Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Staffing, Quality of Care, and Access Issues Central Alabama Veterans Health Care System Tuskegee, Alabama

Report No. 07-03359-156 **July 7, 2008**

VA Office of Inspector General
Washington, DC 20420

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

Contents

Executive Summary

The purpose of the review was to determine the validity of allegations regarding mental health care at the Central Alabama Veterans Health Care System in Tuskegee, AL. We substantiated the allegation that inadequate mental health staffing resulted in clinic appointment cancellations, and that ward 4A-3 (the 30-bed locked mental health unit) did not provide sufficient therapeutic and recreational activities for hospitalized patients. We also determined that nursing staff did not receive adequate, ongoing mental health-specific training, and that nursing competencies were not assessed annually as required.

While we found that managers were aware of a community residential care (CRC) home incident but did not take appropriate action, we determined that VA staff generally provided adequate oversight of the CRC patients as required. We also determined that the system had not adequately addressed corrective actions as recommended by a Veterans Integrated Service Network (VISN) 7 mental health review team.

We did not substantiate the allegation of excessive mental health clinic wait times or that patients were inappropriately discharged from ward 4A-3. We could not confirm or refute the allegation that patients were told they could not be seen on a walk-in basis for urgent care.

The system has been actively recruiting qualified staff to fill mental health vacancies; therefore, we made no recommendations relative to staffing. We recommended that: (1) A structured program of therapeutic activities be provided for patients on ward 4A-3 and that staff document their activities appropriately; (2) Staff on ward 4A-3 receives ongoing mental health-specific training; (3) Supervisory staff perform initial and ongoing competency assessments for nursing staff and document the findings; (4) The CRC incident is fully evaluated, and that appropriate actions are taken as indicated; (5) Events occurring in CRC homes are appropriately documented, reported, evaluated, and followed-up in accordance with guidelines; and (6) Staff more actively address the VISN 7 recommendations and develop a process to track and document ongoing progress.

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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Staffing, Quality of Care, and Access 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 staffing, quality of care, and access issues in the Mental Health Service (MHS) 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 (CBOCs) in Dothan, AL and Columbus, GA. The system provides primary and mental health care, including group and individual therapy, post-traumatic stress disorder (PTSD) and substance abuse treatment, and high-intensity mental health hospitalization. The system is part of Veterans Integrated Service Network (VISN) 7.

A confidential complainant contacted the OIG hotline with multiple allegations regarding the system's mental health services and programs. In addition, the complainant alleged improper recruitment and hiring practices in the MHS and discrepancies related to one employee's time and attendance. The latter two personnel-related allegations were not addressed in this report.

Scope and Methodology

We conducted a site visit October 23–25, 2007. During our visit, we interviewed system managers, clinical and quality management staff, a community residential care (CRC) home caregiver, the patient advocate, and the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) Coordinator. Prior to our visit, we interviewed the complainant. We reviewed patient medical records, staffing reports, waiting time data,

pertinent system and Veterans Health Administration (VHA) policies and procedures, and a VISN 7 report of the system's mental health services. We performed the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Staffing

We substantiated the complainant's allegation of inadequate staffing on ward 4A-3 (the 30-bed locked mental health unit), in the outpatient substance abuse treatment (OSAT) program, and at the Dothan CBOC as well. However, we did not identify any vacancies in the PTSD program.

We found that staffing levels were a common concern throughout MHS and the basis for several of the allegations. System managers reported that they have had a number of staff retire, resign, or go on extended sick leave. They also reported that recruiting full-time staff and arranging for contracted community mental health services had been difficult. The system attributed the recruitment challenges to a national shortage of mental health practitioners and the rural community in which the medical center is located.

At the time of our visit, several positions in the cited programs were vacant. On ward 4A-3, vacancies included the nurse manager (for over a year), addiction therapist (since April 2007), two registered nurses, one licensed practical nurse (LPN), and one physician's assistant. Clinical staff told us that some new staff had been assigned to ward 4A-3, including a new locum tenens[1] physician; they also said that staffing was adequate most of the time. However, they reported that when two or three patients required 1:1 observation, staffing on the rest of the ward suffered. They acknowledged that management approved overtime or limited admissions if necessary to ensure patient safety. We also found that the system had an LPN, a clinical psychologist, and a part-time social worker vacancy in the OSAT program.

Additionally, the Dothan CBOC VA psychiatrist retired in January 2007, and the nurse practitioner (NP) retired in May 2007. The Chief of Staff (COS) reported that during the break in providers, the system had difficulty arranging fee basis care for Dothan CBOC patients as local mental health providers were reluctant to accept the VA contract rate. He reported that while the system still had some vacancies, they had recently hired a psychiatrist and NP for the Dothan CBOC.

Managers assured us that they would continue to recruit aggressively for appropriate mental health practitioners. We made no recommendations.

[1] Locum tenens is a temporary employee.

Issue 2: Quality of Care

A. Ward 4A-3

The complainant alleged that:

- Acutely mentally ill patients were inappropriately discharged so that substance abuse patients could be admitted to those beds.
- Suicidal patients were permitted to sign out against medical advice (AMA) without regard for their mental or medical condition.
- The ward did not provide a therapeutic environment for patients.
- Nursing staff were not adequately trained.

Inappropriate Discharges. We did not substantiate the allegation that acutely mentally ill patients were discharged so that substance abuse patients could be admitted. Facility policy 116-02, *High Intensity Psychiatric Unit*, dated May 2007 but still in draft format, states that the attending psychiatrist is responsible for documenting daily changes in each patient's mental status and behavior. Patients should be discharged when they no longer meet InterQual Continued Stay Criteria (ICSC).[2] We reviewed a random sample of 30 medical records of patients discharged during the 3rd quarter fiscal year (FY) 2007 and determined that all patients met discharge criteria.

The Associate Chief of Staff for Mental Health (ACOS/MH) told us that patients needing admission were transferred to Birmingham and Tuscaloosa VA medical facilities or to private hospitals in the community when beds were not available on the ward. The clinical staff denied knowledge of any incidents when acutely mentally ill patients were discharged inappropriately.

Discharges Against Medical Advice. We did not substantiate the complainant's allegation that patients who were potentially suicidal were allowed to sign out of the hospital AMA. In FY 2007, 27 patients were discharged AMA from ward 4A-3. We found that all 27 medical records contained appropriate discharge notes documenting each patients' mental status. None of those patients met criteria for involuntary commitment.[3]

Therapeutic Environment. We substantiated the complainant's allegation that ward 4A-3 did not provide sufficient therapeutic and recreational activities for hospitalized patients. We reviewed 50 medical records of patients hospitalized on ward 4A-3 during the

[2] The ICSC establishes conditions under which patients should remain hospitalized, as follows: 1) immediate risk of injury to self, 2) immediate risk of injury to others, 3) continued deficits in psychiatric condition, or 4) immediate psychiatric management required and complicated due to active medical condition.
[3] Legal process used to commit persons to a mental health facility against their will if they are deemed at risk to themselves or others.

3rd quarter of FY 2007. While 72 percent of the treatment plans included therapeutic groups or leisure activities, we found no documentation that patients actually participated in those activities.

Ward 4A-3 nursing staff told us that they attempted to establish therapeutic groups in the past; however, those attempts were unsuccessful, primarily due to staffing issues, rapid turnover of patients, and a shift in care to crisis intervention, stabilization, and discharge planning. As a result, patients watched television or slept most of the day. They reported the only activities for patients were arts and crafts and a weekly class on a health-related topic presented by the Education Service. The ACOS/MH confirmed that more therapeutic groups were needed.

Staff Training. We substantiated the allegation that nursing staff did not receive adequate, ongoing mental health-specific training. Facility Memorandum 05-07, Ass*essment of Employee Competence,* dated January 2007, states that "managers will assure annual verification of competence in skills specific to assignment and that staff are determined competent for their responsibilities through in-service training and continuing education programs." Staff told us, and the Associate Chief Nurse (ACN)[4] confirmed, that the only mental health-specific training 4A-3 staff received from October 2006 to October 2007 was the mandatory class on disruptive behavior. The ACN reported that an intensive 3-day schedule of training was planned for staff but has been on hold since October 2006 because of financial constraints.

During the course of our review, we also found that the annual assessments of nursing competencies were lacking. The Joint Commission requires that medical centers assess and document employees' abilities to carry out assigned responsibilities safely, competently, and in a timely manner at the completion of orientation. Ongoing assessments of staff competency should be completed annually according to the medical center's competency assessment process. We reviewed 28 nursing employee records for initial and annual (recurring) competency assessments. The documentation of annual competency assessments was not consistently present between FY 2005 and 2007 in any of the 28 records we reviewed. We found one initial assessment that was completed and signed by the preceptor, but signatures and dates of the employee and immediate supervisor were missing. The ACN acknowledged that the documentation of annual competencies was insufficient. Ongoing training and staff competency reviews are necessary to ensure the safe delivery of patient care.

Recommendation 1: We recommended that the VISN Director ensure that the System Director requires a structured program of therapeutic activities be provided for patients on ward 4A-3 and that staff document their activities appropriately.

[4] The ACN was also the acting Nurse Manager for MHS.

Recommendation 2: We recommended that the VISN Director ensure that the System Director takes action to require that staff on ward 4A-3 receives ongoing mental health-specific training.

Recommendation 3: We recommended that the VISN Director ensure that the System Director takes action to require that supervisory staff perform initial and ongoing competency assessments for nursing staff and document the findings.

The VISN and Medical Center Directors agreed with our findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective actions. The system has added additional staff to ensure that patients on ward 4A-3 receive appropriate therapeutic services. In addition, the system will implement a structured educational plan to include mandatory mental health-specific training for appropriate staff and ensure that Human Resource Service reviews nursing competency files and forwards the compliance result to the system's Office of Performance Improvement for tracking. We will follow up on the planned actions until they are complete.

B. Community Residential Care Homes

The VA CRC Program program was established in the 1950s as an outplacement program for mental health patients who did not require hospitalization or nursing home care, but because of medical or mental health conditions, were unable to live independently. The CRC Program program utilizes an extensive network of local foster home caregivers who provide enrolled patients with room, board, personal care, and general health care supervision. VA policies[5] prescribe that a VA nurse or social worker visit each home monthly to ensure that patients are receiving appropriate services, and that VA personnel inspect CRC homes annually to ensure compliance with care and safety standards.

The Mental Health Intensive Case Management (MHICM) Program helps veterans with a history of mental illness maintain themselves in the community. MHICM case managers conduct frequent (at least weekly) face-to-face visits in the patient's residence, coordinate care, assist with medication management, and provide crisis management.

The complainant alleged that:

- A patient was "grossly" mismanaged in a CRC home in 2005,[6] and as a result, suffered "severe brain damage."
- Medical center managers knew about the case but failed to take corrective action.
- The care of CRC patients is not adequately supervised by VA staff.

[5] M5 (Geriatrics and Extended Care), Part III (Community Residential Care Program), Chapters 1 through 9, April 26, 1991.
[6] The event described by the complainant actually took place in March 2006.

Case Summary and Events

The patient is a male veteran in his late 50's, with a primary history of a mental illness (for which he has been 100 percent service-connected for over 25 years), chronic obstructive pulmonary disease (COPD), adult onset diabetes mellitus, and hyperlipidemia (high cholesterol). The patient's mental illness has prompted multiple admissions to the system's mental health unit over the years, and he is well known to mental health staff. He has been residing in supportive housing facilities, including VA CRC homes, for more than 10 years. The patient has a court-appointed guardian who manages his affairs.

The patient has resided in several different CRC homes and has routinely expressed dissatisfaction with his CRC placements. In October 2005, one social worker wrote, "Although sponsors [CRC home caregivers] are willing to work with him, it is difficult for him to be pleased with any of the homes. He stated emphatically today that he wants to do whatever he wants to do in the homes."

The patient was first admitted to the specific CRC home in early 2006, after he declined to return to his previous CRC residence. He had medications for diabetes, anxiety, and his mental illness, and an inhaler for COPD. His weight was 190 pounds.

The caregiver, who has operated a CRC home for a decade, told us that approximately 3 months after admission, she found the patient lying on the floor in his room. He told the caregiver that he was comfortable in that position. According to the caregiver, the patient got up to eat his meals that day. He did not voice any complaints and he seemed to be his "same old self."

The next day, the caregiver again found the patient lying on the floor. While he denied being in pain or distress, he did not get up to eat. The caregiver told us that she was concerned, as the patient had a good appetite and always ate his meals. She contacted the VA CRC social worker to advise him of the situation. The social worker documented the phone call that afternoon. His note reflects that, "This is not the first time veteran has chosen to lay on the floor." The plan was to monitor the situation for any changes.

The following day, the caregiver notified the social worker that the patient was still on the floor. He had not eaten dinner the previous night and refused to eat breakfast or take his medications that morning. The social worker documented that morning that he would request the MHICM nurse, who was already scheduled to visit the patient that day, to evaluate him for possible rehospitalization. The caregiver told us that while she couldn't recall the exact time, she checked on the patient again after her call to the social worker, but before the MHICM nurse arrived. She said that his voice had become weaker since earlier that morning, and that when she touched him, his skin "didn't feel like normal skin."

It is unclear precisely when the MHICM nurse arrived, although it would appear to be sometime before noon. The MHICM nurse told us that she found the patient unresponsive, with cold extremities, and what appeared to be an old laceration on his face and bruising on his hand. The patient was immediately transported via ambulance to a local community hospital. The MHICM nurse documented in her progress note that the patient's blood glucose level was checked by the ambulance crew and found to be 158.[7] The ambulance trip sheet was not available for our review.

The MHICM nurse documented the event in a progress note made the day of the veteran's admission to the private hospital; she later completed an addendum to the note indicating that she had spoken with the CRC caregiver and learned that the patient was awake and responsive at the private hospital. Two days later, the patient was transferred from the private hospital to the system's emergency room with diagnoses of low blood pressure, acute renal failure, Rhabdomyolysis,[8] stage IV sacral ulcer,[9] and altered mental status. The medical records from the private hospital could not be located for our review.

The patient was admitted to the system's intensive care unit (ICU) at the Montgomery VA medical center with an oxygen saturation of 86 percent (normal is 94–100), pneumonia, diffuse abrasions, and blisters on both arms and legs. His albumin level was below normal (a sign of malnutrition), and he had lost almost 20 percent of his former body weight. The patient was placed on a ventilator.

After appropriate treatment for his multiple medical problems, the patient no longer needed ventilator support and the physician removed the patient's breathing tube in mid-March. He also documented that the patient was oriented to self and place. In late March, a surgeon removed the dead tissue from the patient's sacral ulcer. He was discharged in stable condition to a non-VA adult care home the following day. The patient has remained bedridden since that admission and receives home health care services. He had a follow-up appointment at the facility in January 2008.

Management of a CRC Patient. We did not substantiate the allegation that the patient was "grossly" mismanaged in a CRC home, and the patient's medical record did not reflect evidence that he suffered "severe brain damage."

In her note in mid-March, 2006, the VA ICU physician who admitted the patient noted that a computed tomography scan of the brain completed at the private hospital found "no evidence of stroke or bleed." Progress notes from May and June state that there were no focal neurologic deficits.[10] Also in June, a primary care physician noted that although weak, the patient was able to move all his extremities. In mid-June 2007, 15 months after

[7] This is an acceptable reading for a diabetic patient.
[8] Rhabdomyolysis is the rapid breakdown of muscle cells. The damaged muscle cells are released into the blood stream but cannot be filtered by the kidneys, resulting in kidney failure.
[9] Pressure ulcer at the base of the spine where the tissue covering the bone had died and the bone is exposed.
[10] Nerve problems that affect specific body locations or functions.

the incident, a psychiatrist noted the patient to have clear speech and logical thought processes.

Managers' Knowledge of Case. We substantiated the allegation that VA managers were aware of the CRC case but did not take action. VHA guidelines require employees to report patient incidents and untoward events to the proper officials.

The MHICM nurse documented the March 2006 events that led to the patient's being transported via ambulance to a local private hospital in a progress note and stated, "MHICM team leader and administrative staff notified of above information." The progress note was electronically cosigned 2 days later by the nurse manager responsible for the MHICM program and by the acting Chief of Social Work a week later. However, it appears that these mid-level managers failed to communicate this information to the appropriate Quality Management (QM) and senior level staff. We interviewed the former Chief of QM (who was in the role in March 2006) and the ACN, both of whom told us that they were unaware of the incident but agreed that they should have been informed. The current System Director did not assume his position until May 2006 (2 months after the incident); he reported that he was not briefed about the incident until the OIG began asking for information.

While we were told that the MHICM nurse completed a patient incident report, system staff were unable to provide us with a copy of this document. In addition, the Patient Safety Officer told us that she had no record of the incident in her incident database. The CRC social worker reported that he notified his supervisor of the event, but could not find documentation of that report. The supervisor has since retired.

Because appropriate managers were not informed of the incident, the necessary fact-finding reviews were not initiated to determine whether protocols were followed or whether corrective actions were indicated. The System Director told us that since our site visit, Administrative Board of Investigation and Root Cause Analysis teams had been chartered to evaluate the incident and the patient's care. Without appropriate reporting and evaluation of patient incidents, the system could miss opportunities to improve patient care and processes.

VA Oversight of CRC Patients. We did not substantiate the allegation that VA staff did not provide adequate oversight of the CRC Program. The complainant specifically alleged that VA staff did not routinely visit CRC patients as required.

We found that from January to March 2006, the MHICM nurses and CRC social worker visited the patient 13 times and made 2 telephone calls to the caregiver to check on the patient. Except for the first March visit when the patient was "acting out," all other observations noted that he was alert, cooperative, and compliant with medications.

At the time of our inspection, the system had 21 active VA-approved CRC homes that housed 62 veterans. We reviewed progress notes for 15 of those veterans for the period 2004–2007 and found that, in general, VA CRC staff visited veterans monthly and documented those contacts. We also determined that progress notes reflected veterans' current status, service or treatment needs, and discussions with guardians, caregivers, or other providers. In addition, we noted that some CRC veterans were also enrolled in the MHICM program and were visited several times per week by MHICM staff. It appeared that these contacts were appropriately documented.

We found that VA staff were completing CRC home inspections annually, and that identified deficiencies were being corrected. The patient advocate had no record or recall of any patient or CRC caregiver complaints about the CRC Program. Despite this incident, we found that, overall, VA staff provided oversight in accordance with CRC guidelines.

Recommendation 4: We recommended that the VISN Director ensure that the System Director takes action to require that the March 2006 incident is fully evaluated and that appropriate actions are taken as indicated.

Recommendation 5: We recommended that the VISN Director ensure that the System Director requires that events occurring in CRC homes are appropriately documented, reported, evaluated, and followed-up in accordance with VHA guidelines.

The VISN and Medical Center Directors agreed with our findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective actions. The system completed an internal review of the incident and forwarded the recommendations to the Chief, Social Work Service, for implementation. We will follow up until the corrective actions identified in the system's internal review are completed.

Issue 3: Access to Care

The Dothan CBOC is located in southern Alabama and provides primary mental health care. The Montgomery VA medical center houses the system's emergency room and is 100 miles northwest of Dothan. Tuskegee is 40 miles east of Montgomery.

The complainant alleged that:

- Mental health appointments were routinely cancelled due to the shortage of providers, resulting in excessive wait times.
- Patients seen at the Dothan CBOC were forced to receive treatment at the Montgomery campus due to the lack of mental health practitioners.
- OIF/OEF veterans were not provided timely access to mental health care.
- Patients with urgent care needs were told they could not be seen on a walk-in basis.

Appointment Cancellations. We substantiated the complainant's allegation that mental health clinic appointments were routinely cancelled due to the lack of providers. We reviewed 500 mental health outpatient clinic and CBOC appointment cancellations for the 4th quarter FY 2007 and found that 60 percent of the time, appointments were cancelled due to "no available provider."

We did not substantiate that clinic cancellations resulted in excessive wait times. As the complainant did not provide us with specific examples of patients known to have experienced excessive appointment scheduling delays, we reviewed wait times in the mental health outpatient clinics and CBOCs from April to August 2007. We found that from April to June, the average wait times at the Montgomery and Dothan sites were 14 and 21 days respectively; however, there was an increase in the average wait times for July and August (54 and 55 days, respectively). Although not ideal, we do not believe that these wait times were "excessive," especially in light of the staffing shortage. Additional staff have been added and the condition has improved.

Dothan CBOC. We substantiated the complainant's allegation that due to a lack of mental health practitioners, patients at the Dothan CBOC were diverted to the outpatient mental health clinic at the Montgomery VA medical center. As previously mentioned, the CBOC did not have a psychiatrist from January to June 2007 or a NP from May to October 2007. As the CBOC was short-staffed and existing staff had difficulty managing the volume of patients, some patients were sent to the outpatient mental health clinic or the emergency room at the Montgomery VA medical center for urgent care needs or to facilitate medication refills.

The new psychiatrist, hired in June 2007, reported providing telephone assessments and follow-up for some stable, non-acute patients in need of medication refills for whom appointments were not immediately available. As of March 2008, the backlog was eliminated and the clinic no longer needed to refer patients to Montgomery.

OIF/OEF Veterans. We did not substantiate the allegation that OIF/OEF veterans were not provided timely access to mental health care. System memorandum 00-06-30, *Treatment of Servicemen/Women Returning From Combat Theaters of Afghanistan and Iraq*, dated July 2006, states that OIF/OEF veterans should be provided "priority care" for urgent medical issues and will be scheduled an appointment within 30 days of the date of application for care. The system's OIF/OEIF Coordinator tracked all returning combat veterans to ensure timely access to services. We reviewed the tracking report for the 2nd and 3rd quarters FY 2007 and found that of 290 patients reviewed, 283 (98 percent) were scheduled for appointments, including mental health appointments, according to system policy.

We confirmed that some OIF/OEF veterans at the Dothan CBOC were told to go to the Montgomery VA medical center for treatment due to the lack of mental health

practitioners at the Dothan CBOC. Additional staff have been hired and the condition has improved.

Urgent Care. We could not confirm or refute the allegation that patients were told they could not be seen on a walk-in basis for urgent care issues. The complainant did not provide the names of patients who were allegedly told this, so we could not interview patients to confirm what they were or were not told. The COS reported that the system provides urgent care in Montgomery. A nurse triages patients and refers non-urgent care needs to the CBOCs; patients with urgent care needs are treated at the Montgomery location.

Issue 4: VISN 7 Report Follow-Up

VISN 7 Mental Health Report. The system had not adequately addressed deficiencies identified in a VISN-level review of the system's MHS. In June 2006, VISN 7's Mental Health Sub-Council conducted a comprehensive assessment of the system's mental health programs and made recommendations in several areas. An action plan was completed in October 2006; however, this plan was incomplete as it did not contain target dates, responsible parties, or the status of actions. Managers of program areas outlined in the plan were responsible for providing quarterly updates; however, we noted only minimal differences between the initial action plans and the updates. In addition, we found that in some cases, the updates did not address all actions identified in the initial plan. There did not appear to be any single person or office responsible for reviewing, assembling, and updating the action plan; thus, it was difficult for us to determine the system's progress in addressing the VISN's recommendations.

The COS acknowledged that, due to staffing shortages, the system had not made the desired progress toward implementing the recommendations. Although we recognize the system had difficulty recruiting qualified staff, we determined that managers did not take an aggressive approach to implementing corrective actions such as initiating staff training, developing a procedure for comprehensive triage of new patient consults, and implementing service agreements between MHS and other clinical Services. In addition, managers did not develop a process for tracking and documenting the status of those actions.

Recommendation 6: We recommended that the VISN Director ensure that the System Director requires staff to more actively address the VISN 7 recommendations and develop a process to track and document ongoing progress.

The VISN and Medical Center Directors agreed with our finding and recommendation, and the VISN Director concurred with the Medical Center Director's corrective action. The system will review the VISN 7 report and ensure that all recommendations have been adequately addressed. We will follow up on the planned action until it is completed.

Conclusions

We substantiated the allegation of inadequate mental health staffing on ward 4A-3, in the OSAT program, and at the Dothan CBOC. Due to insufficient staffing, some patients were diverted to the Montgomery VA medical center for mental health care, and mental health clinic appointments were cancelled because no provider was available. The system has hired additional staff and the conditions have improved.

We did not substantiate that patients were improperly discharged from unit 4A-3 or that suicidal patients were allowed to leave AMA. It appeared that patients either met discharge criteria or, in the case of the AMA discharges, were appropriately evaluated and determined not to be at risk for self harm. We confirmed that ward 4A-3 did not provide sufficient therapeutic treatment or activities for patients, and we determined that staff on 4A-3 had not received necessary mental health-specific training and that documentation of nursing staff competencies was lacking.

We did not substantiate the allegation that a CRC patient's care was "grossly" mismanaged and as a result, he suffered severe brain damage. However, we believe that he should have been monitored more closely and that the March 8 incident could have been managed differently. We did find that system managers were aware of the incident but failed to take appropriate action to investigate the event.

We did not substantiate the allegation that OIF/OEF veterans were not provided with timely access to mental health care. System tracking logs reflect that these veterans were scheduled and seen in accordance with policy. We could not confirm or refute that patients were told they could not receive urgent care on a "walk-in" basis. The system offers urgent care at the Montgomery site and patients can avail themselves of those services as needed.

We noted that VISN 7 conducted a comprehensive assessment of the system's MHS programs and made recommendations for improvement. However, it appeared that the system had not implemented aggressive corrective actions at the time of our visit.

Comments

The VISN and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–18 for the full text of their comments.) We will follow up on on all planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 6, 2008

From: Director, VA Southeast Network (10N7)

Subject: Healthcare Inspection – Staffing, Quality of Care, and Access Issues, Central Alabama Veterans Health Care System, Tuskegee, Alabama

To: Acting Director, St. Petersburg Office of Healthcare Inspections (54SP)

Thru: Director, Management Review Service (10B5)

1. Attached is CAVHCS's response to the Office of Inspector General (OIG) Healthcare Inspection report.

2. I concur with the responses and actions plan submitted by the Medical Center Director to have all these issues completed by August 1, 2008.

(original signed by

Mark Anderson for:)

Lawrence A. Biro

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 27, 2008

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

Subject: Healthcare Inspection – Staffing, Quality of Care, and Access Issues, Central Alabama Veterans Health Care System, Tuskegee, Alabama

To: Director, VA Southeast Network (10N7)

1. This is to acknowledge receipt and thorough review of the Healthcare Inspection – Staffing, Quality of Care and Access Issues, Central Alabama Health Care System, Tuskegee, Alabama draft. I concur with all recommendations identified in the report.

2. The responses and actions with identified target dates are enclosed.

3. Should you have any questions regarding comments or implementation plans, please contact me at 334-272-4670, ext. 4098.

(original signed by:)

Shirley M. Bealer, MS RN, CNAA, BC, CPHQ

Acting Director, CAVHCS

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

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

OIG Recommendations

Recommendation 1: We recommended that the VISN Director ensure that the System Director requires a structured program of therapeutic activities be provided for patients on ward 4A-3 and that staff documents their activities appropriately.

Concur **Target Completion Date: August 1, 2008**

We have no disagreement with the lack of psychotherapy as described. We intend to implement your recommendations and have already added staff to provide a full complement of psychotherapy.

The HIPU has historically been a stabilization unit at CAVHCS. It has been a short term with a brief LOS and consequently a rapid turnover. The case mix has been weighted toward the acutely psychotic with a goal of rapid control through medication and an equally rapid return to the community and outpatient care. Psychotherapy is difficult in such circumstances and previous efforts have emphasized the recreational and psychoeducational. Documentation of the former has not been at all thorough even though it has been provided and this will be immediately addressed.

Recommendation 2: We recommended that the VISN Director ensure that the System Director takes action to require that staff on unit 4A-3 receive ongoing mental health specific training.

Concur **Target Completion Date: June 30, 2008**

While nursing staff assigned to inpatient mental health participate in on-site training/in-servicing (Nursing Journal Club) at the unit level, a structured plan for on-going mandatory training in mental health specific education does not exist.

A structured education plan to include quarterly 8 hour mental health specific mandatory training for all nursing staff assigned to inpatient

psychiatry will commence by June 30, 2008. Documentation of compliance will be entered into annual training records and monitored by Performance Improvement.

A Clinical Nurse Specialist is being recruited for 4A-3 to assist with the ongoing training and education for staff assigned to inpatient psychiatry.

Recommendation 3: We recommended that the VISN Director ensure that the System Director takes action to require that that supervisory staff perform initial and ongoing competencies for nursing staff and document the findings.

Concur **Target Completion Date: June 30, 2008**

While consistent documentation of competencies was not present in all employee folders, training records that included mandatory annual education was present for all nursing staff assigned to inpatient mental health. Competencies for the current rating period initial and ongoing are being completed.

Nurse Manager for inpatient mental health unit enters on duty May 4, 2008.

Quarterly reviews of 100% of competency folders will be completed by Human Resources for all nursing staff assigned to inpatient mental health with documentation of compliance submitted to the Office of Performance Improvement for tracking.

Recommendation 4: We recommended that the VISN Director should ensure that the System Director takes action to require that the March 8 incident is fully evaluated, and that appropriate actions are taken as indicated.

Concur **Target Completion Date: Completed**

CAVHCS completed a thorough assessment of the incident by charging an Administrative Board of Investigation to specifically look at the program. Recommendations for the Community Residential Care Program were forwarded to the Chief, Social Work Service for action. Same was accomplished and forwarded to the Risk Manager and the Acting Health Care System Director.

Recommendation 5: We recommended that the VISN Director should ensure that the System Director requires that events occurring in CRC homes are appropriately documented, reported, evaluated, and followed-up in accordance with VHA guidelines.

Concur **Target Completion Date: Completed**

An AIB was initiated within CAVHCS to assess vulnerabilities of the CRC program, guidelines for documentation, reporting, evaluation and follow-up has been specifically outlined in the addendum to Central Alabama Veterans Health Care System Policy Memorandum No. 122-06-01, dated November 6, 2006, SUBJECT: Community Residential Care (CRC) Program.

Recommendation 6: We recommended that the VISN Director ensure that the System Director requires staff to more actively address the VISN 7 recommendations and develop a process to track and document ongoing progress.

Concur **Target Completion Date: June 30, 2008**

CAVHCS substantially complied with completing the majority of actions identified by VISN 7 site team (see attachments[11]); however, updates submitted did not reflect a complete listing and reporting of all accomplishments to date.

CAVHCS will review the VISN 7 site team recommendations in its entirety to insure that all recommendations have been thoroughly and aggressively addressed.

Report will be submitted to the VISN by 6/30/2008.

[11] Attachments are not included in this report.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates, Acting Director St. Petersburg Office of Healthcare Inspections (54SP) (404) 929-5962
	Deborah R. Howard, Health Systems Specialist Michael Shepherd, M.D.

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.