

From the desk of — **R. Scott Williams**

October 27, 2014

John U. Young
Attorney, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, DC 20036-4505

Re: OSC File No. DI-14-1666

Dear Mr. Young:

As a preliminary matter, I would like to express my gratitude to the United States Office of Special Counsel Disclosure Unit for its work in relation to my whistleblower disclosures. Moreover, I do thank The Office of Medical Inspector (OMI) for their investigation and subsequent finding. I am however, disappointed that they would accept the standard “pat” answers given by SAVAHCS regarding the allegations. I am appalled that the OMI has put their name on a report that **does not substantiate** their argument. Hence, there is clear evidence of misfeasance here and critical questions remain.

Case in point:

Page D3:

Reason for entering the whistleblower's EHR:

Friday, April 13, 2012, at 3:24 p.m., and 3:32 p.m.:

Monday, September 9, 2013, at 1:08 p.m., and 1:19 p.m.:

As I pointed out in my letter to Senator McCain, I was told during my interview with the privacy officer, Donna Wilson, in January of 2014 that nothing was scanned into my medical record on 4/13/12 and 9/9/13. Therefore, I request that this claim be supported with documentation, as there seems to be a contradiction (see conclusion below).

Monday, September 9, 2013, at 1:08 p.m., and 1:19 p.m.:

Perioperative nursing care notes are part of the anesthesia scanning packet. According to SAVAHCS Scanning Unit Assignment Calendar, anesthesia scanning packets were assigned to scanning technician, Hank Butler¹ on this date.

Page D4 and D6:

Reason for entering the whistleblower's EHR:

D4 "Mr. Hayes accessed the whistleblower's electronic health record on Tuesday, September 10, 2013, to verify that the appropriate report had been properly completed; D6 'However, the report is not considered complete until the surgeon of record, the attending surgeon, also signs it. On Monday, September 9, 2013, Mr. Martin reviewed all the operative reports between September 4 and 6, 2013, to ensure the presence of an attending's signatures.' " I concur; these statements serve as SOP benchmarks for the policy currently used within HIM. As chairperson of the Medical Records Committee, Chief Hoopes, actually implemented these policy herself, as outlined in the committee's charter²

Page D4:

Reason for entering the whistleblower's EHR:

Operative reports validated by HIM personnel are maintained³. This duty falls on the records processing staff (transcriptionist) Eva Moreno, as evident by her three entries— September 9, 2012, at 08:44; September 9, 2012, at 08:44:10; September 12, 2012, at 14:44—on the SPAR report. When I spoke to Eva on 10/17/14, she affirms that she is the only one of three people that checks the daily status of h&p's, discharge summaries, and operative reports—unsigned, un-cosigned, unverified, and undictated. Moreover the national Health Information Management's (HIM) website (<http://vaww.vhahim.va.gov>) argues that each facility must incorporate a systematic selection and analysis of health records as part of their overall information management, performance measurement and quality management programs. Recommend processes for an ongoing health record review program, including authentication and completion of health record documentation are presented in the "practice brief" on the website⁴. In other words, HIM role in the design and deployment of a health record review program is a vital part of any record review process.

Page D5:

Reason for entering the whistleblower's EHR:

Monday, September 9, 2013, at 8:45 a.m.:

Regardless of the definition used, the only "demographic information" in the operative report is my name and last four of the social security number⁵, which, according to the OMI report, had already been validated by Asst. Chief, Elaine Wallet.

¹ support document (s/d) # 1

² s/d # 2

³ s/d # 3

⁴ s/d # 4; + attachment PB7_Health_Record_Review_April_2014

⁵ s/d # 5

Furthermore, Chief Hoopes knew before going into the chart that she had safeguards in place, specifically, Mr. Hayes, Mr. Martin, whose job duties (according to the report) were to conducting weekly reviews of deficient and/or delinquent medical records; performs quality assurance reviews of EHRs, including operative reports, to ensure accuracy, timeliness, and completeness, respectively, and Ms. Moreno.

Page D9:

Reasons for entering whistleblower's EHR:

Monday, April 29, 2013, at 10:46 10:56 and 10:59 a.m.:

“A second MRI safety information form was completed on February 26. The forms were documented in hard copy rather than directly into the EHR. On Monday, April 29, 2013, at 10:46 a.m., 10:56 a.m., and 10:59 a.m., Ms. Yant scanned the two forms into the whistleblower's EHR as evidenced by the index of the documents in VistA imaging.”

So, four entries into the EHR; two forms were scanned, and the list of “past clinic visits” shows only one “TUC IMAGING MRI AM NC” appointment on 02/19/13 @ 07:00⁶. By definition, this is called a violation, and substantiates allegation #1. Actually, this is two violations because; the report “forgot” to mention the access by Ms. Yant at **11:01 a.m.** on this date.

Thursday, September 26, 2013, at 12:53 p.m.:

According to the report, under “**main job responsibilities around time of access:**” Mr. Hayes and Mr. Martin had already completed “quality check,” as noted above. As had Ms. Eva Moreno on September 12, 2012, at 14:44. For the record, regarding, “These checks are not documented by date of review or by signature of the person performing the review” from page four of the report, is untrue (see s/d#3).

Page D11

Reasons for entering whistleblower's EHR:

On **Wednesday, August 1, 2012, at 3:24 p.m.;** “The whistleblower's SPAR shows an access on June 24, 2012, by an employee who shared the same last name as the whistleblower. As part of his weekly audit, Mr. Pearson accessed the whistleblower's EHR on August 1, 2012 to ascertain if this employee was related to the whistleblower; there was no relationship, thus the access was proper.”

The SPAR report, which according to page 1 of the OMI report is “identical to the list first identified in his OSC complaint,” shows that 4 employees with the same last name as me accessed my EHR, on 12 different occasions, none of which were on 6/24/12, which, by the way, was a Sunday.

Thursday, September 12, 2012, at 3:03 p.m.; “The whistleblower's SPAR shows an access on August 1, 2012, by an employee who shared the same last name as the whistleblower. As part of his weekly audit, Mr. Pearson accessed the whistleblower's EHR on September 12, 2012 to ascertain if this employee was related to the whistleblower; there was no relationship, thus the access was proper.”

The SPAR report, which according to page 1 of the OMI report is “identical to the list first identified in his OSC complaint,” shows that 4 employees with the same last name as me accessed my EHR, on 12 different occasions, none of which were on 8/1/12.

Tuesday, April 2, 2013, at 12:37 p.m.; “The whistleblower's SPAR shows an access on March 14, 2013, by an employee who shared the same last name as the whistleblower. As part of his weekly audit, Mr. Pearson accessed the whistleblower's EHR on April 2, 2013 to ascertain if this employee was related to the whistleblower; there was no relationship, thus the access was proper.”

The SPAR report, which according to page 1 of the OMI report is “identical to the list first identified in his OSC complaint,” does indicate my EHR was accessed (three times) on this date by medical support assistant, Athea Williams. Also, the list of “past clinic visits” does show an appointment on—ZZTUC SAG PC FLATEAU and a leave request was submitted for this date⁷. Ergo, I would concur with this statement, and stipulate that proper protocol was followed.

⁶ s/d# 6

⁷ s/d# 7

That said it would seem reasonable to conclude that Mr. Pearson accesses on August 1, 2012, at 3:24 p.m., the Thursday, September 12, 2012, at 3:03 p.m., and Monday, December 16, 2013, at 1:41p.m., were improper.

Monday, December 16, 2013, at 1:41p.m.; “The whistleblower's SPAR shows an access on December 16, 2013, by an employee who shared the same last name as the whistleblower. In this instance, Mr. Pearson's audit was delayed until April 2, 2014, at which time he verified that the employee was not related to the whistleblower, and thus the access was proper.”

The SPAR report, which according to page 1 of the OMI report is “identical to the list first identified in his OSC complaint,” shows that 4 employees with the same last name as me accessed my EHR, on 12 different occasions, none of which were on 12/16/13.

Conclusions:

Look, you can't have it both ways—either, proper policy and procedure was followed, or it wasn't!

The former, which I believe is more likely than not, is that Mr. Hayes, Mr. Martin and Ms. Moreno were performing their respected job duties established by the department's chief, Mrs. Hoopes.

Furthermore, given that Hank Butler is not listed on the SPAR it's plausible that he recognized my name, and past the packet to his supervisor, Mr. Dycus, who then scanned the paperwork, as stated in the OMI report. This option would **substantiate** allegation #1 sevenfold—Alma Yant 3 times, Rob Pearson 3 times, Chief Hoopes 1 time, and Supervisor Dycus 2 (see **D3** above).

The latter, vis-à-vis validates management neglected responsibility to inform Mr. Hayes and Mr. Martin and Ms. Moreno to stay out of my EHR, as they (management) would process the surgery paperwork. Simply saying that these managers “forgot” does not meet the definitions listed on page 4, VI Methodology, of the report. This option would **substantiate** allegation #1 sevenfold—Eva Moreno 3 times, Donald Hayes 1 time, Marvel Martin 1 time, and Alma Yant 2 times.

During the OMI interview on April 14, 2014, immediately following the introductions, I agreed with the Deputy Medical Inspector, Edward Huycke, M.D., that basically we have two issues—the medical records intrusions and the two log-in breaches. Likewise, subject matter expert Carol Farer, RHIA, CHPS, CIPP/G, CHPC, Privacy Specialist, VHA Privacy Office, agreed that immediately following my opening statement at the 8/21/13 meeting, the meeting should have been terminated, and referred to the Privacy Officer, which supports the privacy officer opinion during our talks in the January 2014.

With regards to ISO Robert Pearson, in addition to the three improper accesses outlined above, he verbally agreed on November 5, 2013, that he (ISO Pearson) would report the incident to VA's Network Security Operations Center (NSOC), and the Privacy Officer, Donna Wilson, within one hour, as per protocol⁸. This entire argument is expressed in my letter to Senator McCain, yet not mentioned in the OMI report. Consequently, **substantiating** allegation #2, fourfold, plus two log-in breaches.

It should be noted, that my 9/6/13 surgery was scheduled on 8/21/13, and that Supervisor Dycus and Chief Hoopes approved my request for annual/sick leave, as well as my application for advanced leave⁹. That, most of my colleagues knew I would be absent for three weeks, secondary to surgery. Additionally, Chief Hoopes has mentioned many times the importance of “why we monitor” in monthly staff meetings¹⁰. Thank you for your time and attention.

Respectfully,



Mr. Randall Scott Williams

⁸ s/d# 8

⁹ s/d# 9

¹⁰ s/d # 10

5/17/11

Search: Assignment Calendar



Organize > Burn > Business > HIMMS > Scanning > Scanning > Assignment Calendar

Organize > Burn > New folder

Favorites

Desktop

Downloads

Recent Places

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Documents

Music

Pictures

Videos

Computer

OSDisk (C:)

Services (S:)

AFGE

AmbCare

AMMS

AODs

Attending Sign Outs

Business

Canteen

Care Coordination Unit

CBOC

Clinical care support

Contracting V18

COS

Cred&Priv

7 items

Date modified

9/17/2011 9:53 AM

10/11/2011 4:28 PM

12/19/2011 9:35 AM

3/5/2012 9:26 AM

1/9/2013 10:26 AM

12/2/2013 9:07 AM

9/10/2014 12:50 PM

Name

2011

REVISED 2011

REVISED WITH UNAUTH FEE 2011

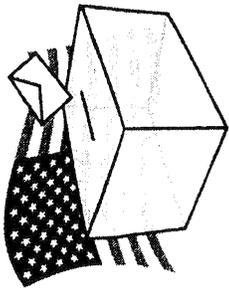
Unit Assignment Calendar 2011

Unit Assignment Calendar 2012

Unit Assignment Calendars 2013

Unit Assignment Calendars 2014

Select a file to preview.



[SAVAHCS Scanning Unit Assignment Calendar]

September 2013

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	2 HOLIDAY	3 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	4 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	5 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	6 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	7
8	9 FEE BASIS – ANTHONY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - SIDNEY	10 FEE BASIS – ANTHONY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - SIDNEY	11 FEE BASIS – ANTHONY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - SIDNEY	12 FEE BASIS – ANTHONY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - SIDNEY	13 FEE BASIS – ANTHONY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - SIDNEY	14
15	16 FEE BASIS –HANK UNAUTH FEE– RENE ANESTHESIA – RENE BLOOD – ANTHONY AD’S - MARVELL	17 FEE BASIS –HANK UNAUTH FEE– RENE ANESTHESIA – RENE BLOOD – ANTHONY AD’S - MARVELL	18 FEE BASIS –HANK UNAUTH FEE– RENE ANESTHESIA – RENE BLOOD – ANTHONY AD’S - MARVELL	19 FEE BASIS –HANK UNAUTH FEE– RENE ANESTHESIA – RENE BLOOD – ANTHONY AD’S - MARVELL	20 FEE BASIS –HANK UNAUTH FEE– RENE ANESTHESIA – RENE BLOOD – ANTHONY AD’S - MARVELL	21
22	23 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	24 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	25 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	26 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	27 FEE BASIS –SIDNEY UNAUTH FEE– RENE ANESTHESIA – HANK BLOOD – DONALD AD’S - MARVELL	28
29	30 FEE BASIS – SCOTT UNAUTH FEE– RENE ANESTHESIA – RENE BLOOD – ANTHONY AD’S – SIDNEY					

SD #2

MEDICAL RECORD COMMITTEE CHARTER

Scope: The SAVAHCS is committed to maintaining the highest standards for the patient record of care in both the electronic and paper record formats. Medical Record quality reviews will contribute to initial and ongoing professional practice evaluations. The Medical Record Committee will specifically ensure a uniform record of care to be consistent with, but not limited to: The Joint Commission Standards (TJC), VHA Handbook 1907.01 and System Memorandum 11-11-55.

Objectives: The Medical Record Committee is tasked to:

- a. Identify common HIMS related trends found in OIG, SOARS, JCAHO and other site surveys and address issues determined to be significant to SAVAHCS, including Care Coordination documentation.
- b. Monitor National HIMS Metrics
- c. Identify and provide recommendations to correct medical record problems.
- d. Review all paper forms currently being utilized and contained in the record, ensure the form meets documentation requirements, review to see if the form can be computerized, if not assign appropriate SAVAHCS form number.
- e. Approve and control all new form requests, both electronic and paper.
- f. Facilitate steps to achieve file room closure in 3 years.
- g. Identify and resolve barriers to the EHR.
- h. Provide data that will contribute to initial and ongoing professional practice evaluations
- i. Make recommendations and provide input regarding implementation of ICD-10-CM.
- j. Make recommendations to Quality Executive Board and other boards/committees as appropriate, regarding process changes, documentation concerns as related to Medical Records.
- k. Track and Trend performance measures related to medical record documentation.
- l. Work with EPRP Coordinator.
- m. Evaluate and advise on policies and procedures as they pertain to medical record documentation.
- n. Evaluate and advise on need for training in documentation in the medical record
- o. Monitors for review include but or not limited to: Use of Prohibited Abbreviations, H&P completion statistics, Discharge Summary component review, Copy and Paste monitor, HIMS Metrics, Joint Commission Hospital Medical Record Statistics Form and facility Medical Record Deficiency and Delinquency rates.

Communication: The Medical Record Committee will meet at least quarterly or as needed to address program objectives. Attendance will be monitored at all meetings. A report on the issues identified and status of the workgroup will be provided to the SAVAHCS Quality Executive Committee on at least a quarterly basis.

Subcommittees: There are no subcommittees that report to the MRC.

AUTHORITY: The Medical Record Committee is established pursuant to the direction of the SAVAHCS governing body, the Director.

MEMBERSHIP:

Chairperson, [REDACTED] Manager, HIMS
Co-Chair, [REDACTED], MD; Chief, Quality, Performance Management and
Credentialing Service Line
Facilitator, [REDACTED], Chief, Business Service Line
[REDACTED], [REDACTED], Surgical Care Line,
[REDACTED], Clinical Director, Rehabilitation and Outpatient Programs
[REDACTED], Clinical Nurse Leader, 1 West, Mental Health Care Line
[REDACTED], MSW, CPHQ; Quality Management
[REDACTED] Privacy Officer
[REDACTED] Compliance Officer
[REDACTED] Administrative Officer, Mental Health Care Line
[REDACTED], Coding Unit Supervisor, HIMS
[REDACTED], Asst. Chief, HIMS
[REDACTED] File Room – Scanning Unit Supervisor, HIMS
[REDACTED] Supervisor, Ward Administration
[REDACTED] Administrative Officer, Medicine Service
Clinical Pharmacist Representative

[REDACTED]
Committee Chair

[REDACTED]
Date

6/20/13

[REDACTED]
Committee Co-Chairman

[REDACTED]
Date

6/20/13

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
June 20, 2013

#3
SD3

Organize > Favorites > Desktop > Downloads > Recent Places > Libraries > Documents > Music > Pictures > Videos > Computer > OSDisk (C:) > Services (S) > ~VHATUC\willr (i) > r01tuchsm > Workgroups (W) > Network

Computer > Services (S) > Business > HIMMS > New folder

- 2014 AzHIMS
- HIMS Coder Weekly Rpts
- HIMS Reports
- HIMS Staff Highlight info
- I-med Consent
- Safety-OHSA
- Template Project
- 1D999510
- Adobe LiveCycle
- Consult Titles
- desktop
- HIMM Lunch Break Requests
- HR 2013 Sample of SCA - Indv Aw...
- Outpatient Occupational Therapy...
- Quadramed_V18_Issues
- TIC Standards
- Big73ScannerRoutine
- HIMS Coding Rpts
- HIMS ROI
- HIMS System Memorandums
- Labels
- Scanning
- Timekeeping
- 90 day hold destroy 12-01-13
- BackupMAGFiles
- Contents of New Employee Infor...
- EZF53C60
- HIMS Review Mock Survey 2010 T...
- 1 CareL VA Core Values and Char...
- PracticeBrief8CPT1TelephoneCodes
- R01 Citrix Farm- LIVE
- VA2237(ES)
- COMPLETED WORK STATE HOM...
- HIMS Daily Reports
- HIMS Share
- HIMS Transcription
- MAGINTEMPLATE
- SSN Survey 2010
- WORKSTATION REFRESH INITIAT...
- 2014 AzHIMS
- Calculator
- Copy of TUCSON-08262013LOG1
- Fall Festivities 11-2011
- HIMS Staff Meeting Agenda Aug ...
- MEDICAL RECORDS EVACUATIO...
- PracticeBrief9_MonitoringCopyan...
- Receipt of RX's.imc
- VA2237
- Forms
- HIMS File Room & Retirement Info
- HIMS SOPs
- 1 CareL VA Core Values and Char...
- MHV
- State Vet Home
- ~VHATUC\Yanta (r01)tuchsm01.r0...
- ADJUSTED FONT Orange Card Ori...
- Consult Titles
- Copy of Work Survey Solutions ve...
- FAQNonVACare
- HIMS Transcription - Shortcut
- Music - Shortcut
- Printer Inventory, Jan 2011
- restoreMAG
- Workgroups (W) - Shortcut

Organize	Open	Burn	New folder	Copy and Paste Monitor FY 09	DAILY NOTIFICATION INFO
Favorites	Amendments	Business Rules	HIMMS Monitors	JCAHO Del Charts by Mc	
Desktop	Discharges FY 09	HIMMS Dashboard Data	Op Report Deficiencies	Op Reports	
Downloads	Med Rec Committee	Memorandums and SOPs	TCF Application_files	Transcription TAT	
Recent Places	Proh Abbr	State Vet Home	2011 Octs	Computer Downtime notes 071410	
Libraries	Uns Unes docs	Unsigned Orders	HIMMS Review Mock Survey 2010 r...	Inform Consent Tele FY 9 & 10	
Documents	DICTIONARY PROVIDER LIST TUCS...	Enctrs Notes 0417 thru 0418	med and PC rctes for past 6 days	Medical Record Review-IC Stand...	
Music	January 2012 Prosthetics	JC Standards for HIMMS Monitors 7...	reassignments 100213	reassignments for CY 2010 thru 1...	
Pictures	Op Rpt Falconer 7867	Physician Documentation SAVAH...	Template Tracking	Trim function example	
Videos	SURROGATES	TCF Application	Users w access to encounter forms		
Computer	Tucson Dictation log 10 18 10	Use of Prohibited Abbreviations 2...			
OSDisk (C:)					
Services (S)					
-VHATUCWILLR (\\V01tuchsm)					
Workgroups (W:)					
Network					

Name	Date modified	Type	Size
ADMISSIONS FY 14	9/17/2014 7:31 AM	File folder	
ADMISSIONS FY 15	10/1/2014 7:06 AM	File folder	
OLD ADMISSIONS	5/22/2014 3:09 PM	File folder	
OLD SURGERIES	5/22/2014 3:18 PM	File folder	
OP Rpt Ref Proc Notes	10/13/2014 2:07 PM	File folder	
SURGERIES FY 14	9/2/2014 9:32 AM	File folder	
SURGERIES FY 15	10/1/2014 7:05 AM	File folder	
Trans Log	10/14/2014 11:09 ..	File folder	
12-13-10	10/15/2010 5:21 PM	Information Storage...	35. MB

- Computer
- DSDisk (C:)
- Services (S)
- \\HATUC\W\HR (\\dltuchsm)
- Workgroups (W)
- Network

Name	Dimensions	Type	Size
SURGERIES FY09	5/2/2014 3:05 PM	File Folder	
SURGERIES FY10	5/2/2014 3:05 PM	File Folder	
SURGERIES FY11	5/2/2014 3:05 PM	File Folder	
SURGERIES FY12	5/2/2014 3:05 PM	File Folder	
SURGERIES FY13	5/2/2014 3:05 PM	File Folder	

Organize > Open > Burn > New folder

Favorites
 Desktop
 Downloads
 Recent Places

Libraries
 Documents
 Music
 Pictures
 Videos

Computer
 OSDisk (C:)
 Services (S:)

-YHATICWHR (Y:\tuchsm
 Workgroups (W:)

Network

Name	Date modified	Type	Size
April	5/4/2012 11:28 AM	File folder	
August	5/3/2012 11:28 AM	File folder	
December	5/2/2012 11:28 AM	File folder	
February	5/2/2012 11:28 AM	File folder	
January	5/2/2012 11:28 AM	File folder	
July	5/2/2012 11:28 AM	File folder	
June	5/2/2012 11:28 AM	File folder	
March	5/2/2012 11:28 AM	File folder	
May	5/2/2012 11:28 AM	File folder	
November	5/2/2012 11:28 AM	File folder	
October	5/2/2012 11:28 AM	File folder	
September	5/2/2012 11:28 AM	File folder	
Oct 2012 Surg Debbie	10/23/2012 11:28 AM	Microsoft Excel 97-2003	38 KB
Oct 2012 Surg Elaine	10/23/2012 11:28 AM	Microsoft Excel 97-2003	38 KB
Oct 2012 Surg Mark	10/23/2012 11:28 AM	Microsoft Excel 97-2003	38 KB

File Name	Icon	File Name	Icon	File Name	Icon	File Name	Icon
Copy and Paste Monitor	Document	Discharge Component Monitor	Document	Discharge Summ Timeliness Mon...	Document	Discharges Raw Data by month	Document
ED Monitor	Document	ED Raw Data by month	Document	FY 13 Daily Discharge Monitor	Document	g_reassign	Document
H&P Comp Data FY 8-12	Document	H&P Comp Data FY 13	Document	H&P Comp Data FY 14	Document	H&P Comp Data FY 15	Document
HIMS Record Deficiency & Delin...	Document	Master Forms - Gimi Only	Document	MRC CHECKLIST	Document	MRC MINUTES AND SUMMARY	Document
Nurse Assessment Monitor	Document	Proh Abbr FY 13	Document	Proh Abbr FY 14	Document	Proh Abbr FY 15	Document
Scanning QA Monitor	Document	Surg Immediate and Op Rpt Moni...	Document	Surgeries FY 13	Document	Unsigned Unassigned Clin Docs	Document
Active Clinics as of May 5 2011	Document	Alerts Unprocessed Fin Nov 2012	Document	ARK duplicates	Document	ARK duplicates	Document
Attachment A - Monitor Plan	Document	Auditing and Monitoring Plan - O...	Document	Audits and Monitors	Document	dc summary example - meds	Document
DC Summary excerpt from 1907.01	Document	DC Summary Template revised Ju...	Document	Disch 1005 thru 100714	Document	Disch 1005 thru 100714	Document
Disch Notes 1003 thru 100714	Document	Disch Notes 1003 thru 100714	Document	Discharge Notes 1008 to 1013	Document	DISCHARGE SUMMARY NOTE	Document
Discharge Summary Proposed Ch...	Document	Discharges 10-08-13	Document	Discharges 10-09-13	Document	Discharges 1008 to 1013	Document
discharge-summary template-exa...	Document	FY 14 HIMS Monitor Summary	Document	Header Master a	Document	Header Master	Document
HIMS Monitors check list	Document	JC Med Rec Rev Standards	Document	JCRReviewTool	Document	Medical Record Review-JC Stand...	Document
Monitor Quick-Review	Document	MRC H&P, PA Communication S...	Document	Pivot Table DC Summ Totals	Document	Shortcut to Header Master.xlsx	Document
Uns Uncs Und Unv Op Rpts 01010...	Document	Uns Uncs Und Unv Op Rpts 01010...	Document	Unsigned Unassigned Clin Docs 1...	Document		

Library	Folder/Item	Form
2014 AzHIMS	Completed Work State HOM...	Forms
HIMS Coder Weekly Rpts	HIMS Daily Reports	HIMS File Room & Retirement Info
HIMS Reports	HIMS Share	HIMS SOPs
HIMS Staff Highlight info	HIMS System Memorandums	I Care! VA Core Values and Char...
I-med Consent	Labels	MHV
Safety-OHSA	Scanning	State Vet Home
Template Project	Timekeeping	~VHATUCYantA (r01)uchsm01.r0...
1D999510	90 day hold destroy 12-01-13	ADJUSTED FONT Orange Card Ori...
Adobe LiveCycle	BackupMAGFiles	Consult Titles
Consult Titles	Contents of New Employee Infor...	Copy of Work Survey Solutions ve...
desktop	EZF53C60	FAQNonVACare
HIM Lunch Break Requests	HIMS Review Mock Survey 2010 r...	HIMS Transcription - Shortcut
HR 2013 Sample of SCA - Indv Aw...	I Care! VA Core Values and Char...	Music - Shortcut
Outpatient Occupational Therapy...	PracticeBrief8CPTTelephoneCodes	Printer Inventory, Jan 2011
Quadramed_V18_Issues	R01 Citrix Farm- LIVE	restoreMAG
TIC Standards	VA2237(ES)	Workgroups (W) - Shortcut

A FBCS	A Meeting Agendas	Advance Directive Template Rev...	Anesthesia Reports
capture settings & instructions	Completed AZ State Consult Req...	CRISP	Damaged Scanner 1-2012
Dashboard 2012	Discharges	EQUIPMENT	For Med Rec Committee
FujiScannerConfigFile	Ideals-Huddle-Staff Mgt	Inpatient Monitor-checklist	Mail outs
Monitors	OMR Scanning Cover Ltr	PICIS	Priorities
QC Findings 2014	Record Arrangement	Sanitization Tracking Log	Scanning
Training	1907.01 external documents	2010 0126 Final ITFD Software Req...	A FBCS - Shortcut
Approved Clinical Capture Device...	Copy of FY 13 HIMMS Monitor Sum...	Copy of Retired 2005 - VHA-10-07...	CDRS notes to resend 2-11-10.xls
DELETE	Field_Guide_20130927	FRONT DESK COVERAGE ROSTER ...	FRONT DESK COVERAGE ROSTER ...
FRONT DESK COVERAGE ROSTER ...	FRONT DESK COVERAGE ROSTER	HIMS Form Review	HIMS Form Review
Jul 2012 surgical monitor	JW Gyno	OPM Form 71 (addition)	Scanning assignments
TR_CARE CHAMPVA FINANCIAL ...	TR_CARE CHAMPVA FINANCIAL ...	VHA Handbook 1907.01 GUIDANCE	Volunteer Position Description 2011
Volunteer Position Description 2011			

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- Jan 2014 - 20% QC
Author: Yant, Alma A.
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Libraries

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Computer

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Network

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From: [REDACTED]
Sent: Wednesday, January 22, 2014 7:41 AM
To: [REDACTED]
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Subject: RSW - 01/13/14 - No Discrep.

FYI

28 documents scanned - 10% = 3 QC'd
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S/D #4A

HIM Practice Brief #7 Health Record Review

Updated April 2014

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INTRODUCTION

The purpose of this practice brief is to recommend processes for an ongoing health record review program, including authentication and completion of health record documentation. Each facility must incorporate a systematic selection and analysis of health records as part of their overall information management, performance measurement and quality management programs. The health record review program must adapt as regulations and accreditation standards evolve. Health record reviews meet many requirements, including mandatory reporting for regulatory and accreditation purposes, performance, record completion monitoring, and quality improvement. Health Information Management's (HIM) role in the design and deployment of a health record review program is a vital part of any record review process.

GUIDING PRINCIPLES

It is recommended that existing or newly established ongoing record review functions are integrated across the organization and include clinical practitioners. All staff involved in any aspect of the health record review program must understand the scope of review activities in order to minimize redundant reviews and conflicting data definitions. Reasons for an integrated program include:

- Developing a holistic view and management of health record activities
- Prioritizing interventions for improvement
- Identifying mechanisms to utilize resources more efficiently
- Reducing the number and average age of incomplete and delinquent documents
- Improving reporting processes for management, and
- Facilitating communication between clinicians and those responsible for tracking documentation trends.

Key health record review requirements for Veterans Health Administration (VHA) are derived from the department level of Veterans Administration (VA), as well as accrediting agencies. Examples include the Joint Commission ([TJC](#)), VA Office of Inspector General ([OIG](#)), Commission on Accreditation of Rehabilitation Facilities * ([CARE](#)), VA's Academic Affiliations Office, VA performance monitors, and VHA Directives and Handbooks. It is important to understand and have a working knowledge of the requirements of these accrediting agencies regarding health record reviews.

Getting Started

In planning and developing a local program, the following must be considered to determine health record monitors:

- Current priorities for VA Department level, VHA, your site specifically, accrediting and/or regulatory agencies. Of these priorities, determine the areas that lend themselves to health record reviews.
- Performance measures must provide information on facility performance, achievement of goals, customer satisfaction show processes are in control, and where improvements are necessary.
- Align key organization strategic objectives and action plans to performance measures.
- Determine if aspects of care and documentation need and/or require 100% monitoring and/or review.
- Determine aspects that require periodic monitoring, frequency, and sampling methodologies that will be employed.

- Identify an appropriate statistically valid sample size and what it is based on – discharges, appointments, etc.
- Identify the frequency each review will be conducted and/or reported.
- Identify the measure of compliance that must be met, e.g., 90%, 95%, etc.
- Identify where data collection, analysis and presentation will make a difference in performance.
- Identify what will realistically be accomplished based on resources, staffing etc.
- Identify reports that may be generated and where automated data is available.

Stakeholders

Collaborate with the health care system executives responsible to ensure a health record review process is in place. Determine if any clinical staff is willing to champion the review process. Verify whether other Services already conduct or would participate in health record reviews. For example, Quality Management (QM), Nursing Service, other service line or department managers, administrative officers, business managers, various clinicians, and Medical Record Committee members may already be conducting reviews. Find out what would motivate stakeholders to participate in such a program, for example, areas of concern that they may have regarding documentation. Find out who decides when and what data to collect.

In addition, determine what Services create and maintain data dictionaries. A data dictionary is a descriptive list of data elements to be collected from the health record. The purpose of the list is to ensure consistent usage and interpretation. ([Appendix B](#))

Reporting Structure

Review the organizational reporting structures at your facility. It is important to provide your entire organization with a representation of how well the organization is performing and the areas that need improvement. It is also important to report results to leaders who will be able to understand the importance of the data and will plan and follow through with appropriate action.

Consider presenting results of the health record reviews on your facility Intranet. Before posting results on the facility Intranet, ensure that privacy, confidentiality and security requirements are met in order to distribute the results by this means.

Data Presentation

Data must be presented in such a way that information and trends are easily understood. Graphical displays must include a narrative description of what is being measured including the standards, what the data means, where, when and how it was collected, a summary of the findings, recommendations for improvement, and when and how the changes are being followed up, including a date for re-review.

Performance Improvement Plans

The oversight group/committee receiving the results of the reviews must be responsible for documenting their prioritized recommendations/actions for resolving issues and identifying improvements when established compliance/performance measures are not met. Meeting minutes must be well documented.

It is suggested that the recommended action plans (or changes) include the following:

- Who – who is responsible for the action/change; who is the subject of the action/change?
- What – what element of performance is to be changed/improved?

- When – when is the action to be taken and when is the expected completion date?
- How – how is the action to be accomplished; how is the evaluation to be done; how frequently will the follow up occur?

TYPES OF REVIEWS RELATED TO THE HEALTH RECORD

Accreditation Organizations

The Joint Commission (TJC)

Their primary mission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. Organizations must undergo an on-site survey by a Joint Commission survey team at least every three years. (Laboratories must be surveyed every two years.)

Health Information Management (HIM) may be held responsible for developing health record review processes and procedures based on the Information Management (IM) and Record of Care, Treatment, and Services (RC) chapters of the TJC standards. However, since January 1, 2004, TJC has no longer provided a specific health record review form. Instead, specific data elements on which to perform health record reviews are left to the discretion of the individual health care organization.

The Office of Quality, Safety and Value, Division of External Accreditation Services and Programs, provides a website to assist VHA facilities with meeting standards of the various accrediting organizations. Maintaining Joint Commission accreditation for all VHA facilities is consistent with one of VHA's goals to "Provide Excellence in Healthcare Value." Joint Commission accreditation confers recognition that healthcare organizations meet certain standard of quality and safety, and also confers deemed compliance with health care quality standards of payors, both public (e.g., Medicare) and commercial. The site provides VHA facilities with access to several informational and educational resources to assist with meeting TJC standards.

In addition, Joint Commission Manuals via E-dition* are available to VA staff. These manuals provide each facility with the latest accreditation standards. You will find the latest FAQs submitted related to specific standards, as well as other useful information on the TJC's website.

RC 01.04.01 states that the hospital audits its medical records. Elements of performance include:

- The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also MS.05.01.03, EP 3)
- The hospital measures its medical record delinquency rate at regular intervals, but no less than every three months. (See also MS.05.01.03, EP 3)

The medical record delinquency rate averaged from the last four quarterly measurements is 50% or less of the average monthly discharge (AMD) rate. Each individual quarterly measurement is no greater than 50% of the AMD rate. (See also MS.05.01.03, EP 3)

Note: To calculate the quarterly and annual average medical record delinquency rate, the TJC Medical Record Statistic Form may be used

- The health record review process should include a multidisciplinary clinical pertinence review performed at or immediately after the point of care by the individuals who document in the record. Providers should assess the adequacy of the documentation with respect to aspects such as the patient's complaint/reason for admission, diagnoses, assessments, conclusions or impressions, and appropriateness of diagnostic and therapeutic tests and procedures, etc.

Quantitative reviews must be completed at least quarterly, and may occur at the point of care or retrospectively. It is suggested that a schedule be established for the reviews and include all services of the facility, both inpatient and outpatient. An example is provided in Appendix A. The sampling approach must involve either systematic random sampling (for example, select every second or third case for review) or random sampling (for example, using a series of random numbers generated by a computer). Sample size for the review may be based on a percentage determined by the facility that ensures a representative quantity is reviewed.

TJC provides sample size guidance in determining a "Measure of Success" (MOS), defined as a numeric or other quantifiable measure, usually related to an audit, which determines whether an action was effective and sustained. The Joint Commission's MOS sample sizes* are:

Population Size	Sample Size
Fewer than (<) 30 cases	100% of cases
30 to 100 cases	30 cases
101 to 500 cases	50 cases
Greater than (>) 500 cases	70 cases

TJC encourages organizations to follow this sample size when demonstrating achievement with an MOS, but it is not required.

To capture the raw review data, several facilities have developed innovative/creative methods such as constructing databases or designing direct-entry electronic forms. Some facilities are still effectively completing health record reviews with a paper review form. The VHA HIM website has several record review tools available. As long as the required elements are being reviewed, whatever method works for the facility is acceptable. Reviews must continue to be performed even when waiting to convert from paper to electronic.

VA/VHA Requirements

VHA Directives and Handbooks, in addition to local bylaws and facility policies, provide potential monitoring criteria or requirements. VHA Handbook 1907.01, Health Information Management and Health Records states that HIM must "define, develop, or in conjunction with facility quality management initiatives, ensure that health records are reviewed on an ongoing basis at the point of care by people who document in the health record based on organizational defined indicators that address presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity, accuracy, completeness, and authentication. Results of the health record reviews must be completed and presented to the overseeing committee on a quarterly basis. Both quantitative and qualitative reviews must be completed. A representative sample from both inpatient and outpatient care for all services must be performed to ensure that TJC and VHA standards are being met."

Monitoring unauthenticated documentation must be a part of the ongoing health record review process and must, at a minimum, include the following:

- Encounters without an associated progress note in VistA;
- Unsigned and un-cosigned notes, addenda, discharge summaries, operative reports; and
- Unsigned orders.

Examining inappropriate documentation needs to be included in the review process and needs to encompass some, or all, of the following areas:

- Copy and paste use within CPRS;
- Authenticity of user electronic signatures (see subpar. 25f);
- Unauthorized entries into the health record (see par. 14); and
- Results of other facility inquiries, monitors, or concerns that stem from improper or inadequate documentation. **NOTE:** Facility policy determines who is responsible for tracking resident supervision requirements and reporting, no less than quarterly, to the appropriate medical staff committee.

Below are a few monitor criteria examples.

a) Resident Supervision

For those sites that have residents, VHA Handbook 1400.01, Resident Supervision, states that "a local policy entitled, "Monitoring of Resident Supervision" must be created and it must define the procedures to be followed. The policy must also define the procedures for monitoring the following elements.

- Inpatient care
- Outpatient care
- Procedural care
- Emergency care
- Consultative care
- Surgical care, including a review of the appropriateness of levels E and F."

The Handbook also states "monitoring of resident supervision is a health record review process, and a quality management activity. Documents and data arising from this monitoring are confidential and protected under Title 38 United States Code (U.S.C.) 5705, and its revised implementing regulations."

b) Copy and Paste Monitoring

Monitoring of copy and paste use within CPRS is a requirement stated in VHA Handbook 1907.01, Health Information Management and Health Records. Each facility must have a policy and process in place outlining the rules for importing and copying text into CPRS entries, and for monitoring and reporting instances of copy and paste when identified. Practice Brief #9 Monitoring Copy and Paste on the VHA HIM website provides guidance on establishing a copy and paste monitoring process. Until such time as a system-wide electronic method of identifying copy and paste entries within CPRS is available, this monitor remains a manual process.

Department of Veteran Affairs Office of Inspector General

The Office of Inspector General (OIG) is an independent organization with the goal of minimizing fraud, waste, and abuse in the Department of Veterans Affairs' programs, activities

and functions. The Office of Healthcare Inspections (OHI) was created to monitor the health care provided to the veterans. To carry out its inspections responsibilities, the OHI is legally authorized to gain access to all records, reports, audits, reviews, documents, papers, recommendations, or other pertinent materials.

In performing its assigned functions, OHI inspects individual health care issues, performs quality program assistance reviews of medical center operations, evaluates nationwide health care programs, and provides clinical consultations that are designed to strengthen VHA's health care, and other missions, in order to help VHA enhance patient care programs and prevent and deter fraud, waste, and abuse.

The Department of Veteran Affairs Office of Inspector General (OIG) recommends health record reviews on many of the same subject areas as the Joint Commission, although occasionally with a more specific criterion or outcome. The references used in the OIG reviews, are VHA Handbook 1907.01, Health Information Management and Health Records, local facility policies, and Medical Staff bylaws. The subject areas that the OIG reviewers focus on change from time to time. Areas of focus may be:

- History & Physical
- Post-procedure note
- Informed Consent
- Initial Assessment/Re-Assessment
- Joint Commission National Patient Safety Goals
- Operative/Invasive Procedure Report
- Medical Necessity
- Unauthenticated Documentation
- E/M coding compliance
- Do Not Use Abbreviations
- Discharge Summary
- Care/Treatment Planning
- Advance Directive
- Unsigned/Un-cosigned progress notes
- Read back of verbal orders/critical values
- Focusing on the quality of health record reviews
- Copy and Paste
- Resident Supervision
- Outpatient encounters in Vista

Project and Quality Improvement Projects

Focused reviews, special projects, or documentation improvement activities may all give rise to health record review criteria and/or health record reviews. Any of these reviews must be coordinated and reported through the appropriate facility oversight committee(s). Data previously collected may need to be analyzed from a different viewpoint to meet a new need. For example, data collected to track delinquency may also be used to pinpoint timeliness of documentation. Clinical and allied health providers may have documentation reviews taking place. Be sure to evaluate what reviews are already being done and integrate the appropriate reviews, findings, and follow up into your health record review process to avoid redundant reviews.

Appendices:

- A. Sample Tools
- B. Sample Data Dictionary
- C. TJC 2014 Survey Activity Guide

Prepared by:
VHA Health Information Management Program Office

APPENDIX A: SAMPLE TOOLS

A. Electronic data collection tools using Microsoft Access. Raw data for reports may be displayed in Excel and available on a shared drive with restricted access. Reports are generated from the database and can be generated at the facility, service, specialty, or even provider level.

Sample 100% Admission Event H&P and Resident Supervision Review

The screenshot shows a Microsoft Access database window titled "Medical Record Review - Database (Access 2007) - Microsoft Access". The interface includes a ribbon with tabs for "Home", "Create", "External Data", and "Database Tools". The main area displays a form titled "Admit Resident Supervision and History & Physical hybrid".

The form contains the following fields and controls:

- Buttons: "New Record" and "Delete Record"
- Reviewer: [Dropdown menu]
- Date Reviewed: [Text box]
- Patient SSN Query: [Text box]
- Patient SSN entry: [Text box]
- Patient Last Name: [Text box]
- Patient First Name: [Text box]
- Author: [Text box]
- Admit or Encounter Date: [Text box]
- Admit or Encounter Time: [Text box]
- Discharge Date: [Text box]
- Ward ID: [Dropdown menu]
- Service Line: [Dropdown menu]
- Treating Specialty ID: [Dropdown menu]
- AttendingName: [Text box]
- RS ResidentInvolvedInCare: [Checkbox]
- RS AttendingAdmitNoteDate: [Text box]
- HP ChiefComplaint: [Text box]
- HP DetailsOfPresentIllness: [Text box]
- HP ReleventPastHistory: [Text box]
- HP SocialHistory: [Text box]
- HP FamilyHistory: [Text box]
- HP ReviewOfBodySystems: [Text box]
- HP ConclusionsImpressions: [Text box]
- HP Plan: [Text box]

At the bottom of the form, there is a status bar showing "Record: 1 of 1" and a search field.

Sample Focused Review Form

INPATIENT DEATHS

Date of Death:	
Patient Name:	
SSN:	
Unit Death Occurred? (5S, 7E, etc.):	
Attending:	
On what shift did Patient die?	
Day: 0730A – 1600P	
Evening: 1600P – 1200A	
Night: 1200A – 0730A	
Patient's age?	
Was Autopsy performed?	
Was patient on Seriously Ill List?	
Did patient have Advance Directives?	
Critical Days in MICU:	

Sample Report

**Health Information Briefing: Clinical Executive Board
3/1/2012**

Resident Supervision on Admission

HIMS conducts a random review of admissions involving residents in the patient's care. This review collected data from the first quarter of fiscal year 2012. Resident Supervision is a national performance measure. The national monitor looks at how well our facility complies with the 'met' and 'presumed met' status (in green and yellow).

Criteria

- Does the Attending physician meet and physically examine each patient within 24 hours of admission? **and**
- Does the Attending document his/her findings and recommendations not later than the end of the day after admission?

Analysis

VA Puget Sound is currently reflecting 100% compliance! Previous quarters reflected a range from 90% to 97% compliance. The national performance monitor expects 85% or better compliance; 90% is exceptional. We currently are well above the expectation.

Recommended Action

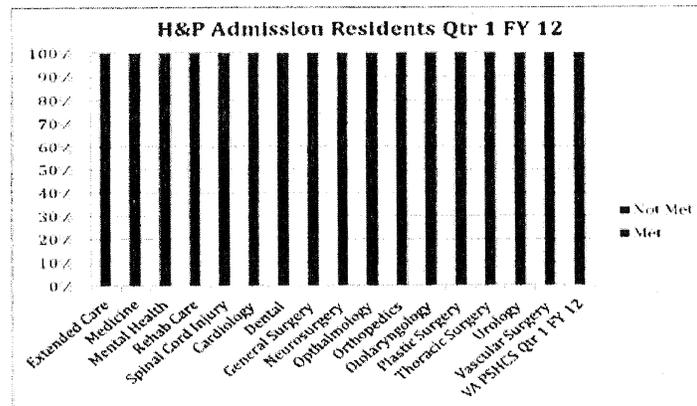
Continue to review the information, looking for trends within your Service Line and take appropriate action when needed.

Data

Data supporting this monitor can be found at:

G:\WorkGrps\MRR_Data\FY 2012 Data\Res Sup Admission Qtr1 FY 12.xls

Graphic Display



Sample Outpatient Surgical Review Form

MainForm

SSN: Surgical Specialty:

Patient LastName: Op Date:

Patient FirstName: Op Time In:

Attending On Schedule: Op Time Out:

FOLLOW-UP

FOLLOW-UP REPORT

Pre-Operative | Post-Operative

Cystoscopy

Informed Consent

Present?

Dated?

Timed?

Signed by Doctor?

Signed by Patient?

Witnessed?

Signed by I-Med?

Pre Operative History and Physical

Present?

Date:

Time:

Title:

Author:

Pre-Op H&P Attending Not Applicable

Attending Name:

Attending Note Title:

Attending Note Date:

Pre-Operative Anesthesia

No Pre-Op Anesthesia Given

Date:

Time:

Title:

Author:

Immediate Pre-Op Note

PreOpDxSpecified

Date:

Time:

Title:

Author:

Intra-Operative Anesthesia Note

Present?

PreOpCheck?

Anesthes Attending:

ADD RECORD

DELETE RECORD

Sample Weekly Incomplete Record Report

JC is coming soon. Please review the lists and take action accordingly.

Click on the following links for the Incomplete Record, Unsigned Notes/Addenda, and Unsigned Orders lists:

g:\WorkGrps\JC Reports\Incomplete Records\Incomplete 1-8-10.xls

g:\WorkGrps\JC Reports\Incomplete Notes\Unsigned\1-8-10.xls

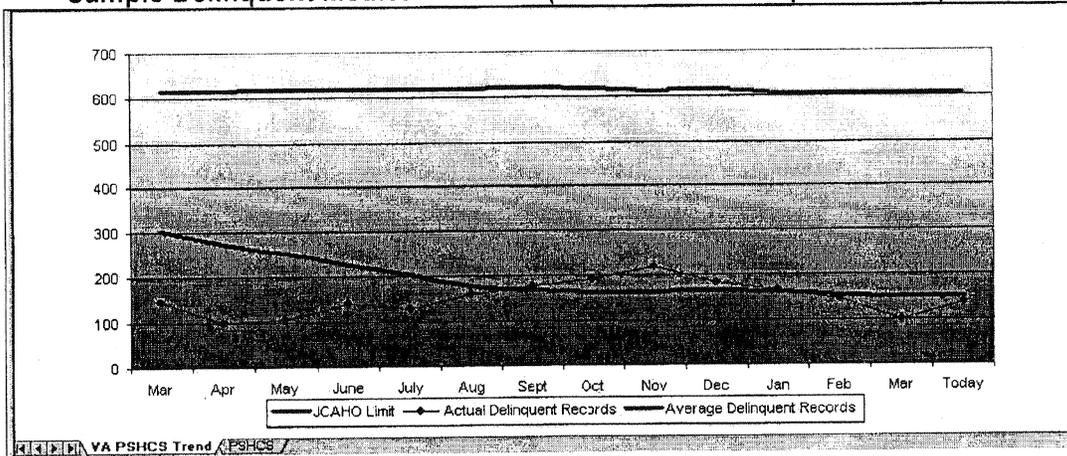
g:\WorkGrps\JC Reports\Incomplete Orders\Unsigned\1-8-10.xls

Sample Delinquent Record List (Published Weekly)

	A	B	C	E	F	G	H	
	Patient	SSN	D/C Date	Responsible Clinician	Action Required	Document	Cosigner	Days Old
1	Patient 1	1234	3/12/2005	Resident 1	Dictate	Summary	Attending 1	2
2	Patient 2	P1235	3/11/2005	Physician's Assistant 1	uncosigned	Summary	Attending 2	3
3	Patient 3	1236	3/11/2005	Resident 1	Dictate	Summary	Attending 1	3
4	Patient 4	P1237	3/10/2005	Physician's Assistant 1	unsigned	Summary	Attending 2	4
5	Patient 5	P1238	3/9/2005	Physician's Assistant 1	unsigned	Summary	Attending 2	5
6	Patient 6	1239	2/15/2005	Resident 1	Dictate	Summary	Attending 2	29
7	Patient 7	1240	2/14/2005	Resident 1	Dictate	Summary	Attending 2	30
8	Patient 8	1241	1/12/2005	Resident 2	Dictate	Summary	Attending 3	62

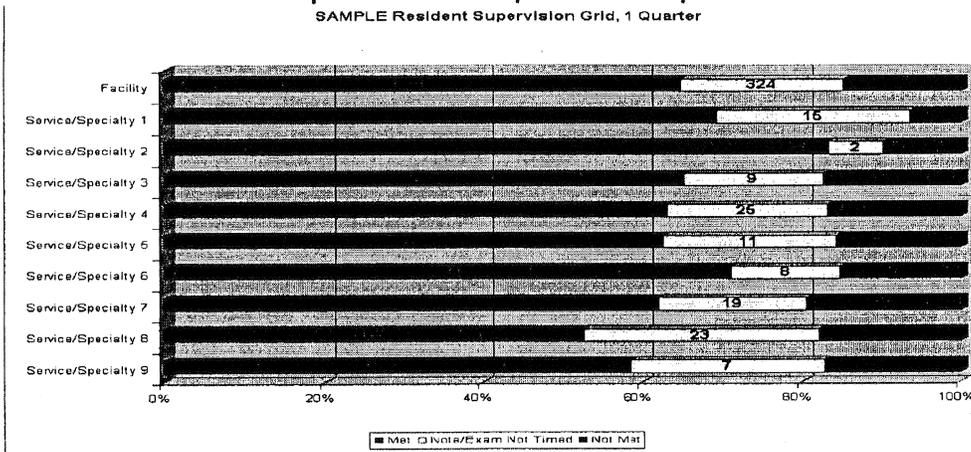
Ready NUM

Sample Delinquent Medical Records (Summaries and Operative Reports)

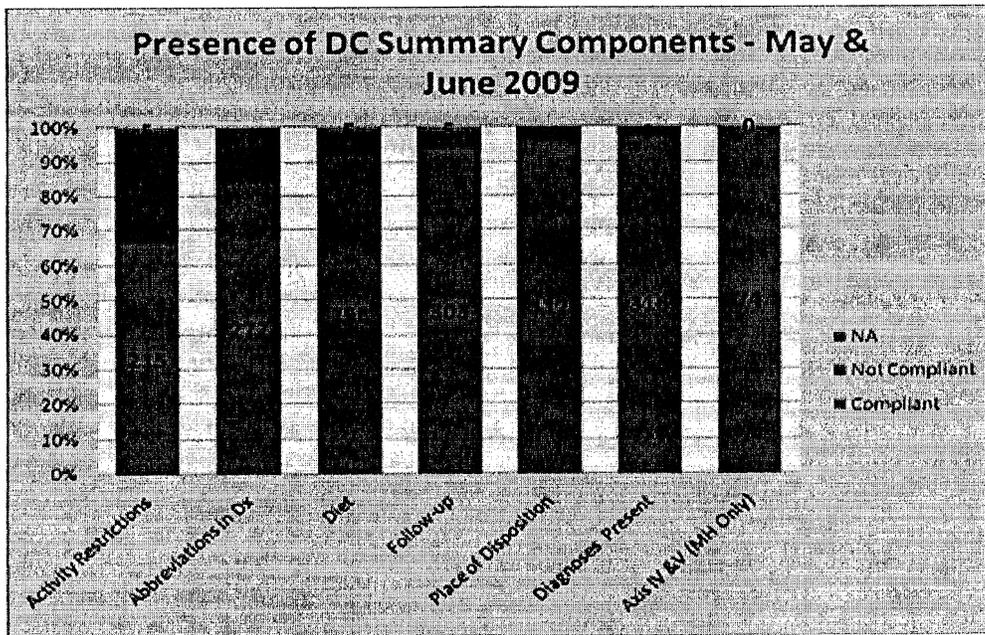


Sample Resident Supervision Report

SAMPLE Resident Supervision Grid, 1 Quarter

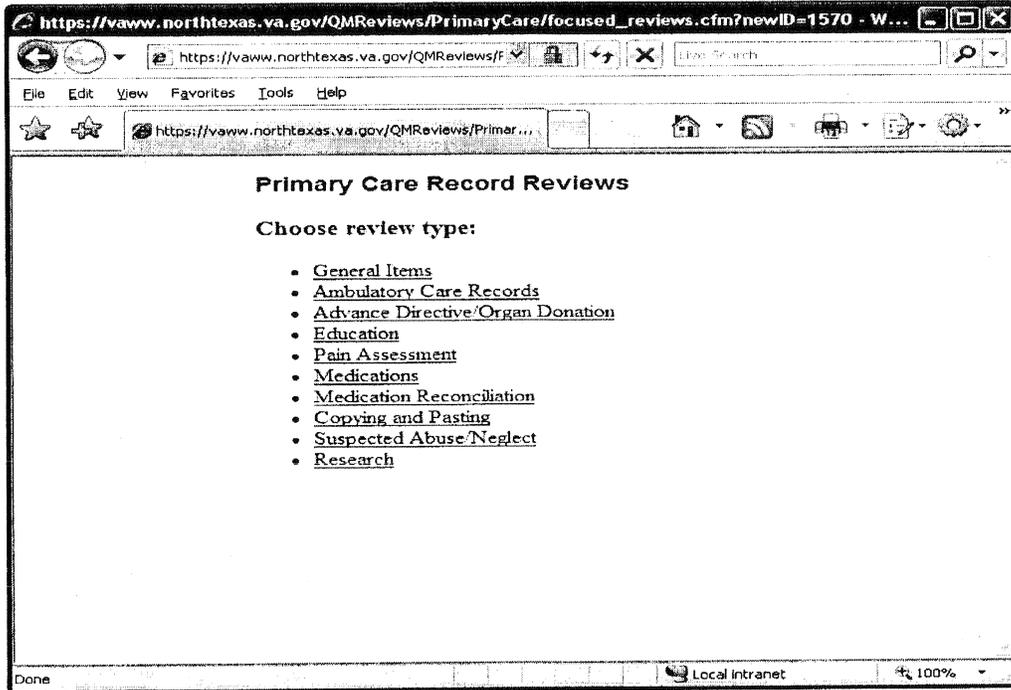


Sample Presence of Discharge Summary Elements Report



B. Web-based Health Record Review Tool. See the North Texas Health Record Review Tool presentation on the VHA HIM website for additional information.

Sample Review Screens



https://vaww.northtexas.va.gov/QMReviews/PrimaryCare/copypaste1.cfm?newID=15...

File Edit View Favorites Tools Help

Copying and Pasting

Was information directly copied from another part of the record that does not deal with this episode of care? :	<input type="checkbox"/>
Were any lab findings, radiology reports, procedure reports or other information copied into the progress notes verbatim? :	<input type="checkbox"/>
Was any data imported via patient data objects: such as problem lists/current medications that don't deal with this episode of care.? :	<input type="checkbox"/>
Was any templated documentation copied as a "mirror image" of the care given on a previous visit? :	<input type="checkbox"/>
Were any email interactions (between patient and provider) copied into CPRS? :	<input type="checkbox"/>
Were any signature block(s) copied from another note? :	<input type="checkbox"/>
Was information copied that identified another provider that was not directly involved with the current occasion of service? :	<input type="checkbox"/>
Comments:	<input type="text"/>
<input type="button" value="Submit"/>	

Done Local Intranet 100%

https://vaww.northtexas.va.gov/QMReviews/PrimaryCare/general1.cfm?newID=157...

File Edit View Favorites Tools Help

Primary Care General Items

Only authorized individuals make entries in the medical record.	<input type="checkbox"/>
The author of each medical record is identified in the medical record.	<input type="checkbox"/>
Entries in the medical record are authenticated by the author.	<input type="checkbox"/>
Entries in the medical record are dated.	<input type="checkbox"/>
A summary is available in the medical record with information to provide care. (HP, Med Orders, Dr. Orders, and D/C Summary).	<input type="checkbox"/>
Record contains information unique to the patient for patient identification.	<input type="checkbox"/>
Patient's name, address, date of birth, and the name of any legally authorized representatives	<input type="checkbox"/>
Patient's sex.	<input type="checkbox"/>
Legal status of any patient receiving behavioral health care services.	<input type="checkbox"/>
Patient's language and communication needs.	<input type="checkbox"/>
Any Allergies to food are documented	<input type="checkbox"/>
Informed consent when required by hospital policy	<input type="checkbox"/>
Consultation reports.	<input type="checkbox"/>
Progress notes	<input type="checkbox"/>
Records of communication with the patient regarding care (telephone calls or e-mails).	<input type="checkbox"/>
Patient-generated information (information entered into record over the WEB).	<input type="checkbox"/>

Done Local Intranet 100%

C. Paper based review tool. Using Excel or Word, a paper review form can be developed for use as a Joint Commission Review Tool or as a tool to monitor other facility specific requirement.

The screenshot shows a Microsoft Excel spreadsheet titled "JCReviewTools.xls [Read-Only] [Compatibility Mode]". The spreadsheet is designed as a review tool for health records. It includes a header section for patient information, a table for general items, and a table for clinical information. The interface includes the standard Excel ribbon with tabs for Home, Insert, Page Layout, Formulas, Data, Review, View, and Get Started. The status bar at the bottom indicates "Ready" and "100%".

Area of Review	Standard	Y	N	N/A	Location in Record	Notes/Comments
GENERAL ITEMS						
The medical record contains the following demographic information:						
The patient's name, address, date of birth, and the name of any legally authorized representative	RC 02.01.01 EP 1				From Cover Sheet, "Click" on patient demographic box	
The patient's sex	RC 02.01.01 EP 1				From Cover Sheet, "Click" on patient demographic box	
The legal status of any patient receiving behavioral health care services (N/A if not behavioral health care)	RC 02.01.01 EP 1					
The patient's language and communication needs	RC 02.01.01 EP 1				Nursing admit note	
The medical record contains the following clinical information:						
The reason(s) for admission for care, treatment, and services	RC 02.01.01 EP 2				H&P/ Resident Admit Note	
The patient's initial diagnosis, diagnostic impression(s) or condition(s)	RC 02.01.01 EP 2				H&P/ Resident Admit Note	
Any findings of assessments and reassessments	RC 02.01.01 EP 2				Assessment and Plan section of the H&P/ Progress notes	
Any allergies to food	RC 02.01.01 EP 2				Cover Sheet/ Nursing Admit Note	
Any allergies to medications	RC 02.01.01				Cover Sheet/ Nursing Admit Note	

D. Sample Monitoring Schedule. A calendar-type document created to identify review elements and their scheduled reporting timeframes.

Sample of a Monitoring Schedule

Copy of frequency of MRRXs (Compatibility Mode)

	A	B	C	D	E	F	G	H
1	Review	Collected	Analyzed (Rpt In Wkgrp)	Last Reported	CEB Reporting	Next Scheduled		
14	Discharge Summary Components	semi-annually	semi-annually	July, 2009	Jan & July	Jan-10		
15	Presence of Discharge Notes	Annually	Annually	July, 2009	July	Jul-10		
16	E & M Distribution	semi-annually	semi-annually	December, 2008	Apr & Oct	Oct-10		
17	Resident Supervision Non-OR	semi-annually	semi-annually	April, 2009	Apr & Oct	Oct-10		
18	Timeliness of Discharge Summaries	Annually/P4P x2	Annually/P4P x2	June, 2008	October	Oct-10		
19	Timeliness of Op Reports	Annually/P4P x2	Annually/P4P x2	June, 2008	October	Oct-10		
20	Timeliness of OutPt Notes	Annually/P4P x2	Annually/P4P x2	June, 2008	October	Oct-10		
21	SDU Paper Records	semi-annually	semi-annually	April, 2009	Apr & Oct	Oct-10 if nec		
22	Verbal Orders	Annually	Annually	April, 2009	April	Apr-10		
23	Delinquency List	weekly	Annually	January, 2008	Jan	Jan-10		
24	Unsigned Orders	weekly	weekly					
25	Incomplete Documentation List	weekly	weekly					
26	Pending Consults Trend	monthly	monthly	April, 2009				
27	Clinician Point of Care Review	monthly	semi-annually	N/A	Jan & July	Jul-10		
28								

E. Sample Clinician Review Form. Data elements for clinician review can be identified with the review form created and linked to CPRS. (Format was modified here for display purposes.)

CLINICIAN QUALITY REVIEW				
Reviewer Name: _____				
Provider Reviewed: _____		Position of provider reviewed: _____		
Location of Patient Visit: _____		Service Type: _____		
Patient Identifier (initial_L4): _____		Date of encounter: _____		
The record is legible without assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No				
History and Physical/Provider progress note documentation is adequate for patient care and includes the following documentation:				
	1-Above Average	2- Satisfactory	3- Unsatisfactory	N/A
- current meds with dosage				
- allergy documentation				
- chief complaint/reason for visit				
- physical present & includes at least one body system				
- appropriate diagnostic tests ordered				
- diagnoses are appropriate for findings				
- health record entry includes appropriate plan of care				
Medical testing and consultations are provided to the patient adequately:				
- consultations are provided appropriately and timely				
- lab reports are recorded accurately and timely				
- radiology reports are recorded accurately and timely				
- evidence of abnormal test findings are documented				
- evidence of abnormal test findings are discussed with patient				
- provider involvement in patient education is documented				
Other documentation assessments for patient care:				
- all documentation appears adequate for care				
- all abbreviations used are approved				
Signature block(s) were copied from another note				
Length reports are pasted into the provider's note				
Progress note is copied/pasted multiple times over several visits				

Sample – Inpatient Health Record Review

INPATIENT HEALTH RECORD REVIEW

**Note – This form is a suggested format. It is recommended that this form be compared to The Joint Commission web site to ensure that all data is captured.*

PATIENT:	SSN:
DISCHARGE DATE:	SERVICE:
PROVIDER:	

Evaluate the documentation on the following forms. If YES or NO cannot be determined due to lack of documentation, a NO should be marked. (Example: 3c. History & Physical completed within 24 hours of admission. If date and/or time is not present, the proper response cannot be determined, therefore it should be marked NO).

	YES	NO	N/A
1. ADMISSION PROGRESS NOTE			
Signed by Provider			
2. DISCHARGE SUMMARY:			
a. Diagnoses (Principal & secondary)			
b. Operations, Procedures, Treatments			
c. Chief Complaint			
d. Pertinent past medical history			
e. Review of systems, includes allergies & drug sensitivities			
f. Pertinent lab and x-ray data			
g. Pertinent physical exam findings			
h. Hospital course with significant clinical findings			
i. Medications			
j. Diet restrictions			
k. Physical activity limitations			
l. Condition on discharge			
m. Plans for follow-up			
n. Discharge instructions			
o. Specific date to return to work			
p. If a psychosis or organic mental impairment, statement regarding competency to handle VA funds			
q. If death, include statement regarding whether autopsy was or was not approved.			
3. HISTORY & PHYSICAL (H&P)			
a. Available within 24 hours of admit or if over 30 days, interval H&P done.			
b. Dated			
c. Timed			
d. Chief Complaint			
e. Present illness/condition			
f. Past medical, social and family history			
g. Psychosocial assessment			

h. Inventory of body systems			
i. Thorough physical exam			
j. Conclusion or impression			
k. Initial treatment plan			
k. Signed			
4. PHYSICIAN ORDERS:			
a. Signed			
b. All verbal orders signed within 24 hours			
5. OPERATIVE REPORT(S) DICTATED/AVAILABLE PRIOR TO CHANGE TO NEXT LEVEL OF CARE			
6. NURSING			
a. Nursing assessments completed and signed			
b. Nursing discharge note present and signed			
7. PROGRESS NOTES:			
a. Daily notes for ICU			
b. All signed			
8. FINAL AUTOPSY SIGNED/FILED WITHIN 30 DAYS OF AUTOPSY			
9. Any "Do Not Use" abbreviations			
10. Any inappropriate use of Copy and Paste			
11. Resident supervision appropriate (Handbook 1400.1)			
Reviewer:	DATE:		

Sample – Outpatient Health Record Review

**OUTPATIENT HEALTH RECORD REVIEW
Data Collection Sheet**

Patient:	SSN:
Clinic:	Visit date:
Provider:	

Does the documentation for the outpatient visit contain the following:

	YES	NO	N/A
1. PROBLEM LIST			
a. Diagnosis			
b. Procedures/surgeries (including outside VA)			
2. MEDICATION PROFILE			
a. Allergies			
b. Drugs including OTC, Herbals, etc.			
3. PROGRESS NOTE:			
a. Dated			
b. Timed			
c. Chief complaint			
d. History & objective data relevant to problem			
d. Findings/Impressions			
e. Plan of care			
f. Follow-up including Patient Instructions			
g. Practitioner signature			
4. PHYSICIAN ORDERS:			
a. Dated			
b. Timed			
c. Provider signature			
5. Ambulatory Surgery/Procedures:			
a. Anesthesia Report			
b. Timely History & Physical (for procures with use of anesthesia)			
c. Pre-procedure note			
d. Operative report/procedure report			
e. Post-procedure note prior to change to next level of care			
e. Pathology report			
f. Informed Consent including progress note			
6. Emergency and Urgent Care			
a. Times and means of arrival			
b. Presenting problem			
c. History and objective data relevant to problem			
d. Assessment of problem			
e. Diagnoses treated at this visit			
f. Treatment plan			

g. Reason for ordering tests, consult, change of medication			
h. Condition at discharge			
i. Discharge instructions			
7. Documentation on Emergency Transfers			
a. Reason for Transfer			
b. Stability of patient			
c. Acceptance by receiving facility			
d. Responsibility during transfer			
8. Any Joint Commission "Do Not Use Abbreviations"			
9. Any Copy & Pasted documentation			
10. Are entries legible? Review scanned documents			
a. If no, specify.			
Total:			
Reviewer:			
	DATE:		

APPENDIX B: SAMPLE DATA DICTIONARY

Following is an excerpt.

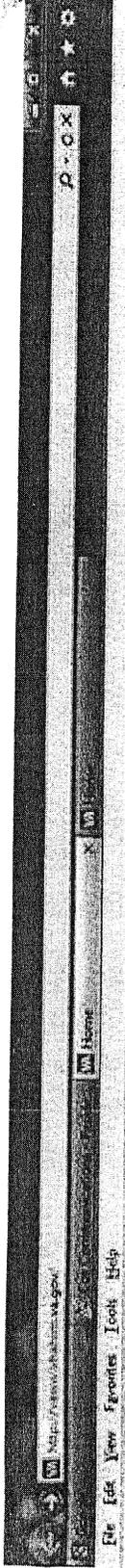
Sample Data Dictionary for Health Record Reviews

DATA ELEMENT	Check YES when	Check NO when	Check NA When
HISTORY AND PHYSICAL			
Details of Present Illness <u>Location:</u> Notes/Surgical Consults A chronological picture of the development of the patient's present illness from the first sign/symptom to the present. Consider timing, severity, quality, location, duration, context, etc.	- documentation in the History records the details of the present illness - Check YES if patient is readmitted within 30 days or is a transfer in - AND the prior History documents the Details of the Present Illness - AND there is documentation in the physicians progress note of pertinent changes	- documentation is NOT present in the History recording the Details of the Present Illness	
RESIDENT SUPERVISION			
Type of Note <u>Location:</u> Notes	- Indicate the appropriate type of note by selecting the category from the drop down box - addendum to resident's note - independent note or - no note (when attending has not documented evidence of resident supervision)		
INFORMED CONSENT			
Patient Signed <u>Location:</u> Examine paper AND/ OR scanned consents, Imaging	- Patient or patient's representative signed the form	- Patient or patient's representative did not sign the form	
PHONE/VERBAL ORDERS			
Accepted by Appropriate Staff <u>Location:</u> Electronic Orders See Attachment C	- All phone or verbal orders are accepted by appropriate staff	- Staff who is NOT authorized to accept phone/verbal orders accepted some phone/verbal orders	- Record reviewed did not contain any phone/verbal orders

APPENDIX C

The Joint Commission Survey Activity Guide

44
5/19/04



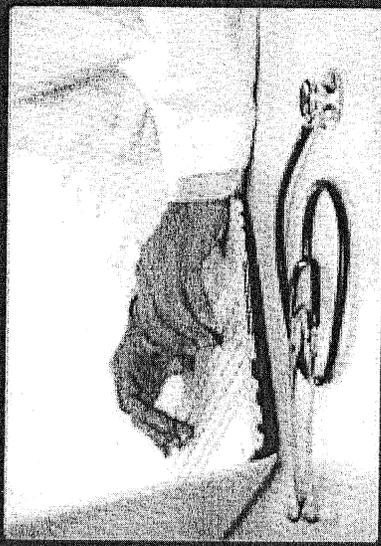
Department of Veterans Affairs Health Information Management

- Home
- Coding
- Records Management
- Health Record
- Release of Information
- Resources

Health Information Management

HIM includes multiple programs in the functional areas of:

- Computerized patient record system (CPRS)
- Medical Coding (ICD-9, ICD-10, CPT, HCPCS)
- HIM Metrics
- Release of Information
- Clinical Documentation Improvement (CDI)
- VHA Records Management



The Health Information Management (HIM) Program Office, as the custodian of the health record, is responsible for assuring an accurate, timely, clinically pertinent, readily accessible health record that is maintained and retrievable for 75 years after the last date of patient activity. HIM is, therefore, responsible for health record policy development that includes regulatory and accrediting requirements relevant to health records and is an active participant in the development of national standards within VHA and external to VHA that impact electronic health records and health data. The HIM Program Office also provides expertise and resources for the national HIM community around electronic health record documentation, coding, and data capture while preserving the integrity of the health record to support direct patient care, business functions, and population health. The office is also responsible for establishing national policy on Records Management and providing training and expert guidance to the field.

HIM Resources

- Fast Sheets
- Handbooks
- Practitioner Tipsheets
- QMA Database

Latest Documents

- Scanning Instructions
- Sample Inpatient Questions
- Compliance Release Minutes for 10/20/04
- Disability



[Resources](#) > [HIM Reference Documents](#) > [Practice Briefs](#)

Practice Briefs

Title	File Size	Created Date	Download
#01 Remote Data Sources	2.33 MB	01-01-2014	Download
#03 Electronic Document Corrections	0.59 MB	10-15-2014	Download
#04 Delimiting the Health Record for Legal Purposes	1.11 MB	10-15-2014	Download
#05 ASU Document Business Rules	136 KB	06-26-2014	Download
#06 Handling Medical Information in Exchange Format	1.71 MB	08-30-2014	Download
#07 Health Record Review	2.22 MB	05-02-2014	Download
#08 Guidelines for Coding Clinical Care-Telephone Encounters	04 KB	05-04-2014	Download
#09 Monitoring Copy and Paste	111.5 KB	01-01-2013	Download
#10 TLU Titles and Templates	60.5 KB	05-02-2014	Download
#11 VHA Provider Query Process	361.65 KB	10-01-2013	Download
#12 Virtual Lifetime Electronic Record Health Information Exchange	3.56 MB	02-01-2014	Download
#13 Impeding Documents From Free Basis Claim System (FBCS)	2.29 MB	06-02-2014	Download

Last Updated on 31 March 2014

HIM Resources

- [FBI Sheets](#)
- [Handbooks](#)
- [Practice Briefs](#)
- [OSA Database](#)

Latest Documents

- [Scanning Technician Sample Interview Questions](#)
- [Conference Minutes for 10/20/14](#)
- [Disability](#)



**DEPARTMENT OF
VETERANS AFFAIRS**

*Southern Arizona VA HCS
3601 South 6th Avenue
Mail Stop: 11-136D3
Tucson, AZ 85721*

*DATE: 10/14/2014
In Reply Refer To: 11-136D3
SSN: [REDACTED]*

[REDACTED]
[REDACTED]
[REDACTED]
RE: ROI Plus Request for [REDACTED]

Dear [REDACTED]

This individually identifiable information is privileged. Its confidentiality should be maintained along with appropriate security safeguards to protect against individual harm (identity theft), embarrassment, or inconvenience.

Sincerely,

[REDACTED]
Assistant Chief of HIMS

Surgical Information

Printed On Oct 14, 2014

S/D #5

OPERATION REPORT

LOCAL TITLE: OPERATION REPORT
STANDARD TITLE: OPERATIVE REPORT
DICT DATE: SEP 06, 2013
SURGEON: [REDACTED]
URGENCY: priority
SUBJECT: Case #: 101089

ENTRY DATE: SEP 06, 2013@10:21:37
ATTENDING: [REDACTED]
STATUS: COMPLETED

PATIENT NAME: [REDACTED]

SOCIAL SECURITY NUMBER: [REDACTED]

SURGICAL CASE NUMBER: 101089

ATTENDING: [REDACTED]

SURGEON: [REDACTED]

ASSISTANT: None.

SPECIMENS REMOVED: none

PREOPERATIVE DIAGNOSIS: Chronic lateral epicondylitis left elbow.

POSTOPERATIVE DIAGNOSIS: Chronic lateral epicondylitis left elbow.

ANESTHESIA: General.

OPERATION: Common extensor tendon repair with lateral epicondylectomy.

IMPLANTS: None.

INDICATION FOR SURGERY: Resistant left lateral epicondylitis.

PROCEDURE: The patient was given a general anesthetic. His left upper extremity was prepped and draped. Longitudinal incision was made along the common extensor tendon from the epicondyle 2 cm distally. The common extensor tendon was exposed and longitudinal incision along its fibers was made. The tendon was taken down off the lateral epicondyle. There was an area of granulation tissue and extremely deteriorated tendon on the undersurfaces. This was completely debrided. The lateral epicondylectomy was performed with an osteotome exposing cancellous bone. The intact tendon was then repaired tightly over the exposed bone with 3-0 PDS. The

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

[REDACTED]
[REDACTED]
[REDACTED]

VISTA Electronic Medical Documentation

Printed at SOUTHERN ARIZONA VA HCS

Surgical Information

Printed On Oct 14, 2014

subcutaneous tissue was then closed with Vicryl and the skin was closed with 4-0 nylon. Sterile dressings were applied. The patient was put in a short-arm splint and was sent to recovery in good condition.

Dictated by: [REDACTED]

1785455/dm(09/06/2013 13:48:19)9606691

/es/ [REDACTED]

ORTHOPEDIC SURGEON

Signed: 09/09/2013 08:51

Addendum to NURSE INTRAOPERATIVE REPORT

LOCAL TITLE: Addendum

STANDARD TITLE: ADDENDUM

DATE OF NOTE: OCT 21, 2013@11:38:09 ENTRY DATE: OCT 21, 2013@11:38:09

AUTHOR: [REDACTED] EXP COSIGNER:

URGENCY: STATUS: COMPLETED

SUBJECT: Case #: 101089

The Principal Procedure field was changed
from LEFT ELBOW COMMON EXTENSOR TENDON REPAIR
to LEFT COMMON EXTENSOR TENDON REPAIR WITH LATERAL EPICONDYLECTOMY

/es/ [REDACTED]

RN

Signed: 10/21/2013 11:38

--- Original Document ---

09/06/13 NURSE INTRAOPERATIVE REPORT:

Operating Room: 12-OR

Surgical Priority: ELECTIVE

Patient in Hold: SEP 06, 2013 08:30

Patient in OR: SEP 06, 2013 09:26

Operation Begin: SEP 06, 2013 09:52

Operation End: SEP 06, 2013 10:16

Patient Out OR: SEP 06, 2013 10:20

Major Operations Performed:

Primary: LEFT ELBOW COMMON EXTENSOR TENDON REPAIR

Wound Classification: CLEAN

Operation Disposition: PACU (RECOVERY ROOM)

Discharged Via: STRETCHER

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

[REDACTED]
[REDACTED]
[REDACTED]

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Surgical Information

Printed On Oct 14, 2014

Surgeon: [REDACTED]
Attend Surg: [REDACTED]
Anesthetist: [REDACTED]

First Assist: N/A
Second Assist: N/A
Assistant Anesth: N/A

OR Support Personnel:
Scrubbed
[REDACTED] (ORIENTEE)

Circulating
[REDACTED] (FULLY TRAINED)

Preop Mood: AWAKE
Preop Skin Integ: INTACT, WARM, DRY
Confirm Correct Patient Identity: YES
Confirm Procedure To Be Performed: YES
Confirm Site of the Procedure, Including Laterality: YES
Confirm Valid Consent Form: YES
Confirm Patient Position: YES
Confirm Procedure Site has been Marked Appropriately and that the Site of the Mark is Visible After Prep and Draping: YES
Pertinent Medical Images Have Been Confirmed: N/A
Correct Medical Implant(s) is Available: NOT APPLICABLE
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: NOT APPLICABLE
Checklist Comment: NO COMMENTS ENTERED

Preop Consc: ALERT-ORIENTED
Preop Converse: RESPONDS TO QUESTIONS

Checklist Confirmed By: [REDACTED]

Skin Prep By: [REDACTED] Skin Prep Agent: 2% Chloraprep

Preop Surgical Site Hair Removal by: [REDACTED]
Surgical Site Hair Removal Method: CLIPPER
Hair Removal Comments:
CLIPPER IN OR PER PROTOCOL

Surgery Position(s): SUPINE Placed: N/A

Restraints and Position Aids:
GEL DOUGHNUT Applied By: N/A
BOTH ARMS/GEL/SEC/ARMBOARDS Applied By: N/A
RIGHT ARM <90 DEGREE Applied By: N/A
LEFT ARM RESTING AT SIDE Applied By: N/A
SAFETY STRAP CHEST Applied By: N/A
PILLOW UNDER LOWER LEGS Applied By: N/A
BILATERAL SCD Applied By: N/A

Electrocautery Unit: [REDACTED]

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

[REDACTED]
[REDACTED]
[REDACTED]

VISTA Electronic Medical Documentation

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Surgical Information

Printed On Oct 14, 2014

ESU Coagulation Range: 50
ESU Cutting Range: 50
Electroground Position(s): RIGHT ANT THIGH

Material Sent to Laboratory for Analysis:

Specimens:

NONE PER [REDACTED]

Cultures:

NONE PER [REDACTED]

Anesthesia Technique(s):

GENERAL

REGIONAL

Tubes and Drains:

NONE

Tourniquet:

Time Applied: SEP 06, 2013 09:52

Site Applied: LEFT UPPER ARM

Applied By: [REDACTED]

Time Released: SEP 06, 2013 10:09

Pressure Applied (in TORR): 250

Thermal Unit:

BLANKET40083

Time On: SEP 06, 2013 08:00

GAYMAR#61686

Time On: SEP 06, 2013 09:50

Temperature: N/A

Time Off: N/A

Temperature: 43

Time Off: N/A

Medications:

BACITRACIN TOPICAL OINT 30 GM

Irrigation Solution(s):

NORMAL SALINE

Sponge Count Correct: YES

Sharps Count Correct: YES

Instrument Count Correct: NOT APPLICABLE

Counter: [REDACTED]

Counts Verified By: [REDACTED]

Dressing: ADDAPTIC W/BACI, 4X8, WEBRIL, ACE, SPLINT, SLING

Packing: NONE

Postoperative Mood: STABLE

Postoperative Consciousness: STABLE

Postoperative Skin Integrity: WARM DRY

Postoperative Skin Color: PALE

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

VISTA Electronic Medical Documentation

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Surgical Information

Printed On Oct 14, 2014

Sequential Compression Device: YES

Devices: SCD#62712

Flash Sterilization Episodes:

Contamination: 0
SPD Processing/OR Management Issues: 0
Emergency Case: 0
No Better Option: 0
Loaner or Short Notice Instrument: 0
Decontamination of Instruments Not for Use In Patient: 0

Nursing Care Comments:

[REDACTED] INTERVIEWED IN PRE-OP. VERBALLY VERIFIED FULL NAME, SSN, SURGICAL SITE AND PROCEDURE. CONFIRMED NPO STATUS, NKA, NO METAL. TRANSFER TO OR, MOVED SELF TO OR TABLE. POSITIONED BY ANESTHESIA, STAFF AND [REDACTED] TRANSFER TO PACU W/CRNA FOR RECOVERY BY ANESTHESIA.

/es/ [REDACTED]
RN
Signed: 09/06/2013 10:22

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

[REDACTED]
[REDACTED]
[REDACTED]

VISTA Electronic Medical Documentation

Printed at SOUTHERN ARIZONA VA HCS

██
██
██

DOB:

----- CVP - Past Clinic Visits

(continued)

05/13/2013 13:20	TUC SCL ORTHO OBRIEN	CANCELLED BY
PATIENT		
05/03/2013 11:15	TUC IMAGING US 1 NC	
05/03/2013 10:15	TUC IMAGING US 2 NC	CANCELLED BY
PATIENT		
04/30/2013 11:30	ZZTUC SAG PC FLATEAU	CANCELLED BY
PATIENT		
04/26/2013 14:30	TUC IMAGING MRI 81 NC	CANCELLED BY
PATIENT		
04/24/2013 09:40	TUC SCL ORTHO OBRIEN	CANCELLED BY
PATIENT		
04/04/2013 13:40	TUC SCL ORTHO OBRIEN	CANCELLED BY
PATIENT		
04/04/2013 08:00	TUC SPU IMAGING SPEC PROC	
04/04/2013 07:30	TUC SPU SPECIAL PROCEDURE	
04/01/2013 13:00	TUC SCL ORTHO OBRIEN	
03/26/2013 12:42	TUC SAG RN SAG 4 PACT PHO	UNSCHEDULED
03/20/2013 11:15	TUC SCL VASC HUNTER	
03/14/2013 13:00	ZZTUC SAG PC FLATEAU	
03/13/2013 09:30	ZZTUC MHC EMELITY	CANCELLED BY
CLINIC		
03/09/2013 09:06	TUC ED	
02/28/2013 14:15	TUC SCL VASC HUNTER	CANCELLED BY
CLINIC		
02/19/2013 07:00	TUC IMAGING MRI AM NC	
02/13/2013 10:40	TUC SCL ORTHO OBRIEN	
02/11/2013 08:30	ZZTUC MHC PCT KAUSCH NEW	
02/06/2013 09:40	TUC SCL ORTHO OBRIEN	
01/15/2013 15:05	TUC PERSONNEL HEALTH	UNSCHEDULED
11/29/2012 13:15	TUC SCL VASC HUNTER	
11/19/2012 07:00	TUC IMAGING MRI AM NC	
11/19/2012 06:30	TUC IMAGING MRI AM NC	
11/16/2012 13:28	TUC FLU OR PNEUMO SHOT	UNSCHEDULED
10/17/2012 10:20	TUC SCL ORTHO OBRIEN	
10/17/2012 08:00	ZZTUC MSS DERM LOCUM NEW	
09/20/2012 12:15	TUC SCL VASC HUNTER NEW	
09/18/2012 14:15	TUC IMAGING VASC LAB PM N	
09/14/2012 11:00	ZZTUC SAG PC FLATEAU	
09/13/2012 12:15	TUC SCL VASC HUNTER NEW	CANCELLED BY
CLINIC		
09/12/2012 13:45	TUC IMAGING VASC LAB PM N	CANCELLED BY
CLINIC		
09/12/2012 09:30	ZZTUC MHC EMELITY	
09/10/2012 09:36	TUC NURSING LIAISON PHONE	UNSCHEDULED
08/20/2012 16:00	TUC IMAGING VASC LAB 1 NC	
08/15/2012 09:20	TUC SCL ORTHO OBRIEN	
08/09/2012 14:40	TUC SCL ORTHO OBRIEN	
07/25/2012 10:30	ZZTUC MHC EMELITY	CANCELLED BY
CLINIC		
07/10/2012 13:30	ZZTUC SAG PC FLATEAU	
07/06/2012 14:13	TUC NURSING LIAISON PHONE	UNSCHEDULED
07/03/2012 11:19	TUC NURSING LIAISON PHONE	UNSCHEDULED
04/18/2012 10:40	TUC SCL ORTHO OBRIEN	CANCELLED BY
CLINIC		
04/12/2012 09:00	TUC SCL ORTHO OBRIEN	
04/11/2012 15:20	TUC SCL ORTHO OBRIEN	CANCELLED BY

Printed for data from 01/01/2012 to 08/01/2014
10:27

10/23/2014

*** ***** CONFIDENTIAL SUMMARY pg. 3
*** *****

██
██
██

DOB:

----- CVP - Past Clinic Visits

(continued)

03/05/2012 15:30	TUC IMAGING US 1 NC	
03/01/2012 07:30	ZZTUC MHC EWING	
02/29/2012 09:40	TUC SCL ORTHO OBRIEN	
02/27/2012 13:51	TUC SAG PHONE-X	UNSCHEDULED
02/24/2012 08:30	ZZTUC SAG PC FLATEAU	
01/18/2012 13:00	TUC SCL ORTHO OBRIEN	
01/10/2012 08:00	TUC MOVE IND	UNSCHEDULED
01/04/2012 07:30	TUC EYE OPTOMETRY 2	

*** END ***** CONFIDENTIAL SUMMARY pg. 3
*** *****

S/D #7

01:30P 22-Mar-13 to 04:30P 22-Mar-13 3 hrs Annual Leave Approved
sick; al in lieu of sl; lunch 13:00 to 13:30

Requested: 22-Mar-13 1:02pm

11:15A 20-Mar-13 to 11:45A 20-Mar-13 .5 hrs Sick Leave Approved
vascular appointment; lunch 1145 - 1215

Requested: 20-Mar-13 12:27pm

01:30P 18-Mar-13 to 04:30P 18-Mar-13 3 hrs Annual Leave Approved
courting hearing regarding son

Requested: 18-Mar-13 8:28am

11:45A 15-Mar-13 to 12:15P 15-Mar-13 .5 hrs Annual Leave Approved
extended lunch

Requested: 15-Mar-13 8:06am

→ 01:00P 14-Mar-13 to 02:00P 14-Mar-13 1 hrs Sick Leave Approved
saguaro clinic appointment

Requested: 14-Mar-13 1:54pm

08:00A 5-Mar-13 to 08:15A 5-Mar-13 .25 hrs Sick Leave Approved
blood draw

Requested: 5-Mar-13 8:34am

12:30P 5-Mar-13 to 04:30P 5-Mar-13 4 hrs Sick Leave Approved
not feeling well

Requested: 5-Mar-13 11:53am

Press RETURN to Continue.

T&L 541 Telework Ind: Z

Date	TW	Scheduled Tour	Tour Exceptions	
Sun 10-Mar-13		Day Off		
Mon 11-Mar-13		08:00A-04:30P		
Tue 12-Mar-13		08:00A-04:30P		
Wed 13-Mar-13		08:00A-04:30P		
→ Thu 14-Mar-13		08:00A-04:30P	01:00P-02:00P	SL SICK LV
		UNSCHEDULED		
Fri 15-Mar-13		08:00A-04:30P	11:45A-12:15P	AL ANNUAL LV
		SCHEDULED		
Sat 16-Mar-13		Day Off		
Sun 17-Mar-13		Day Off		
Mon 18-Mar-13		08:00A-04:30P	01:30P-04:30P	AL ANNUAL LV
		SCHEDULED		
Tue 19-Mar-13		08:00A-04:30P		
Wed 20-Mar-13		08:00A-04:30P	11:15A-11:45A	SL SICK LV
		SCHEDULED		
Thu 21-Mar-13		08:00A-04:30P		
Fri 22-Mar-13		08:00A-04:30P	01:30P-04:30P	AL ANNUAL LV
		Unscheduled - AL in lieu of SL		
Sat 23-Mar-13		Day Off		

SD #8

VA Privacy and Information Security Awareness and Rules of Behavior

MENU | Module 7: Reporting Incidents

exit

7 of 10

The Steps to Report an Incident

If you see or hear something that is of concern, report it to your supervisor, ISO, and PO. If you work in VHA, you can also report it to your Administrator of the Day (AOD). All incidents should be reported.

Your ISO or PO will report the incident to VA's Network Security Operations Center (NSOC) within one hour of being discovered or reported.

Additional contact information to report incidents may be found in the Privacy and Information Security Resources document in the Resources section.

Select the image to learn more about how to report an incident:



How? When? Why? Who? What?



S/D #9

LEAVE USED SUMMARY
 from: JAN 01, 2012 to: AUG 01, 2014
 for: [REDACTED] - T&L: [REDACTED]

DATE: Oct 23, 2014

PP	DATE	TYPE	FROM	TO	LENGTH	
16	Mon 19-Aug-13	Annual Leave	08:00A	08:15A	0.25 Hours	
		Family Care	02:00P	04:30P	2.50 Hours	
	Wed 21-Aug-13	Sick Leave	10:30A	11:30A	1.00 Hour	
17	Mon 26-Aug-13	Annual Leave	08:00A	08:15A	0.25 Hours	
		Sick Leave	09:30A	11:30A	2.00 Hours	
		Family Care	02:45P	04:30P	1.75 Hours	
	Thu 29-Aug-13	Family Care	08:00A	10:30A	2.50 Hours	
	Tue 3-Sep-13	Family Care	08:00A	11:00A	3.00 Hours	
	Wed 4-Sep-13	Annual Leave	08:00A	08:15A	0.25 Hours	
	Fri 6-Sep-13	Sick Leave	08:00A	02:45P	6.75 Hours	
		Annual Leave	03:15P	04:30P	1.25 Hours	
18	Mon 9-Sep-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Tue 10-Sep-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Wed 11-Sep-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Thu 12-Sep-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Fri 13-Sep-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Mon 16-Sep-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Tue 17-Sep-13	Sick Leave	08:00A	04:30P	8.00 Hours	
	Wed 18-Sep-13	Sick Leave	08:00A	04:30P	8.00 Hours	
	Thu 19-Sep-13	Sick Leave	08:00A	04:30P	8.00 Hours	
	Fri 20-Sep-13	Sick Leave	08:00A	04:30P	8.00 Hours	
19	Mon 23-Sep-13	Sick Leave	08:00A	NOON	4.00 Hours	
		Annual Leave	12:30P	04:30P	4.00 Hours	
	Tue 24-Sep-13	Annual Leave	08:00A	02:45P	6.75 Hours	
		Sick Leave	03:15P	04:30P	1.25 Hours	
	Wed 25-Sep-13	Sick Leave	08:00A	04:30P	8.00 Hours	
	Thu 26-Sep-13	Sick Leave	08:00A	10:45A	2.75 Hours	
		Annual Leave	11:15A	04:30P	5.25 Hours	
	Fri 27-Sep-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	20	Tue 15-Oct-13	Annual Leave	02:30P	04:30P	2.00 Hours
		Thu 17-Oct-13	Annual Leave	10:00A	10:30A	0.50 Hours
Fri 18-Oct-13		Without Pay	08:00A	08:30A	0.50 Hours	
21	Thu 24-Oct-13	Annual Leave	03:00P	04:30P	1.50 Hours	
	Mon 28-Oct-13	Annual Leave	03:30P	04:30P	1.00 Hour	
22	Mon 4-Nov-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Wed 13-Nov-13	Annual Leave	03:30P	04:30P	1.00 Hour	
	Thu 14-Nov-13	Annual Leave	02:30P	04:30P	2.00 Hours	
	Fri 15-Nov-13	Annual Leave	01:00P	02:00P	1.00 Hour	
23	Mon 18-Nov-13	Annual Leave	09:30A	10:30A	1.00 Hour	
	Mon 25-Nov-13	Annual Leave	08:00A	09:30A	1.50 Hours	
		Annual Leave	02:30P	04:30P	2.00 Hours	
	Wed 27-Nov-13	Annual Leave	04:15P	04:30P	0.25 Hours	
24	Mon 2-Dec-13	Annual Leave	08:00A	08:15A	0.25 Hours	
	Tue 3-Dec-13	Annual Leave	NOON	12:15P	0.25 Hours	
	Thu 5-Dec-13	Annual Leave	01:15P	01:45P	0.50 Hours	
	Mon 9-Dec-13	Annual Leave	08:00A	04:30P	8.00 Hours	
	Tue 10-Dec-13	Annual Leave	04:00P	04:30P	0.50 Hours	
	Wed 11-Dec-13	Annual Leave	10:00A	11:00A	1.00 Hour	
		Annual Leave	01:00P	03:30P	2.50 Hours	

[REDACTED]

From: [REDACTED]
Sent: Tuesday, August 27, 2013 12:03 PM
To: [REDACTED]
Subject: FW: Advance Leave Application
Attachments: Test--Advanced Leave Application.pdf

From: [REDACTED]
Sent: Tuesday, August 27, 2013 10:48 AM
To: [REDACTED]
Subject: Advance Leave Application

There are three basic ground rules for advance leave:

1. The maximum advance SL you can have is 240 hours.
2. The maximum advance AL you can have is no more than the amount of AL you will earn between the start of your leave use to the end of the leave year. Note that this is a diminishing number as the year progresses.
3. Advance leave cannot be used on an intermittent basis. In the application, you must stipulate the dates when you will use the leave.

[REDACTED]
HR, Employee-Labor Relations Specialist (9-05)
ext. 4449 (fax ext. 1833)

How was your HR service today? Please take a few moments to complete the HR Customer Service Quick Card at this link: [HR Quick Card](#).

No virus found in this message.
Checked by AVG - www.avg.com
Version: 2013.0.3392 / Virus Database: 3211/6611 - Release Date: 08/26/13

[REDACTED]

From: [REDACTED]
Sent: Friday, September 13, 2013 12:09 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: Advance Leave is Approved - RSW
Attachments: [REDACTED]

Mr [REDACTED]

Your attached request for advance annual & sick leave was approved.

[REDACTED]
HR, Employee-Labor Relations Specialist (9-05)
ext. 4449 (fax ext. 1833)

How was your HR service today? Please take a few moments to complete the HR Customer Service Quick Card at this link: [HR Quick Card](#).

No virus found in this message.
Checked by AVG - www.avg.com
Version: 2013.0.3408 / Virus Database: 3222/6661 - Release Date: 09/12/13

Department of
Veterans Affairs

MEMORANDUM

Date: SEP 13 2013

From: HR Manager (9-05)

Subj: Approved Advance Leave Application

To: 
Business Service Line (11-136)

1. Your application for **36 hours** of advance **sick leave** and **33 hours** of advance **annual leave** is approved. Your application indicated that you will use your advance leave between **September 17** and **September 27, 2013**. You may not use more advance leave than that for which you are approved and you cannot use your advance leave outside of the above dates.

2. As you utilize the advance leave, your balance will reveal as a negative number. As long as you remain in a pay status, you will continue to accrue leave. Such accrual will eventually raise your leave balance to zero. If, however, you begin to experience a non-pay status, such as leave without pay (LWOP), there is a threshold beyond which you will not accrue leave and your negative leave balance will not progress toward zero. If you have questions concerning LWOP, please contact Human Resources.

3. Since your absence is related to your own medical condition, when you return to work, you **must** bring with you a notice from your health care provider that clearly indicates either (1) you are no longer incapacitated for duty and can return to work without restriction or (2) that you have some physical restrictions that prevent you from performing the full range of your duties. Please note that without this document, the agency may delay your return until such documentation is provided.

4. If you are not capable of returning to work, contact your supervisor before the date you are expected to return. You will be required to provide additional justification for your extended absence.

5. If you have any questions, contact Robert McLaren, HR Specialist, at (520) 792-1450, extension 4449, or you may e-mail Robert.McLaren@va.gov.


Assistant HR Manager

cc: Supervisor (11-136)

SP #10

Organize ▾ Burn New folder

Computer ▾ Services (S) ▾ Business ▾ HIMS ▾ Scanning ▾ Monitors ▾ Search Monitors

Name	Date modified	Type	Size
FY 13	5/2/2014 6:08 PM	File folder	
FY 2014	9/3/2014 8:42 AM	File folder	
FY 2015 DC Timeliness	10/1/2014 7:17 AM	File folder	
Copy of December 12 Discharge Summar...	4/2/2013 4:44 PM	Microsoft Excel W...	128 KB
Copy of Sample email 3-27-13-op reports	10/10/2014 9:41 AM	Microsoft Excel 97...	30 KB
Defecancies 120112 - 123112 (gini)	1/17/2013 7:52 AM	Microsoft Excel W...	15 KB
Fm Gini-why we monitor	4/3/2012 10:20 AM	Microsoft Word D...	12 KB
Sample email-Guide 3-27-13	11/7/2013 7:37 AM	Microsoft Excel 97...	40 KB

Libraries

- Desktop
- Downloads
- Recent Places
- Documents
- Music
- Pictures
- Videos

Computer

- OSDisk (C:)
- Services (S:)
- ~\HATUC\HIMR (\H01tuchsm)
- Workgroups (W:)

Network

8 items

From: [REDACTED]
Sent: Tuesday, April 03, 2012 8:17 AM
To: [REDACTED]
Subject: auditing and monitoring - Practice Brief 7

<http://vaww.vhaco.va.gov/him/refsresources.html#briefs>

Above is the link to the HIMS web site and specifically the practice briefs. (See practice brief 7) Based on the OIG CAP findings and as we discussed yesterday, one of the main issues found by these reviews is that the findings of the audits were not consistently reported to oversight committees.

I think we can take that one step further and say that it is not consistently reported to the physician staff involved, which is why we are trying to find ways to have our work mean something.

As a lot of time and effort goes into these monitors we need to make sure that the findings can be compiled and communicated in a way that is meaningful to the staff being monitored.

I believe we are successful with H&P data, Prohibited Abbreviations data and to some extent with unsigned data,

I think we need to improve with the method of reporting for copy and paste, discharge summary data and then the new monitors we are creating.

Please review the practice brief and when we regroup on the 13th we can determine if there is any information of value that we can implement here.

Thanks,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Southern AZ VA HCS

[REDACTED]