Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01119-168

Healthcare Inspection

Community Living Center Patient Care Gulf Coast Veterans Health Care System Biloxi, Mississippi

May 28, 2014

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 allegations of inadequate Community Living Center (CLC) physician staffing, improper supervision of surgical residents, refusal of nursing staff to provide care to CLC patients, a lack of action by the system in response to quality of care concerns, and poor quality of care provided in the Emergency Department at the Gulf Coast Veterans Health Care System, Biloxi, MS.

We substantiated that physician staffing in the CLC, which is part of the Extended Care Service, is inadequate. We found that the CLC currently only has one physician, who is the chief of the service. The Extended Care Service has four physician vacancies and no ongoing active recruitment for these vacancies.

We did not substantiate that surgical residents were not properly supervised, that nursing staff refused to provide care to CLC patients, that the system did not respond appropriately when quality of care concerns were raised, or that CLC patients received poor quality of care when transferred to the Emergency Department.

We recommended that the System Director actively recruit and fill approved physician vacancies within the Extended Care Service.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 7–9 for the Directors' comments.) We will follow up on the planned action until it is 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 review allegations of inadequate Community Living Center (CLC) physician staffing, improper supervision of surgical residents, refusal of nursing staff to provide care to CLC patients, a lack of action when quality of care concerns were raised, and poor quality of care provided in the Emergency Department (ED) at the Gulf Coast Veterans Health Care System (system), Biloxi, MS. The purpose of the review was to determine if the allegations had merit.

Background

System and CLC Profiles. The system is part of Veterans Integrated Service Network (VISN) 16 and serves over 63,000 veterans. The system provides comprehensive health care in primary care, medicine, surgery, psychiatry, psychology, neurology, oncology, dentistry, geriatrics, extended care, and physical medicine and rehabilitation. The system operates community based outpatient clinics in Mobile, AL; Pensacola, Panama City, FL; and at Eglin Air Force Base, FL.

The CLC comprises 8 units with 12 beds (96 total beds), including 2 dementia care units, 2 short-stay or rehabilitation care units, 3 long-term care units, and 1 hospice and palliative care unit. The system's Extended Care Service (EC) manages the CLC. Six full-time employee equivalent (FTE) physicians are allocated to EC to cover the Office of the EC Chief, the Biloxi Division, and three of the community based outpatient clinics. The Office of the Chief has one approved physician FTE position to serve as the service chief. The Biloxi Division has four approved physician FTE positions in the CLC, which are designated to provide care within the CLC units, as well as to community programs, such as Home Based Primary Care. The Pensacola Division has one approved and filled physician FTE who also covers one of the current Biloxi Division physician vacancies for community programs.

Resident Supervision. Veterans Health Administration (VHA) actively supports and provides an environment for the training of physician, dental, podiatry, optometry residents, and other allied health students. Within the scope of the accredited training program, physicians in training must function under a supervising practitioner.[1] The patient's record must clearly demonstrate the involvement of the supervising practitioner. VHA[2] and local policy outline the four types of permissible documentation of resident supervision in the inpatient setting:

- Progress note or other entry into the electronic health record (EHR) by the supervising practitioner.
- Addendum to the resident progress note by the supervising practitioner.

[1] A supervising practitioner is responsible for the care provided by residents to individual patients in all clinical settings.
[2] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

- Co-signature of the progress note or other EHR entry by the supervising practitioner.
- Resident progress note or other EHR entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment.

Allegations. The complainant contacted the OIG in December 2013 and January 2014 with the following allegations:

- There are inadequate physicians to care for the number of CLC patients.
- Surgical residents are not properly supervised.
- CLC nurses and nursing support staff refuse to or do not provide direct patient care services, specifically citing:
  - A nurse lied about providing medication and withheld a patient's narcotic.
  - A nurse failed to properly administer an inhaled medication.
  - A licensed practical nurse (LPN) has refused to dispense medications at night and threatened veterans with retaliation if they complain.
  - Nursing assistants refuse to change veterans' soiled diapers.
- The system does not take action when quality of care concerns are raised.
- CLC patients received poor quality of care when transferred to the ED.

Scope and Methodology

We interviewed the complainant prior to conducting a site visit on January 14–16, 2014. During our site visit, we interviewed system leadership, staff involved in direct patient care in the CLC and ED, and staff involved in quality management programs. We reviewed VHA directives, relevant system policies and procedures, EHRs, Human Resources Management Service recruitment documents, and CLC patient care quality indicator data. We also inspected all units of the CLC.

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: Inadequate CLC Physician Staffing

We substantiated the allegation of inadequate physician staffing to care for patients in the CLC. We reviewed the EC organizational chart, including the list of EC physician positions approved by facility leadership in August 2013. We reviewed the system's Human Resources Management Service list of approved positions to recruit and the CLC's current census. During our onsite visit, the CLC's census was 75 patients.

We found that current EC physician staffing included the Chief of EC and a physician at the Pensacola Division who managed the Home Based Primary Care program. The Pensacola Division physician was also serving in an acting capacity as the Biloxi Division physician managing community programs.

In addition to the Chief of EC, we found that four nurse practitioners (NPs) were providing care to CLC patients. However, in this facility, NPs are dependent providers and cannot independently provide all the functions required in the CLC. The NPs were not available for patient care issues after hours, and although all four CLC NP positions were filled, a full complement of NPs was not available for many months due to approved absences.

Additionally, system policy required verbal physician-to-physician communication when a patient transferred between levels of care. Therefore, the CLC physician was responsible for handoff communication to the ED physician when a CLC patient was sent to the ED for evaluation.

The system had developed an action plan to support CLC staffing, which included assigning Medical Service hospitalist staff, who did not routinely practice in the CLC setting, to the CLC for limited times on a rotating basis. To decrease staffing needs, the system was also reducing the CLC census by attrition on all units, except the hospice/palliative care unit, until the EC service is appropriately staffed. At the time of our visit, all eight units were open.

We found that no active Human Resources Management Service recruitments were in progress for the four vacant CLC physician positions.

Issue 2: Improper Supervision of Surgical Residents

We did not substantiate the allegation that surgical residents were not properly supervised. We reviewed all 46 inpatient surgical consults initiated in the CLC for fiscal year 2013. We found documentation of resident supervision (co-signature of progress notes by the supervising physician) in all the consults reviewed.

Additionally, while we were reviewing the EHRs of the patients in the ED for Issue 5, we also reviewed surgical progress notes for care provided in the ED by surgical

residents and found the required documentation elements for resident supervision in all the reviewed records.

During our interviews, we were told that a surgical resident sees patients in the CLC every Saturday for regular follow-up. The resident then discusses the patients with the surgical supervising attending physician the following Monday morning.

Issue 3: Staff Refusal to Provide Care

We did not substantiate that nursing staff refused to provide direct patient care to CLC patients. We interviewed the nurse managers of each CLC inpatient unit and members of the nursing staff on the CLC's day, evening, and night shifts. We also reviewed care quality indicator data for CLC patients from fiscal year 2013 and inspected each inpatient unit in the CLC.

We did not find evidence that a nurse lied about providing medication and withheld a patient's narcotic. We reviewed the EHR of the identified patient who was admitted to the CLC for respite care. The nurse, who was familiar with the patient from previous respite care admissions, reviewed the patient's medications and adjusted the timing of the administration of three sedating medications to avoid over sedation. We found documentation that the nurse provided the patient with all ordered medications.

We did not find evidence that a nurse failed to properly administer an inhaled medication. We reviewed the EHR of the patient involved in the allegation and found that the medication was administered as ordered by the physician.

We did not find evidence that an LPN had refused to dispense medications at night and threatened veterans with retaliation if they complained. We interviewed all nursing management staff for the CLC as well as nursing staff from all three tours of duty and each specialty area in the CLC. No one interviewed had knowledge of an LPN refusing to dispense medications at night or threatening patients with retaliation if they complained.

We did not find evidence to support the allegation that nursing assistants refused to provide continence care for patients. During our interviews, all staff reported that they made regular rounds every 2 hours and as needed to determine if patients needed continence or other care. Staff reported answering patient call lights and responding to family requests to meet patient needs when initiated.

We reviewed CLC pressure ulcer and wound care data from October 2013 through January 10, 2014. We did not find a significant number of post-admission sacral coccygeal pressure ulcers. We found documentation that patients with pressure ulcers were being monitored and receiving wound care. While touring the units, we did not encounter patients in need of care, foul odors, or staff who appeared to be unengaged.

We found that the CLC was neat and clean. The units were painted with various colors and decorated with non-institutional objects such as a fireplace, dining table, and lamps

to provide a home-like atmosphere. We found some patients up and participating in activities, while others were sleeping, appearing comfortable in their beds.

Issue 4: System Inaction to Reported Quality of Care Concerns

We did not substantiate the allegation that the system failed to take action in response to quality of care concerns. We interviewed system staff and leadership involved in direct patient care, patient safety, risk management, and quality management and reviewed documents that included the facility's responses to various reported quality of care concerns. We found that the system took actions for reported concerns, utilizing appropriate supervisory and quality management options.

Issue 5: Poor Care in ED

We did not substantiate the allegation that CLC patients received poor quality of care when transferred to the ED.

When CLC patients required urgent care, they were transferred to the ED for evaluation and/or for consultation from other services. If the ED physician requested a surgical consult, surgical service residents came to the ED to evaluate the patient. Supervising attending surgeons would see the patient in the ED when indicated. Without the full complement of CLC physicians, many patients were transferred to the ED where the ED physicians provided primary care evaluations and consultations.

We reviewed the EHRs for six patients who were identified as having difficulty getting ED and/or surgical care after transfer from the CLC. We did not find evidence from either the record review or staff interviews that the patients received poor care in the ED.

Conclusions

We substantiated the allegation that the system did not have enough physicians to care for the patients in the CLC. The complexity of the patients' medical needs on the eight units varied and required different physician expertise. These medical needs are reflected in the number of approved physicians for EC. One physician cannot meet the demands as a service chief and the needs of all CLC patients 24 hours a day and 7 days a week.

The CLC has not been fully staffed with physicians for more than 2 years, and during our visit, we found no active recruitment for the four approved FTE physician positions in EC. The limited help offered to the CLC for physician coverage is not adequate to meet the patient care needs. Rotating various acute care staff through the CLC does not provide the specialized continuity of care needed for the long and short-term care of patients in the CLC.

We did not find that surgical residents were not appropriately supervised. We reviewed all surgical consults placed in the CLC, as well as surgical progress notes in the EHR on

patients reported as not receiving appropriate ED care, and did not find evidence to support this allegation.

We did not find evidence that the nursing staff refused to care for patients, refused to give them medications, or threatened them.

We did not find that the system ignored concerns about quality of patient care. We found that the system and quality management service took appropriate actions when concerns were reported.

We did not substantiate that patients received poor care in the ED. During our EHR reviews of patients who were reported to have not received quality care in the ED, we found that the ED physicians provided appropriate care, made recommendations to the CLC providers, generated consults to specialty services, and that specialty services evaluated patients in the ED as requested.

System leadership had recently reviewed and approved physician positions in EC to meet the diverse demands of the populations served. However, leadership has not ensured that an appropriate number of physicians was consistently present in EC or that Human Resources Management Service actively recruits EC physicians to fill the vacancies.

Recommendation

Recommendation 1. We recommended that the System Director actively recruits and fills approved physician vacancies within the Extended Care Service.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 29, 2014

From: Director, South Central VA Health Care Network (10N16)

Subject: **Draft Report—Healthcare Inspection—Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi**

To: Director, Dallas Regional Office of Healthcare Inspections (54DA)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I concur with the findings and conclusions identified in the Office of Inspector General's Report for the Community Living Center at the Gulf Coast Veterans Health Care System, Biloxi, MS.

2. If you have any questions or need additional information, contact Reba T. Moore, VISN 16 Accreditation Specialist, at (601) 206-7022.

Lynn Ryan
Deputy Network Director

For and on behalf of

Rica Lewis-Payton, MHA, FACHE
Director, South Central VA Health Care Network (10N16)

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 29, 2014

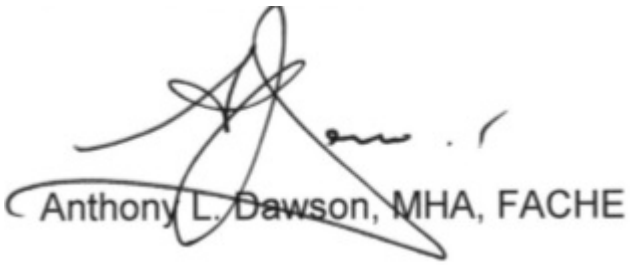
From: Director, Gulf Coast Veterans Health Care System (520/00)

Subject: **Draft Report—Healthcare Inspection—Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi**

To: Director, South Central VA Health Care Network (10N16)

1. I concur with the draft report and the identified recommendation made as a result of the Health Inspection review conducted at Gulf Coast Veterans Health Care System.

2. Action to address the recommendation has been initiated with a targeted completion date of September 30, 2014.



Comments to OIG's Report

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

OIG Recommendation

Recommendation 1. We recommended that the System Director actively recruits and fills approved physician vacancies within the Extended Care Service.

Concur

Target date for completion: September 30, 2014

System response:

The process of recruiting to fill physician vacancies within the Community Living Center has commenced. As of this date, we have selected two staff physicians for this patient care area. Both are currently undergoing credentialing and privileging and are expected to be on board by August 1, 2014. Recruitment and hiring will continue until the four vacancies are filled.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Cathleen King, MHA, CRRN, Team Leader Larry Ross, MS Jerome Herbers, MD Misti Kincaid, BS, Management and Program Analyst

Appendix D

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