Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Patient Care and Staffing Issues
Gulf Coast Veterans Health Care System
Biloxi, Mississippi

Report No. 04-01946-196 **September 2, 2005**

VA Office of Inspector General
Washington, DC 20420

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

TO: Director, South Central VA Healthcare Network (10N16)

SUBJECT: Healthcare Inspection – Patient Care and Staffing Issues, Gulf Coast Veterans Health Care System, Biloxi, Mississippi

1. Purpose

The Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding the care of mental health (MH) patients at the Gulfport division of the Gulf Coast Veterans Health Care System (GCVHCS).

2. Background

GCVHCS has two divisions, located in Biloxi and Gulfport, MS, and provides primary and secondary medical, surgical, and long-term care services. MH services have primarily been provided at the Gulfport division.

In June 2004, GCVHCS managers converted an acute inpatient MH unit (62-G2) to a 23-hour MH observation unit. Many MH employees expressed anger that they were not consulted about the reorganization, and told us that the changes had resulted in poor communication and patient care lapses. While initially unable to provide us with specific patient cases or examples, the complainant later submitted additional information for our review. The complainant alleged that:

- Suicidal and violent patients were being discharged prematurely from the acute MH and 23-hour observation units.
- Staffing levels were insufficient, which negatively impacted staff safety when managing patients with violent behavior.

3. Scope and Methodology

We visited the GCVHCS in November 2004. We conducted telephone interviews with MH physicians, nurses, psychologists, and social workers, and interviewed facility managers that had knowledge of the issues. We reviewed selected patients' medical records, MH staffing plans, policies and procedures, patient incident reports, and performance improvement documents. We interviewed the complainant to better understand the allegations.

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

4. Inspection Results

The MH reorganization took place in June 2004. At the time of our November review, medical center managers were in the process of implementing changes, which included the recruitment of a new MH Medical Director, a new nurse manager (NM) for the acute inpatient MH unit (62-G1), and the reassignment of a NM to the 23-hour observation unit (62-G2). At the conclusion of our on-site visit, we presented our preliminary findings to the new MH management team, and we acknowledged they should have the opportunity to address problems and implement corrective actions. In April 2005, GCVHCS managers submitted a status report, at our request, on the corrective actions implemented, along with supporting documents showing the effectiveness of those actions.

Issue 1: Premature Discharge of MH Patients

We did not substantiate the allegation that MH providers discharged several suicidal or violent patients prematurely. The complainant could only provide us with one patient name to illustrate this allegation. We reviewed this record along with 12 other MH patients' records and determined that the discharges were appropriate. The patients were stable, had appropriate arrangements for accommodations, and all received discharge medications, instructions, and follow-up appointments.

While we did not substantiate the allegation of premature discharge, we found that the average length of stay (ALOS) for MH patients exceeded the CMS (Centers for Medicare and Medicaid Services) standard for ALOS based on the comparison utilization review data collected by the medical center. Managers explained that the increased ALOS in MH was, in part, due to the success of the observation bed program, which reduced short-term length of stay admissions to the acute inpatient MH unit. Patients treated on the observation unit are considered outpatients, and their one-day length of stay is not included in the ALOS calculation. Patients that were admitted to the acute unit were usually severely ill and required longer hospitalizations. The MH Medical Director told us that she was in the process of reviewing admission and continued stay criteria for MH patients.

Issue 2: Staffing on the Mental Health Units

We did not substantiate that insufficient staffing negatively impacted staff safety when managing patients with violent behaviors. We reviewed incident reports related to patient-on-patient (nine) and patient-on-staff (two) assaults, and psychiatric emergency reports (six) for the period April 2004 through October 2004. Neither the post-event critiques nor incident reports reflected staff perceptions or other indications that these events occurred because of insufficient staffing.

The Chief Nurse Executive explained the minimum staffing expectations for each shift on the MH units. We reviewed the actual staffing for June and July 2004 on all three shifts and determined that staffing met or exceeded minimum requirements. However, nursing staff were utilized to escort MH patients from Gulfport to Biloxi for appointments, which decreased the number of nursing staff available on the units. We brought this issue to the attention of management, and the Chief of MH agreed that the process for sending acute MH patients to Biloxi for appointments needed evaluation. Nursing management revised the fiscal year 2005 staffing plan to provide additional staff for escort without negatively impacting patient care and developed a monitor to evaluate the frequency and reasons for appointments. Results for December 2004 and March 2005 showed that nursing staff escort patients to Biloxi for high priority medical appointments only, and there is sufficient staffing for this function.

Issue 3: Other Issues

Interviews with staff indicated a general lack of understanding of the purpose, policies, and procedures related to the 23-hour observation unit, and we also found that performance improvement (PI) activities in MH were limited. Use of restraints was the only PI activity being monitored at the time of our review.

In response to our concerns, MH managers provided documentation of staff education on the 23-hour observation unit policies and procedures. Education will continue until all staff are trained. Nursing Service designated an individual to work with the Quality and Performance Management Service to develop and implement additional PI activities. MH staff received training on PI principles, including the development of monitors. Managers revised the restraint usage monitor, and implemented additional monitors for recidivism, falls, medical record content, violent patient behavior, and PRN[1] (as needed) medication effectiveness. Management provided a MH PI quarterly summary as evidence of their efforts.

5. Conclusion

Medical center managers were responsive to our concerns and provided acceptable documentation to support corrective actions. In March 2005, the 23-hour observation

[1] PRN means “as needed,” rather than scheduled. It is the commonly used medical acronym for the Latin phrase “pro re nata,” which translates as “for the occasion that has arisen.”

unit was closed due to a low average daily census, and observation patients are now treated on 62-G1. Staff were transferred to unit 62-G1, allowing the unit to have a one-to-four staff to patient ratio. The NM also told us that the ALOS has been reduced by 10 days. Because managers are making appropriate efforts to improve MH services, we did not make any recommendations.

(original signed by:)
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Appendix A

OIG Contact and Staff Acknowledgments

OIG Contact	Hotline Call Center (800) 488-8244
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