



Department of
Veterans Affairs

Office of Inspector General

OFFICE OF HEALTHCARE INSPECTIONS

**INSPECTION OF ALLEGED MULTIPLE CLINICAL AND
ADMINISTRATIVE DEFICIENCIES ON LONG-TERM CARE; A FOCUS
REVIEW OF NURSING UNIT 8A; AND A QUALITY
PROGRAM ASSISTANCE REVIEW,
DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
NORTHPORT, NEW YORK**

[This electronic version of the report does not include the questionnaire graphs from Attachments A-D or Appendix B (they could not be electronically converted). The results of the questionnaires are discussed in Appendix A]

REPORT NUMBER: 9HI-A28-062

DATE: MARCH 17, 1999

Office of Inspector General
Washington DC 20420

Date: March 17, 1999

From: Assistant Inspector General for Healthcare Inspections (54)

Subj: Final Report – Inspection of Alleged Multiple Clinical and Administrative Deficiencies on Long-Term Care; a Focus Review of Nursing Unit 8A; and a Quality Program Assistance Review, Department of Veterans Affairs Medical Center Northport, New York (**Report Number: 9HI-A28-062**)

To: Director, Northport, New York (632/00)

1. Enclosed is the final report of findings and conclusions based on the Office of Healthcare Inspections (OHI) evaluation of multiple clinical and administrative allegations in long-term care and Nursing Unit 8A at your medical center. This final report also includes a Quality Program Assistance (QPA) Review that we conducted to place the many allegations and inspection findings into the full context of the medical center's activities. The QPA review was also done to assess the adequacy and efficiency of key operating elements in providing support for health care delivery.

2. At your request, we initiated this inspection in February 1998 when a preliminary visit was made to your facility. Subsequently, inspectors conducted inspection visits in March, April and eventually in July to conduct the QPA review. We identified 14 issues which are grouped into 3 areas: management issues, quality management weaknesses, and clinical care issues. We concluded on all these issues that executive managers need to focus on improving certain operations in order to ensure the continuing provision of good quality patient care.

3. We made 10 Recommendations, and you provided your concurrence on all of them and you have initiated comprehensive actions and plans. We consider recommendations 6 through 10 closed. Recommendations 1 through 5 are unimplemented pending the receipt of monitoring and evaluation results that you have planned to implement or are already in process.

(Original signed by:)
JOHN H. MATHER, M.D.

Enclosure

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PART I INTRODUCTION

BACKGROUND

At the request of Northport Medical Center Director, the Office of Inspector General began an investigation into clinical concerns regarding the VAMC's Nursing Home Care Units. In January 1998, the Office of Inspector General's (OIG), Office of Investigations asked the Office of Healthcare Inspections (OHI) for assistance in exploring allegations of possible patient abuse and neglect in Nursing Home Care Units (NHCUs) at the Department of Veterans Affairs Medical Center (VAMC) Northport, New York. On February 2, 1998, at the Medical Center Director's request, an OHI inspector made a preliminary visit to the facility to assess the concerns of the senior management team regarding patient care in the NHCUs.

OHI inspectors and OIG investigators conducted an unannounced visit of NHCUs and a Psychiatry Ward from March 1, to March 4, 1998. The OIG team identified numerous clinical leadership, quality management, and nursing care practices and behaviors in these areas that impair patient care and medical center operations. OHI organized and categorized the discrepancies into the following areas:

- Systems issues that prevented long-term care managers from performing their duties;
- Inadequate environmental management and patient safety practices;
- Inadequate quality management and risk management oversight;
- Medication error under-reporting;
- Management of Disturbed Behavior and Annual Training for Restraint and Seclusion Procedures Are Inconsistent
- Inadequate administrative investigation procedures;
- Non-reporting of possibly serious patient incidents;
- Overt patient abuse and neglect;
- Inadequate patient assessment and treatment planning;
- Inconsistent nursing procedures;
- Inaccurate pressure sore evaluation and reporting;

- Falsification of nursing care documentation;
- Questionable patient feeding and nutrition assessment practices; and
- Some employees inattentive to patient care

Based on the scope of these issues, OHI elected to conduct a more comprehensive inspection. In order to facilitate such a broad inspection, OHI recruited a team of Veterans Health Administration (VHA) healthcare professionals who are recognized experts in long-term care, psychiatry, and nursing management to assist and supplement OHI inspectors' efforts.

SCOPE

At the beginning, OHI limited the scope of this inspection to reviewing the 14 issues delineated above. These issues include significant clinical and administrative events that range from alleged improper actions and behaviors by employees ranging up from the lowest operating level; from first line managers to senior level clinical managers and their supervisors. Subsequent to the initial comprehensive inspection of these issues, OHI conducted a Quality Program Assistance (QPA) review of all medical center clinical operations in order to develop a balanced perspective on all of the VAMC's operations. The QPA report is at Appendix A.

This inspection was done in accordance with the Quality Standards for Inspections, published by the President's Council on Integrity and Efficiency.

METHODOLOGY

OHI inspectors visited the Northport VAMC three times (February 2, March 1 through 4, and April 5 through 10, 1998), in order to evaluate the allegations. During the latter visit, a panel of six nationally recognized nursing experts assisted OHI inspectors, and corroborated or clarified previous findings. OHI selected expert panel members who are employed in areas that are geographically separate from the Northport VAMC so that they would not be influenced by possible close interactions with Northport employees. OHI inspectors and OIG investigators worked collaboratively in each stage of this inspection.

OHI inspectors and expert panel members reviewed numerous documents including, medical center policies and procedures; local investigative reports (Boards of Investigations [BOI]), patients' medical records, patient incident reports, official personnel actions (awards and disciplinary actions), staff and organizational management meeting minutes, staffing reports, quality management (QM) and risk management (RM) reports, organizational charts, budget plans, patient advocate reports, consultant reports, and associated documents which inspectors and expert panel members thought could clarify medical center operational issues and outcome measures. We also reviewed a September 1997 Joint Commission on Accreditation of

Healthcare Organizations (JCAHO) survey report which awarded the medical center an average score of 94 out of a possible 100 for long-term care.

OHI inspectors and expert panelists interviewed complainants at length in order to clarify and to better understand their patient care and ward management concerns. Inspectors evaluated the allegations by means of extensive employee and manager interviews, and discussions with local labor organization leaders. We also interviewed patients and family members, and conducted numerous unannounced tours of the NHCU and long-term Psychiatry (unit 8A) wards on all tours-of-duty. We observed procedures and patient care activities, and followed-up on specific complaints as witnesses articulated them during the visit.

A seven-person OHI inspection team conducted a quality program assistance review (QPA) (Appendix A) from July 27, to July 31, 1998, in order to generally and broadly evaluate the medical center's ability to provide an adequate level of patient care to the greatest possible number of eligible veterans, at the lowest possible cost. QPA team members interviewed top and mid-level managers, and randomly selected inpatients and outpatients. We also solicited anonymous comments from randomly selected employees (QPA report at Attachment D).

CONCLUSIONS

Numerous systems deficiencies impeded long-term care (LTC) managers' ability to perform their duties. Ineffective management practices were prevalent on the LTC wards, and throughout the medical center. Weak and ineffective management practices led to widespread distrust among employees and to employees' fear of retaliation and reprisal for reporting concerns or allegations. Communication within the organization is often indirect or does not reach employees who have the authority to resolve problems. Therefore, failure to report problems became normal behavior.

NHCU wards are adequately staffed. However, inadequate staff utilization and inequitable workload assignments led to employees' and patients' perceptions that wards have inadequate nursing staffing.

The risk management (RM) program is not adequately organized to decrease the likelihood that potentially harmful patient care errors will occur. The Quality Assurance and Improvement (QA&I) Coordinator and Risk Manager do not provide the support that clinical managers need to ensure patient safety and facilitate performance improvement. The Medical Center's quality management program did not provide comprehensive analysis, tracking or trending as required by JCAHO and VHA standards. Quality/Risk Management did not adequately disseminate information to clinicians. While numerous performance improvement activities were noted within the medical center, the system lack an effective flow of information to report these improvements.

Medication administration procedures do not ensure that patients receive needed drugs. Nurses do not always initial continuing medication records (CMR) to certify that they administered patients' drugs. Some nurses circle the dosing entry, denoting that they did not administer the drug, but fail to record an explanation for not administering the medication on the CMR, as required.

Senior managers were aware of, but did not appear to have initiated inquiries into two incidents of alleged patient abuse, that occurred in March and April 1998.

Many issues that executive managers ordered to be fully investigated did not appear to merit full administrative investigations. Investigations frequently did not comply with VHA policy, nor was there any uniformity in the investigative process. Local investigators did not always follow their charge, base conclusions on evidence, or make appropriate recommendations. There is no evidence to demonstrate that managers implemented, or followed up on investigators' recommendations.

The use of restraint and seclusion is integrated into the overall management of crisis intervention in the psychiatric areas. Tracking and trending data of restraint and seclusion usage is available to VAMC psychiatric treatment teams when needed.

LTC nursing employees do not make 2 hourly patient observation rounds as required by local policy. This presented a potential danger to restrained patients.

NHCU clinicians do not always adequately assess patients at the time of admission, following an accident/incident, or at the time of required 60-day reviews. Monthly RN reassessments occur; however nurses need to strengthen documentation to more accurately reflect the residents' conditions. Interdisciplinary Care Plans do not always clearly reflect residents' problems or needs, individualized interventions, or realistic, measurable goals. Interdisciplinary participation in assisting patients, to achieve treatment goals is minimal. The facility has a program to assess patients for the risk of developing pressure sores but it is not always effective. Nurses complete pressure sore assessment forms weekly without visually assessing the patient's skin, until a long-standing sore is ultimately discovered. Nurses who administer medications also certify that all treatments are completed even though they may not personally complete or witness the treatments. Nursing employees do not consistently record patients' activities of daily living (ADL).

LTC nursing assignments on the 12:00 mid-night to 8:00 a.m. tour-of-duty were inequitably distributed.

Most NHCU patients appeared to be clean and well-groomed but some were unshaven. Nursing employees on one psychiatry ward allowed several patients to go to sleep at night wearing street clothing and shoes, during an April 7, 1998 3:00 a.m. to 5:30 a.m. inspection.

PART II INSPECTION FINDINGS

A. Management Issues

Five management deficiencies adversely affected medical center operations. These deficiencies included systems deficiencies, ineffective communications, inadequate staffing distribution and assignments, adversarial union relationships, and inequitable distribution of performance awards. These issues are discussed below.

Issue #1. Systems Deficiencies Prevent Long-Term Care Managers From Performing Their Duties

Systems Deficiencies

Long-Term Care (LTC) managers (i.e., Medical Director, ACNS/Extended Care) have responsibility to plan, design, direct and improve operating systems. This was not accomplished, as evidenced by, the numerous systems failures documented in the Nursing Home, both clinical managers were ineffective in fulfilling their leadership roles. Other clinical managers, with responsibility for providing support to the nursing home did not fulfill their role in improving the operation of the nursing home. LTC managers do not make NHCU rounds often enough to confirm or act on information that subordinate employees communicate to some of them.

Numerous nursing employees whom we interviewed told us that nursing managers do not foster open communication, and that employees sense an atmosphere of intimidation and fear. Fear, intimidation and a sense of hopelessness were pervasive among LTC nursing employees whom we interviewed. Employees consistently conveyed a sense of “helplessness” to inspectors. They all had the perception that the NHCU is the last area to receive consideration for resources, whether it is staffing, linen, or patient care supplies. Nursing employees asserted that when they identified problems, and reported them to their supervisors, the supervisors did nothing to correct the problems. To the contrary, employees are convinced that supervisors target for reprisal those who raise issues that need to be addressed. Therefore, failure to report problems became normal behavior. Employees at virtually all nursing supervisory levels confirmed these perceptions of disquietude, but attributed the source of the problems to higher supervisory levels.

One employee expressed the opinion that employees who are military veterans do not have to work at the same intensity as other employees, and that these employees cannot be terminated for not meeting their performance standards. Several supervisors confirmed this assertion.

First Line nursing supervisors told inspectors that they lacked authority to assign work to some employees unless they negotiated working conditions with the union. Inspectors

concluded that some senior managers apparently are not aware of the basic rules, regulations, and procedures, for administering employee discipline.

LTC nursing employees asserted that they frequently lacked basic operating supplies and logistic support to provide adequate patient care. We confirmed that, prior to the March 1998 OHI site visit, linen shortages were commonplace, especially on the weekends, and other patient care supplies were frequently not available. NHCU nurse managers told us that if patients need evaluation and/or care during irregular tours-of-duty (4:00 p.m. through 8:00 a.m., or on weekends), NHCU employees have to transport the patients to the Emergency Room (ER) rather than having a physician come to the NHCU. Inspectors confirmed this practice. Employees and clinical managers who responded to OHI's QPA questionnaires also indicated that operating supply shortages may also occur occasionally in the VAMC's acute care sections.

The Chief of Nursing Service (CNS) acknowledged that she had not visited the NHCU for more than 6 years. She relied instead on her Associate Chief Nurse, who is assigned to the area, to manage, monitor, and keep her apprised of all issues. On one occasion during the month prior to our April inspection, the Chief Nurse spent about 17 hours in the NHCU in order to assess the level of care and staffing issues. She told OHI inspectors that she was appalled at some of the treatment practices she found. On March 13, 1998, the CNS sent the Chief of Staff (COS) a report outlining the standards of care, recommendations, and corrective actions that nursing managers implemented after OHI's March 1 to 4 unannounced visit. The CNS contracted with a geriatric care consulting group to assist her in upgrading NHCU employee skills, developing nursing care standards, and enhancing quality improvement measures. Nursing employee and consultant interviews, and meeting minutes that pertain to quality improvement progress confirmed these efforts.

Ineffective Communications

Communication within the organization is often indirect, or does not reach senior employees who have the authority to resolve problems. Our interviews and anonymous responses to employee questionnaires confirmed that inadequate management communications to employees, about a variety of important topics is widespread in the medical center. Inspectors identified several examples of communications breakdowns that adversely affected patient care.

Numerous nursing employees and first-line NHCU nursing managers asserted that change-of-shift reporting procedures are ineffective because employee tours-of-duty do not overlap. Specifically nursing assistants (NA) leave the floor at the same time that their replacements report for duty. Senior nursing managers told inspectors that bargaining unit leadership would not tolerate NA tour overlap. The American Federation of Government Employees (AFGE) is the bargaining unit at the Northport VAMC except for nurses, policemen and firemen. The AFGE representative whom we interviewed told inspectors that the bargaining unit was aware of the problem, but that nursing managers would not support the tour overlap, and that if managers would not support

the overlap, it would not happen. Inspectors could not find any evidence that any nursing manager had submitted a proposal for tour-of-duty overlap to AFGE, and Labor-Management meeting minutes do not show that Union negotiators opposed such a proposal. To the contrary, AFGE meeting minutes contain discussions about the need for tour overlap in order to facilitate information exchange.

Numerous LTC employees, at all levels, recalled that they had unsuccessfully requested resolution of problems involving the need for facility cleaning and equipment repair, and that they had asked for assistance with feeding patients. Ward staff meeting minutes confirm these assertions. In one instance, employees reported that the Hoyer™ lift was broken, but nursing managers did not forward the information to the safety officer or the Safety Committee, nor is there any evidence that nursing managers ever initiated a work order to repair the equipment. Employees told us that it is very difficult to track a problem such as this through to resolution. Most employees told inspectors that they do not know who they should talk to in order to resolve problems or concerns, nor did they know who has responsibility for follow-up and feedback.

Senior nursing managers do not routinely inform the CNS about patient care events for which she has overall responsibility. During an OHI inspector's interview with the CNS and her staff, the Women's Coordinator related a patient care incident that had occurred during the previous weekend. The CNS was apparently not aware of the problem, even though the Nursing Officer of the Day (NOD) had been involved with the situation. OHI believes this particular incident may be associated with the CNS' management style of undue reliance on her subordinates. It certainly exemplifies the ineffective communication that exists at the medical center, that detracts from timely issue resolution.

The OHI team interviewed the Associate Chiefs of Nursing Service (ACNS). The ACNSs asserted that they had limited knowledge of patient abuse that reportedly occurred in the VAMC, and they denied any knowledge about the number of such incidents that occurred within the past year. This testimony was incongruent given the number of employees who these managers had reassigned to other areas pending the results of formal inquiries. On the April 8, 1998, 12:00 midnight to 8:00 a.m. tour-of-duty, NHCU I and NHCU II, had two Nursing Assistants assigned to non-direct care duties, in other areas of the medical center, due to their alleged involvement in patient abuse incidents.

OHI inspectors interviewed nine Patient Care Coordinators (PCC) each of whom asserted that they all lacked the authority to resolve problems. The PCCs told us that they were aware that employees had failed to report many adverse patient incidents. They perceived that their efforts to report, and seek help in resolving, past problems had not resulted in any positive outcomes. Their frustration with their inability to achieve problem resolution contributes to distorting communication processes throughout the organization.

Many nursing employees identified an environment of fear and distrust as the leading barrier to adequate communication. Employees whom inspectors interviewed believed that the fear of retaliation and reprisal for any unwelcome activity, such as reporting problems, was the standard method by which both managers and bargaining unit officials accomplish their objectives. One employee who attended an open forum meeting with the OHI team received two police traffic citations and two warnings at 5:45 a.m., on the following day. The employee believed that these police actions comprised union retaliation against him because he attended the IG team meeting. This employee has worked in the medical center for 10 years, during which time he asserted that he has driven the same speed (10 miles per hour), and has never before received a citation. He asserted that the speed at which he was driving was below the posted speed limit.

Inadequate Staffing Distribution and Assignments

Many employees whom we interviewed asserted that certain nursing wards were badly understaffed. We did not substantiate these allegations. The Medical Center Director has made a commitment to fund the hours of care that the CNS identifies as being needed to provide safe and proper care in all locations. OHI analyzed the master Hours of Care Report (HCR) and concluded that the NHCU does not have a nursing staff shortage. There are at least two reasons that contribute to the understaffing perceptions. First, ineffective employee assignment procedures such as, long periods of limited-scope duty assignments in non-clinical areas, while employees await formal investigative results, remove employees from active patient care. Second, time needed for permanent employees to orient temporarily detailed and contract nursing employees, subtracts an unmeasured amount of professional nursing time from direct patient care. These two factors, when coupled with low staff morale, result in the perception of an understaffed NHCU.

The absolute numbers of direct care employees who are assigned to Nursing Service does not appear to be a problem, however, nursing managers need to critically assess: how they schedule employees, how they administer tour-of-duty rotations, the quality of assigned employees, the practice of reassigning employees, staff training, hiring and firing procedures, and temporary reassignments and detailing of employees.

The medical center contracts with a private agency to support temporary nursing staff needs. However, employees at all levels believe that this support is inadequate. Permanent nursing employees believe that these contract employees are not adequately trained. They cited what they believe to be the excessive time that full-time VAMC nursing employees devote to supervising and supporting the contract employees.

OHI inspectors did not review medical center staffing patterns in every service. However, we did review staffing discussions in organization and staff meeting minutes and other documents. Patients and employees who responded to our QPA questionnaires described scattered incidents of perceived understaffing, but employees

and patients generally indicated staffing is adequate to meet patient's needs. In addition, in open forum discussions, and during individual interviews, employees constantly discussed their concerns about the perceived lack of adequate staffing, and lack of specifically skilled employees. OHI team members received comments from a dietitian who associated perceived nurse staffing shortages with the limited number of nursing employees who are available to feed patients. She had a recommended solution for the patient feeding problem but she was not sure who she should contact to evaluate or implement her idea. This lack of knowledge about how employees participate in IDT improvements confirms the need to strengthen staff participation in resolving identified problems. It also validates the Medical Center communication deficit and the need for a clear system to involve all levels of staff in the decision-making process.

PCCs verbalized their concern about issues that affect staffing such as their inability to influence employee selection, assignments, and the practice of temporarily detailing employees to different work areas. The PCCs asserted that they don't have the authority to interview or select employees who are assigned to their units. PCCs believe that senior nursing managers transfer problem employees from one location to another instead of attempting to resolve the basic problems. Similarly, ward nursing employees told us that nursing managers reassign employees as a form of punishment. Chronic mental health ward employees believe that nursing managers assign poorly performing or incompetent employees to their areas because managers perceive that the wards have low workloads. These concerns were repeated in numerous interviews with employees at all grade levels.

RNs whom we interviewed asserted that they do not have any authority to ensure that subordinate employees perform their duties. They expressed frustration that when there is a need for assistance to help address unexpectedly high workloads, they do not know whom to ask for assistance. One staff nurse described her experience in attempting to obtain assistance with an urgent situation at a time when her ward had inadequate staffing. She recalled that a patient required urgent medical evaluation, but her staffing resources were too limited to transport the patient to the ER, two buildings away. She reportedly asked the Medical Officer of the Day (MOD) to walk to the NHCU, but he refused, and she was forced to assign an employee to accompany the patient to the ER. The patient and the employee returned to the NHCU 2 hours later. This incident was documented on the 24-hour nursing report, but we could not find any evidence that managers acted to prevent similar problems from recurring. Senior nursing managers do not plan for these incidents of unexpected additional workload, and the events are often not captured in the HCR.

VAMC managers need to assess the nursing staffing levels in all patient care areas in consideration of identified patient needs, and the current detailing or temporary assignment of employees. Managers should include PCCs in all employee utilization and reassignment actions including screening, and hiring and firing of their respective unit employees.

Adversarial Union Relationships With Medical Center Managers

Several complainants alleged that medical center managers were unsuccessful in dealing with bargaining unit leaders and that over time Union control threatened to impede patient care. Service chiefs and executive managers expressed concern that bargaining unit members control most labor/management meetings. They confirmed that supervisors are afraid to oppose union direction, because they fear grievances or EEO complaints. Some senior managers acknowledged that they have grown tired of fighting with the bargaining unit, and make no effort to meet with their employees in attempts to make changes or solve problems. Employees at all levels told us that union officials severely impair patient care activities. According to the Chief of Medical Service, and other service chiefs, union officials actually refuse to allow some meetings to take place, and prohibit supervisors from conversing with employees without union participation. When union leaders do allow meetings, they allegedly set the agendas and control the meetings. When inspection team members asked senior managers about their understanding of the extent and depth of union power, they could not describe the union span of control. Rather, they suggested that team members speak with the Human Resources Management Service's (HRMS) labor management specialist. They identified this individual as the person who advised managers on union contract rights, as well as management's rights and obligations thereunder. The Medical Center Director indicated that she was aware of the concerns that many managers had regarding local labor organizations.

The PCCs are first-line managers but do not feel that they have the authority to make management decisions. Union officials do not recognize PCCs as having management authority. Employees at all levels told us that union officials severely impair patient care activities. Past efforts at developing a labor-management agreement with National Federation of Federal Employees (NFFE) and American Federation of Federal Employees (AFGE) have been limited. However, this appears to be improving. Since the appointment of a new senior management team, beginning in 1997, union members have filed fewer unfair labor practices (from between 200 and 300 in 1996-97 to less than 10 in 1998). The Chief of Employee and Labor Relations describes his relationship with the bargaining unit as positive, and believes that he has a good relationship with the chief union steward.

The Associate Medical Center Director (AMCD) recalled that he had attempted to implement some initiatives, and was quickly inundated with unfair labor practices to the extent that the VISN Director encouraged him to resolve the open complaints and avoid further problems with the union. The VISN Director advised the AMCD to be fair and reasonable while doing what was right to resolve labor practices. The VISN Director confirmed the discussion had occurred. The AMCD told inspectors that he felt he was unable to do his job, but that he had not discussed the problems with the Regional Counsel who is the medical center's only recognized legal authority.

One of OHI's expert panel member's discussed these issues with the Regional Counsel. The Regional Counsel and his assistant promptly met with the Director and the expert

panel member to clarify and resolve these issues. The expert panel member met with the NFFE Chief Steward. This individual is not the Union President, but meets and negotiates with medical center managers on behalf of the President. The Chief Steward is a long-time medical center employee. He told inspectors that previous medical center managers have been difficult to deal with, and that their reticence forced him to resort to grievance and EEO procedures to protect bargaining unit employees. Nevertheless, he is supportive of the current Director. He told inspectors that he desires a good working relationship with her, and would endeavor to achieve that objective by making an honest effort to establish a workable and progressive partnership agreement. He characterized the HRMS labor relation's specialist as not conducive to maintaining good labor-management relationships. The Chief Steward felt that managers view him as a person who makes them jump through too many hoops.

As previously discussed, medical center managers, and employees do not communicate effectively. This condition has a long history that is associated in large part with the union's strength, and executive managers' failure to seek expert labor relations' assistance and advice from the Regional Counsel. The labor-management problems have adversely affected overall medical center operations, and may have adversely affected the quality of patient care. For example, union officials reportedly advised the Chief of Cardiology not to meet with his employees to resolve the problem of delinquent cardiac catheterization reports. He attempted to address the issue and obtain staff input through quality improvement team efforts. The union official told inspectors during a group staff meeting that union members are not allowed to participate in improvement teams.

Inequitable Performance Awards Distribution

Complainant's alleged that managers improperly administer the incentive award program by excessively rewarding some employees and not recognizing other employees' work. We substantiated these allegations. In reviewing OPF's of NHCU and chronic psychiatry ward senior clinicians, and those for medical center managers, inspectors identified some possibly ill-advised actions. Some employees, including senior managers, received awards that lacked documented justification that is required by medical center policy for the Incentive Awards Program (VHA Policy 05-09). Several employees received two Special Contribution Awards (SCA) within the same calendar year. These SCA's were awarded in addition to other performance awards. HRMS employees were unable to provide inspectors with complete information on awards. Bargaining unit meeting minutes contained discussions about inequitable performance award distribution. Many employees whom we interviewed alluded to awards as "management bonuses." The issue of management incentive awards is so contentious and emotional that it is necessary for this issue to be explored more vigorously by VAMC management.

Employee discontent regarding performance awards practices was verbalized throughout interviews and staff meetings during our visit. It was difficult to validate employees' perceptions in many situations. Executive managers believe that employee

perceptions regarding the awards program do not necessarily represent factual information. However, Medical Center records confirm that approximately \$254,000 was spent on Special Contribution Award's after the JCAHO review, with approximately \$89,000 going to supervisors, and approximately \$166,250 being distributed throughout the general workforce. This information paralleled discussions contained in bargaining unit minutes and other documents, and we confirmed some discrepancies.

Conclusions

OHI concluded that long-term care managers did not take steps to plan, design, direct, integrate and improve operating systems and performance because communication is largely indirect, and information does not reach senior employees who have the authority to resolve issues. Managers do not foster open communications, and this has contributed to an atmosphere of perceived intimidation. Executive managers need to review medical center communication procedures and establish clear and "open" lines of communications for all levels of employees.

NHCU nursing staffing is adequate. However, inadequate staff utilization and inconsistent employee assignments such as assigning nursing employees to non-clinical areas for long periods of time while they await investigative results, limited duty assignments, reassignments and temporary details of employees without respective manager input, and permanent employee time spent orienting detailed and contract employees all contribute to perceptions of understaffing. Inadequate staff utilization and inconsistent employee assignments lead to widespread employee and patient perceptions of nursing staff shortages. Managers should review clinical programs on each patient care area, and realign staffing to correspond with the current workload. Managers should also immediately implement a system for hiring, transferring and detailing employees, which involves first-line managers in the decision process. In addition, first-line managers should receive training and guidance in resolving staff performance problems instead of reassigning problematic employees to non-clinical areas.

Medical center managers and employees do not communicate effectively with union leaders. Employees at all levels told us that union officials severely impair patient care activities. Past efforts at developing a labor-management agreement have been limited, but the relationship appears to be improving since the appointment of a new senior management team and as union members have filed fewer unfair labor practices. Senior managers need to work with union leaders to establish a workable written agreement. This effort would improve the working environment, enhance the quality of patient care, and help managers deal with employee performance problems.

While most employee awards contained adequate justification as required, some did not. This was validated in employees' interviews, bargaining unit minutes and employee OPF's. Executive managers need to review the incentive award process and criteria for giving awards, and ensure that the program is equitably administered.

B. Quality Management Weaknesses

OHI identified numerous QM weaknesses that adversely affected medical center operations and the quality of patient care, especially in long-term care. These weaknesses include inadequate emphasis on patient safety, inattention to quality and risk management, medication errors under-reporting, non-reporting of patient incidents, and inadequate administrative investigative procedures.

Issue #2. NHCU I and NHCU II Were Unclean and Had Patient Safety Hazards

Inspectors made unannounced visits to NHCU wards I, II, III and IV during the evening of March 1, 1998, and the early morning hours of March 2, 1998. NHCU wards III and IV were generally clean and odor free.

However, inspectors noted a strong odor of stale urine in most hallways on NHCU wards I and II. Inspectors also found that NHCU II was filthy and unkempt. Several patients' dresser drawers were open, creating potential tripping hazards; baseboards were dirty, several patients' urine catheter bags were lying on the floor; and intravenous and tube feeding machines, bed rails, and wheel chairs were covered with grime and excreted body fluids. The nurses' break room table and refrigerator were filthy and cluttered; patients' snacks were opened and left at bedsides; open and out-dated patient snacks were sitting in a dirty refrigerator; and the clean utility room had cob webs on the ceiling, and papers on the floor. Furniture in NHCU wards I and II was purchased in the late 1980s when the building was opened. With the large number of total care and incontinent residents, urine evidently soaked into many of these aging mattresses and chairs, leaving a strong noxious odor.

Inspectors reported these findings to medical center executive managers who immediately directed Environmental Management employees to thoroughly clean the wards and furnishings and to develop and follow reliable procedures to maintain consistent cleanliness.

During an interview with a NHCU resident, inspectors noted that the resident was lying on a full-length RoHo™ cushion. The zippered side of the cushion cover was impinging against the patient's skin. This positioning defeats the cushion's intended effect of reducing pressure. Inspectors concluded that employees lacked adequate knowledge of the appropriate use of RoHo™ cushions.

Inspectors learned that a small, contained fire had occurred in the designated outdoor, screened smoking area on Unit 8A (locked psychiatry unit) on December 5, 1997. The fire was directly associated with patients' cigarette smoking. Corrective action was taken to prevent similar incidents. However, fresh cigarette burns were found on the ward furniture and bedding suggested that patients' were still smoking on the unit. Inspectors performed an unannounced inspection on the ward on April 9, 1998, and found smoking materials, i.e., matches, cigarettes, and lighters, as well as razors in patients' bedrooms. The patients voluntarily surrendered the items to team members

for proper storage since they are not allowed to have these in their possession. The safety officer had reported concerns regarding patient smoking on one ward to the Safety Committee, but OHI inspectors could not find any evidence that committee members or managers addressed his concerns.

Issue #3. QM Officials Do Not Have A Program In Place To Monitor QI Activities

OHI inspectors interviewed QM employees and reviewed QM documents. We did not find any evidence that the QM program was integrated or collaborative with medical center clinical programs.

Clinical service managers told us that communication between the QM Office and their services is virtually non-existent. They told us that QM does not have any procedures in place to keep clinical managers informed about patient care incidents or concerns. QM records show very little evidence that QM employees communicate with the service chiefs. The medical center's quality management program did not provide comprehensive analysis, tracking or trending as required by JCAHO and VHA standards. Quality/Risk Management did not adequately disseminate information to clinicians. While numerous performance improvement activities were noted within the medical center, the system lacked an effective flow of information to report these improvements. While performance improvement activities were noted within the medical center, the system lacked communications flow to disseminate the information.

Inspectors concluded that the medical center's Risk Management Program is not designed to identify, analyze, or decrease the likelihood of errors that can harm patients, visitors, and employees. Adverse events are not reported to managers who can effect change and improve service delivery systems. While risk managers do trend incident reports, under-reporting results in incomplete information, and even this incomplete information is not communicated to the management staff.

Patient Incident Reports

OHI inspectors reviewed a sample of (VA forms 10-2633), Report of Special Incident Involving a Beneficiary, for the 18-month period from October 1996 to April 1998. We found that the policy and procedure to forward all required reported incidents to the Medical Center Director and Chief of Staff for review was not always followed. Incident reports, signed by the QA&I Coordinator and/or Risk Manager were not consistently forwarded to the COS and Director based on institution policy.

QM employees do not always share patient incident information with the responsible service chiefs or section managers even when the incidents directly affect them or their respective employees or patients. Consequently, managers frequently do not have the information they need to effect change or improve patient care. Service managers told us that on occasion, when they have requested copies of patient incident reports, QM employees told them that the documents are confidential and they could not have copies. On the other hand, QM employees acknowledged that patient incident reports

have been released to union officials, and attached to Boards of Investigations reports, which are not protected documents.

QA&I managers do not track or trend incidents to determine if medical center-wide system's problems are occurring that have the potential to adversely affect patient care outcomes. There was no documentation to show that anyone had initiated any system improvement actions as a result of patient incident reporting. For example, employees and patients reported numerous incidents of alleged patient abuse during the 4-year period from FY 1994 to April 1998. However, no one in authority could provide the team with any evidence to show that managers had analyzed the incidents or had implemented corrective actions to effectively reduce the number of instances of alleged patient abuse.

Issue #4. Medication Errors Are Not Consistently Reported

Continuing medication records (CMRs) show that nurses do not always initial CMRs, certifying that they administered an ordered medication. Conversely, some nurses circled dosing entries to indicate that they did not administer ordered drugs but did not indicate the reason that they omitted the drugs as required by VA Nursing Policy. The Acting Nursing Home Administrator (NHA) for long-term care told us that she and the PCC found a large number of CMRs that lacked numerous required signatures, in the PCC's office. Employees had not completed incident reports in any of these cases. Further, the Acting PCCs on NHCU Wards I and II found approximately 35 medication transcription errors that had not been reported.

Inspectors interviewed a clinical pharmacist who confirmed that nursing employees under-report medication errors. The pharmacist told us that the Extended Care Council (ECC) had established a task force to determine why large numbers of medications remained in the medication cassettes when they were returned to the Pharmacy for exchange. The task force concluded that the large quantities of medication returns could only be attributed to omission of administration. This finding was documented in the ECC Meeting minutes.

We reviewed the CMRs on ward NU-8A. We found several inconsistencies in medication administration documentation. Several CMRs did not have entries to show that nurses administered medications, as required by Nursing Service policy. However, no one had completed incident reports in any of these cases. One patient's CMR covered a 28-day period. The CMR shows that nurses had administered medications as ordered to a patient. However, during our visit, the evening NOD discovered 79 pills in a candy box that was located in a vacant room adjacent to the patient. The patient acknowledged that he had not taken his medications, and that he had stashed them in the candy box. This incident indicates that nurses gave the patient his medication but did not observe him to ensure that he swallowed it.

Issue #5. Patient Incidents Are Not Consistently Reported Or Properly Reviewed

Employees reported two incidents of alleged patient abuse in March and April 1998, respectively. In March a NHCU patient complained that a specific employee had deliberately broken his finger. Employees were aware of the injury, and one employee completed a patient incident report. Inspectors could not find any evidence that executive managers initiated a BOI or had attempted to identify the reported offending employee in order to take appropriate actions. Similarly, in April a NHCU patient's friend found bruises on the patient's arm, which she believed to be consistent with finger marks. She reported her concerns to the RN on duty. However, the nurse did not complete an incident report so managers did not conduct a BOI. Subsequent to our visits, executive managers provided us with copies of the BOI reports in these cases.

There were no substantiated cases of patient abuse on the Psychiatric Units. It was noted that a verbal altercation occurred on March 1, 1998 between 2 patients. While staff noted this in a logbook, it was not documented in the clinical record.

Employees, patients, and family members told inspectors that fear of retaliation by some employees is the prime reason that they do not report serious incidents to VAMC management. OHI inspectors could not find any evidence that executive managers had taken any action to address this issue as a medical center priority.

Issue #6. Boards of Investigations Do Not Properly Follow Administrative Procedures

We reviewed Boards of Investigations (BOIs) reports and supporting documents that managers completed during the 3½ year period from FY 1994 to April 1998. We found that the assigned investigators generally thoroughly reviewed the issues. However, many of the issues that managers submitted to comprehensive investigations did not appear to merit full administrative investigations. Board members did not always comply with VHA policy, nor was there any uniformity in the way the BOIs were conducted. BOIs did not always follow the Director's charge, base conclusions on evidence, or make appropriate recommendations. We could find no evidence of a central database where recommendations could be tracked systematically to determine the status of implementation and the approval by senior management that actions taken met the intent of recommendations. Consequently, some recommendations were not tracked to completion.

We reviewed several BOI reports that addressed incidents of alleged patient abuse. The recommendations were not consistent for similar offenses. Official Personnel Folders (OPFs) of individuals who investigators found to have committed patient abuse show that some employees were removed from patient care areas while others were not. Inspectors also noted that, in some cases, BOI members were peers of the accused individuals. These particular board members told inspectors that they did not

feel it was appropriate that they were assigned as BOI members in these cases. They felt uncomfortable because they feared retaliation due to their close associations and working relationships with the accused individuals.

Managers were investigating three cases involving alleged patient abuse during our visit. Managers had detailed the three nursing employees, who were being investigated, to non-nursing duties while the allegations were being investigated. Two of the nurses were assigned clerical duties on the night shift on a NHCU ward. The other nurse was assigned escort duties on the evening tour-of-duty.

The QA&I Coordinator and the Medical Center Director told OHI that employees assigned to perform BOIs, or Focused Reviews, had not received proper training. During the OHI visit, medical center top management discussed a plan that included training a core group of employees on how to conduct investigations. Regional Counsel began providing the training in April 1998.

Issue #7. Management of Disturbed Behavior and Annual Training for Restraint and Seclusion Procedures Are Inconsistent

During our visit we did not observe any restrained or secluded patients. Therefore, we could not directly assess the frequency or intensity of nursing supervision of these patients. However, when we visited the psychiatry unit on the night tour-of-duty, we found that nursing employees do not make required every 2 hour patient observation rounds. Nursing employees acknowledged that this was their normal practice. The seclusion area does have panic buttons by which employees can summon assistance.

NU-8A night nurses told OHI inspectors that the night charge nurse, who is the only professional nurse on duty, is responsible for responding to the "Crisis Call" in all buildings. The medical center's policy concerning deployment of the crisis intervention team does address the necessity for maintaining professional nursing coverage on all units during emergency situations, however, staff does not always consistently follow this policy.

OHI inspectors reviewed the facility's documentation of annual employee training for the Prevention and Management of Disturbed Behavior. We found that the annual training requirement involves completion of an individual training module. Employees are required to demonstrate their knowledge of physical take down techniques. Staff on light duty assignments were not reassessed to perform this function.

Conclusions

The medical center's quality management program does not provide comprehensive analysis, tracking or trending as required by JCAHO and VHA standards. Quality/Risk Management does not adequately disseminate information to clinicians. While numerous performance improvement activities were noted within the medical center, the system lacks an effective flow of information to report these improvements.

Additionally, the Risk Management (RM) Program is not adequately organized to reduce the likelihood that errors that may harm patients, visitors, and employees will occur. Executive managers need to develop and operate a QM program that monitors all aspects of quality in the medical center, and focuses on improving administrative and clinical operations.

Medication errors are not consistently reported. Nursing employees do not always initial CMRs certifying that they did or did not administer an ordered medication. Senior managers need to ensure that all personnel review the Medication Administration Policy and properly report and document medication errors.

Senior managers were aware of, but did not appear to have initiated inquiries into two incidents of alleged patient abuse that occurred in March and April of 1998. Subsequent to our visits, executive managers provided us with copies of the BOI reports in these cases. Employees, patients, and family members told us that fear of retaliation by some employees is the prime reason that they do not report serious incidents. Senior managers need to ensure that all VAMC employees follow VHA policy and report all cases of suspected patient abuse and neglect.

Local investigators assigned to BOI teams frequently do not comply with the VHA policy, do not follow the Director's charge, do not base conclusions on evidence, do not make appropriate recommendations, and do not seek uniformity in the way boards were conducted. Many of the investigated issues did not appear to merit full administrative investigations. Senior managers need to develop a comprehensive administrative investigation procedure including a system for monitoring and implementing local investigative actions.

Tracking and trending data on restraint and seclusion usage was available to the VAMC psychiatric treatment teams when needed. The use of restraint and seclusion was integrated into the overall management of crisis intervention on the psychiatric areas. Annual required training on managing violent behavior involves completion of an individual learning module, and requires employees to demonstrate their knowledge of techniques. Senior managers need to review staff training, patient monitoring, and restraint and seclusion procedures to ensure patient safety and adequate monitoring of disturbed patients.

C. Clinical Care Issues

There were several improper clinical care actions and behaviors that adversely affected patient safety and the quality of patient care. The issues include patient abuse, inconsistent or inadequate documentation, inadequate patient assessment, improper evaluation and reporting of pressure sores, and questionable patient feeding and nutrition assessment practices.

Issue #8. Passive and Overt Patient Abuse Exist

During a physical inspection of the LTC wards, inspectors found several patients lying in urine-soaked pajamas. Several patients could not reach their call lights. These patients told us that it took a long time for nursing employees to come to their aid. One patient had a Range of Motion (ROM) Exercise Sheet by his bed, however he told inspectors that no one had helped him to perform the exercises.

Northport's senior management team requested the OIG team to review allegations regarding specific patient incidents of abuse and subsequent boards of investigation. In one incident, management believed that abuse had occurred, although the board could not substantiate this conclusion. The OHI team concluded that patient abuse had occurred. The fact that this patient laid in one position for several hours, apparently without any nursing assistance, we believe represents patient abuse. This patient specifically asked OHI not to further investigate the incident because he feared retaliation by some employees. Facility managers are aware of the patient's concerns and assured OHI that the patient will be appropriately monitored.

Inspectors reviewed monthly NHCU staff meeting minutes from 1996 to May 1998. The minutes show that meeting participants discussed patient abuse concerns during 5 of the 27 monthly meetings. The PCC and the ACNS/EC signed all of these meeting minutes and forwarded them to the Nursing Service's Office of Quality Management. Both the ACNS/EC and the Nursing Quality Manager, who is directly responsible to the CNS, should have informed the Chief Nurse of these patient abuse concerns. The ACNS/EC told inspectors that she discussed unit issues, including concerns of possible patient abuse, during the Chief Nurse's monthly meeting with the PCCs, and expanded role nurses. The ACNS/EC also told inspectors that she had discussed specific incidents of alleged abuse with the CNS. The CNS acknowledged that since QA patient abuse data was not routinely available to nursing, the expectation was that the Nursing Service Office of Quality Management would do the follow-up, but she could not provide any evidence that necessary follow-up was ever done.

Issue #9. Medical Records Lack Documentation of Adequate Patient Assessment and Treatment Planning

OHI inspectors and expert panelists reviewed a diverse sample of active NHCU patient records. The records lacked any evidence to show that clinicians adequately assess patients at the time of admission, following an incident, or at the time of required 60-day reviews. Clinicians should strengthen their documentation of these assessments to better reflect the patient's condition. For example, nurses recorded the reasons for a patient's February 2, 1997 admission, as being the patient "lives alone, unable to care for self." The assessment indicates that the patient needed moderate to maximum

assistance, yet the reverse side of the admission assessment contains a statement that he had “no self care deficits.”

The medical records had inadequate documentation of medical reassessment of brittle diabetic patients. One patient had consistently high accu-check glucose values at 10:00 p.m., but the record did not contain any evidence that the physician or NP had reevaluated the patient in order to reassess the patient’s treatment regimen.

Continuing medication records and diabetic record flow sheets revealed that nursing employees were not consistently compliant with established policies for recording accu-checks and similar interventions. Because there was no consistency in these procedures clinicians could not know with certainty if diabetic patients received insulin coverage when required.

The NHCU Nurse Practitioner or physician usually obtain laboratory specimens (blood), because Laboratory employees do not make routine specimen collection rounds in the NHCU. In the absence of these two clinicians, nursing employees transport patients to the Laboratory to have specimens drawn instead of having the laboratory technician obtain the blood at bedside. This is not only inefficient; it is costly, and constitutes a disservice to the patient.

The Interdisciplinary Care Plan that NHCU clinicians use does not clearly reflect the patient’s problems or needs; does not discuss individualized interventions; and does not define realistic, measurable goals. Interdisciplinary participation in achieving treatment or functional goals is minimal. In one case clinicians indicated on the care plan that the patient had self care deficits. Clinicians established a goal to increase independence on the patient’s daily activities. The only treatment discipline that is listed as responsible for assisting the patient to achieve the goal is nursing, even though the self-care deficit is broadly related to activity intolerance, impaired mobility, cognitive impairment, and his diagnoses of blindness, dementia and status-post myocardial infarction. Clearly the treatment challenges for this patient far exceeded the scope that nursing employees alone could offer.

Inspectors found that substance abuse treatment issues were not fully addressed on Unit 8A. Psychology services were not being used. In fact psychology services are available only through consultation. We concluded that clinical managers need to improve their quality of care monitoring procedures. Managers should also monitor the effectiveness of resource usage, including implementation of clinical manager on-site rounds.

Issue #10. Nursing Employees Do Not Follow Consistent Procedures

NHCU nursing employees do not consistently perform ward rounds during irregular tours-of-duty. Nursing employees whom we interviewed gave a variety of responses when we asked how often they conducted nursing rounds (range from every 1 to every 4 hours). Nursing practice standards require that nursing employees conduct rounds

every hour. It was also clear that employees do not routinely check patients for cleanliness or incontinence, or promptly remediate these problems when they occur. An OHI inspector made rounds with a RN. The RN did not check patients for cleanliness or incontinence. She observed the patients for respiration, safety, and cleanliness of the surrounding area. She did not ask patients if they needed to get out of bed to use the bathroom.

The NHCU daily assignment sheet for the 12:00 midnight to 8:00 a.m. tour-of-duty showed an inequitable workload distribution. The charge nurse assigned each nursing assistant a large number of patients to care for. At the same time, one LPN's assignment consisted of medication administration on one team, feeding one patient and getting one patient out of bed. There were no medications scheduled for administration during the night. Medication rounds began with the administration of insulin in the morning. This inequity in workload distribution led to significant resentment by some employees, and acts as a disincentive for employees to provide optimal services to their patients.

Issue #11. Evaluation and Reporting of Pressure Sores is Inaccurate

The facility has a procedure, to assess patients, at the time of admission, for their risk of developing pressure sores but it is not always effective. Inspectors reviewed three randomly selected medical records of pressure sore patients to evaluate the efficacy of this procedure. The procedure requires that if patients have a score of 8 or higher at the time of admission, nurses must reassess them each week. This does not always work as intended. One patient, of the three patients whose records we reviewed, had been assessed by nurses as not having any pressure sores for approximately 8 weeks in a row. In the ninth week, the record shows that nurses found a stage-2 pressure sore. NHCU-I nurses screened another patient and concluded that he did not have any pressure sores, however, when he was transferred to an acute care unit, the admitting nurse found that he had a stage-2 pressure sore. Nurses had assessed the third patient, for several weeks, as not having any pressure sores. However, the NP had written in the progress note that the patient had a stage-2 pressure sore on the gluteal fold. Nurses completed pressure sore assessment forms each week, but did not consistently inspect and stage wounds appropriately.

Issue #12. Nursing Documentation Does Not Comply With Policy and Procedures

Nursing practice requires that nurses who administer treatments certify completion of these actions by initialing the records in the appropriate place. This does not always occur at the Northport VAMC. The person who is assigned to document treatments initials the completion of all treatments even though she/he may not have personally done or witnessed the task. Nursing employees whom we interviewed confirmed that this practice is common.

Some bowel and bladder flow sheets were inappropriately completed. In several cases, the same person signed the flow sheets each day for as long as 25 consecutive days,

but time and attendance records show that the nurse who certified these flow sheets did not work on all of these days. The PCC on NHCU I discontinued this practice during our initial team visit.

Nursing Service managers are responsible for verifying employee technical competence annually. We found that nursing managers had certified some employee records for several years at the same sitting. Documentation was completed in the same ink and the same certifying person's name. Two sets of competency certificates were found for the same nurse; one set shows verification for 1995, 1996, and 1997. The other set is dated for 1996 and 1997.

OHI did not substantiate an allegation that kinesiotherapists (KTs) signed records of treatments that had not been done. However, even though KT's were scheduled to work until 4:00 p.m., we found that KT service did not schedule any patients for treatments after 2:00 p.m. The schedule did not show that KT's saw any patients at the bedside as displayed on the bedside treatment chart. The assignment schedule shows that one KT had 22 patients and the other had 12 patients to care for. We did not observe any activity in the treatment area at any time when inspectors were in the area during the 5-day site visit.

There were several gaps in medical records (missing flow sheets) documentation of patient's treatment. We requested some of these missing documents but medical center employees could not locate them.

Issue #13. Employees Follow Questionable Patient Feeding and Nutrition Assessment Practices

Nursing employees whom we interviewed consistently expressed concerns about the need for additional staffing to feed patients. A dietitian expressed concerns about the limited number of nursing employees who were available to feed patients during meals. She had a recommended solution for the patient feeding problem, utilizing volunteers and non-clinical employees. The medical center does have a volunteer feeding program, but needs to aggressively recruit for additional volunteers.

The dietitian who was assigned to the NHCU had been assigned to the ward since January 1998. She had not yet had the opportunity to trend data on weights and other nutrition indicator assessment practices. The dietitian was making efforts to establish an appropriate area for feeders (patient's who need assistance with eating) in the rear area of the dining room. The establishment of a feeding area would improve the staff's ability to ensure that all patients are fed.

During OHI inspectors' ward rounds from April 4 through April 8, patients were out of bed and being fed in the dining area. The dining room (feeder room) was very crowded. This crowding presents several potential hazards. The crowding makes it difficult to respond to emergencies. In addition, the crowded condition is not a therapeutic environment for patient eating.

Issue #14. Some Employees Are Inattentive to Patient Care

During OHI's visits, most NHCU residents appeared to be clean and well groomed, but some patients were unshaven. When inspectors mentioned the lack of shaving to the nursing assistants, they immediately remedied the situation. Three patients told inspectors that nursing employees wash them every morning; however, they asserted that they had not been showered for up to 3 months. They told us that they are not more frequently showered because of staffing shortages.

During an April 7, 1998 psychiatry ward inspection, between the hours of 3:00 a.m. and 5:30 a.m., team members observed several patients on ward NU-8A sleeping in their beds while wearing street clothing and shoes. Medical records at this time showed that employees had not recorded the patients' ADL's. The shower checklist was not readily available or current. During an April 9 inspection of patients' closets and bedside tables, inspectors found numerous sets of clean hospital linen and pajamas. Furthermore, nurses should not allow patients to store additional linen and pajamas in their bedside tables.

Conclusions

There was evidence that patient abuse occurred. In one incident a nursing employee turned a patient onto his abdomen during the night, and left him in that position for many hours. The patient was unable to turn himself due to severe contractions, and subsequently sustained abrasions to his face and shoulder. A BOI did not show patient abuse. OHI disagrees with the investigator's conclusions. The fact that this patient laid in one position for several hours, without nursing assistance, we believe represents patient abuse.

NHCU medical records lack documentation of adequate patient assessment and treatment planning. The records lacked any evidence that clinicians adequately assess patients at the time of admission, following an incident, or at the time of required 60-day reviews. Senior managers need to ensure that clinicians adequately assess patients and properly record these actions, and properly record treatment planning.

Nursing employees do not consistently make rounds during irregular tours-of-duty as required by local nursing policy. Nursing employees gave a variety of responses when we asked how often they conducted nursing rounds, none of which complied with local nursing policy. Senior managers need to ensure that the Chief Nurse develops consistent nursing procedures for patient observation rounds, with checklist verification by employees who conduct the rounds.

Nurses complete pressure sore assessment forms each week, but apparently do not consistently visually assess the patients' skin until long-standing sores are discovered. Senior managers need to ensure that clinicians report, stage, track and document pressure sores in the medical records.

Nursing employees follow questionable patient feeding and nutrition assessment practices. The unit dietician had only been assigned to the unit for a short time and was in the process of establishing monitors to trend data on weights and other nutrition assessment practices. The medical center had instituted a volunteer patient-feeding program, which needs additional volunteers. Senior managers need to ensure that clinicians establish systematic procedures for patient feeding and nutrition assessment practices.

PART III RECOMMENDATIONS

The Medical Center Director Should:

- 1. Provide management training for clinical officials (physicians, nurses, etc) in leadership positions with particular emphasis on employee management practices related to communications, staffing, systems deficiencies, union relationships, personnel actions and performance awards.**

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

Training for managers in the areas noted above, as well as other subject areas, has been a regular part of ongoing management training; i.e., mandated supervisory training. Special programs, such as Conflict Resolution, presented in the summer of 1998, and Alternate Dispute Resolution, scheduled for this fiscal year, are provided to enhance our managers' supervisory skills. In addition, training on performance awards was provided to clinical and administrative Service Chiefs on May 12 and June 12, 1998 to update supervisors on revised policy. An expanded set of training programs to address communications, staffing, systems issues, union relationships, and personnel actions with our clinical and administrative managers is being developed for presentation during the remainder of FY '99 and into FY '00.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions and action plans properly respond to the intent of the recommendation. The issue is unimplemented pending receipt of the training plan for the planned management training and development seminars.

- 2. Establish a labor-management agreement with Union officials and mutually clarify the responsibilities of both parties to facilitate the conduct of medical center operations, and improve the quality and safety of patient care.**

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

A labor-management agreement was signed February 12, 1999. This agreement reflects the ongoing improvements that have been effected among management and union leadership since the appointment of the new senior management team in 1997. Since 1997, the number of grievances and unfair labor practices has continued to decrease dramatically. Since the Director's appointment in June 1997, she and union leaders meet on a monthly basis. This continued commitment to improve labor-management communications and relationships has already facilitated improvements in

the conduct of Medical Center operation, and in the quality and safety of patient care, most notably in the nursing home.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions properly respond to the recommendation. We consider this issue to be unimplemented pending receipt of a copy of the signed February 12, 1999 agreement.

- 3. Ensure that clinicians follow established documentation procedures and standards of patient care.**

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

Several significant changes have been made in order to assure that long-term care clinicians are following established documentation procedures and standards of care. A new nursing home leadership team was appointed in March of 1998. This new leadership team evaluated staff skills and education was provided. The newly appointed patient care coordinators conduct daily rounds to observe that care is consistent with established standards of practice. The new long-term care leadership team provides oversight of these activities. Monitoring of documentation and standards of care are consistently incorporated into the quality management/performance improvement program in long-term care. These measures have been enhanced by a private sector consultant with extensive years of experience in assisting both private and public sector nursing homes.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions properly respond to the recommendation. We consider this issue to be unimplemented pending receipt of copies of continuous monitors that reflect continuing improvement in long-term care clinical practices and comportment with standards of care.

- 4. Ensure that the Quality Assurance/Improvement Manager develops and operates a quality management program that monitors all aspects of quality in the medical center and focuses on improving administrative and clinical operations, and that QM/RM information is provided to clinicians for their use in improving patient care.**

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

The Medical Center's Quality Assurance/Performance Improvement plan continues to be refined and improved. Recruitment is near completion for a new Medical Center QA manager. Process improvement activities have been restructured. Examples of improvements in the program include, but are not limited to, improved patient incident reporting and information flow to clinical managers and staff, enhanced monitoring of important aspects of care and the use of improved data collection tools. Staff education has been completed in such areas as incident reporting and the conduct of BOIs and root cause analysis training has been initiated. The current QA/I program has been restructured to provide enhanced support and expertise to all services and the Nursing Home. Northport has received favorable external peer review and patient satisfaction scores in 1998. VA Nation performance indicators as well as national studies of selected clinical programs show similar positive trends over the past years. These measures will continue to be monitored for compliance.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions properly respond to our recommendation. We consider the issue to be unimplemented pending receipt of local program evaluation of the QA/I program after 6-months under new leadership.

- 5. Require that clinicians follow established procedures for: skin assessment, patient incident reporting, medication administration, and nutrition assessment.**

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

The new long-term care leadership team, appointed in March 1998, designed and implemented an educational program to meet the learning needs for skin and nutrition assessment and compliance with policies that govern medication administration and patient incident reporting. Two nursing staff development instructors who specialize in nursing home care facilitated this educational program in collaboration with the long-term care consultants. Ongoing monitoring and evaluation to assure clinicians are following established procedures continues to be provided through close supervision by the new leadership team and through the Medical Center's quality assurance/performance improvement program.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions properly respond to the recommendation. We consider this issue to be unimplemented pending receipt of continuous monitors of the performance of these clinical activities for a period of at least 6 months from the date they were initiated.

- 6. Require senior managers to follow-up and adhere to the procedures for implementing and monitoring BOI recommendations.**

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

The Medical Center's BOI process is being restructured to include the establishment of a centralized database to support the tracking of recommendations approved by the Chief of Staff and Director. Tracking will encompass the entire process, including responsibility, action plans and implementation. This will assure that actions taken are in compliance with the intent of recommendations. Follow-up of outcomes will be monitored by the Quality Manager and reported to Senior Management.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions properly respond to the recommendation. We consider this issue to be closed.

7. Require responsible managers to schedule regular environmental management and patient safety rounds with the EMS Supervisor and Patient Care Coordinator.

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

The Multidisciplinary Environmental Rounds Review Team, including the Associate Medical Center Director and Chiefs of Nursing and EMS, routinely conducts Medical Center inspections throughout the year according to schedule. PCCs are interviewed routinely during the rounds by various inspectors to discuss concerns, problems and to elicit their recommendations for improvements. "Front Line" EMS supervisors join with their Service Chief on these rounds to better establish their link with the PCCs and upper management.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions properly respond to the recommendation. We consider this issue to be closed.

8. Improve lines of communication between managers and employees.

MEDICAL CENTER DIRECTOR'S RESPONSE:

Concur

As noted on page 32 of OHI's draft report, significant improvements in communication between managers and employees have been accomplished during the Director's

tenure. The draft report specifically states “executive managers...regularly visit patient care areas and talk to employees and patients...The Director expects all managers and supervisors to discuss and promote planned organizational changes with their respective subordinate employees to ensure that everyone is kept informed...these efforts were confirmed in patient and employee interviews and survey questionnaires.” The Director continues to emphasize the need to communicate at all levels of the organization. An example of this proactive communication is the weekly patient care rounds conducted by Senior Management with the Chief Nurse and specific Service/Section Chiefs. Individual Services conduct regularly scheduled meetings with staff in order to keep employees up to date regarding matters of interest and concern. Minutes of the Director’s staff meeting are distributed to all Services for informational purposes. The One VA Survey will be further utilized to monitor communication and identify performance improvement plans for areas of concern.

HEALTHCARE INSPECTIONS’ COMMENT:

The Director’s actions properly respond to the recommendation. We consider this issue to be closed.

9. Ensure that the process and criteria for giving awards is consistent with VHA Policy 05-09.

MEDICAL CENTER DIRECTOR’S RESPONSE:

Concur

As noted in OHI’s draft report, while most employee awards contained adequate justification, it was noted that some did not. All award nominations are now reviewed for adherence to policy by HRM staff prior to approval by senior management.

HEALTHCARE INSPECTIONS’ COMMENT:

The Director’s actions properly respond to the recommendation. We consider this issue to be closed.

10. Have PCCs participate in decisions involving utilization and assignment actions including screening, transfers, hiring and firing.

MEDICAL CENTER DIRECTOR’S RESPONSE:

Concur

PCCs now have greater involvement and input into operational, staffing, and human resources issues on a unit level. Specifically, the PCCs have sole responsibility to conduct interviews and make selections based on existing vacancies by unit and shift.

HEALTHCARE INSPECTIONS' COMMENT:

The Director's actions properly respond to the recommendation. We consider the issue to be closed.

APPENDIX A

QUALITY PROGRAM ASSISTANCE REVIEW

QUALITY PROGRAM ASSISTANCE REVIEW

INTRODUCTION

BACKGROUND

Based on broad experience in health care oversight, the Office of Healthcare Inspections (OHI) has developed a quality program assistance (QPA) review process that is focused on helping medical center and Veterans Integrated Service Network (VISN) managers identify potential problems and strengthen patient care operations. The QPA process provides a balanced perspective of a medical center's ability to provide safe, effective patient care to the greatest possible number of eligible veterans, at the least possible cost. OHI elected to use the QPA process subsequent to the March, 1998 hotline inspection in order to provide a balanced portrait of medical center operations. The hotline case was comprised of numerous alleged leadership, quality management, and nursing care deficiencies that reportedly impaired long-term and chronic psychiatric patient care, and some medical center operations. We used the QPA process to assess the adequacy and effectiveness of key operating systems, and their ability to ensure the provision of adequate, effective patient care, in the context of our hotline inspection findings. Since our March 1998 visit, senior managers initiated some quality improvement measures that reflect some changes in the medical center operations.

Northport VAMC is part of the New York/New Jersey VA Healthcare Network (VISN 3). Affiliated with the State University of New York at Stony Brook, the Northport VAMC has 489 operating beds and offers primary and secondary medical, surgical, and psychiatric services; and long-term rehabilitative and psychiatric care to Long Island's *300,000* veterans. Services include: ambulatory surgery; cardiac catheterization; day hospital/day treatment center; dermatology; gynecology, mammography, and other women's health services; hospital-based primary care; nursing home care; optometry; orthopedics; physical medicine and rehabilitation; preventive medicine; respite care; substance abuse treatment; visual impairment center for optimizing remaining sight; and Vietnam Veterans Outreach. According to the September 30, 1998 Bed Status Report, the facility's 489 operating beds include 77 acute medical beds, 19 surgery beds, 4 neurology beds, 8 rehabilitation medicine beds, 20 intermediate medicine beds, 191 psychiatry beds, and 170 nursing home care beds.

The medical center's Primary/Specialty Care Pavilion, which centralizes all outpatient clinics, was opened in 1996. According to the September 30, 1998 Bed Status Report, the Northport VAMC had a cumulative fiscal year (FY) 1998 average daily census of 261 patients. The facility reported 284,515 outpatient visits for FY98.

SCOPE

OHI inspectors conducted a QPA review at the Northport VAMC from July 27 to 31, 1998. Inspectors conducted comprehensive reviews of selected patient care services and functions. Inspectors visually inspected most of the facility's inpatient and

outpatient areas, reviewed numerous quality management documents, and reviewed 58 patients' medical records.

Inspectors interviewed the medical center's top managers, 45 clinical managers, 33 randomly selected clinicians, and 114 randomly selected patients. We also distributed questionnaires to 310 employees whom we randomly selected from the VAMC's staffing roster. Employees returned 120 completed questionnaires (38.7% return rate).

The QPA was done in accordance with the Quality Standards for Inspections, published by the President's Council on Integrity and Efficiency.

CONCLUSIONS

Quality management indicators, supplemented by patient and employee responses to standardized questionnaires, indicate that medical center acute care employees provide generally good patient care. Top managers are working cooperatively to reevaluate the way the medical center provides patient care services. Managers have involved selected employees at various organizational levels in addressing quality improvement (QI) measures. Employees whom we interviewed told us that they support QI improvements, but that they want to be more thoroughly involved in permanent patient treatment and QI teams that focus on improving overall patient care.

Employees at all levels expressed concerns about communications, the quality of facility management and the strength and influence of Union involvement in the medical center. From comments and personal interviews by employees, there is a substantial difference between managers' perceptions about the positive effect that their communications and employee involvement efforts have had on employees' attitudes and the employees' perceptions about these issues. A large proportion of employees, nevertheless, who responded to our questionnaire told us that:

- Their workloads are manageable
- Their supervisors are familiar with their daily activities
- The quality of care at Northport is a source of satisfaction for them
- They would recommend treatment at this facility to friends or relatives
- The medical center is an employer of choice, but the recognition and performance awards system does not reflect performance
- Incompetence is encouraged and rewarded

In view of the comments regarding the performance awards process, managers should critically assess and explore ways to improve these programs.

We concluded that patients were generally satisfied with their acute, nursing home, psychiatric and outpatient treatment. A large percentage of the patients whom we interviewed expressed satisfaction regarding staff courtesy, quality of care, cleanliness of the facility, adequacy of discharge planning, prescription and appointment waiting times, adequacy of employee staffing levels, and the taste and temperature of the food. This may be an example of an improvement after our hotline visit to the NHCU and Nursing Unit 8A in March 1998. All of the patients whom we interviewed rated their care as good to excellent. However, a large percent of the patients interviewed told us that waiting times for prescriptions and to see their provider for scheduled appointments were excessive and that they could not schedule appointments with their primary care provider within 7 days.

QPA REVIEW FINDINGS

MANAGEMENT PLANNING AND OVERSIGHT ACTIVITIES

The Northport VAMC's top management team consists of the Director, the Associate Director, and the Chief of Staff. The Director and the Chief of Staff have occupied their positions for about a year. Our review concluded that the senior management team continues to work cooperatively to assess how they can better provide patient care services. They will continue to focus on providing high quality patient care services and maximizing resources.

Managers have involved selected employees, at all organization levels, in evaluating the quality of care through participation in process improvement teams (PIT). These PITs are actively involved in efforts to improve communications, management, coordination of primary care, contract consultant assistance with standards development, enhancement of QM/RM programs, and sharing agreements. Managers convene employee forums with executive manager feedback. Executive managers have begun making frequent rounds throughout the facility. They are visible, and appear to be aware of their customers' needs. Employees in many areas acknowledged that under the present Director's leadership, managers visit their areas frequently, and discuss potential ways to improve operations.

In order to facilitate communication regarding the many active and contemplated institutional and organizational changes, executive managers conduct monthly town hall meetings with employees, union officials, and congressional staff. They regularly visit patient care areas and talk to employees and patients. They hold regular meetings with Veteran Service Organizations, local community organizations and other local health facilities, and hold quarterly meetings with the VISN Chief of Staff Council. The Director also established a Stakeholders' Advisory Group. The Director expects all managers and supervisors to discuss and promote planned organization changes with their respective subordinate employees to ensure that everyone is kept informed. The Director emphasizes the need for managers to communicate, encourage input, from employees and other stakeholders, listen to and respond to concerns, and to focus all changes on the patients' well-being and benefit. These efforts were confirmed from patient and employee interviews and survey questionnaires. The medical center has an active affiliation agreement with the State University of New York at Stony Brook.

ENSURING ACCESS TO HIGH QUALITY CARE

- A new Primary Care Chief physician has been appointed under the direction of the Chief of Staff to refine the Medical Center's Primary Care Program, which was established June 1993. Northport has recorded marked improvements in patient satisfaction according to national survey data.
- Executive managers told us that they had begun to restructure QM/RM services to improve medical center operations.

- The Chief of Staff regularly conducts teaching rounds on the wards and actively participates in clinical patient care. He recently reduced, by amalgamation, the primary care teams from 4 to 3 to improve patient care and staff efficiency.
- Reduction of Emergency Room (ER) treatment times, from triage to discharge, resulting from a 1997 process improvement initiative, has improved patient access to and quality of care.
- Clinical managers converted the substance abuse treatment program from an inpatient-based program to an outpatient-based program.

REDUCING HEALTH CARE COSTS

- Managers closed 149 acute care beds and 20 NHCU beds during the 18-month period from January 1997, through the second quarter of FY98, facilitating better use of resources for ambulatory care.
- The directors and the clinical managers from all the VISN medical facilities meet monthly to discuss ways to work more cooperatively and to find ways to reduce and/or eliminate duplication of services.
- Clinical managers implemented clinical guidelines for diabetes, chest pains, and hypertension.
- The Medical Center participates in consolidated contracts, which have resulted in cost savings.
- The establishment of observation beds in November 1997 has significantly reduced the number of non-acute hospital admissions.

PHYSICAL PLANT

Inspectors toured the inpatient wards, ancillary service areas and the outpatient clinic areas.

- Wards (hallways, patient rooms, nursing stations, and bathrooms) were generally clean and odor free.
- Generally, the patient and community bathrooms were clean, appeared to offer adequate privacy and were wheelchair accessible. However, the public restroom near the Canteen was unclean throughout our visits and the waste bins were overflowing with garbage.
- Exit and fire evacuation routes were clearly marked, and unobstructed.

- The patient representative's name and location were clearly and prominently posted in patient care areas, except for the psychiatric units and the Mental Health Clinic.

MANAGERS' QUESTIONNAIRE RESULTS (Attachment A)

We interviewed 45 acute care clinical managers. The responses to our questions show that clinical managers generally believe that the initiation of primary care has had, and will continue to have, a major positive effect on patient satisfaction. A new primary care Chief Physician was recently appointed. Clinical managers also told us that the emphasis on outpatient care has reduced hospital lengths-of-stays, while at the same time increased the number of patient contacts. Clinical managers generally believe that:

- Patients are involved in decisions about their health care.
- That emotional support is available and accessible to all patients.
- Coordinated care is provided for all patients.
- Patients are provided understandable information and education about their health and treatment.
- Adequate medical technology and specialized care is available to provide excellent care.
- Clinical staff is sufficient to treat all patients who need medical care.
- Patients are seen within 30 minutes of their scheduled appointments.
- The medical center is clean.
- The patient's feel that the food is good and of the right temperature.

Thirty-seven out of the 42 managers who responded to the question rated the overall quality of patient care as very good to excellent. Thirty-eight out of 44 managers told us that if patients could go to any hospital, most or all of the time they would prefer to return to this facility. And 39 out of 43 managers told us that, if eligible, most or all of the time they would recommend medical care at this facility to family members or friends.

Clinical managers told us that patients complain that clinicians do not triage them within 15 minutes of their arrival in the Walk-in Clinic. They also hear patients complain about the long waiting times for magnetic resonant imaging (MRI) examinations. Managers told us that they need additional training on computers, they need access to adequate

numbers of computers to do order entry, and they need supplies and equipment to do their jobs.

We asked the clinical managers to discuss performance improvement measures that have been taken and how these measures have reduced costs and/or improved quality. Some of their comments follow:

- Clinical guidelines have improved treatment for diabetes, chest pain, and hypertension.
- The Medical Center has shown a significant reduction in restraint use. The goal is to be a restraint-free medical center.
- Implementation of a telephone prescription refill procedure has decreased pharmacy-waiting times and improved patient satisfaction.
- Patient waiting times have been reduced in pharmacy and in scheduling for MRI examinations.

We asked clinical managers what performance improvement measures should be initiated to further improve productivity and quality. Following are some of their comments:

- Need to further reduce length-of-stay, and readmission rates.
- Need to provide training for clinical employees on early discharge planning to enable more patients to be outplaced to the community.
- Development of admission and LOS criteria would reduce bed-days-of-care.
- Positive feedback from top managers would improve employee morale.
- The staff needs more computers and computer training.

CLINICIANS' QUESTIONNAIRE RESULTS (Attachment B)

We interviewed 33 randomly selected clinicians from the inpatient and outpatient treatment areas. Generally, clinicians whom we interviewed believe that more input on management decisions and improved communications with senior managers would improve the quality of patient care. Clinicians also told us that top managers need to improve communications pertaining to planned changes and that clinicians are not always adequately involved in changes that directly affect patient care.

Generally, clinicians told us that employees treat patients courteously; that each patient is assigned one primary care provider; that patients are involved in decisions about their health; that emotional support is available and accessible to all patients; that

coordinated care is provided to all patients; that patients are provided understandable information about their health and treatment; that adequate medical technology and specialized care is available to provide excellent care; and that clinical staffing is sufficient to treat all patients who need medical care. Thirty-two of the 33 clinicians who responded to the question told us they would rate the quality of care provided to patients as very good or excellent. Twenty-two out-of 31 clinicians told us that if patients could go to any hospital, most or all of the time they would prefer to return to this facility; and 27 of 31 told us that if eligible, most or all of the time they would recommend medical care at this facility to family members or friends.

We asked clinicians to discuss performance improvement measures that have been taken and how these measures have reduced costs and/or improved productivity and quality. Some of their comments follow:

- Increased clinical staffing has improved productivity and morale, thereby improving quality of care provided to patients.
- Acquisition of new and better equipment makes patient care safer and easier for the staff.
- Reduction and reorganization of patient care units allows for more effective patient care.
- Implementation of clinical pathways increases productivity, coordination among services, and reduces length-of-stay.
- Decreased waiting time in outpatient clinics has improved patient retention and provides more time for patient teaching.
- The Resident Council was re-started in May 1998, and is now linked to the Decentralized Hospital Computer Program (DHCP). This provides tracking of service-specific problems identified by the beneficiaries. The Resident Council also works with employees to educate and work with families about their concerns.

We asked clinicians to discuss performance improvement measures that are planned and how they thought these measures would reduce costs and improve productivity and quality. Some of the responses were:

- New computers in the Operating Room (OR) will make the OR schedule available directly to the wards without having someone hand deliver it
- Implementing a psycho-tropic drug monitor and incorporating it into the behavioral management program will result in more effective medication use.

- A scheduled series of lectures in rehabilitation nursing principles will enable clinical employees to better evaluate patient needs
- Development of a coumadin monitor and diabetic indicators will improve quality of care for this patient population
- Relocation of Alzheimer's patients to another building will provide a more appropriate environment for these patients
- Installation of bedside telephones will give nursing employees more time for other patient care activities

Clinicians believed that some measures had a negative effect on patient care. These concentrated on:

- The closure of patient care wards that created overflows to other wards
- Too many forms result in duplicate documentation
- Increase in staff turnover increases the need for training and impedes the provision of consistently good care.

We asked clinicians if they could identify performance improvement measures that should be initiated to reduce costs. Following are some of their comments:

- Appropriate patient evaluations at the time of admission would avoid duplication and unnecessary examinations thereby reducing costs
- Allowing nursing staff to submit consultation requests via computer for diabetic teaching or nutrition classes would speed this process and improve care.
- Scheduling 12 hour shifts for nursing staff would decrease use of overtime
- Increasing the scope and breadth of patient education programs would promote independence and decrease patient lengths-of-stay
- Faster placement of community nursing home patients will decrease length-of-stay

PATIENTS' QUESTIONNAIRE RESULTS (Attachment C)

We interviewed 114 randomly selected patients, (37 inpatients, and 77 outpatients). Sixty-eight of 114 patients had service connected conditions, and 103 were male. The greatest number of patients were between 45 and 54 years old (35.09 percent); 86 were white (79.90 percent); 36 were World War II veterans (32.14 percent) and 47 (41.96%)

were Vietnam veterans. Twenty-seven patients told us that they now receive treatment/procedures as outpatients that they formerly received as inpatients, but only 4 patients told us that programs they used to be involved in have been eliminated.

From the patients who were randomly selected for interviews at the Northport VAMC, the following positive insights were conveyed.

- Nearly nine-out-of-ten (88.9%) patients responded good-to-excellent to the question "Overall, how would you rate the quality of care you receive?"
- Nearly nine-out-of-ten (89.8%) patients responded good-to-excellent to the question "Overall, are you pleased with your treatment?"
- Over nine-out-of-ten (93.7%) patients responded positively to the question "Staff treat you with courtesy?"
- Nearly eight-out-of-ten (76.8%) patients responded positively to the question "You know who your primary care provider is?"
- Nearly nine-out-of-ten (88.6%) patients responded positively to the question "Emotional support is available and accessible to you when you need it?"
- Nearly nine-out-of-ten (88.9%) patients responded positively to the question "You are provided understandable information about your health and treatment?"
- Nearly all of the patients (97.3%) responded positively to the question "The Medical Center is usually clean?"
- More than nine-out-of-ten (93.9%) patients responded positively to the question "The posted signs make it easy to find where I need to go in the medical center?"
- Nearly nine-out-of-ten (87.0%) patients responded positively to the question "If I could go to any hospital, I would prefer to return to this facility?"
- Nearly nine-out-of-ten (87.8%) patients responded positively to the question "If eligible, I would recommend this facility to a family member or friend?"

VAMC managers should be aware of and explore actions to improve the following patient perceptions:

- One-out-of-four (25%) applicable patients responded negatively to the question "Prescriptions are available for the pharmacy with 60 minutes?"

- Nearly three-out-of-ten (29.6%) applicable patients responded negatively to the question "Your family and/or significant others are involved in your care when appropriate?"
- Nearly one-out-of-four (23.1%) applicable patient responded negatively to the question "There is sufficient staff to treat the patients who need treatment?"

We asked patients to comment on what they think VAMC managers could do to improve care. Their most frequent suggestion was to hire more employees. Patients also told us that they think that the Pharmacy Service needs more qualified people; because Pharmacy waiting time for medications is too long; that managers could devise more transportation options to and from treatment; and that neurologists need to have more knowledge about Agent Orange.

EMPLOYEES' QUESTIONNAIRE RESULTS (Attachment D)

We asked 310 randomly selected employees to anonymously complete questionnaires. We received responses from 120 employees (38.7 percent response rate). Generally, employees who responded feel that they are qualified for the jobs they do; that their jobs contribute to improving patient satisfaction; that they feel safe coming to, and leaving the VAMC; and that they gain personal satisfaction from their jobs.

Out-of the 120 responding employees, 77 indicated that they are involved in direct patient care. Seventy of these employees indicated that they receive annual TB testing, 72 said that annual flu shots were made available to them, and 61 employees indicated that they were offered Hepatitis B immunization. In addition, sixty-one out-of 76 employees also indicated they had received training in managing and preventing violent behavior.

Of the 38 employees who told us that they are members of permanent patient treatment teams, 31 told us that their teams have clearly defined team leaders and that the persons who evaluate their performance are qualified to do so and 8 out of 38 employees told us that they could provide input into other team members' performance evaluations.

The employees raised several concerns that management need to address. These concerns are:

- 54 out-of 118 (45.8%) responding employees either strongly agree or agree with the statement "I can not be totally efficient because of inadequate resources"
- 50 out-of 117 (42.7%) responding employees either strongly disagree or disagree with the statement "Recognition and awards adequately reflect performance"

- 55 out-of 118 (46.6%) responding employees either strongly agree or agree with the statement "Sometimes I feel incompetence is encouraged and rewarded"
- 51 out-of 120 (42.5%) responding employees either strongly agree or agree with the statement "Who you know is what counts not what you do"
- 62 out-of 117 (53.0%) responding employees either strongly disagree or disagree with the statement "There is sufficient staff in my area to provide care to all patients who need care"

One-out-of-three (40 out-of 120) employees provided written comments, in addition to the requested survey responses. Six of the employees (15%) made positive comments regarding the good treatment provided to patients in the Cardiology Section and Dental Service. They generally think the VA is a fine place to work and offers the potential for career growth. Other employees feel that the medical center has hardworking employees who were willing to go the "extra mile" to provide the best possible care for veterans, and that the Medical Center Director is addressing the issues and wants the best care for the patients.

More than half of the additional comments (21 out-of 40) were directed towards management practices. Some of the comments were: staff morale is low, and managers do not support and do not care about employees; lack of upward mobility programs; leaders do not consider employees' input when making decisions, and poor management and supervision.

Other comments indicate that due to the lack of ancillary employees, providers in the inpatient and outpatient areas or wards need to perform tasks that take away time from direct patient care. Three employees (7%) felt that salaries, in general, were low compared to the areas' high cost of living. Four (10%) employees had other responses such as: security police should carry firearms, and comments with names of other employees to interview.

Surveys of employee perceptions at the Northport VAMC have been conducted in each of the past two fiscal years: the One VA Survey in April 1997, and the survey by the Office of Healthcare Inspections (OHI) in July 1998. These two surveys, while not identical in either their methodological sampling strategy* or question design, had a number of items which were similar and enabled comparisons between FY97 and FY98.

The thirteen items were similar enough in content to evaluate changes in the perceptions of Northport employees covered the areas of supervisors expectations

* The One VA survey conducted in April 1997 was a population based survey and involved no sampling design. The QPA employee survey was based upon a 20% random sample of all full-time employees that worked at the Northport VAMC. Any statistical tests of differences between observed responses requires the basic assumption that the responses come from two, independent samples.

clear, workload reasonable/manageable, fair performance evaluations, workplace is safe, inadequate resources, job satisfaction, job training adequate, presence of customer orientation, quality of care, continuing education, equal opportunity, managers' focus on quality, and recommend to family/friend. The following table indicates the comparable questions between the two surveys, the respective responses, and the direction of change in employee perceptions.

On the thirteen items that were comparable between the two surveys, the following nine items showed statistically significant improvement in the overall responses from FY97 to FY98 based upon a simple chi-square test of differences in the observed responses:

- Clarity of Supervisors Expectations ($p < 0.001$)
- Workload Reasonable/Manageable ($p < 0.001$)
- Fair Performance Evaluations ($p < 0.001$)
- Workplace Safety ($p < 0.05$)
- Job Satisfaction ($p < 0.001$)
- Adequacy of Job Training ($p < 0.001$)
- Presence of Customer Orientation ($p < 0.001$)
- Continuing Education ($p < 0.001$)
- Willingness to Recommend to Family or Friend ($p < 0.001$)

Those four items, which showed no statistically significant change between FY97 and FY98, concern areas related to:

- Inadequacy of resources (n.s)¹
- Quality of care (n.s)
- Equal opportunity (n.s)
- Managers' focus on quality (n.s)

While the overall picture indicates that employee perceptions improved between FY97 and FY98, major issues still exist regarding employee perceptions in their dealings with the system.

¹ n.s – observed differences not significantly different from zero.

Comparing Northport Employee Perception, FY97 & FY98

AREA	ONE VA SURVEY QUESTION	FY97 ^a ONE VA SURVEY	QPA SURVEY QUESTION	FY98 ^a OHI SURVEY	DIRECTION OF CHANGE
SUPERVISORS EXPECTATIONS	#98	62%	#10	79%	IMPROVEMENT
WORKLOAD REASONABLE	#54	34%	#4	63%	IMPROVEMENT
FAIR PERF. EVALUATIONS	#96	45%	#7	63%	IMPROVEMENT
WORKPLACE SAFETY	#62	63%	#20	75%	IMPROVEMENT
INADEQUATE RESOURCES	#58	43%	#5	46%	NO CHANGE
JOB SATISFACTION	#131	50%	#2	84%	IMPROVEMENT
JOB TRAINING	#9	55%	#1	98%	IMPROVEMENT
CUSTOMER ORIENTATION	#24	52%	#3	92%	IMPROVEMENT
QUALITY OF CARE	#117	75%	#15	79%	NO CHANGE
CONTINUING EDUCATION	#157	10%	#16	51%	IMPROVEMENT
EQUAL OPPORTUNITY	#41	44%	#23	47%	NO CHANGE
FOCUS ON QUALITY	#30	54%	#18	60%	NO CHANGE
RECOMMEND TO FAMILY/FRIEND	#155	45%	#17	66%	IMPROVEMENT

^a The percentage reported reflects those who agree (disagree) as well as those who strongly agree (disagree)

MEDICAL RECORD REVIEW

We reviewed a random sample of 58 medical records; 19 records for patients who had a diagnosis of ischemic heart disease, 22 records for patients who had a diagnosis of diabetes mellitus, and 16 records for patients who had a diagnosis of substance abuse. We reviewed the records to assess the extent to which Northport VAMC physicians follow clinical guidelines that they developed for monitoring treatment of these three diseases. We found that physicians generally follow the guidelines. All of the medical records that we reviewed show that clinicians properly record patient care following their established guidelines and the patients' response to treatment. All of the medical records demonstrated proper documentation and we concluded that medical care was appropriate for these conditions.

OHI inspectors also reviewed nine medical records of patients whom employees alleged had received less than optimal care. While we found some minor delays in treatment and one minor medication error, overall the treatment, as documented in the medical records, was good.

TOTAL QUALITY MANAGEMENT

Patient Incident Reports

OHI inspectors reviewed the completed Reports of Special Incident Involving a Beneficiary (326) for January, February, and March 1998. The incidents met criteria for reporting, were generally documented appropriately and a clinical provider appropriately examined the involved patients. We found that the policy and procedure to forward required incidents to the MCD and COS for review was not always followed.

We reviewed 39 additional completed Reports of Special Incident involving a beneficiary for April 1998. Although we question whether all of the 39 reported incidents meet the criteria for a reportable event we recognize that individual facilities create VA Form 2633 reporting categories in order to meet local needs and issues.

OHI believes that a delay due to difficulty starting an IV, and holding a medication because of low blood pressure, should simply have been documented on the medication flow sheet. Similarly a patient's failure to return from a pass on time, and a patient returning intoxicated should have been documented in the medical record. While OHI believes it is important to encourage incident reporting, we caution managers to closely monitor the reporting process to ensure that the spirit of performance improvement can flourish. Employees whom we interviewed expressed concerns that this is not yet occurring.

ATTACHMENT A

Managers' Questionnaire Results Histogram Reports

[This electronic version of the report does not include the questionnaire graphs from Attachment A (they could not be electronically converted). The results of Attachment A are discussed in [Appendix A, pp. 37-38](#)]

ATTACHMENT B

Clinicians Questionnaire Results Histogram Reports

[This electronic version of the report does not include the questionnaire graphs from Attachment B (they could not be electronically converted). The results of Attachment B are discussed in [Appendix A, pp. 38-40](#)]

ATTACHMENT C

Patients' Questionnaire Results Histogram Reports

[This electronic version of the report does not include the questionnaire graphs from Attachment C (they could not be electronically converted). The results of Attachment C are discussed in [Appendix A, pp. 40-42](#)]

ATTACHMENT D

Employees' Questionnaire Results Histogram Report

[This electronic version of the report does not include the questionnaire graphs from Attachment D (they could not be electronically converted). The results of Attachment D are discussed in [Appendix A, pp. 42-45](#)]

APPENDIX B

VAMC Northport' 1997 National Patient Satisfaction Survey Results

[This electronic version of the report does not include the questionnaire graphs from Appendix B (they could not be electronically converted). The results of Appendix B are discussed in [Appendix A, pp. 43-45](#)]

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