Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02186-227

Healthcare Inspection

Nursing Care in the Community Living Center for Spinal Cord Injury Louis Stokes VA Medical Center Cleveland, Ohio

June 27, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations regarding poor quality care and management on the long-term care (LTC) spinal cord injury (SCI) unit at the Louis Stokes VA Medical Center (facility) in Cleveland, OH. Specifically, the complainant alleged that staff: documented poorly; neglected residents by frequently skipping residents' showers and bowel care; refused to make rounds; and ignored infection control precautions by not wearing gloves to feed residents and leaving dirty linen scattered over the unit. In addition, it was alleged that nurse managers did not: take action in response to nursing staff's misconduct; adequately staff the LTC SCI unit, especially with experienced nurses; and assigned inexperienced nurses as charge nurse. During the course of our inspection, we also reviewed call bell response time.

We found that staff nurses did not consistently document resident care as required, leaving us unable to ascertain whether staff actively provided expected care. However, several LTC SCI unit residents and non-unit staff interviewed reported positive perceptions of care. We did not substantiate allegations regarding infection control infractions.

Nurse managers acknowledged and were aware of staff not conducting resident care rounds, unscheduled leave issues, and misconduct, but they had not taken effective actions in response to these issues.

Overall, we found understaffing on all shifts — with significant shortages of up to five employees on some day shifts. While some newer staff were periodically assigned charge nurse responsibilities, we did not find evidence of resulting problems with patient care or LTC SCI unit activities. However, float staff pulled from other units during staffing shortages lacked the training and competencies to work with this complex and challenging patient population.

We recommended that the Facility Director ensure that: staffing levels on the LTC SCI unit are consistent with Veterans Health Administration requirements and the facility's SCI Master Nurse Staffing Plan, LTC SCI nursing staff consistently provide and document resident care, LTC SCI nurse managers take action to investigate and address conduct related issues, and float staff assigned to the LTC SCI unit have the training and competencies required for the unit.

Comments: The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 14–17 for the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations regarding poor quality care and management on the long-term care (LTC) spinal cord injury (SCI) unit at the Louis Stokes VA Medical Center (facility) in Cleveland, OH.

Background

Facility

The facility is one of five facilities in Veterans Integrated Service Network (VISN) 10. With 673 beds, the facility provides care through a medical complex at Wade Park campus, 13 community-based outpatient clinics, and numerous community-based contract nursing homes. The facility offers a full range of primary, secondary, and tertiary care services to more than 105,000 veterans from 24 counties in Northeast Ohio.

Through its 120 affiliation agreements, such as with Case Western Reserve University, the facility trains more than 500 physician and dental residents and interns annually. The facility supports research and is home to eight Centers of Excellence,[1] including SCI care. The SCI and Disorders Service functions as a hub to support several other VA SCI primary care teams and oversees an acute SCI unit at the facility. In 2011, the facility opened the 26-bed LTC SCI unit in the Capital Asset Realignment for Enhanced Services (CARES)[2] Bed Tower to serve as a specialized community living center (CLC) for residents with SCI.

SCI

Spinal cord damage can result in loss of muscle control and/or strength, a condition referred to as "paralysis" or "plegia" as well as loss of sensation. According to the *VA and Spinal Cord Injury* Fact Sheet, dated January 2009, "Paraplegia results from injury to the lower part of the spinal cord, causing paralysis of the lower part of the body, including the [muscles that control] bowel and bladder. Tetraplegia (sometimes called quadriplegia) results from injury to the spinal cord in the neck area, causing [more extensive] paralysis to the lower body, upper body, and arms."[3]

[1] http://www.hsrd.research.va.gov/centers/centers_of_excellence.cfm, Centers of Excellence are affiliated with VA facilities, receive funding from VA, develop their own research agendas, and collaborate with local schools of public health and universities.
[2] The CARES tower's name derived from an independent commission called the Capital Asset Realignment for Enhanced Services (CARES) Commission. Approved by the Secretary of VA in October 2004, the CARES report called for consolidation of Brecksville and Wade Park campuses, and it included the construction of the new CARES tower at Wade Park to accommodate the relocated Brecksville residents and patients.
[3] http://www1.va.gov/opa/publications/factsheets/fs_spinal_cord_injury.pdf, accessed January 21, 2013.

Depending upon the severity and location of the injury, residents with SCI typically have significantly reduced functional ability, and in some cases, the need for a machine to assist with breathing. As a result, patients with SCI may be fully dependent upon others for activities of daily living (ADL), such as grooming, bathing, dressing, personal hygiene, toileting, eating, and mobility. While the ability to communicate may be retained, loss of internal signals of bodily functions and movement give rise to physical changes that increase the need for close observation. For example, autonomic dysreflexia (AD) is a life threatening condition in the SCI population. AD often results from a distended bowel or bladder that dangerously elevates blood pressure, which must then be properly assessed and quickly treated.[4]

The emotional impact related to losses of independence and function in SCI residents may be distressing to the resident, family, and friends. Over time, such losses may contribute to feelings of depression, anxiety, fear, or anger, which can jeopardize relationships with others and progress towards other emotional complications.

Allegations

OIG's Hotline Division received allegations that the LTC SCI unit staff:

- Documented poorly.
- Neglected residents by frequently skipping their showers and bowel care.
- Ignored infection control (IC) precautions such as nurses not wearing gloves to feed residents and leaving dirty linen scattered over the unit.

It was also alleged that nurse managers (NM):

- Did not take action in response to nursing staff conduct problems including leave (time off) abuse, refusal to make rounds, and insubordination.
- Did not adequately staff the LTC SCI unit, especially with experienced nurses.
- Assigned inexperienced nurses as charge nurses.[5]

Scope and Methodology

OIG inspectors conducted a site visit June 12–15, 2012. We interviewed unit staff, residents, a resident's family member, and other key personnel knowledgeable about the care provided on the LTC SCI unit. We reviewed electronic health records (EHRs); facility and Veterans Health Administration (VHA) policies, directives, and handbooks; quality assurance documents; quality indicator reports, Minimum Data Sets (MDS)[6] and

[4] Paralyzed Veterans of America/ Consortium for Spinal Cord Medicine, *Acute Management of Autonomic Dysfunction: Adults with Spinal Cord Injury Presenting to Health-care Facilities*, July 2001, available at http://www.pva.org/site/lookup.asp?c=ajIRK9NJLcJ2E&b=6423003, accessed January 21, 2013.
[5] A charge nurse is a staff nurse given responsibility to assign tasks to co-workers and oversee the unit's operation for the day.
[6] The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing facilities. In addition to providing provides a core set of screening, clinical, and functional status

resident advocate reports; staff training records; meeting minutes; and other relevant documents. In addition to addressing the above allegation, we also reviewed call bell response time, an important facet of nursing care, particularly on an SCI unit.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Documentation and Resident Care

Documentation

We substantiated that the LTC SCI unit staff nurses did not consistently document patient (resident) care.

VHA requires that staff assist any resident with impaired ADL, develop a plan of care to address the level of assistance needed for the resident,[7] and use the EHR to document and authenticate each care event.[8] The facility's policy requires that staff assess the resident's pain level before and 1–2 hours after pain medication administration, and document the assessment using the barcode medication administration (BCMA) software program.[9] This facility further expects that staff perform and document residents':

- Bowel care in the EHR
- Showers in the EHR
- General care in a weekly nursing note in the EHR
- ADL for each shift in the EHR
- Initial pain assessment (in the BCMA software)
- Response to pain medication administration, called the "1-2-hour pain reassessment" (in the BCMA software)

In order to assess documentation and authentication of case events, we evaluated compliance with the facility's AD protocol, and we reviewed eight residents' EHRs who, over the past year, experienced an episode of AD and were treated on the unit or transferred to the emergency department. Because AD can reoccur soon after an episode, staff members are required to monitor the resident by checking blood pressure (BP) every 30 minutes for two hours after an episode. We found that staff consistently documented all required elements of initial AD assessment and intervention for all eight residents. Two of the residents were transferred to the emergency department for

elements for residents, MDS can be used to determine per diem rates and measure quality of care. Source: https://www.ascp.com/articles/minimum-data-set-mds-resources, accessed 1/20/2013.

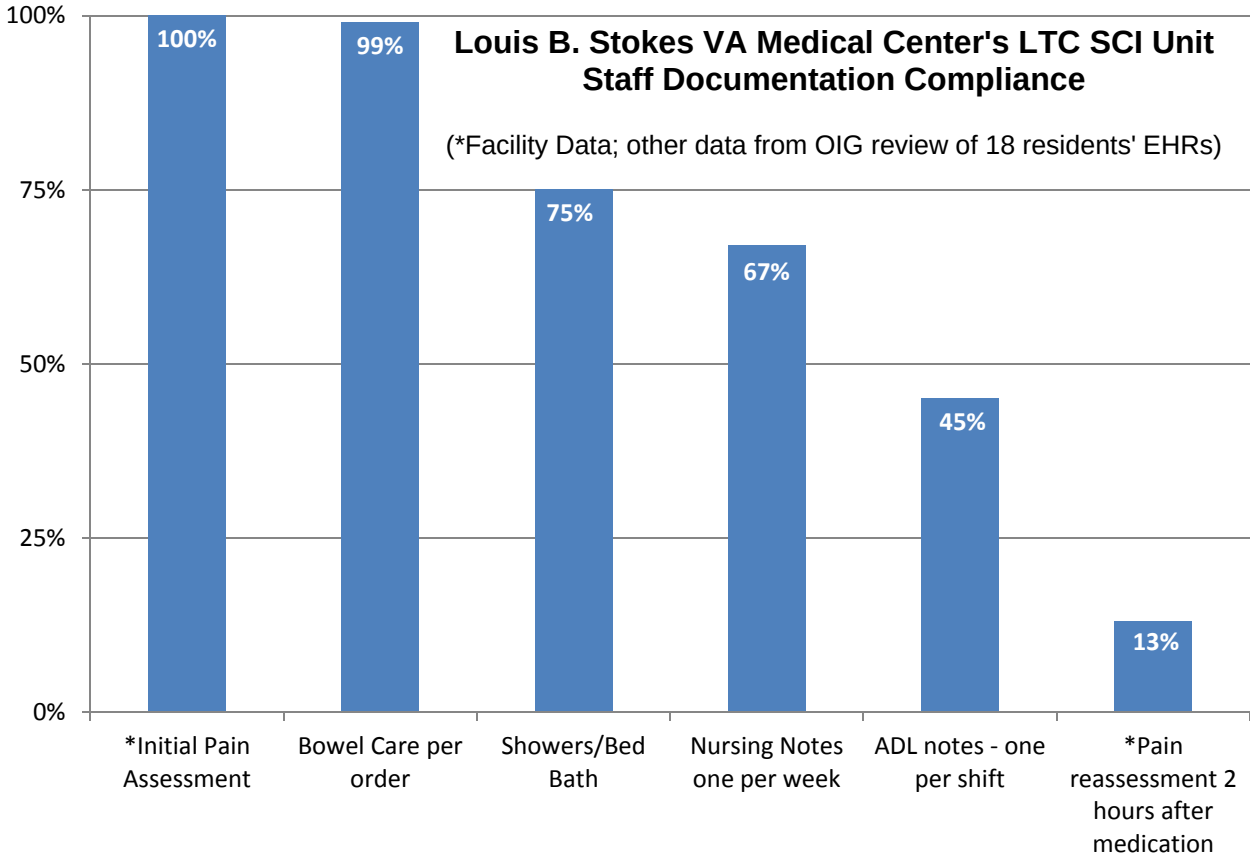
[7] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Center (CLC),* August 13, 2008.

[8] VHA Handbook 1907.01 *Health Information Management and Health Records*, September 19, 2012**.**

[9] MCM 119-001, *Bar Code Medication Administration*, July 30, 2010.

further post-AD care. However, of the six residents who remained on the unit, staff did not document the required post-episode BPs in five of the resident EHRs.

To further assess documentation and authentication of case events, we reviewed 10 residents' EHRs for 3 selected weeks during January–May 2012. We found varied compliance with documentation requirements, as shown on the graph below. The graph also includes findings from the facility's internal review of the LTC SCI unit's staff BCMA documentation.



Although, we found that documentation of an initial pain assessment occurred 100 percent of the time, documentation of pain reassessment (within 2 hours after pain medication was given) only occurred 13 percent of the time. Documentation of bowel care occurred 99 percent of the time. Areas where documentation fell below a 75 percent threshold included weekly nursing assessments (minimal standard of at least one nursing assessment per resident per week) and ADL notes for each shift. Documentation is an essential tool to communicate management of resident care with other healthcare providers.

However, some staff described documenting resident care as an ongoing issue because they believed it to be "over-documentation and overkill," placing a higher priority on documentation than direct resident care. Staff also described documentation challenges when residents repeatedly postponed their care or left the unit and did not

return in time for a scheduled assessment, such as the evaluation of a pain medication's effectiveness.

LTC SCI unit meeting minutes documented the NM's reminders to staff to complete and document assessments, resident showers, and other care. These reminders indicate that NMs were aware of care and documentation issues. However, we found no evidence that NMs took actions to address the problems.

Resident Care

We did not substantiate the allegation that staff neglected patients by frequently skipping showers and bowel care.

As illustrated in the graph above, showering and/or bed bath documentation occurred 75 percent of the time. Additionally, to assess residents' perception of whether showering and/or bed bath care was provided, we interviewed 18 LTC SCI unit residents.[10] Seventeen residents reported that they were routinely offered showers and/or bed baths. One resident's family member and several staff, including the unit housekeeper, described the LTC SCI unit's staff care as "good," and denied any neglect of hygiene. The facility's patient advocates reported visiting the LTC SCI unit regularly and hearing very few complaints regarding the quality of care.

IC

We did not substantiate that staff ignored IC procedures regarding feeding and linen.

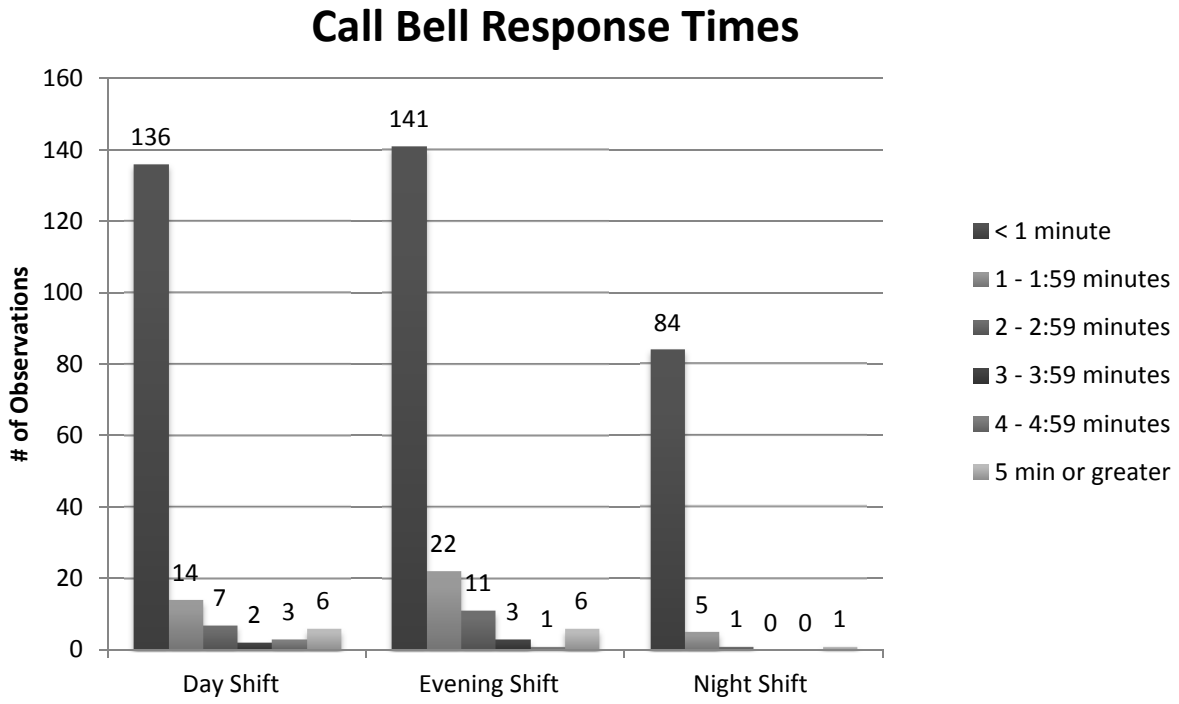
Local policy states that all personnel working with CLC residents will follow facility-wide IC procedures.[11] We conducted unannounced visits to the unit during mealtime and other care activities and observed no IC violations with resident feeding or linens scattered about the unit. The facility's infection preventionist confirmed that gloves are not normally required to feed residents when hand sanitization is practiced. We interviewed staff and residents and heard no reports of IC infractions. The annual training records showed that all LTC SCI unit staff were current with mandatory IC training. We also found no evidence of issues from the facility's recurring environment of care reports or IC Committee meeting minutes.

Call Bell Response

Call bells are communication devices used by the residents to summon or alert LTC SCI unit staff for assistance. Residents' call bell devices vary to accommodate their cognitive function and mobility of the upper extremities, such as an easy push-button or a specialized "sip and puff" or straw-like device. Once the resident activates the call bell system, the LTC SCI unit staff can answer the residents' call at the unit nursing station or at the resident's bedside. The time from activation of the call bell by the resident to the staff response is electronically recorded by the call bell system.

[10] Although the resident census was 26, not all patients were available or able to talk with us during our site visit.
[11] Facility's *CLC Infection Prevention and Control Policy*, March 23, 2011.

We reviewed electronic call bell response times over 6 days in May 2012, and the following graph illustrates the results from "call placed" to the initial "place answer."



The data showed that, across all shifts, staff answered 81 percent of call bells in less than 1 minute and the majority (97 percent) of all call bells in less than 5 minutes. However, staff took 5 minutes or longer to answer 13 (3 percent) calls. The longest call bell response time found in our sample was 17.4 minutes.

Issue 2: Management Issues

We partially substantiated that NMs did not take effective action to investigate or follow up on issues related to nursing staff conduct issues.

Time and Attendance Issues

We partially substantiated that some of the LTC SCI staff did not report for duty as scheduled or use leave appropriately.

Nursing leadership instituted an 8-hour schedule of 10 days per pay period, which typically necessitates split (versus consecutive) days off. Several LTC SCI unit nurses had formally requested to change to an alternative 12-hour schedule of 7 days per pay period, which they believed would allow them more days off to recover from the physical and emotional demands of the job and mirror the schedule of other units in the facility.

In our interviews, 13 of 16 LTC SCI unit staff members said that "call offs" (employee taking unscheduled leave[12]) contributed to problems with staffing, morale, and resident care. However, they asserted that only a few staff members abused leave in this way. LTC SCI unit meeting minutes documented the NM's reminders regarding unscheduled leave. These reminders indicated that NMs were aware of unscheduled leave issues. The Assistant NM reported working with a team of LTC SCI unit staff to address call off issues.

The following factors may have contributed to these time and attendance issues.

- Eleven LTC SCI unit employees filed reports of injuries from November 2011–June 2012. These injuries included back strain from positioning residents, a foot injury from a wheelchair running over it, contusions, and head trauma from a ceiling lift failure.
- Some staff were newly hired and earned fewer hours of leave than others earn.
- Sick leave and family leave related to illness or surgery.
- The need for physical and emotional recovery from the demands of the work.

One employee we interviewed told us that some employees were granted time off but were not charged leave. To investigate this, we compared 10 random weeks of handwritten leave entries, including sick or annual leave and compensatory time used, to the VA official time and attendance record. We found only minor discrepancies and all were attributable to clerical errors by the timekeeper.

Some staff had perceptions that a LTC SCI/CLC manager abused leave because of time sheet issues. However, we found that unofficial time sheets kept on the unit did not accurately reflect this manager's time and attendance. The nursing administration office maintains official time sheets for managers. When we compared the manager's official time and attendance record with the unit time sheet, we found discrepancies that incorrectly made it appear that the manager in question was not charged for leave taken. In fact, the manager had been correctly charged for leave taken.

Resident Care Rounds

LTC SCI NMs knew staff did not consistently conduct resident care rounds but did not take action to address the problem.

A change-of-shift report is a meeting between nursing staff members ending their tour of duty and those starting their tours of duty. Resident medical condition and care needs are discussed during these meetings. Local practice, as identified in nursing staff meeting minutes, requires the charge nurse or designee going off duty conduct "resident care rounds" with the charge nurse or designee coming on duty after the change-of-shift report. Resident care rounds are conducted to inspect the condition of each room and the resident if present in the room. The November 2011 and April 2012 LTC SCI unit staff meeting minutes document that the NMs were aware that staff were

[12] Unscheduled leave or "call off" is an unscheduled absence from work, which was not requested and approved in advance, such as sick leave or emergency annual leave.

not conducting change of shift rounds. However, NMs could not provide evidence to support any actions taken to address this issue

Staff Conduct

Managers knew that staff actions and conduct were not always consistent with VHA expectations but did not take effective action in response to misconduct.

VHA requires that employees "…maintain the highest standards of honesty, integrity, impartiality, conduct, and effectiveness. Whenever an employee's performance of duty or professional competence is determined to be unsatisfactory or when an employee's professional or personal conduct is not satisfactory, prompt and appropriate disciplinary or major adverse action, or other corrective action will be taken."[13]

A NM's staff meeting minutes document that the NM was aware of conduct issues and that the NM directed staff to comply with the LTC SCI unit's conduct rules and expectations as shown by the following examples:

> "Behavior-It is totally unacceptable for staff to be loud, aggressive, or threatening to other [sic] patients or staff members. If another employee acts out and creates a hostile work environment for others, the VA police need to be notified immediately. Call the nursing supervisor. […] Then afterwards you get on the computer and type up a Report of Contact to document the event accurately and timely."
>
> "If you don't want to care for SCI patients, I need a request for transfer to another area. There will be no exceptions to this. Failure to properly care for our SCI patients will result in progressive discipline."
>
> "Equipment-Already our new medication carts have been damaged… [sic] KEY BOARDS AND HOOKS. Our new wound cart and the cart [name] had donated are also damaged. This looks purposeful. If the identity of person or persons responsible is revealed, they may be charged with destruction of government property. I don't understand why anyone would do this. If you are that angry and/or unhappy-go see a therapist or leave. This is not a prison."

VHA outlines progressive discipline and actions for facilities to take to address misconduct.

An Assistant NM stated that she had verbally referred one staff member to the Employee Assistance Program for anger management issues. However, facility managers were unable to provide us with any documentation to support this referral.

[13] VA Handbook 5021/7, Part II, Chapter I, *Employee/Management Relations*, November 25, 2011.

LTC SCI Unit Nurse Staffing

We substantiated allegations that nursing staff on the LTC SCI unit were at times understaffed and other times overstaffed.

VHA's SCI & Disorders Handbook identifies the minimum number of unit nursing staff based upon the number of employees.[14] VHA also requires that NMs determine staffing levels using the Full Time Equivalent Calculator Tool. This tool includes a required minimum replacement factor of at least 1.2, which accounts for annual leave, sick leave, holiday leave, education offerings, and other administrative activities.[15] We found that the facility approved staffing levels of 42 full time employee equivalents, consistent with the SCI & Disorders Handbook. However, at the time of our inspection, the LTC SCI unit had seven staff vacancies according to the facility's September 2011 and May 2012 SCI Staffing and Bed Survey Reports.

When the SCI LTC unit schedule indicated insufficient staffing or employees took unscheduled time off, the NM used voluntary or mandatory overtime, along with staff from other areas of the facility (called "float staff") to make up the needed staff hours.

In the graphs below, we compared the facility's SCI Master Nurse Staffing Plan (benchmark) with the LTC SCI actual staffing across the three 8-hour shifts for April 17–May 17, 2012. The actual staffing included a combination of LTC SCI staffing, overtime hours, and float staff.

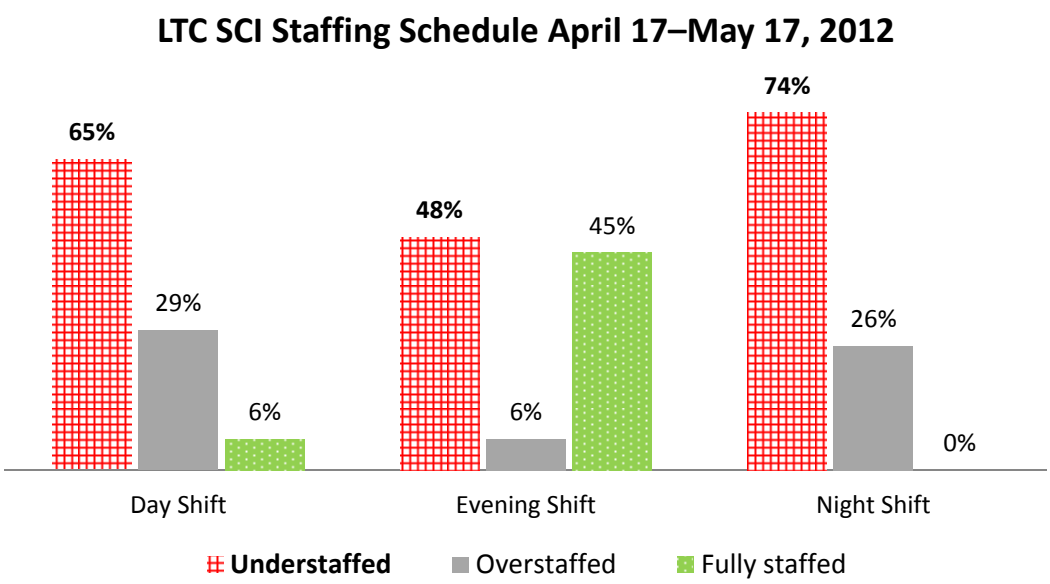
[14] VHA Handbook 1176.02, *Spinal Cord Injury and Disorders (SCI&D) Extended Care Services*, June 13, 2007.
[15] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

Facility data shows that during the period reviewed:

- April overtime usage was 175 hours (equating to approximately 22 8-hour shifts)
- May overtime usage was 486 hours(equating to approximately 61 8-hour shifts)
- May float staff usage was 116 hours (equating to approximately 15 8-hour shifts)

Despite the use of overtime and float staff, these comparison graphs demonstrate variations in staffing over the 31 days reviewed with a number of days where the number of staff needed did not meet the approved staffing levels for the LTC SCI unit.[16] The graph below summarizes the above data to demonstrate the percentage of time that the LTC SCI unit staffing was below, above, and in compliance with threshold levels.

[16] Day shift is 7:30 a.m.–4 p.m., evening shift is 3:30 p.m.–12 midnight, and night shift is midnight–8:00 a.m.



Overall, there was a preponderance of understaffing, with significant shortages of up to five employees on some days. Such understaffing compromises the ability of remaining staff to provide care. We recognize that employee use of unscheduled leave, employee special accommodation (such as light duty), and other variables can affect staffing. However, we could not determine from the available information whether there were abuses by management or staff in the overtime or unscheduled leave seen on the actual schedule. These scheduling issues are worthy of further investigation at the local level.

Inexperienced Nursing Staff

We substantiated the allegation that NMs operated the LTC SCI unit with some inexperienced nursing staff, including assignments of charge nurse.

VHA and The Joint Commission do not specifically address expectations or requirements regarding "experience" in this setting. However, they do require that the facility assess and document an employee's ability to carry out assigned responsibilities safely, competently, and timely at the completion of orientation. SCI resident care demands special nursing skills to manage complex ventilator, bowel, bladder, and psychological care, and to recognize and treat AD. We selected and reviewed the training records for 10 LTC SCI unit nursing staff members and confirmed that all had appropriate training, including initial and ongoing competencies.

We were told that several staff members were new to the nursing profession, caring for LTC SCI residents. LTC SCI unit staff meeting minutes reflected discussions regarding "experienced staff helping newer staff." We found that while some newer staff were periodically assigned charge nurse responsibilities, we did not find evidence of resulting problems with patient care or LTC SCI unit activities.

We also found that some float staff assigned to the LTC SCI unit were not experienced in working with the unique needs of SCI residents. An LTC manager explained that float staff had general nursing competencies but often did not have specialized SCI training and competencies. Therefore, the NMs assign the float staff to provide only "basic care rather than the specific care." The facility uses float staff during periods of short staffing to provide basic care to the LTC SCI residents; and while they alleviate some of the resident care responsibilities, this practice necessarily leaves all specialized care to the unit's regular staff.

Conclusions

We found that the LTC SCI unit's nurses did not consistently document post-medication pain reassessments, nursing assessments, and ADL notes. While staff answered the majority of resident call bells within 5 minutes or less, there is potential for improvement.

Reasons for these and other issues, such as "call-offs," appear to be related to frequent, and occasionally significant, staffing shortages, staff fatigue from working overtime hours, and the use of float staff who lack the training and competencies to work with this complex and challenging patient population. Further, unchecked staff misconduct likely negatively influences the unit's milieu. Importantly, we found that NMs did not take effective actions to follow up on issues related to nursing staff conduct issues.

Recommendations

Recommendation 1. We recommended that the Facility Director ensure that the staffing levels on the Long-Term Care Spinal Cord Injury unit be consistent with Veterans Health Administration's requirements and the facility's spinal cord injury Master Nurse Staffing Plan.

Recommendation 2. We recommended that the Facility Director ensure that Long-Term Care Spinal Cord Injury nursing staff consistently provide and document resident care.

Recommendation 3**.** We recommended that the Facility Director ensure that Long-Term Care Spinal Cord Injury nurse managers take action to investigate and address staff conduct related issues.

Recommendation 4. We recommended that the Facility Director ensure that float staff assigned to the Long-Term Care Spinal Cord Injury unit have the training and competencies required for the unit.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 22, 2013

From: Director, VA Healthcare System of Ohio (10N10)

Subject: **Healthcare Inspection – Nursing Care in the Community Living Center for Spinal Cord Injury, Louis Stokes VA Medical Center, Cleveland, OH**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for this thorough review and opportunity to improve our processes.

2. Please see the Cleveland VAMC response to Draft Report of the Healthcare Inspection of the Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio.

3. If you have any questions or need additional information, please contact Jane Johnson, Deputy Quality Management Officer, VISN 10 at (513) 247-4631.

(original signed by:)
Jack G. Hetrick
Network Director

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 22, 2013

From: Director Louis Stokes Cleveland VA Medical Center (541/00)

Subject: **Healthcare Inspection – Nursing Care in the Community Living Center for Spinal Cord Injury, Louis Stokes VA Medical Center, Cleveland, OH**

To: Director, VA Healthcare System of Ohio (10N10)

1. Thank you for the thorough review of the Nursing Care in the Community Living Center for Spinal Cord Injury at the Louis Stokes VA Medical Center, Cleveland, Ohio. Immediate actions have been taken to address the recommendations.

2. Please see the Cleveland VAMC response to Draft Report of the Healthcare Inspection of the Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio.

3. If you have any questions or need additional information, please contact Kristen Guadalupe, PhD, RN Chief, Quality Management at (216) 791-3800 extension 3456.

(original signed by:)
Susan M. Fuehrer

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that the staffing levels on the long-term care spinal cord injury unit be consistent with Veterans Health Administration's requirements and the facility's spinal cord injury Master Nurse Staffing Plan.

Concur

Target date for completion: Completed May 17, 2013

Facility response: Long Term Care (LTC) Spinal Cord Injury (SCI) unit staffing levels monitored via a daily review of census and staff assignment sheets by the SCI-LTC Associate Chief Nurse and Nurse Manager. The Nursing Service FTEE tracker is maintained by the Nurse Recruiter. Staffing vacancies and recruitment consistently reviewed by and discussed with the Associate Director of Patient Care Services and Medical Center Director. Current staffing on the LTC SCI unit includes 20 Registered Nurses (RN), 14 Licensed Practical Nurses (LPNs), and 8 Nursing Assistants (NA). An NA was selected on May 12, 2013 to bring the total NA FTEE to nine. A newly hired RN is scheduled to come on board in June 2013. There are currently no vacancies and staffing patterns are consistent with VHA requirements and facility Master Nurse Staffing Plan.

Recommendation 2. We recommended that the Facility Director ensure that long-term care spinal cord injury nursing staff consistently provide and document resident care

Concur

Target completion date of audit-August 30, 2013. Implementation of this recommendation is still in progress.

Facility response: The LTC SCI unit staff was educated during centralized orientation on documentation requirements specific to the CLC. Documentation requirements include the RN weekly Assessment, Activities of Daily Living (ADL) shift note, and documentation of pain assessment/reassessment. Quality Management (QM) will conduct a weekly medical record review of documentation of nursing care provided to Wade Cares Tower Level B (WCTB) patients. The monthly QM audit will begin June 1, 2013 through August 30, 2013. The denominator will equal the total number of LTC SCI patients on WCTB. The numerator will equal the number of LTC SCI patients with timely documentation of nursing care in RN weekly notes and ADL shift notes. Audit results will be reviewed for trends associated with specific individuals or shifts. Audit results with action plans for all deficiencies will be reported and monitored monthly by QM at the Executive Leadership Board (ELB) until 90% for 90-days. The Nursing

Performance Improvement (PI) Coordinator will continue monthly monitoring of randomly sampled medical records following 90% for 90-days. Results of the QM and Nursing PI Coordinator review will be shared by the LTC SCI Associate Chief Nurse and Nurse Manager with staff at the CLC PI Council meeting and WCTB staff meetings.

Recommendation 3. We recommended that the Facility Director ensure that LTC SCI nurse managers take action to investigate and address conduct related issues.

Concur

Target date for completion: Completed-May 17, 2013. Conduct and disciplinary related issues being addressed promptly per policy.

Facility response: The LTC SCI Associate Chief Nurse reviewed Medical Center Policy (MCP) 005-005 entitled "Discipline and Adverse Actions" with the LTC SCI Nurse Manager. The LTC SCI Associate Chief Nurse and Nurse Manager meet weekly to discuss staff issues related to conduct or performance. The weekly discussion also provides a forum for positive recognition of staff going above and beyond to provide safe, quality care to Veterans on the LTC SCI unit. Since 2012, the LTC SCI Nurse Manager has investigated four issues related to conduct and performance. Unscheduled leave continues to present a challenge in maintaining staffing levels. The Nurse Manager works closely on a weekly basis with Employee Labor Management to review staff conduct and performance issues on the LTC SCI unit. In the spirit of continuing to foster a cohesive team environment on the LTC SCI unit, the Medical Center Director approved training by John Fuller, VHA Office of Diversity for June or July 2013.

Recommendation 4. We recommended that the Facility Director ensure that float staff assigned to the long-term care spinal cord injury unit have the training and competencies required for the unit.

Concur

Target completion date-June 28, 2013. Implementation of this recommendation is in progress.

Facility response: To ensure safe, competent care on the LTC SCI unit a decision to gradually admit long-term SCI patients to WCTB was made prior to opening the unit, thus gradually increasing the census of this specialized population. The decision to phase in slowly the SCI WCTB admissions over a 12-month period allowed time for competency evaluation of permanent staff. All 2013 required population specific competencies for permanent LTC SCI staff are complete. Population-specific training of float pool staff is in process. Currently, there is training underway for four additional float pool staff to be fully cross-trained.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Donald Braman, RN (Team Leader) Melanie Oppat, MEd, LDN (Project Leader) Margie Chapin, RT (R), JD Nathan Fong, CPA, CFE Terri Julian, Ph.D. Alan Mallinger, M.D., Physician Consultant Nelson Miranda, LCSW Joanne Wasko, LCSW

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare System of Ohio (10N10)
Director, Louis Stokes Cleveland VA Medical Center (541/00)

Non-VA Distribution

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House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Senate Committee on Homeland Security and Governmental Affairs
Related Agencies
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Sherrod Brown, Rob Portman
U.S. House of Representatives: Marcia L. Fudge

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