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Memorandum to the File - Administrative Closure Report

Alleged Insufficient Staffing Issues at the
Alaska VA Healthcare system and Regional Office, Anchorage, AK
MCI# 2009-00775-HI-0111

Purpose

The Department of Veterans Affairs Office of Inspector General's -Office of Healthcare Inspections (OHI) received allegations from an anonymous complainant regarding insufficient staffing at the Alaska VA Healthcare system and Regional Office Domiciliary (AVAHSRO). The complainant alleged that the domiciliary is providing inadequate mental health care and turning patients away due to inadequate staffing.

Background

An initial complaint was received from an anonymous source on December 19, 2008. The anonymous source alleged that [b;(6;] (former employee), of the Alaska VA Healthcare System and Regional Office in Anchorage, claimed several veterans at the facility were in danger of committing suicide due to poor care. [b;(6;] was interviewed regarding the allegations. The AVAHSRO Director and VISN 20 Director provided detailed information regarding a multitude of approaches that had been implemented including a fulltime Suicide Prevention Coordinator, staff training, outreach events with the community and the Anchorage Police, increased veteran contact and improved administrative processes. Based on the interview with [b;(6;] and the VISN responses, the allegation was found to be unsubstantiated.

On April 9, 2009, additional information was received from [b;(6;] who was the conduit for the anonymous source. He alleged there is a lack of mental health care and that patients are being turned away due to inadequate staffing at the AVAHSRO Domiciliary. Due to the similarity of the previous complaint, the case was reopened.

Scope and Methodology

On May 1 and May 5, 2009, Virginia Solana, Director Denver/LA OHI left messages for [b;(6;] to contact her regarding the complaints at AVAHSRO Domiciliary.

On May 15, 2009, Ms. Solana spoke with [b;(6;] who stated that [b;(6;] [b;(6;] had been appointed. [b;(6;] told [b;(6;] that the complaints regarding staffing issues and lack of mental health care had been resolved because he was now in charge of the scheduling and admissions to the domiciliary. Ms. Solana requested that [b;(6;] have [b;(6;] call her to validate that the issues had been resolved.

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On May 26, 2009 Ms. Solana emailed [redacted] to inform him that we had not received a call from [redacted] Ms. Solana asked again that he give [redacted] contact information so he could call her.

[redacted] called Ms. Solana on Friday evening, May 29, 2009. He stated he [redacted] He stated that he "felt that the mental health care was good and that the care at Anchorage may be better than other facilities". He stated that administration had increased staffing; however, two weeks prior, [redacted] was told by "an inside source" that these positions might not be re-filled. The census was 37 patients with 6 patients on "suicidal flags". A suicidal flag means that the patient has had past suicidal ideation but is not actively suicidal. The capacity of the AVAHSRO domiciliary is 50 beds. He expressed concern because the updated VHA Handbook 1162.02 dated May 26, 2009 stated that a wider variety of diagnoses including homeless patients would be admitted to the domiciliary.

[redacted] stated that he had written an email to [redacted] about 2 weeks ago stating that he did not think the staffing was safe since [redacted] forwarded the memo to VISN administration and was waiting for a response. [redacted] attended a VISN meeting during the week of May 26-29 where she was going to discuss his concerns. At the time of the call, [redacted] had not received feedback from [redacted] or administration. Ms. Solana requested that [redacted] fax a copy of the official staffing plan and a copy of his email to [redacted] to her and he agreed to do so. Ms. Solana requested that he speak to [redacted] regarding her discussions with administration and the VISN. Another call was scheduled with [redacted] for 2P MT, June 1, 2009.

On June 1, 2009, Ms. Solana and [redacted] called [redacted] [redacted] told us he had not obtained an official staffing plan or spoken to [redacted]. Ms. Solana discussed the new VHA Handbook which outlines the minimum staffing FTE by number of beds. [redacted] stated that he had an appointment with [redacted] that afternoon. Ms. Solana asked again for the staffing plan and scheduled a follow-up call for June 2, 2009 at 2P MT.

On June 2, 2009, Ms. Solana and [redacted] made three attempts to call [redacted] on the cell phone number he provided. On the third attempt, a message was left for [redacted] to return our call. [redacted] left a message for Ms. Solana on Tuesday evening, June 2, 2009. An additional follow-up call was scheduled for June 3, 2009.

On June 3, 2009, Ms. Solana and [redacted] made a final call to [redacted] stated that he was able to meet with [redacted] and [redacted]. During the meeting, [redacted] expressed his concerns that "eventually something bad was

going to happen" and that despite the increase in FTE, he still did not think staffing was sufficient. [redacted] confirmed that the domiciliary staffing complies with minimum staffing requirements outlined in the VHA Handbook. He confirmed that the ACOS/MH has allowed him to hold the census at 37. He denied being pressured into admitting additional patients to attain an 85% occupancy rate per VHA Handbook 1162.02. He continued to state he was uncomfortable with staffing but felt the care was "good and probably better than other places".

Ms. Solana asked [redacted] again if he would share his email to [redacted] and his notes regarding his conversation with [redacted] declined and stated that he did not feel comfortable sharing this information as [redacted] and felt he would be fired if administration found out he was talking with the IG.

Ms. Solana confirmed that staffing met minimum guidelines according to the VHA Handbook 1162.02. [redacted] validated that he was [redacted] and that [redacted] had told him he could hold the census lower when he felt that the acuity was higher. [redacted] was given the VA OIG Hotline number in case any other issues arose.

Results

[redacted] told us that mental health patients were receiving good care and that staffing met the minimum guidelines outlined in Handbook 1162.02. [redacted] still feels the staffing should be increased and has spoken to senior leadership at the AVAHSRO to express his concerns. [redacted] felt very positive about his meeting with administration and told us he would prefer more staff but felt the reported issues were resolved since he was [redacted]

Recommendations
We recommend an administrative closure since the complainants have told us they consider the issues resolved

SUBMITTED BY:

_____ *//S//* _____ Date: _____
Virginia Solana, RN, MA.
Director, Denver/LA Office of Healthcare Inspections
VA Office of Inspector General

APPROVED BY:

_____ *//S//* _____ Date: _____
John D. Daigh, JR., M.D.
Assistant Inspector General for Healthcare Inspections
VA Office of Inspector General