Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01241-250

Healthcare Inspection

Provider Availability
VA Roseburg Healthcare System
Roseburg, Oregon

July 18, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to complaints about the quality of inpatient care at the VA Roseburg Healthcare System, Roseburg, OR. The complainant alleged that on-call hospitalists live too far away from the facility to provide onsite care between the hours of 7:00 p.m. and 7:00 a.m. and therefore only provide orders that temporized care until the hospitalist arrived at 7:00 a.m. The complainant alleged that the inpatient nursing staff was unable to secure medical intervention and that patients failed to receive prompt care from 7:00 p.m. until 7:00 a.m. unless they were to deteriorate to the point of requiring a full medical code.

We did not substantiate the allegation that hospitalists on-call lived too far away to provide onsite care overnight. We found that hospitalists are available from 7:00 a.m. to 7:00 p.m. after which the system utilizes a tiered system of medical coverage that includes onsite care. Hospitalists do not work the evening or night shift nor do they work in an on-call capacity.

We did not substantiate the allegation that inpatient nursing staff was unable to secure medical intervention between the hours of 7:00 p.m. and 7:00 a.m. We found that nursing staff had a number of options to ensure care for the veterans. A second on-call (SOC) process is in place for routine, non-emergent issues that arise. For patients with more immediate care needs, the nurses have access to the emergency department staffed by the medical officer of the day, the rapid-response team, and the code system.

We identified issues in hand-off communication from the hospitalist to the SOC. We also determined that incomplete admission orders resulted in night-shift nurses needing to call the SOC. We found that facility leadership was aware of these problems and was committed to addressing them.

We made no recommendations.

The Veterans Integrated Service Network and Facility Director concurred with the report.

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 that hospitalists on-call between the hours of 7:00 p.m. and 7:00 a.m. live too far from the inpatient facility to provide onsite care and therefore only provide temporizing orders over the phone until the hospitalist arrives at 7:00 a.m., that inpatient nursing staff is unable to secure needed medical intervention, and that veterans failed to receive prompt care from 7:00 p.m. until 7:00 a.m. unless the veteran deteriorated to the point of requiring a full medical code.

Background

VA Roseburg Healthcare System (system) is part of Veterans Integrated Service Network (VISN) 20. The system provides care for veterans residing in central and southern Oregon and northern California. The main campus includes an emergency department, community living center, and provides primary care and hospital services in medicine, surgery, and mental health. The system has four CBOC's in the state of Oregon including two located in Eugene, one in Brookings and one in North Bend.

The system is a designated Veteran Rural Access Hospital with no Intensive Care Unit and a low volume emergency department. A waiver was granted in calendar year 2012 to allow the emergency department physician to cover acute cardiopulmonary and respiratory emergencies on the inpatient units when the hospitalist is not on duty. This process is a change from prior practice when the system utilized 24-hour daily hospitalist coverage for inpatient medical care.

Scope and Methodology

We conducted a site visit March 26–27, 2013.

We interviewed the system's Associate Director, Chief of Staff, Chief of Medicine, Deputy Nurse Executive, and Accreditation Coordinator, and we interviewed inpatient staff from the night shift. We reviewed relevant facility policies and procedures, utilization data, on-call schedules, and incident reports. We toured the environment of care relevant to the complaint.

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: Provider Proximity to Main Facility

We did not substantiate the allegation that hospitalists on-call lived too far away to provide onsite inpatient care overnight. Hospitalists are scheduled and available onsite 7:00 a.m. to 7:00 p.m. seven days a week. Beginning at 7:00 p.m. each day, the Medical Officer of the Day (MOD) provides bedside response to inpatient medical emergencies and is available to provide less urgent inpatient assessments in the emergency department. In addition to the MOD, a 24-hour call schedule comprised of main facility and CBOC providers is in place to cover inpatient care and come to the system should the need arrive. The providers on this schedule are referred to as the second on-call (SOC) and serve as back-up to the hospitalists and the MOD. The role of the SOC is to provide routine, non-urgent medical orders or consultations for inpatients. We confirmed that providers from the Eugene CBOC were on the SOC rotation, as are providers from the system's other 3 CBOCs. These providers live more than an hour away from the main inpatient facility. However, the system indicated that these providers were not expected to provide onsite immediate care. If a nurse determines that an inpatient bedside medical assessment is warranted on the night shift, the nurse is supposed to call the Administrative Officer of the Day (AOD). The AOD contacts the SOC, and if the SOC is not available for onsite care, the AOD contacts specified physicians who live in close proximity to the inpatient facility.

We were not provided examples of patient specific cases supporting the allegation of telephone orders being provided to forestall or temporize care. Nursing staff reported instances of delays in orders such as pain medications and diet menus; however, these were not attributed to the lack of physician proximity to the facility. Rather, these were related to incomplete admission orders and the responsiveness of the SOC.

Staff identified two instances in the prior twelve months when a provider was needed onsite for non-emergency care during the 7:00 p.m. to 7:00 a.m. timeframe. In both of these instances, the patient was on a medical ward and was in behavioral restraints that required a provider to reassess the patient and write new orders every four hours. The AOD was able to reach a provider to perform these duties.

Issue 2: Access to Care and Alleged Lack of Available Medical Care

We did not substantiate the allegation that nursing staff were unable to secure medical intervention between the hours of 7:00 p.m. and 7:00 a.m. We found that inpatient nursing staff had a number of options to ensure care for the veterans in this situation. The SOC process is in place for routine, non-emergent issues that arise. For patients with more immediate care needs the nurses have the emergency department, MOD, rapid-response team, and code system available. We discussed these options with the night staff and they confirmed the success with which these options worked.

Other Findings:

We found that the system triages patients and admits only those with an acuity level consistent with available services. The system has community partnerships in place to provide treatment to patients requiring higher-level care.

We identified issues in hand-off communication from the daytime hospitalist to the SOC that impacted the efficiency with which the SOC addressed inpatient needs when contacted by nursing. We also found that incomplete daytime admission orders often resulted in night-shift nurses needing to call the SOC to secure additional orders. We found that facility leadership was aware of these problems and was committed to addressing them.

Conclusions

We did not substantiate the allegations.

In summary, we found that the system admitted only those patients with an acuity level appropriate to that for which they were staffed and had the infrastructure/technology to handle and that the system had processes in place to manage the care of inpatients on all shifts.

We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 21, 2013

From: Director, VA Northwest Health Network (10N20)

Subject: **Healthcare Inspection – Provider Availability, VA Roseburg Healthcare System, Roseburg, OR**

To: Department of Veterans Affairs, Office of the Inspector General

As the Director of VISN 20 I concur with the response from Roseburg that they agree with the report in its entirety with no changes.

(original signed by:)

Lawrence H. Carroll

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 11, 2013

From: Director, VA Roseburg Healthcare System

Subject: **Healthcare Inspection – Provider Availability, VA Roseburg Healthcare System, Roseburg, OR**

To: Department of Veterans Affairs, Office of the Inspector General

Director, VA Northwest Health Network (10N20)

VA Roseburg Healthcare System concurs with this report in its entirety.

(*original signed by:*)

Carol S. Bogedain, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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