹⁴ Artifactual signal is anything on an ECG that is not caused by the electrical currents generated by the heart.

the American Nurses Association.¹⁵ On the night of January HD 3, there were nine patients on the telemetry unit, and staffing included two RNs from 7:30 p.m. to 8:00 a.m., a third RN from 12:00 a.m. to 8:00 a.m., and one nurse's aide from 3:30 p.m. to 12:00 a.m. Therefore, the patient-to-RN staffing ratio of 3:1 was well within the target ratio of 5:1.

Although we could neither confirm nor refute the allegation that the patient was not continuously monitored during his hospitalization in January, our review did find that the unit had two system weaknesses that increased the risk of patients not being adequately monitored. Specifically, we found that medical record documentation by unit staff did not meet The Joint Commission or facility requirements and that telemetry unit nursing and biomedical engineering staff were not trained to properly use the monitoring equipment.

Medical Record Documentation Did Not Meet Requirements

JC requires that a complete and accurate medical record be maintained for each patient.¹⁶ Facility policy requires an RN to print out an ECG strip every shift and to evaluate each alarm printout. The RN is also required to document any abnormal rhythms, provide a rapid response to each alarm, and review all alarms every hour.¹⁷

We found that patient care documentation lacked sufficient detail to verify whether patients were continuously monitored while on the unit. We found significant time gaps in nursing documentation in the subject patient's medical record. For example, the record contained a telemetry unit admission note for HD 3 at 6:15 p.m.; however, no further nursing notes were documented by a telemetry unit RN until 4:33 a.m. on HD 4, after the patient had been transferred back to the MICU. Furthermore, we did not find any ECG strips in the patient's medical record from the time he entered the unit on HD 3 at 7:30 p.m. to the time he was found unresponsive on HD 4 at 3:35 a.m.

According to telemetry unit staff, they also use unit-wide records to document patient observations and reviews of telemetry monitor alarms. Documentation of these records is for all patients on the unit and is not included in individual patient medical records. For example, we reviewed a unit report for HD 3, indicating that all patients on the unit were on telemetry monitors at 7:31 p.m. We also reviewed a telemetry observation record for HD 4, indicating that nursing staff reviewed telemetry monitor alarms every hour, as indicated by a check mark. However, as previously discussed, this telemetry observation record was not patient specific and did not reflect whether any alarms had occurred. Furthermore, we found that unit staff did not retain these unit records in a structured

¹⁵ Utilization Guide for the American Nurses Association *Principles for Nurse Staffing*, 2005.

¹⁶ Joint Commission, RC 01.01.01: The hospital maintains complete and accurate medical records for each individual patient.

¹⁷ NYHHS Policy No: 111-05.

format. As a result, unit staff were unable to provide us a telemetry observation record for HD 3, and records for most other days in January were also missing.

Staff Were Not Properly Trained on Monitoring Equipment

The AHA recommends that staff assigned to telemetry units receive initial and periodic refresher training on critical elements of cardiac monitoring. In addition, VHA policy requires that all personnel involved in the use of reusable medical equipment, such as telemetry monitors, have documented training on the setup, use, reprocessing, and maintenance of the equipment.¹⁸

During our interviews of the unit nursing staff, the unit nurse manager, and a biomedical engineer, we received inconsistent responses as to what type of alarm would be generated in the event that a telemetry lead became disconnected from a patient's chest. According to some staff, a "red alarm" would be triggered since a disconnected lead was considered critical; whereas other staff told us that a disconnected lead would trigger a yellow alarm or that it would not trigger any alarm at all. The staff were also inconsistent in their responses as to whether an ECG strip would automatically print if a lead became disconnected. However, all of the staff told us that an ECG strip would automatically print in the event of a red alarm.

We visited the unit to have the biomedical engineer and the nursing staff demonstrate the use of the monitoring system. During our observation of the system demonstration, several patients experienced yellow or red alarm incidents in realtime, yet no ECG strips automatically printed. We found that the alarm parameters to automatically generate ECG printouts were not properly set up on the monitoring system for any of the alarms. Furthermore, neither the unit nursing staff nor the biomedical engineer in attendance knew how to set the parameters on the monitoring system.

We also found that the unit nursing staff present did not know how to retrieve and print a patient's electronically saved telemetry history. The monitoring system automatically stores each patient's history for 24 hours and only purges it from the system once a telemetry box is cleared and connected to the next patient admitted. However, the history can be manually cleared once a patient is discharged. One physician we spoke to stated that an RN told him he would have to call the manufacturer's customer service and speak to a technician in order to retrieve a telemetry history.

Furthermore, we did not find evidence of competency training on the use of the telemetry monitoring system conducted by the manufacturer or any recent refresher training for the monitoring system in unit staff competency folders. For example, for one RN involved in the care of the subject patient, we found evidence of training that was last documented

¹⁸ VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

13 years ago; although, the RN's competency records indicated that this training should have been occurring annually.

Conclusion

We could neither confirm nor refute the allegation that a patient on the telemetry unit was not continuously monitored during his hospitalization in January, 2011, due to a disconnected telemetry lead, malfunctioning monitoring equipment, or short staffing. However, we did find that patient care documentation lacked sufficient detail to verify whether patients were, in fact, being continuously monitored while on the unit. In addition, we found that telemetry staff were not sufficiently trained in the use and understanding of the telemetry monitoring equipment to ensure that the correct patient parameters were set and that alarms sounded when necessary to alert staff to potential problems. Specifically, there was inconsistent knowledge among telemetry unit nursing staff as to the triggering events for various alarms, or even when an alarm would be triggered. As a result of these system weaknesses, patients on the telemetry unit are at increased risk of not being properly monitored.

Recommendations

Recommendation 1. We recommended that the facility Director implement procedures to ensure that telemetry unit nursing staff comply with The Joint Commission and facility policies on charting and telemetry documentation to maintain a timely, complete, and accurate medical record for each patient.

Recommendation 2. We recommended that the facility Director ensure that telemetry unit nursing and biomedical engineering staff receive initial and refresher training on the telemetry monitoring system in accordance with VHA and facility policies.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 2, 2011

From: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Subj: **Healthcare Inspection—Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, NY**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Thru: Director, Management Review Service (10A4A4)

Attached please find the response to the draft alleged telemetry unit deficiencies report for VA New York Harbor Healthcare System (VANYHHS).

The VISN concurs with the action plan submitted by the facility.



Michael A. Sabo, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 2, 2011

From: Director, VA New York Harbor Healthcare System (630/00)

Subject: **Healthcare Inspection—Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, NY**

To: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

This is to acknowledge receipt and review of the draft alleged telemetry unit deficiencies report for VA New York Harbor Healthcare System (VANYHHS). Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact Kim Arslanian, the Performance Improvement Manager at (718-630-2865).



MARTINA A. PARAUDA

Director's 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's report:

OIG Recommendations

Recommendation 1. We recommended that the facility Director implement procedures to ensure that telemetry unit nursing staff comply with JC and facility policies on charting and telemetry documentation to maintain a timely, complete, and accurate medical record for each patient.

Concur

Target Completion Date: 6/15/11

Facility's Response:

Effective 6/15/11, the Associate Director, Patient Services (Chief Nurse) issued an e-mail to the appropriate Nursing management staff mandating compliance with the documentation requirements as per the current policy.

In addition, a workgroup that includes the Associate Director, Patient Services, Associate Director Facilities and Human Resources and the Performance Improvement Manager has been meeting since July to review current telemetry practices and have modified the policy as per the suggestions made during the OIG site visit. The revised documentation will be scanned into CPRS. The final draft policy has been forwarded to the Clinical Executive Board (CEB) for review and approval. Once approved by the CEB the policy will be reviewed by the Executive Council (EC) for approval. Once approved, the revised policy will include a system for monitoring compliance and a medical record review to monitor documentation. The EC is scheduled to meet on Oct 26th.

Status: Policy approval pending CEB and EC approval.

Recommendation 2. We recommended that the facility Director ensure that telemetry unit nursing and biomedical engineering staff receive initial and refresher training on the telemetry monitoring system in accordance with VHA and facility policies.

Concur

Target Completion Date: 9/6/11

Facility's Response:

The manufacturer provided training for all appropriate staff on several days (July 12, 13, 14, 28, August 1, 2, and September 6). 98% of staff were trained. Remaining 2% reflect those staff on extended leave.

In addition, Nursing Education has developed a curriculum for training new and current employees. The plan will be added to TMS for tracking and assigned to all appropriate employees. Initial and annual competency assessment checklists were reviewed as well.

Status: Complete

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Claire McDonald, MPA, Project Leader Glen Pickens, RN, MHSM, Team Leader Thomas Jamieson, MD Frank Keslof, EMT, MHA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA New York/New Jersey Healthcare Network (10N3)
Director, VA New York Harbor Healthcare System (630/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Charles E. Schumer, Kirsten E. Gillibrand
U.S. House of Representatives: Carolyn B. Maloney

This report is available at <http://www.va.gov/oig/publications/reports-list.asp>.