



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Emergency Care, Patient Discharges, and Staffing Issues Central Alabama Veterans Health Care System Tuskegee, Alabama

**To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244**

Executive Summary

The purpose of the review was to determine the validity of allegations made regarding emergency care, patient discharges, and staffing issues at the Central Alabama Veterans Health Care System in Tuskegee, Alabama.

We substantiated the allegation that there was a shortage of nursing staff in the nursing home care unit (NHCU) that could have affected the provision of care to patients; however, we found no adverse outcomes related to staffing.

While we did not substantiate the allegation that closure of the emergency care unit, known locally as the Life Support Unit or LSU, adversely impacted patient care, we verified the allegation that system providers did not respond in a timely manner to two resuscitation events on the Tuskegee campus. We found that the system investigated the resuscitation events and conducted a Healthcare Failure Mode and Effect Analysis (HFMEA) of their policy and processes; however, managers did not ensure that all HFMEA recommended actions were implemented.

We did not substantiate the allegation that a patient was discharged from the NHCU after making a complaint, or that patients were discharged prematurely. We could not confirm or refute that the ambulance service was not always available to transport patients.

The system has taken action to improve NHCU staffing; therefore, we made no recommendations relative to staffing. We recommended that all 2007 HFMEA recommendations are monitored and tracked until completion.



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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Emergency Care, Patient Discharges, and Staffing Issues, Central Alabama Veterans Health Care System, Tuskegee, Alabama

Purpose

The VA Office of Inspector General’s (OIG) Office of Healthcare Inspections received allegations regarding emergency care, patient discharges, and staffing issues at the Central Alabama Veterans Health Care System (the system). The purpose of our review was to determine whether the allegations had merit.

Background

The system consists of the Montgomery and Tuskegee VA medical centers and the community based outpatient clinics in Dothan, AL, and Columbus, GA. The Tuskegee facility provides mental health, domiciliary, and geriatrics and extended care services, and the Montgomery facility provides medical and surgical care and houses the system’s emergency room. The two medical centers are located about 40 miles apart. The system is part of Veterans Integrated Service Network (VISN) 7.

At the request of the Chairman of the Senate Veterans’ Affairs Committee, we reviewed allegations regarding the management of medical emergencies, as well as patient discharge and staffing issues in the nursing home care unit (NHCU) of the Tuskegee facility. Specifically, the allegations were that:

- The LSU¹ closed, which has adversely affected patient care.
- The Code Blue² team did not respond to a code blue event for 45 minutes.

¹ Life Support Unit or LSU is the local term for the outpatient emergency care department.

² Term generally used to indicate a patient requiring resuscitation, most often as the result of a cardiac arrest.

- A crash cart³ was not accessible to staff during another code blue event.
- The contract ambulance service is not always available to transport patients.
- A patient was discharged from the NHCU because he made a complaint.
- Patients were discharged prematurely from the NHCU.
- Nurse staffing in the NHCU was inadequate.

There were other allegations regarding administrative issues, which were referred elsewhere for review.

Scope and Methodology

We conducted a site visit April 8–10, 2008. During our visit, we interviewed system managers, clinical staff, the patient advocate, and the acting Chief of Police. Prior to our visit, we interviewed the original complainant by telephone. We reviewed patient medical records, staffing reports, training records, the ambulance contract, internal reviews and their corrective action plans, quality improvement data, and system and Veterans Health Administration (VHA) policies and procedures. We performed the inspection in accordance with *Quality Standards for Inspections* published by the President’s Council on Integrity and Efficiency.

Results

Issue 1: Emergency Care

Closure of the LSU. We did not substantiate the allegation that closure of the Tuskegee LSU adversely affected patient care.

When the Montgomery and Tuskegee VA medical centers were merged into the Central Alabama Veterans Health Care System, managers attempted to minimize duplication of services by consolidating specific services at one or the other facility. In fiscal year (FY) 2004, managers closed the critical care unit, operating room, and medical acute care unit at Tuskegee and relocated those services to Montgomery. After the consolidation, the Tuskegee facility primarily provided mental health and long term care services.

The Chief of Staff (COS) told us that the decision to close the LSU was based on a utilization review of LSU resources and the decreased capacity at the Tuskegee facility to care for acutely ill patients (because surgery and critical care services were no longer available onsite). Managers completed a Risk-Benefit-Cost Analysis and forwarded a proposal to the VISN recommending closure of the Tuskegee LSU with continued

³ Wheeled cart that contains all basic equipment necessary to potentially save someone’s life.

operation of the Montgomery LSU. In December 2005, the Under Secretary for Health approved the request to close the LSU and replace it with a triage clinic at the Tuskegee facility. The LSU closed in June 2006.

We reviewed patient incident reports and code blue critique sheets for the 14 months immediately preceding our site visit and found no evidence of adverse events resulting from closure of the LSU. The Quality Manager, COS, and nursing staff in the clinics denied knowledge of any adverse events related to the LSU closure. The system had the following policies and procedures in place to ensure that emergent events are appropriately managed:

- Response to Medical Emergency Policy (24/7 Medical Officer of the Day coverage)
- Cardiopulmonary Resuscitation (CPR) Policy
- Rapid Response Team Policy

During the course of this review, we found opportunities for the system to improve the code blue process at the Tuskegee facility. The system conducted a Healthcare Failure Mode and Effect Analysis⁴ (HFMEA) in FY 2007 and determined that the code blue policy was unclear and staff were not compliant with many of the practice requirements. In response to the HFMEA, managers revised the code blue policy in January 2008; however, it appeared that additional recommendations such as a quarterly mock code blue training or weekly testing of code blue pagers were not fully implemented.

Code Blue Events. We substantiated the allegation that system providers did not respond in a timely manner during two code blue events at the Tuskegee facility. We reviewed documentation related to the events and found that in one case, the CPR data sheet did not reflect a 45-minute delay in treatment as alleged; however, the telephone operator delayed calling the code for 10 minutes. We verified a nurse and fireman initiated CPR 2 minutes after the code was announced. The patient was successfully resuscitated and transported to a local community hospital for further treatment.

System managers also investigated the second code blue event as detailed in a memorandum dated March 7, 2008. The investigation concluded that the crash cart was not stored on the unit where the code blue took place, and staff were unaware that they could use their unit-specific keys to access the room where it was located. The investigative report outlined several recommendations that were approved by the system's Associate Director on March 21. We were told that the recommendations were still being implemented; therefore, the actions had not been completed at the time of our visit in April.

⁴ A systematic process for identifying potential design and process failures before they occur, with the intent to eliminate or minimize the risk associated with them.

Contract Ambulance Service. We could not confirm or refute the allegation that ambulance services were not always available to transport patients. The system had an ambulance contract that did not include 911 emergencies (which were handled through the county); thus, we could not evaluate this aspect of the complaint. Our review of the system's non-emergency transport data from February 2006–March 2007⁵ revealed that, in general, ambulance services were available and timely. However, the system's 2007 HFMEA reflected concerns about the availability of an advanced cardiac life support (ACLS) ambulance. The HFMEA recommended that managers develop a contingency plan for ACLS transports; however, managers did not provide us with evidence that the contingency plan was implemented.

Issue 2: NHCU Discharges

We did not substantiate the allegation that the patient identified in the complaint was discharged inappropriately after making a complaint about the NHCU. His medical record shows that discharge planning for this patient occurred over several months. He was discharged to his home with the support of family and home health services. In addition, Social Work Service arranged for his admission to the State Veterans Home if the home discharge was unsuccessful. We interviewed staff, including patient advocates and social workers, who told us that they did not know of any instances when NHCU patients were discharged after making complaints.

We did not substantiate the allegation that 100 percent service-connected patients were discharged prematurely. Managers told us that they discharge patients when they meet the discharge criteria as outlined in Medical Center Memorandum, *Nursing Home Care Unit*, issued June 15, 2007. The discharge criteria require that patients:

- No longer need skilled nursing care.
- Are medically stable.
- Can be safely discharged to another setting in the community or to home.

The Associate Chief of Staff (ACOS) for Geriatrics, Extended Care, and Rehabilitation Service (GEC&R) told us that they include the patient and the family in the discharge decision-making process. At the time of admission, the family signs a memorandum of understanding acknowledging that the patient will move to a more appropriate level of care upon meeting discharge criteria. The interdisciplinary care team (IDT) reviews care plans every 3 months to determine if patients meet the continued stay or discharge criteria. Discharges for both service-connected and non service-connected patients occur when the IDT determines that patients no longer need NHCU services and are in agreement with the discharge plan. Only then are patients discharged to a safe and appropriate community-based setting.

⁵ The system was compliant with the measure and stopped monitoring this issue in March 2007.

We reviewed the medical records for 8 of 59 patients discharged from the NHCU between January 2007 and March 2008. We did not find any evidence of patients inappropriately discharged or placed in housing that did not meet their needs. We also reviewed GEC&R patient advocate tracking reports from March 2007 to March 2008 and found no evidence of patient or family complaints related to premature discharge from the NHCU.

Issue 3: Inadequate Nurse Staffing

We substantiated that a shortage of NHCU nurses could have affected the provision of care to patients; however, we found no specific evidence of adverse outcomes related to staffing. The ACOS for GEC&R told us that to assure patient safety, the number of authorized NHCU beds was reduced from 160 to 100 in FY 2006, and the three units were consolidated to two because of inadequate nursing staff to support patient care needs.

In August 2007, the Long Term Care Institute, Inc.⁶ conducted an unannounced survey and noted that the NHCU was assigned 125 full-time nursing employees (FTEs) and had 15 FTE vacancies. Surveyors recommended that managers develop a staffing requirement of from 3.9 to 4.1 (3.9–4.1) nursing hours per patient day (NHPPD) and assign staff based on patient care needs. In response to these recommendations, system managers developed minimum staffing guidelines. We reviewed the NHCU's FY 2008 NHPPD data and found that since October 2007, the NHPPD has increased to 4.53–6.14.

We also reviewed the rehabilitation strength report⁷ and the NHCU daily staffing schedules over several pay periods. We found that the medical center monitors staffing and patient care needs daily, making adjustments as needed. Managers told us that the system's efforts to recruit nurses included staffing a full-time nurse recruiter position, participating in recruitment fairs, and utilizing media resources and recruitment bonuses. Additionally, managers authorized hiring contract nurses to supplement staff. A process action team evaluated the nurse hiring process and found that, on average, it took 89 days to hire a nurse. After making changes to the process, the system was able to hire a nurse in 14 days.

Conclusion

We did not substantiate the allegation that closure of the LSU adversely impacted patient care. We found that the system implemented policies to manage emergent events at the Tuskegee facility. We substantiated the allegation that system providers did not respond in a timely manner to two code blue events on the Tuskegee campus. We verified that there was a delay in calling the first code blue and in staff accessing emergency

⁶ An agency conducting VA nursing home unannounced surveys to evaluate care and services in relation to VA and Joint Commission standards.

⁷ A summary of the required nursing FTE in GEC&R, actual nursing staff on duty, and the variances.

equipment in the second code blue. The system investigated the code blue events and conducted an HFMEA of their code blue policy and processes; however, managers did not ensure that all HFMEA recommended actions were implemented.

We could not confirm or refute that the ambulance service was not always available to transport patients, as the system only monitored non-emergency response times. In general, non-emergency transports were available and timely. The HFMEA recommended a contingency plan for ACLS transports; however, we found that the system did not implement the plan.

We substantiated the allegation that the NHCU had a shortage of nursing staff; however, we did not identify any negative outcomes related to inadequate staffing. System managers reduced the number of NHCU beds to assure adequate staff to patient ratios. In addition, managers had taken action to improve NHCU staffing through their recruitment efforts, use of overtime, and hiring of contract staff.

We did not substantiate the allegation that a patient was discharged from the NHCU after making a complaint, or that patients were discharged prematurely. We reviewed medical records and interviewed clinical staff and found no evidence that patients were inappropriately discharged from the NHCU.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that all 2007 HFMEA actions are monitored and tracked until completion.

Comments

The VISN and System Directors agreed with the findings and recommendation and provided an acceptable improvement plan. The system will monitor all 2007 HFMEA recommendations until completion. We will follow up on the planned action until it is completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 1, 2008

From: Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection – Emergency Care, Patient Discharges,
and Staffing Issues, Central Alabama Veterans Health Care
System, Tuskegee, Alabama**

To: Acting Director, St. Petersburg Office of Healthcare Inspections

Director, Management Review Service (10B5)

1. Attached is CAVHCS' response to the Office of Inspector General (OIG) Healthcare Inspection report.
2. I concur with the response and we will follow-up to ensure that all 2007 HFMEA actions are completed.

(original signed by:)

Lawrence A. Biro

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 27, 2008

From: Acting Director, Central Alabama Veterans Health Care System
(619/00)

Subject: **Healthcare Inspection – Emergency Care, Patient Discharges,
and Staffing Issues, Central Alabama Veterans Health Care
System, Tuskegee, Alabama**

To: Director, VA Southeast Network (10N7)

Dear Dr. Daigh:

This is in response to your Inspector General report dated June 13, 2008. We have enclosed the Director's response as an inclusion within the report and provided an update of ongoing monitoring.

If you should have any further questions or concerns, please contact Cliff Robinson, Jr., MD, FAAFP, at (334) 262-4670 extension 4096.

Sincerely,
(original signed by:)
Cliff Robinson, Jr., MD
Acting Director

**Director's Comments
to Office of Inspector General's Report**

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

OIG Recommendations

Recommendation 1: We recommended that the VISN Director ensure that the System Director requires that all 2007 HFMEA actions are monitored and tracked until completion.

Concur: **All 2007 HFMEA recommendations are being monitored until completion.**

Target Completion Date: September 15, 2008

OIG Contact and Staff Acknowledgments

OIG Contact

Deborah R. Howard
Health Systems Specialist
St. Petersburg Office of Healthcare Inspections
(727) 395-2415

Nancy Albaladejo
Victoria Coates
Susan Zarter

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southeast Network (10N7)
Director, Central Alabama Veterans Health Care System (619/00)

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: Richard Shelby, Jeff Sessions
U.S. House of Representatives: Robert Aderholt, Spencer Bachus, Jo Bonner,
Bud Cramer, Artur Davis, Terry Everett, Mike D. Rogers

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