# Department of Veterans Affairs
# Office of Inspector General

# Healthcare Inspection

# Administrative Issues
# VA Pacific Islands Health Care System
# Honolulu, Hawaii

**Report No. 09-01108-106** **April 7, 2009**

VA Office of Inspector General
Washington, DC 20420

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays**

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# Executive Summary

The purpose of this inspection was to respond to the following questions from Senate Committee on Veterans' Affairs Chairman Daniel K. Akaka:

- Which entity (Tripler Army Medical Center (TAMC) or VA Pacific Islands Health Care System (VAPIHCS)) is responsible for the quality of care administered on the inpatient psychiatric unit (Ward 3B2)?
- Does the state of equipment or staffing on Ward 3B2 comply with VA policies, procedures, and standards of care?

The joint policy states that TAMC has administrative and clinical oversight of Ward 3B2, which functions under the general oversight of TAMC's Department of Psychiatry. The piece of equipment in question is an electrocardiogram (ECG) machine. We were unable to locate any requirement that inpatient psychiatric units must have ECG machines. Recently, a decision was made not to place an ECG machine on Ward 3B2; however, other acceptable options are available to staff when an ECG is needed. VAPIHCS managers were actively recruiting to fill vacancies in the interdisciplinary team. Nurse staffing has generally met the ward's staffing plan. We were unable to locate any VA staffing standards or guidelines for inpatient psychiatry wards.

We concluded that responsibilities for Ward 3B2 are defined in policy and generally appear to be clear to managers at both TAMC and the VAPIHCS. Also, we found that equipment and staffing issues have been addressed adequately. Therefore, we made no recommendations.

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

**TO:** Director, Veterans Integrated Service Network (10N21)

**SUBJECT:** Healthcare Inspection – Administrative Issues, VA Pacific Islands Health Care System, Honolulu, Hawaii

## Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, reviewed questions raised regarding oversight, equipment, and staffing on the inpatient psychiatric unit (Ward 3B2) at Tripler Army Medical Center (TAMC). This unit is operated through a sharing agreement between TAMC and the VA Pacific Islands Health Care System (VAPIHCS). The purpose of this inspection was to respond to the following questions from Senate Committee on Veterans' Affairs Chairman Daniel K. Akaka:

- Which entity (TAMC or the VAPIHCS) is responsible for the quality of care administered on Ward 3B2?
- Does the state of equipment or staffing on Ward 3B2 comply with VA policies, procedures, and standards of care?

## Background

Fifteen employees working on Ward 3B2 sent similar letters to Chairman Daniel K. Akaka, Senator Daniel K. Inouye, and Veterans Integrated Service Network (VISN) 21 Director Sheila M. Cullen. The complainants' letters included the following allegations:

- The loss of Ward 3B2 staff has resulted in reduced inpatient capacity.
- Equipment and dayroom furniture requests for Ward 3B2 have been ignored.
- Some psychiatric patients stay on the unit for inappropriate lengths of time while acutely ill patients are sent to community facilities.

Ms. Cullen directed the VAPIHCS Director to conduct an internal review, which addressed the three allegations listed above. The VAPIHCS Director wrote a response to Senator Inouye and also wrote a response that Ms. Cullen sent to a member of the employee group. We evaluated the internal review and response and found that the

VAPIHCS adequately addressed the three allegations listed on the previous page. Below are the details of the internal review.

- One of the unit's two psychiatrists resigned effective August 8, 2008. A replacement psychiatrist has been hired and is expected to be on board by late March 2009. Until the new psychiatrist is fully oriented, the bed census is capped at 10. Several Ward 3B2 staff, including a clinical nurse specialist and a substance abuse counselor, transferred to the new post-traumatic residential recovery program. A replacement substance abuse counselor was hired on January 30, 2009.
- The Ward 3B2 environment is monitored by both TAMC and the VAPIHCS. The ward has been remodeled to meet safety requirements for a locked inpatient psychiatric unit (including replacing door hinges, doorknobs, and bathroom fixtures). Dayroom furniture was targeted for replacement, but a delay was experienced when a damaged shipment had to be returned.
- Utilization management is practiced on Ward 3B2, and admissions and continued stay days are reviewed for compliance with criteria. Patients sometimes remain on the unit for longer periods than their acuity would require due to a lack of resources in the community for placement in long-term care facilities.

We limited our review to the two questions Chairman Akaka asked us to address.

The VAPIHCS is based in Honolulu, HI, and provides outpatient medical and mental health care at an ambulatory care clinic in Honolulu and at five community based outpatient clinics. Inpatient psychiatric care is provided in a 16-bed VA operated ward in TAMC through a sharing agreement. The VAPIHCS is part of VISN 21.

## Scope and Methodology

We conducted a site visit at the VAPIHCS March 10–11, 2009. We interviewed senior leaders at TAMC and the VAPIHCS, Ward 3B2 physician and nursing managers, and other ward staff members. Also, we reviewed documents, including policies, meeting minutes, and reports. The scope of our review was limited to the two questions raised by Chairman Akaka.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

## Inspection Results

### Question 1: Which Entity, Tripler Army Medical Center or the VA Pacific Islands Health Care System, Is Responsible for the Quality of Care Administered on Ward 3B2?

The joint policy, dated February 19, 2008, defines responsibilities for Ward 3B2. It states that TAMC has administrative and clinical oversight of Ward 3B2, which functions under the general oversight of TAMC's Department of Psychiatry.

All senior managers interviewed stated that although the ward is staffed with VAPIHCS employees, it follows TAMC policies. The ward is included in TAMC's Joint Commission accreditation surveys and status. VA psychiatrists maintain clinical privileges at both TAMC and the VAPIHCS and participate in reviews of other psychiatrists' VA and non-VA care. TAMC resident physicians rotate through both Ward 3B2 and the TAMC inpatient psychiatric unit. Ward 3B2 staff document patient care in the TAMC computerized medical record, which can also be read by other VAPIHCS staff. Some duplication of effort is involved for Ward 3B2 managers to ensure that information is communicated to both entities. The Joint Clinical and Quality Work Group is the defined venue for discussion of joint quality of care issues. Our review of the work group's fiscal year 2008 meeting minutes indicated that although no mental health concerns were discussed, there was meaningful discussion of select clinical quality issues occurring on both psychiatry units. Managers appeared to be clear about the responsibilities for Ward 3B2.

### Question 2: Does the State of Equipment or Staffing on Ward 3B2 Comply with VA Policies, Procedures, and Standards of Care?

We inspected Ward 3B2 and discussed equipment and staffing with all managers interviewed.

Equipment. The piece of equipment in question is an electrocardiogram (ECG) machine. The complainants' letters indicate that staff have requested an ECG machine repeatedly throughout the past 10 years. We were unable to locate any requirement that inpatient psychiatric units must have ECG machines. Recently, a decision was made not to place an ECG machine on Ward 3B2. The options available to staff when an ECG is needed are as follows:

1. Request a consult (non-urgent).
2. Call the Junior Medical Officer of the Day to conduct the ECG (non-urgent off tours, urgent but non-emergent).
3. Call the Rapid Response Team (emergent).
4. Transport the patient to the emergency department (emergent).

These options appear to be reasonable for this patient population.

Staffing. Nurse staffing on the ward has generally met the ward's staffing plan, and supplemental agency psychiatric nursing assistants have been used when needed. We were unable to locate any VA staffing standards or guidelines for inpatient psychiatry.

## Conclusions

Responsibilities for Ward 3B2 are defined in policy and generally appear to be clear to managers at both facilities. Equipment and staffing issues have been addressed adequately. Therefore, we made no recommendations.

## Comments

The VISN Director agreed with our findings and conclusions. (See Appendix A, page 5, for the Director's comments.)

*(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:** March 24, 2009

**From:** Director, VA Sierra Pacific Network (10N21)

**Subject:** **Healthcare Inspection** – Administrative Issues, VA Pacific Islands Health Care System, Honolulu, Hawaii

**To:** Director, Los Angeles Regional Office of Healthcare Inspections, Office of Inspector General (54LA)

**Thru:** Director, Management Review Service (10B5)

Thank you for the opportunity to review the draft report on the Office of Inspector General's Healthcare Inspection of the VA Pacific Islands Health Care System's inpatient psychiatric unit (Ward 3B2) at the Tripler Army Medical Center (TAMC), a shared 16-bed VA operated ward. I find the draft report to be accurate as written.

(original signed by:)
Sheila M. Cullen

**Appendix B**

## OIG Contact and Staff Acknowledgments

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|---|---|
| OIG Contact | Julie Watrous, RN, Director<br>Los Angeles Office of Healthcare Inspections<br>(213) 253-2677 ext.4972 |
| | Kathleen Shimoda, RN |

**Appendix C**

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