COMPANION PODCAST TRANSCRIPT

Nurse Staffing Shortages at the Community Living Center within the San Francisco VA Health Care System

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INTRODUCTION

Hello listeners! Thank you for listening to this companion podcast produced by the Department of Veterans Affairs Office of Inspector General. Companion podcasts summarize and increase awareness of VA OIG published reports and regularly feature those OIG employees who conducted the report, inspection, or investigation. Find all VA OIG podcasts online at va.gov/oig.

Kevin Hosey:

Hello, this is Kevin Hosey. I am a health systems specialist at the VA OIG and, today, I am speaking with Alison Loughran, a director within our Office of Healthcare Inspections. We're going to be talking about a healthcare inspection at the community living center, a nursing home within the San Francisco VA Health Care System in California.

The VA OIG report published last fall and titled, *Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California*, was the result of an investigation into several allegations that leaders at the facility failed to adequately address known nurse staffing shortages, yet continued to accept resident admissions.

Alison, what services do community living centers provide to patients and how did our office become involved in this one?

Alison Loughran:

Kevin, thank you for that introduction. VA community living centers offer short- and long-term care to residents. Like most nursing homes, residents receive assistance with day-to-day living activities like bathing, eating, and dressing. Staff nurses and other medical professionals provide wound care and

administer medication. They take care of patients with dementia and provide palliative and hospice care to those patients with terminal illnesses.

In September 2019, the OIG Hotline division received a complaint that center leaders did not address known nurse staffing shortages and continued to accept resident admissions. There were further concerns that the inadequate staffing led to adverse events, such as wandering residents and disruptive behaviors. Additionally, the allegations included concerns regarding a lack of 24-hour housekeeping staff, that the center was dirty and infested with fruit flies, and that staff did not wash their hands. It was also reported that the center had temporarily closed multiple times due to infectious disease.

Kevin Hosey:

So, the hotline tip produced several allegations with staffing shortages as the root cause. Let's start there. How does the Veterans Health Administration manage nurse staffing and prevent shortages?

Alison Loughran:

To determine proper staffing levels, VHA uses a calculation referred to as NHPPD, which stands for nursing hours per patient day, to manage patient workload. The calculation considers a mix of nursing staff, including nursing assistants, that would be required to manage a certain number of patients during a 24-hour period.

Facility nursing managers determine the number and type of nursing staff needed through an analysis of multiple variables like resident needs, organizational supports, and clinical judgment. VHA requires the nurse executive to approve the staffing levels and facility nurse leaders review these levels daily.

In the current report, the OIG identified that the NHPPD calculation in use was never approved by the nurse executive and did not meet patient needs. The OIG found that the facility director and the nurse executive retroactively approved a staffing methodology in November 2018, that covered a two-year period of October 2017 through September 2019—already one year into the time period of use. The center's facility director reported that the staffing methodology was not signed timely because, quote: "nobody knew how to do it," end quote.

The center's staffing methodology coordinator—the nurse who has responsibility to submit the staffing plan—was unable to articulate what the numbers should be and needed training on how to do calculations correctly.

Kevin, getting the NHPPD calculation correct is critical as accurate staffing supports safe and effective patient care.

Kevin Hosey:

This seems like a leadership issue as well.

Alison Loughran:

Yes, correct.

The OIG determined that due to competing priorities, facility leaders failed to provide the community living center with the attention necessary to address the staffing shortages. Complicating the matter further, the center had experienced frequent change over and vacancies at the leadership level.

In fact, these issues with changeover and vacancies extended to the recruitment and hiring of staff as well. Living in the San Francisco area can be expensive, and we heard from managers that filling nursing assistant positions was difficult. In October 2019, less than 50 percent of this center's authorized nursing assistant positions were filled.

So, not surprisingly, as the community living center struggled with inconsistent leadership and endured progressive staffing challenges, patient care was compromised due to management turnover and the nurse executive's competing priorities.

Kevin Hosey:

How did they end up managing the staffing shortages?

Alison Loughran:

It remains an ongoing process. We learned that the center has 120 authorized beds. However, prior to 2010, leaders internally, and without VHA authorization, reduced the number of operating beds to 104, to account for the insufficient nurse staffing. So, as you can see, this was a long-term and well-known problem. Despite nurse staffing being insufficient, leaders have not further reduced the number of beds since 2010. The OIG recommended that the center work with VA's central office to determine the appropriate number of approved beds.

Kevin Hosey:

The report discussed the use of contracted staff to fill vacant nursing slots and address staffing shortages. Why was the OIG concerned with this approach?

Alison Loughran:

It is not unusual to use temporary contract staff, called registry staff, to fill slots. Temporary staff becomes a problem though when center management relies primarily on this solution to meet staffing needs. Studies indicate that long-term use of registry staff may jeopardize resident safety. The objective would be for a center to be fully staffed with nursing assistants, as they provide most of the hands-on care and their presence supports continuity and knowledge of the patients.

We found that the center's use of registry staff quadrupled from September 2018 through December 2019. Registry staff often do not know the residents, so you don't have consistency and familiarity. Also, center residents are usually elderly, have multiple health issues, mobility and communication problems, often stay for extended periods, and can have behavioral and cognitive issues. Staff who consistently identify and respond to these complex and unique needs are vital to resident safety and clinical care.

We also found that the registry staff generally could not document care into the electronic health record because they did not have VA-issued personal identity verification cards and were unable to access the electronic health records of residents. Care provided should be documented to ensure safe and appropriate care and coordination, and, importantly, that electronic health record data feeds into staffing methodology calculations.

The OIG learned that managers struggled with the significant number of nursing assistant vacancies and increasingly relied on registry staff to supplement staffing. Additionally, management was often unsuccessful in tracking registry staff use, and therefore, shifts were regularly understaffed.

Kevin Hosey:

What about the other allegations you mentioned earlier? Like the handwashing issue. Beyond the obvious important of good hygiene, why is it important for centers to monitor handwashing?

Alison Loughran:

Yes, handwashing is critical for infection control and reduces the transfer of germs between patients and staff. Center management are required to monitor staff and regularly check that staff is meeting handwashing goals. The OIG found that managers were not consistently tracking handwashing and monitoring compliance. Additionally, some staff reported that because of low staffing levels, they were quote "too busy" end quote to wash their hands.

Kevin Hosey:

Too busy?

Alison Loughran:

Yes. Too busy. That's never an excuse, but given that centers can be very busy with patients needing diverse care often simultaneously, plus when we consider the lack of staff available, it is reasonable to believe that sometimes, a simple yet incredibly important act such as handwashing would be overlooked.

Kevin Hosey:

What did the OIG find in reference to concerns about 24-hour housekeeping and the fruit flies?

Alison Loughran:

We found the center to be clean but learned that the staff performed some deep cleaning prior to our visit. We did, however, find some flying insects, specifically fruit flies. Staff attributed the insects to food left in residents' rooms and a lack of screens on windows. Since then, management has increased housekeeping staff at the center to mitigate some of the reported issues.

Kevin Hosey:

Given these issues at the center, did the OIG link them to any adverse patient outcomes?

Alison Loughran:

We did not link any adverse outcomes directly to the staffing shortages or related allegations. We did look at adverse events such as falls, disruptive behavior, and wandering residents in the center, but it's

important to recognize that a variety of contributory factors can affect resident safety and quality of care. This often makes it difficult to conclusively attribute these adverse events to just nurse staffing shortages.

Kevin Hosey:

There was also a concern that the center was closed to visitors on multiple occasions due to infectious disease. What led to these closures? And is that normal?

Alison Loughran:

The entire center, or one of its floors, was closed to admissions and visitors on six different occasions between January 3, 2018, and September 3, 2019, due to infectious disease. Visitors of all ages and demographics visit these centers and it's difficult to prevent exposure to infectious diseases. Here at the OIG, we recognize that closures are disruptive to residents and families; however, we found these steps necessary to limit potential exposure to others.

Kevin Hosey:

What were the report's recommendations? And what is the status of the center today?

Alison Loughran:

During and following our inspection, center leaders took actions to address some of these issues, including resolving the overuse of registry staff. We made some recommendations we believe will help improve operations and resident safety. For instance, we recommended that the center take a close look at nursing assistant staffing including methodology, recruitment, and hiring practices and use of registry staff.

As to the complaints about cleanliness and infection control, we recommended they develop a clear communication pathway for center staff to request assistance for all shifts, resolve the insect problems, and consistently track handwashing.

Regarding center management, the OIG knows that manager vacancies and competing priorities led to some of these problems. Since October 2017, this center experienced high turnover or vacancy in the center chief and nurse manager positions. In other inspections, the OIG examined leadership roles VA-

wide and recognized that stable and effective leadership is critical to improving care and it can affect a facility's ability to provide care in all selected clinical areas of focus.

Kevin Hosey:

Alison, I really appreciate your time today and hope this podcast gives our listeners a better understanding about what we do here in the OIG and how we help improve the veteran experience in our community living centers around the country.

Alison Loughran:

I do too Kevin and thank you as well.

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