



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

Office of Healthcare Inspections

Report No. 15-00506-420

Healthcare Inspection

Nurse Staffing and Patient Safety Reporting Concerns VA Roseburg Healthcare System Roseburg, Oregon

October 12, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Congressman Peter A. DeFazio in response to allegations about inadequate nurse staffing in the Community Living Center (CLC) and patient safety reporting at the VA Roseburg Healthcare System (system), Roseburg, OR. Specifically, the allegations were:

- Roseburg's CLC units do not have enough nursing staff and are not in compliance with Veterans Health Administration nurse staffing policy.
- Failure to correctly staff the CLC and dementia units has resulted in patient falls and employee injuries.
- The CLC does not have a working alarm system.
- Patient safety concerns are not reported.

We did not substantiate the allegation that the system's CLC nurse staffing was inadequate and not in compliance with Veterans Health Administration (VHA) policy. System leadership implemented VHA's staffing methodology for the CLC and adjusted the number of operating beds based on available staffing.

We did not substantiate the allegation that failure to correctly staff the CLC units resulted in patient falls or employee injuries. The overall system, including the CLC, had a comprehensive approach to identifying high risk patients and managing fall prevention, although staffing levels were not consistently analyzed after falls occurred.

We did not substantiate the allegation that the CLC had no working alarms. Nurse call and elopement prevention system alarms functioned as required, and the system generally met environment of care requirements.

We did not substantiate the allegation that patient safety concerns are not reported. Patient safety issues were communicated to leadership. We repeatedly heard complaints of low staff morale; however, we determined leadership at both the system and Veterans Integrated Service Network level continued to take action regarding improving workplace culture such as the creation of system redesign teams and measurement of employee satisfaction by requesting additional assessments from the National Center for Organizational Development. System scores in Employee Satisfaction (senior management and promotion opportunity) and Organizational Climate measured during annual All Employee Surveys between FY2010 and 2015 showed improvement over time.

We recommended that the System Director strengthen processes to ensure staffing levels are analyzed and documented in applicable safety and quality of care reviews and annually reported to leadership.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 9–11 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 at the request of Congressman Peter A. DeFazio in response to allegations about inadequate nurse staffing in the Community Living Center (CLC) and patient safety reporting at the VA Roseburg Healthcare System (system), Roseburg, OR. The purpose of the inspection was to determine if the allegations had merit.

Background

System Profile. The system is part of Veterans Integrated Service Network (VISN) 20 and provides care for veterans residing in central and southern Oregon and northern California. The main campus includes an Emergency Department, CLC, and primary care clinics and provides inpatient medical, surgical, and mental health services. The system has three community based outpatient clinics located in Eugene, Brookings, and North Bend, OR. The system is a designated Veteran Rural Access Hospital with no Intensive Care Unit and a low volume Emergency Department.

CLC. The CLC provides a skilled nursing environment and houses a variety of specialty programs for persons needing short and long-term care services. Services on the CLC are provided in patient-centered environments to meet the individual needs of patients and may include programs for patients with special needs, such as skilled nursing, rehabilitation, or dementia care.¹ The system's CLC is divided into two units—the Lodge and the River House. The Lodge serves long-stay patients with end stage dementia needs. The River House provides palliative/hospice, rehabilitation, skilled nursing, and long-stay care. In this report, the term CLC will refer to both units.

Allegations. Congressman DeFazio sent a letter to the OIG Hotline Division on September 25, 2014, containing allegations from multiple constituents. Specifically, the allegations related to patient safety were:

- Roseburg's CLC units do not have enough nursing staff and are not in compliance with Veterans Health Administration (VHA) nurse staffing policy.
- Failure to correctly staff the CLC and dementia units has resulted in patient falls and employee injuries.
- The CLC does not have a working alarm system.
- Patient safety concerns are not reported.

¹ VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. This VHA Handbook was scheduled for re-certification on or before the last working day of August 2013 but has not been re-certified.

Scope and Methodology

The period of our review was November 4, 2014–March 26, 2015.

We reviewed system documentation, including VHA handbooks and directives, Joint Commission Standards, system policies and procedures, quality management and nurse staffing documents, committee minutes, employee survey data, CLC Employee Accident Incident Reports, and other relevant documents. We completed a statistical analysis of the system's nursing hours by day for fiscal year (FY) 2014.

We conducted the system's regularly scheduled Combined Assessment Program review the week of November 17, 2014, at which time we inspected the CLC to determine if the system maintained a clean and safe health care environment, and we reviewed the use of the elopement prevention and nurse call system alarms.²

We conducted a separate site visit December 1–3, 2014. We interviewed the Director, Associate Director, Chief of Staff, and the Associate Director for Patient Care Services. We interviewed service line directors, mid-level managers, providers, and other staff with relevant knowledge of or insight into the system's CLC program.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

² *Combined Assessment Program Review of the VA Roseburg Healthcare System*, Roseburg, Oregon, (Report No. 14-04222-141, March 4, 2015), <http://www.va.gov/oig/pubs/VAOIG-14-04222-141.pdf> (accessed March 5, 2015).

Inspection Results

Issue 1: Nurse Staffing

We did not substantiate the allegation that CLC units do not have enough nursing staff and are not in compliance with VHA policy.

Each facility is expected to establish safe and effective staffing levels that incorporate a mix of staff to meet patient care demands.³ VHA issued Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010, which provided a nationally standardized method for determining appropriate direct care nurse staffing.⁴ The methodology is based on an analysis of multiple variables, which include patient needs, direct care staffing responsibilities, environmental support, and professional judgment. These variables are used to recommend staffing levels or targets at various points of care.

This allegation was originally reported to system management in April 2012 and then later to the OIG Hotline Division in the letter dated September 25, 2014. We learned that the number of operational beds varied over FY 2013 and FY 2014 due to changing levels in staffing and environmental renovations of the CLC.

The system implemented the staffing methodology in the CLC as required. The system's nurse staffing methodology review for FY 2014 (a prospective review completed in August 2013) calculated the variance between current staffing and required staffing for 54 admission beds⁵ in the CLC, which was the expected number of operational beds by the end of FY 2014. Variance was noted with significant vacancies for nursing assistants and practical nurses.⁶ The system identified this gap in staffing and adjusted the bed number to 39 for FY 2014 in order to meet target numbers and provide proper care.

Senior leadership and nurse managers from the CLC acknowledged that nursing vacancies existed and they were having trouble filling positions. Managers reported it became particularly difficult to fill vacant positions for nursing assistants after a VHA directive, published in March 2014, required certification for newly hired nursing assistants.⁷ Managers also indicated a cumbersome and lengthy recruitment process contributed to delays in filling positions.

³ VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This VHA Directive expired July 31, 2015 and has not been updated.

⁴ Ibid.

⁵ An admission bed is a bed for patients who are admitted to the CLC.

⁶ A practical nurse is a nurse who has undergone training to provide routine care for the sick.

⁷ VHA Handbook 5005/71, *Staffing*, March 24, 2014.

The Staffing Methodology Directive refers to the number of direct care hours related to patient workload as nursing hours per patient day.⁸ To determine if nurse staffing met identified targets, we reviewed the actual nursing hours per patient day for both CLC units for 60 randomly selected days between October 1, 2013, and September 30, 2014. Despite the reported difficulties, the system met or exceeded the target staffing levels each day. See Table 1 below.

Table 1. Estimated CLC Nursing Hours Per Patient Day For Selected Days in FY 2014

Unit	Estimates (Sample Size=60)		Targets	Are Estimates Statistically Significantly Different from the Targets?
	Mean	95% Confidence Interval		
Lodge	7.59	(7.344, 7.841)	(6.10, 7.40)	Not Different
River House	6.43	(6.293, 6.560)	(5.51, 6.00)	Above Target

Source: *OIG Biostatistics Analysis of System Data*

Issue 2: CLC Safety

We did not substantiate the allegation that failure to correctly staff the CLC has resulted in patient falls and employee injuries.

Patient Falls

VA guidelines define “a fall as a loss of upright position that results in landing on the floor, ground, or an object or furniture, or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair.”⁹ The system’s fall prevention program was updated in October 2014 and included a falls risk assessment upon admission, discharge, or change in condition.¹⁰

The CLC instituted a Fall Reduction Observation Group in June 2014. This interdisciplinary group meets within 24 hours of an actual fall, assesses for root causes, and implements prevention interventions specifically for that patient. Prevention interventions are also developed for all patients identified by the assessment to be at high risk for falls. Some of the system’s interventions included red non-slip socks, bed or chair alarms, hip protectors, and frequent checks on patients.

The program policy further specifies that every patient in the CLC who sustains a fall is placed on alert charting for 3 days, requiring a note every shift documenting a fall

⁸ VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

⁹ VA National Center for Patient Safety Virtual Breakthrough Series, *Implementation Guide for Fall Injury Reduction*, 2013 <http://www.patientcarelink.org/uploadDocs/1/Implementation-Guide-for-Fall-Injury-Reduction-VA-NCPS-508.pdf>. Accessed March 9, 2015.

¹⁰ VA Roseburg Healthcare System MCM 653-00B-020, *Fall Prevention and Management Program*, October 2014.

assessment. This note automatically generates an alert to the provider, pharmacist, physical therapist, occupational therapist, and dietician for their review.

Falls Analysis and Reporting

VHA requires that each facility conduct at least one falls aggregate review every fiscal year.¹¹ One of the purposes of an aggregate review is to identify trends and patterns that would not be discernable through analysis of an individual fall review.

During FY2013-2014, the system followed VHA guidance¹² with respect to annual tracking and analysis of fall rates by bed days of care per unit and falls with major injury rates per bed days of care. The number of falls is determined by incident reports, which are entered by staff and may not represent the number of actual events. The fall rate accounts for patient census changes so that fall rates can be adjusted and compared across clinical units.¹³

Joint Commission standards require that analysis of aggregate data or a single incident include the adequacy of staffing (number, skill mix, and competency of all staff).¹⁴ Additionally, the standards require that at least once a year, leaders are provided written reports from staff that contain analysis of system or process failures, including results of the analysis related to the adequacy of staffing. We reviewed system reports to leadership that had system or process failure data and analysis information including the system's annual aggregate analysis of falls. We found no evidence that staffing levels were consistently analyzed.

Employee Injuries

We did not substantiate that employee injuries resulted from inadequate nurse staffing.

We reviewed six employee accident incident reports from 2014. Safety program officials and nurse managers reviewed each incident and reported staffing levels were factored in and assessed. The system's reviews found no definitive indicators that injuries were related to low staffing levels. Reported causes for accidents included failure to use appropriate lift equipment and agitated patients pushing and/or pulling against the employee.

¹¹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.

¹² VA National Center for Patient Safety Virtual Breakthrough Series, *Implementation Guide for Fall Injury Reduction*, 2013 <http://www.patientcarelink.org/uploadDocs/1/Implementation-Guide-for-Fall-Injury-Reduction-VA-NCPS-508.pdf>. Accessed March 9, 2015.

¹³ Quigley, P, Neily J, Watson M., Strobe K *Measuring Fall Program Outcomes online J Issues Nurse* 2007 Mar 2, 12 (2):8 <http://www.ncbi.nlm.nih.gov/pubmed/21848355>. Accessed January 13, 2015.

¹⁴ Joint Commission Standard LD.04.04.05 EP 13 and PI.02.01.01 EP14.

Issue 3: Alarms

We did not substantiate the allegation that the CLC did not have working alarms.

VHA requires medical facilities to have an effective and reliable plan to prevent and effectively manage wandering and missing patients.¹⁵ The use of electronic technology, such as an elopement prevention system with patient tracking bracelets for those patients considered to be at-risk, may be used as a tool to augment other processes for minimizing the risk of patients wandering away from a care site. When such electronic technology is used, all critical components of the system must undergo systematic and frequent checks. System staff documented elopement prevention system functionality checks at least every 24 hours and complete system checks annually as required.

Nurse call system alarms were functional and provided audio communication between patients and system personnel.¹⁶

Issue 4: Patient Safety Reporting

We did not substantiate the allegation that patient safety concerns were not reported.

Joint Commission standards require leaders to create and maintain a culture of safety and quality throughout the system. One standard states “[s]afety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital.”¹⁷ VHA policy specifies that it is the responsibility of leadership to create and nurture an environment of transparency and a just culture in which employees are empowered to bring concerns forth to leadership, confident that they will be addressed without fear of reprisal.¹⁸

We interviewed system staff and reviewed all 146 patient event reports documented for the CLC during FY 2014. We identified evidence that staff reported patient safety incidents to leadership.

Issue 5: Staff Morale

During our review we heard complaints of a culture that contributed to low staff morale. To evaluate the merit of these complaints, we reviewed the system’s FY 2010–2015 annual All Employee Survey results. See Table 2 on the following page.

¹⁵ VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010. This VHA Directive expired December 31, 2015 and has not yet been updated.

¹⁶ VAOIG, *Combined Assessment Program Review of the VA Roseburg Healthcare System*, Roseburg, Oregon, March 4, 2015 <http://www.va.gov/oig/pubs/VAOIG-14-04222-141.pdf>

¹⁷ Joint Commission Standard, LD.03.03.01 through .03.06.01.

¹⁸ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. A just culture learns and improves by openly identifying and examining its own weaknesses.

VHA conducts an All Employee Survey annually and we reviewed the system's results for FY 2010, through FY 2015.¹⁹ The results indicated adequate response rates by employees. System scores in Employee Satisfaction (senior management and promotion opportunity) and Organizational Climate were consistently lower than the VHA survey administrator's acceptable scores of 3.0.²⁰

Table 2. All Employee Survey Results FY 2010 through FY 2015

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Employee Satisfaction						
Senior Management	2.76	2.58	2.56	2.52	2.53	2.93
Promotion Opportunity	2.72	2.52	2.62	2.66	2.62	2.82
Organizational Climate						
Engagement-Organization	2.87	2.78	2.72	2.74	2.56	2.96

Source: VHA All Employee Survey Data

In November 2013, through a strategic initiative, the system identified it had work to do in these areas with an emphasis on improving workplace culture. All Employee Survey data was provided to leadership and communicated to system staff via the Director's Reveille in April 2014.²¹ Although FY2014 results did not show improvement, FY 2015 results showed improvement in all three areas reviewed.

VISN leaders stated that many organizations have conducted reviews of the system and identified barriers to cultural change implementation. As a result, leadership at both the system and VISN level continue to take actions to improve the workplace culture including the creation of system redesign teams and measurement of employee satisfaction by requesting additional assessments from the National Center for Organizational Development. Because the system developed actions to address culture change implementation barriers prior to our review, we did not make a recommendation.

Conclusions

We did not substantiate the allegation that the system's CLC did not have sufficient nurse staffing and was not in compliance with VHA nurse staffing policy. Nurse managers implemented VHA's nurse staffing methodology for the CLC and adjusted the

¹⁹ The survey is voluntary and asks questions related to job satisfaction, organizational assessment, civility, and culture.

²⁰ Survey administrators indicate a 3.0 score or above is acceptable and scores below 3.0 should be reviewed for improvement opportunities.

²¹ The Director's Reveille is an email message the Director sends to all system staff containing information to be shared with employees.

number of operating beds based on available staffing. The nurse staffing data we reviewed met identified targets.

We did not substantiate the allegation that failure to correctly staff the CLC resulted in patient falls or employee injuries. System and CLC leadership have a comprehensive approach to identifying high risk patients and managing fall prevention. However, staffing levels were not consistently analyzed after falls occurred. The system's safety program and nurse managers reported a review of staffing levels occurred with each employee accident and found no definitive indicators that employee injuries were related to low staffing levels.

We did not substantiate the allegation that the CLC did not have working alarms. Nurse call and elopement prevention system alarms functioned as required.

We did not substantiate the allegation that patient safety concerns were not reported. Patient safety issues were communicated to leadership. We repeatedly heard complaints of low staff morale; however, we determined leadership at both the system and VISN level continued to take action regarding cultural transformation.

Recommendation

1. We recommended that the System Director strengthen processes to ensure staffing levels are analyzed and documented in applicable safety and quality of care reviews and annually reported to leadership.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 6, 2016

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

Subj: Healthcare Inspection—Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and concur with the report: Nurse Staffing and Patient Safety Reporting Concerns.
2. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)

Dan Kelly, Acting VISN 20 Deputy Network Director for Michael J. Murphy,
Acting VISN 20 Network Director

System Director Comments

Department of Veterans Affairs

Memorandum

Date: May 6, 2016

From: Director, VA Roseburg Healthcare System (653/00)

Subj: Healthcare Inspection—Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon

To: Acting Director, VA Northwest Health Network Director (10N20)

1. Thank you for the opportunity to review and concur with the report: Nurse Staffing and Patient Safety Reporting Concerns.
2. If you have additional questions or need further information, please contact James Call, Acting Quality Management Chief and Patient Safety Manager at (541) 440-1000 ex:40098.



Douglas V. Paxton, Sr., MSW, SES
Medical Center Director

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 strengthen processes to ensure staffing levels are analyzed and documented in applicable safety and quality of care reviews and annually reported to leadership.

Concur

Target date for completion: November 1, 2016.

System response: VA Roseburg Healthcare System will analyze unit staffing adequacy, including the number of staff, skill mix, and competency of staff for each reported patient fall that occurs in the CLCs or acute inpatient units.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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