



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-04702-60

Healthcare Inspection

Alleged Insufficient Staffing and Consult Management Issues Carl Vinson VA Medical Center Dublin, Georgia

January 7, 2015

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 Office of Healthcare Inspections conducted an inspection in response to a confidential complaint from a third party on behalf of several medical center employees regarding allegations of insufficient staffing and consult management issues at the Carl Vinson VA Medical Center (facility), Dublin, GA.

We substantiated that telemetry technicians monitor telemetry patients without registered nurse supervision; however, we did not find this practice to be improper. According to facility policy, telemetry technicians or intensive care unit nurses monitor telemetry patients.

We did not substantiate the allegation that when nursing assistants provided close observation (visual monitoring of a patient every 10–15 minutes), it increased the nursing assistant's likelihood of being injured. The complainant expressed concern that the rounding would increase the possibility of job-related injuries. For fiscal year 2014, as of September 16, 2014, unit 8A East had two job-related injuries, neither of which was related to close observation of patients.

We substantiated the allegation that at times unit 8A East staff scheduled for the midnight tour worked shifts other than their regularly scheduled tours of duty. However, the facility nursing standard operating procedures state that tour changes, compensatory time, and overtime are to be used to assure adequate staffing when reassignment of staff from another area is not feasible.

We did not substantiate the allegation that the 8A East midnight tour had a staffing mix of 1 registered nurse and 2 nursing assistants to care for 28 patients. We reviewed the August 2014 8A East staffing assignments but found no evidence of a staffing mix of one registered nurse and two nursing assistants. The typical staffing mix for the midnight tour reflected one registered nurse, one licensed practical nurse, and two nursing assistants.

We did not substantiate the allegation that Non-VA Care Coordination staff members assigned to a consult clean-up project were not properly trained to process backlogged Non-VA Care Coordination consults. In June 2014, the Chief of Health Administration Service sent an email to several employees involved in consult clean-up efforts that provided detailed instructions on how to discontinue, schedule, and complete unresolved Non-VA Care Coordination consults. We found the email instructions aligned with Non-VA Care Coordination standard operating procedures and that staff were aware of who they could contact if they had questions.

We made no recommendations.

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes A and B, pages 6–7, for the Directors' comments.) No further action is required.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections assessed allegations concerning staffing and consult management issues at the Carl Vinson VA Medical Center (facility) located in Dublin, Georgia. The purpose of the review was to determine whether the allegations had merit.

Background

The facility is designated as a Veterans Rural Access Hospital located in Dublin, GA. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of approximately 125,000 throughout 52 counties in Georgia.

The facility operates 34 acute care beds (Intensive Care Unit [ICU] and unit 13B/15B), 161 community living center (CLC) beds (8A East, 8A West, 17B, 12A, and 10A), and 145 domiciliary beds.

Allegations

In July 2014, the OIG received a confidential complaint from a third party on behalf of several medical center employees alleging that:

- Telemetry technicians monitor machines in the ICU and on Medical/Surgical Unit 13B without registered nurse (RN) supervision.
- When nursing assistants (NAs) provide close patient observation, it increases the NAs' likelihood of being injured.¹
- Due to short staffing, unit 8A East CLC staff scheduled for the midnight tour are required to work shifts other than their regularly scheduled tours of duty, and 1 RN and 2 NAs care for 28 patients.
- Some staff members have not been properly trained to close out backlogged Non-VA Care Coordination (NVCC) consults.

Scope and Methodology

We reviewed relevant Veterans Health Administration (VHA) guidelines and facility policies and procedures related to telemetry, protective patient observations, and staffing; the facility's nurse staffing methodology, 24-hour nurse staffing schedules, and vacancy rates for unit 8A East; NAs' position description, telemetry technicians' competency evaluations, and unit 8A East NA's job related injuries.

¹ In the initial written allegation, the complainant reported that NAs do not conduct 1:1 patient observation due to short staffing. Upon interview, the complainant clarified the issue as described here. According to facility policy, close patient observation requires visual observation every 10–15 minutes, and 1:1 patient observation requires continual physical or visual contact.

We conducted phone interviews with the complainant, a telemetry health technician, the Chief of Health Administration Service (HAS), the nurse manager for ICU and 13B, and the nurse manager for 8A East.

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: Telemetry Monitoring

We substantiated that technicians monitor patients on telemetry without RN supervision; however, we did not find this practice to be improper.

Telemetry provides a continuous electrocardiogram reading of the heart's electrical activity through external electrodes placed on the patient's body. Monitoring staff are able to observe the telemetry data through a centralized surveillance device, acknowledge alarms, and notify the nurses responsible for the patient's care of heart rate or rhythm abnormalities. According to facility policy, telemetry technicians or ICU nurses may monitor telemetry patients.² The facility's ICU nurse manager informed us that technicians have to demonstrate competency prior to monitoring telemetry patients. We reviewed the telemetry technicians' competency assessments and confirmed the requirement of an initial and yearly clinical and technical competency on telemetry patient monitoring.

Issue 2: Patient Observation

We did not substantiate the allegation that when NAs provided close patient observation, it increased the NAs' likelihood of being injured. The complainant explained that NAs were conducting close observation of specified patients, requiring the NAs to make constant rounds from one patient to the next every 10–15 minutes. The complainant expressed concern that the rounding would increase the possibility of job-related injuries. We found that the NA job description reflects that the work "involves considerable walking and standing" and that the incumbent accepts assignments in "whatever area services are required." The complainant was not aware of staff or patient injuries related to close observation; this was confirmed with the nurse manager who informed us that unit 8A East has not had patients requiring close observation since December 2013. Additionally, for fiscal year 2014, as of September 16, 2014, unit 8A East had two job-related injuries, neither of which was related to close observation of patients.

Issue 3: Staffing

We substantiated the allegation that at times, unit 8A East staff scheduled for the midnight tour worked shifts other than their regularly scheduled tours of duty. However, facility nursing standard operating procedures state that tour changes, compensatory time, and overtime are to be used to assure adequate staffing when reassignment of staff from another area is not feasible.³ Therefore, nurse managers may assign nurses who typically work the midnight shift to cover the day shift instead, or vice-versa, to assure appropriate nurse staffing.

² Carl Vinson VAMC Memorandum 00-280, *Telemetry Monitoring on Acute Medical Surgical Units*, May 20, 2013.

³ Carl Vinson VAMC Nursing SOP 00-11, *Staffing Methodology and Staffing Practices*, September 16, 2013.

We did not substantiate the allegation that the 8A East midnight tour had a staffing mix of 1 RN and 2 NAs to care for 28 patients. VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*,⁴ requires facilities apply a nationally standardized methodology process to determine staffing for VA nursing personnel for all inpatient points of care.⁵ This includes defining the target nursing-hours-per-patient-day (NHPPD) and the number of required employees for specific care settings to ensure adequate nursing personnel.

In April 2014, facility managers revised and approved a staffing plan for unit 8A East with a target NHPPD of 6.0 and minimum staffing guidelines of 8 RNs, 12 licensed practical nurses (LPNs), and 13 NAs. We assessed the staffing plan and patterns based on the 8A East's targeted NHPPD and the actual NHPPD based on patient census. We found that from April through August 2014, the NHPPD consistently increased from 5.3 to 5.80. Although the NHPPD fell below the target, it was within the facility's 15-percent deviation range from a low of 5.1 to a high of 6.9. Additionally, we reviewed the August 2014 8A East staffing assignments but found no evidence of a staffing mix of one RN and two NAs. The typical staffing mix for the midnight tour reflected one RN, one LPN, and two NAs.

Issue 4: NVCC Consults

We did not substantiate the allegation that non-NVCC staff members assigned to the consult clean-up project were not properly trained to process backlogged NVCC consults. In June 2014, the Chief of HAS sent an email to employees involved in consult clean-up efforts that provided detailed instructions on how to discontinue, schedule, and complete unresolved NVCC consults. This email also appointed a project-lead person and copied several supervisors. We found the email instructions aligned with NVCC standard operating procedures and that staff were aware of who they could contact if they had questions.

Conclusions

We substantiated the allegation that telemetry technicians monitor patients on telemetry without RN supervision; however, we did not find this practice to be improper. According to facility policy, telemetry technicians or ICU nurses monitor telemetry patients.

We did not substantiate the allegation that when NAs provided close observation, it increased their likelihood of being injured. The complainant explained that NAs were conducting close observation of specified patients, requiring the NAs to make constant rounds from one patient to the next every 10–15 minutes. The complainant expressed concern that the rounding would increase the possibility of job-related injuries. We found that the NA job description reflects that the work “involves considerable walking

⁴ VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

⁵ Staffing methodology is a process for determining staffing levels based on an analysis of multiple variables to include patient or resident needs, environmental and organizational supports, and professional judgment to recommend safe and effective staffing levels at various points of care.

and standing” and that the incumbent accepts assignments in “whatever area services are required.” Additionally, for fiscal year 2014, as of September 16, 2014, unit 8A East had two job-related injuries neither of which was related to close observation of patients.

We substantiated the allegation that, at times, unit 8A East staff scheduled for the midnight tour worked shifts other than their regularly scheduled tours of duty. However, facility policy states that tour changes, compensatory time, and overtime are to be used to assure adequate staffing when reassignment of staff from another area is not feasible.

We did not substantiate the allegation that the 8A East midnight tour had a staffing mix of 1 RN and 2 NAs to care for 28 patients. The usual 8A East staffing assignment for the midnight tour included one RN, one LPN, and two NAs.

We did not substantiate the allegation that non-NVCC staff members assigned to the project were not properly trained to process backlogged NVCC consults. In June 2014, the Chief of HAS sent an email to employees involved in consult clean-up efforts that provided detailed instructions on how to discontinue, schedule, and complete unresolved NVCC consults. We found the email instructions aligned with NVCC standard operating procedures and that staff were aware of who they could contact if they had questions.

We made no recommendations.

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: December 3, 2014

From: Director, Veterans Integrated Service Network (10N7)

Subject: **Draft Report**—Healthcare Inspection—Alleged Insufficient Staffing and Consult Management Issues, Carl Vinson VA Medical Center, Dublin, GA

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

1. Thank you for the opportunity to review the allegations from the OIG Hotline as well as the thorough assessment.
2. I concur with the information as submitted and the findings.



Charles E. Sepich
Network Director

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

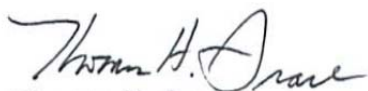
Date: November 19, 2014

From: Director, Carl Vinson VA Medical Center (557/00)

Subject: **Draft Report**— Healthcare Inspection—Alleged Insufficient Staffing and Consult Management Issues, Carl Vinson VA Medical Center, Dublin, GA

To: Director, Name of VISN (10N7)

1. I concur with the conclusions outlined in this OIG draft report.
2. If you have any additional questions or concerns, please contact Kathy Claxton, Acting Quality Manager at 478-272-1210 extension 3369.



Thomas H. Grace
Acting Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Sheyla Desir, RN, MSN, Team Leader Victoria Coates, LICSW, MBA Andrea Buck, MD, JD

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