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Office of Inspector General**

Office of Healthcare Inspections

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**Healthcare Inspection
Quality of Care
and Other Concerns
Captain James A. Lovell Federal
Health Care Center
North Chicago, Illinois**

September 20, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations made by confidential complainants regarding quality of care and other concerns at the Captain James A. Lovell Federal Health Care Center (FHCC), North Chicago, IL.

The FHCC is part of Veterans Integrated Service Network (VISN) 12. It was chartered as a 5-year Demonstration Project on October 1, 2010 after the Department of Defense (DoD) and VA agreed to merge the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes.¹

In July 2015, FHCC operated under a 2010 Executive Agreement between DoD and VA, which outlined the terms of the integration and identified VA as the lead partner with accountability for the overall operation of the FHCC. FHCC is led by a VA Senior Executive Service Officer as Director and a U.S. Navy Captain as Deputy Director. It serves veterans; active-duty service members and their dependents; TRICARE-eligible retirees, their dependents, and survivors; and Navy recruits.

From January through July 2015, OIG received allegations concerning the quality of care at the FHCC, FHCC policies, and FHCC leadership practices, including retaliation and intimidation by FHCC leadership. This review focused on the following allegations:²

- The Home Based Primary Care (HBPC) program's accreditation status was "threatened" during a March 2015 Joint Commission (JC) accreditation survey.³
- A Community Living Center (CLC) patient (Patient A) who fell and fractured his/her hip had an inaccurately low Morse Fall Scale assignment prior to the fall, and the CLC fall rate increased in fiscal year (FY) 2014.⁴
- The FHCC mishandled the suicides of two individuals (Patients B and C), and the FHCC suicide rate was high.
- The Emergency Department (ED) was left unattended by a qualified physician when ED physicians left the ED to perform emergency airway management in other FHCC care areas, and the ED did not have clerical staff support on weekends and most weekdays during the dayshift.⁵
- Veteran patients in the ED had to wait hours for admission to an inpatient hospital bed or were transferred to other hospitals because DoD patients occupied inpatient beds; the VA and DoD electronic health record (EHR)

¹ The National Defense Authorization Act (NDAA) for FY 2010 authorized the demonstration project. Pub. L. No. 111-84, § 1701(a), 123 Stat. 2190, 2567 (2009).

² Allegations that we determined required review were those that could have directly threatened patient safety if substantiated.

³ VA HBPC programs provide health care services in patients' homes.

⁴ The Morse Fall Scale is a tool that can be used to identify risk factors for falls in hospitalized patients.

⁵ An emergent airway is defined as the management of the patient's airway who needs immediate support and intervention. VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.

software programs were not integrated; the ED computer system was cumbersome, which took time away from patient care; and primary care providers referred Navy recruits to the ED for non-emergent care.

- The length of stay (LOS) on the medical/surgical unit was long.
- Nurses did not follow proper handwashing techniques.
- The Associate Director of Inpatient Services (ADIS) lacked the required education and experience to qualify for the position.

The complainants also requested that we review the care provided to 13 additional VA patients whom the complainants alleged received poor quality care.

We initiated our review in July 2015 and conducted a site visit September 21–24, 2015. We did not address allegations for which we did not receive specific information of patient harm or that could not directly threaten patient safety. We referred complainants who alleged retaliation and intimidation by leadership to the Office of Special Counsel.

We substantiated that the HBPC program's accreditation status was "threatened" during a March 2015 FHCC JC accreditation survey. However, JC surveyors determined that the HBPC program successfully addressed all identified noncompliance concerns during follow-up surveys, and the program attained accreditation status prior to our review. To address the program deficiencies, the FHCC developed an action plan and conducted monthly monitoring of the identified deficiencies. In August 2015, JC conducted another follow-up survey and determined the program complied with accreditation standards. During our review, we determined FHCC continued to monitor compliance with JC program requirements.

We substantiated that a CLC patient (Patient A) who fell and fractured his/her hip in February 2015 had an inaccurately low Morse Fall Scale assignment. In addition, we found that Morse Fall Scale Notes in Patient A's EHR were chronologically inaccurate and were not completed monthly and after falls as required.

While we substantiated that CLC patient falls increased during FY 2014, we found that CLC patient falls decreased in FY 2015. Prior to our review, FHCC leadership identified the increase in CLC patient falls and implemented an action plan to reduce them, which included staff education on fall prevention, patient assessment, and the use of tools for fall prevention.

We did not substantiate that FHCC staff mishandled the suicides of two individuals. We also did not substantiate that the FHCC suicide rate was unusually high. For 2014, we found that the FHCC suicide rate was lower than the VISN and Veterans Health Administration (VHA) National suicide rates with 22.0, 29.9, and 39.0 suicides per 100,000 users of VHA services respectively.⁶

⁶ This is the 2014 suicide rate per 100,000 person years, among VHA patients who were alive at the start of 2014 and who used VHA services in 2013 or 2014. National suicide rate data is from the Office of Suicide Prevention report, *Suicide Among Veterans and Other Americans 2001–2014*, August 3, 2016.

We substantiated that on seven occasions the ED was left unattended by a qualified physician when ED physicians left the ED to perform emergency airway management in other FHCC care areas; however, we did not find evidence that this interrupted the timely delivery of patient care. We substantiated the allegation that the ED did not have clerical staff support on weekends and most weekdays during the dayshift; however, we determined the ED clerical support staffing schedule did not conflict with VHA policy and did not negatively affect the timely delivery of patient care.

We did not substantiate that the ED LOS for admitted patients was long or that ED transfer rates were high. The ED met or exceeded VHA ED performance metrics for LOS and boarding thresholds during FY 2015. The FHCC's FY 2015 transfer rate was 1.1 percent, which was less than the 1.4 percent National FY 2015 transfer rate. We substantiated that primary care providers referred Navy recruits to the ED for non-emergent care needs; however, we determined the practice was permitted under the 2010 Executive Agreement to ensure recruits were ready for deployment at any time.

We did not substantiate that the medical/surgical unit LOS was long. The FHCC FY 2015 medical/surgical unit LOS was 2.48 days, which was less than the VISN 12 and National averages. During the same time period, VISN 12 and National FY 2015 averages were 3.28 and 3.12, respectively.

We substantiated that nurses did not consistently follow proper hand-hygiene practices. VHA and FHCC policy require that health care workers' hand-hygiene practices are monitored for adherence to VHA handwashing policy.

We did not substantiate that the ADIS lacked the required education and experience to qualify for the position. The ADIS qualification requirements included a Master's Degree in Nursing or related health-care field and 2–3 years of experience in progressively responsible leadership assignments. The incumbent earned a Master's Degree in Nursing in 2009 and had over 10 years of progressively responsible leadership experience prior to assuming the role of ADIS in 2015.

We did not substantiate 10 of the 13 poor patient care allegations. We substantiated that an outpatient mental health clinic patient, who required one-to-one staff observation, left the FHCC and was deemed missing; however, we determined the patient was not harmed and was later admitted for inpatient care. We could not substantiate the two remaining patient care allegations because we did not receive sufficient information from the complainants to identify one of the patients or to identify the other patient's specific timeframe or episode of care. We reviewed this patient's EHR and did not find documented instances of mismanagement or poor care; however, without specifics to examine, we could not determine if we completely addressed the allegation.

We recommended that the FHCC Director ensure:

- Patients in the CLC receive appropriate fall risk ratings and individualized fall intervention plans.

- Compliance with VHA policies on ED provider coverage.
- Compliance with VHA and FHCC policies on hand hygiene practices.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 18–21, for the Directors' comments.) We consider Recommendation 1 closed. We will follow up on the planned actions for the remaining recommendations until completed.



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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations made by confidential complainants regarding quality of care and other concerns at the Captain James A. Lovell Federal Health Care Center (FHCC), North Chicago, IL.

Background

The FHCC is part of Veterans Integrated Service Network (VISN) 12. FHCC was chartered as a 5-year Demonstration Project on October 1, 2010 after the Department of Defense (DoD) and VA agreed to merge the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes.⁷ At the time of this review in July 2015, FHCC operated under a 2010 Executive Agreement (EA) between DoD and VA, which outlined the terms of the integration and identified VA as the lead partner with accountability for the overall operation of the FHCC.⁸

The FHCC is led by a VA Senior Executive Services Officer as Director and a U.S. Navy Captain as Deputy Director. FHCC serves veterans; active-duty service members and their dependents; TRICARE-eligible retirees, their dependents, and survivors; and Navy recruits. It operates 88 inpatient beds and 120 Community Living Center (CLC) beds. Other services offered and pertinent to this review include an Emergency Department (ED) and primary care.

Prior Relevant FHCC-Specific Publications

In April 2014, OIG received multiple allegations of quality of care deficiencies at the FHCC. Complainants alleged that many of the problems were attributed to a reorganization of leadership positions, which reportedly favored Navy staff over VA staff. We referred the allegations to VISN leaders and determined their responses to be adequate.

In March 2015, OIG published *Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois*, Report No. 14-04473-132.⁹ OIG recommended that the FHCC Director ensure that documentation of procedure results from non-VA gastrointestinal care providers is obtained and available in the electronic health record (EHR) for review

⁷ The National Defense Authorization Act (NDAA) for FY 2010 authorized the demonstration project. Pub. L. No. 111-84, § 1701(a), 123 Stat. 2190, 2567 (2009).

⁸ The National Defense Authorization Act (NDAA) for FY 2010 required the Secretaries of VA and DoD to submit a “final report” on the merger to Congress not later than 180 days after the fifth anniversary of executing the EA, (March 2016) to include an assessment of the merger and a recommendation regarding whether it should continue. At the time of this review, July 30, 2015, the Secretaries had not submitted the final report. Pub. L. No. 111-84, § 1701(d)(2), 123 Stat. 2190, 2567 (2009).

⁹ *Healthcare Inspection—Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois*, (Report No. 14-04473-132, March 3, 2015).

in a timely and consistent manner. Based on information that the FHCC provided, the recommendation was closed in March 2016.

In July 2015, OIG published the *Combined Assessment Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois*, (Report No. 15-00594-389, July 2, 2015).¹⁰ Pertinent to this review, OIG recommended that the FHCC Director ensure the initial clinician emergency airway management competency assessment include documentation of all required elements and that clinician reassessment for continued emergency airway management competency be completed at the time of renewal of privileges. Recommendations were closed May 20, 2016.

In February 2016, Government Accountability Office (GAO) published *VA and DoD Need to Address Ongoing Difficulties and Better Prepare for Future Integration*, which assessed the FHCC's governance structure, leadership processes, and difficulties it faced integrating the workforce and operations. In the February 2016 report, GAO also addressed FHCC technology challenges and bed utilization concerns.¹¹

Allegations

From January through July 2015, OIG received allegations concerning the quality of care at the FHCC, FHCC policies, and FHCC leadership practices, including retaliation and intimidation by FHCC leadership. This review focuses on the following allegations:¹²

- The Home Based Primary Care (HBPC) program's accreditation status was "threatened" during a March 2015 Joint Commission (JC) accreditation survey.¹³
- A CLC patient (Patient A) who fell and fractured his/her hip had an inaccurately low Morse Fall Scale assignment prior to the fall and the CLC fall rate increased in FY 2014.¹⁴
- The FHCC mishandled the suicides of two individuals (Patients B and C) and the FHCC suicide rate was high.
- The ED was left unattended by a qualified physician when ED physicians left the ED to perform emergency airway management in other FHCC care areas, and the ED did not have clerical staff support on weekends and most weekdays during the dayshift.¹⁵

¹⁰ *Combined Assessment Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois*, Report No. 15-00594-389, July 2, 2015.

¹¹ Government Accountability Office (GAO), Report to Congressional Committees, *Federal Health Care Center, VA and DoD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations*, February 29, 2016. Website, <http://www.gao.gov/assets/680/675506.pdf>, accessed November 2, 2016.

¹² Allegations that we determined required review could have directly threatened patient safety if substantiated.

¹³ VA HBPC programs provide health care services in patients' homes.

¹⁴ The Morse Fall Scale is a tool that can be used to identify risk factors for falls in hospitalized patients.

¹⁵ An emergent airway is defined as the management of the patient's airway who needs immediate support and intervention. VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.

- Veteran patients in the ED had to wait hours for admission to an inpatient hospital bed or were transferred to other hospitals because DoD patients occupied inpatient beds; the VA and DoD EHR software programs were not integrated; the ED computer system was cumbersome, which took time away from patient care; and primary care providers referred Navy recruits to the ED for non-emergent care.
- The length of stay (LOS) on the medical/surgical unit was long.
- Nurses did not follow proper handwashing techniques.
- The Associate Director of Inpatient Services (ADIS) lacked the required education and experience to qualify for the position.

The complainants also requested that we review the care provided to 13 additional VA patients, whom the complainants alleged received poor quality care.

Scope and Methodology

We initiated our review in July 2015 and conducted a site visit September 21–24, 2015. During our visit, we interviewed the complainants, FHCC leadership, nurse managers, Suicide Prevention Program staff, Mental Health Service leadership, and Patient Safety and Risk Managers. We also conducted follow-up phone interviews with the complainants and FHCC staff familiar with topics related to this review.

We reviewed relevant Veterans Health Administration (VHA) and FHCC policies and procedures, nurse training records, and medical literature. We reviewed FHCC reports related to patient advocacy, quality reviews, and patient safety. We reviewed the 2010 EA signed by the Secretaries of the Navy, Defense, and VA, which outlined the terms of operation for the FHCC.

We reviewed VHA patients' EHRs,¹⁶ issue briefs, committee meeting minutes, and VA police reports. We reviewed an FHCC-conducted Administrative Investigation Board (AIB) report related to patient care in the ED. We reviewed VA OIG, JC, and GAO reports.¹⁷ We also reviewed computer-processed data obtained from VHA's Support Service Center, specifically: Emergency Medicine Management Tool (EMMT), Emergency Department Integration Software (EDIS),^{18,19} and FHCC CLC patient fall

¹⁶ An OIG senior physician reviewed the EHRs and associated internal and external documents related to all individual patient allegations.

¹⁷ Government Accountability Office (GAO), Report to Congressional Committees, Federal Health Care Center, *VA and DOD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations*, February 29, 2016.

¹⁸ EDIS provides real-time data about ED patient flow, wait times, and length of stay (LOS). VA's Emergency Medicine Management Tool uses EDIS data to analyze and report on the operational performance of VA EDs and Urgent Care Clinics.

¹⁹ VHA Directive 2011-029, *Emergency Department Integration Software (EDIS) for Tracking Patient Activity in VHA Emergency Departments and Urgent Care Clinics*, July 15, 2011. This directive was current at the time of the events discussed in this report. The directive was rescinded and replaced by VHA Directive 1101.05(2) *Emergency Medicine*, September 2, 2016, amended March 7, 2017. Both prior and current directives have the same or similar language regarding the ED and EDIS.

data. We reviewed FHCC medical/surgical unit LOS data and ED LOS and transfer rate data.

The allegations regarding software and bed utilization were broad in nature and the complainants did not identify patients who had been negatively affected by the alleged conditions. However, because extended LOS in the ED has the potential to compromise medical care, we reviewed the FHCC's FY 2015 ED LOS, transfer, and boarding²⁰ data to determine whether the alleged conditions prevented ED staff from providing patients timely care. Consequently, we reviewed select FHCC, VISN 12, and National ED LOS and boarding performance measure data to determine whether the EHR computer system and/or patterns of bed utilization may have negatively affected the timeliness of veterans' care.

We did not address allegations for which we did not receive specific information of patient harm or that could not directly threaten patient safety. We referred complainants who alleged retaliation and intimidation by leadership to the Office of Special Counsel.²¹

Six policies cited in this report were expired or beyond the certification date:

- VHA Directive 2011-00, *Required Hand Hygiene Practices*, February 16, 2011 (expired February 29, 2016).
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010 (expired December 31, 2015).
- VHA Handbook 1100.16, *Accreditation of Veterans Health Administration Medical Facility and Ambulatory Programs*, September 22, 2009 (recertification due date September 30, 2014).
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (recertification due date September 30, 2013).
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010 (recertification due date August 31, 2015).
- VHA Directive, *Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents*, November 7, 2008 (expired November 30, 2013).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),²² the VA Under Secretary for Health (USH) mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a

²⁰ Boarding is the elapsed time from the provider's decision to admit to the time the patient leaves the ED (timed out).

²¹ Office of Special Counsel Web site, <https://osc.gov/>, accessed May 10, 2016.

²² VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

more recent policy or guidance.”²³ The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring “...the timely rescission or recertification of policy documents over which their program offices have primary responsibility.”²⁴

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 *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

²³ VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document*, June 29, 2016.

²⁴ Ibid.

Inspection Results

Issue 1: HBPC Accreditation

We substantiated that the HBPC program's accreditation status was "threatened" during a March 2015 FHCC JC accreditation survey. However, JC determined that the HBPC program successfully addressed all identified noncompliance concerns during JC follow-up surveys and the HBPC program attained accreditation status prior to our review.

HBPC consists of VA health care services provided to patients in their homes.²⁵ VHA policy requires that HBPC programs are in compliance with JC standards and accredited by JC.^{26,27} JC determines compliance by conducting periodic on-site surveys. Accreditation decision categories for existing programs are:²⁸

- Accreditation: The program is in compliance with all standards at the time of the on-site survey.
- Accreditation with Follow-Up Survey: The program is not in compliance with all standards at the time of the on-site survey and requires a follow-up survey. An organization with this accreditation status must demonstrate compliance by successfully addressing all identified noncompliance concerns during the follow-up survey to attain accreditation status.
- Preliminary Denial of Accreditation: The program (1) is not in full compliance with all standards and JC surveyors determine the noncompliance has caused or is likely to cause patient harm or injury (immediate threat to life), (2) falsifies or misrepresents information, (3) lacks a required license or similar issue, (4) fails to resolve requirements of a Contingent Accreditation status, or (5) is significantly non-compliant with JC standards.
- Contingent Accreditation: The program has successfully abated (removed) an immediate threat to life situation, but fails to address all requirements of the Accreditation with Follow-Up Survey decision or shows some evidence of possible fraud or abuse.

In March 2015, JC conducted an on-site HBPC program survey. Among other findings, JC determined the program was not in compliance with standard Provision of Care, Treatment, and Services (PC) 01.02.03, which states, "[t]he organization assesses and

²⁵ VA Home Based Primary Care Web site, http://www.va.gov/geriatrics/guide/longtermcare/home_based_primary_care.asp. Accessed June 18, 2016.

²⁶ VHA Handbook 1100.16, *Accreditation of Veterans Health Administration Medical Facility and Ambulatory Programs*, September 22, 2009. This Handbook was scheduled for recertification on or before the last day of September 2014.

²⁷ Joint Commission standards specify what is required for an organization to provide safe care, https://www.jointcommission.org/accreditation/accreditation_main.aspx. Accessed July 7, 2016.

²⁸ https://www.jointcommission.org/facts_about_scoring_and_accreditation_decisions_for_2014/. Accessed July 7, 2016.

reassesses the patient and his or her condition according to defined time frames.”²⁹ JC surveyors determined an “immediate threat to life” existed because 39 of 72 HBPC program patients reviewed had not been assessed and/or reassessed as required.

Because JC surveyors identified an immediate threat to life situation, the program’s accreditation status became Preliminary Denial of Accreditation. JC surveyors conducted a follow-up survey 2 weeks later and found that the immediate threat to life had been abated and JC determined the program met the criteria for Contingent Accreditation.³⁰

To address the program deficiencies, the FHCC developed an action plan and conducted monthly monitoring of the identified deficiencies. In August 2015, JC conducted another follow-up survey and determined the program complied with accreditation standards. During our review, we determined FHCC monitoring efforts of JC identified deficiencies revealed compliance with HBPC program requirements.

Issue 2: CLC Falls

We substantiated that a CLC patient (Patient A) who fell and fractured his/her hip in 2015 had an inaccurately low Morse Fall Scale assignment. In addition, we found Morse Fall Scale Notes in Patient A’s EHR were chronologically inaccurate, and were not completed monthly and after falls as required. We also substantiated that the CLC fall rate increased in FY 2014; however, CLC falls decreased in FY 2015.

Patient A: Patient A was a wheelchair-dependent CLC resident with a complex medical history. He/she fell twice within 5 days in late 2014. In early 2015, Patient A fell a third time. He/she was transported to the FHCC ED for evaluation and an ED physician diagnosed a right hip fracture.

The VA National Center for Patient Safety Falls Toolkit provides guidance for the systematic assessment of a patient’s risk for falling and recommends interventions.³¹ The guideline includes tools for post fall assessment, fall risk level, interventions, and documentation. One of the fall screening tools is the Morse Fall Scale, a tool used to identify fall risk factors. (See Appendix A.) The Morse Fall Scale score range is 0–125: Low Risk (0–24), Moderate Risk (25–44), and High Risk (>45). The purpose of an individualized fall prevention plan is to identify contributory factors to the individual’s fall risk. Patient fall prevention interventions are based on the score. As a result, the patient’s risk of falling is mitigated by implementation of specific prevention measures.

FHCC policy for the prevention of falls and injuries for the CLC required that nursing staff document patients’ fall risks using the Morse Fall Scale for all patients upon admission, every 30 days, when they are transferred, with a significant change in

²⁹ http://www.jointcommission.org/assets/1/6/HAP_Deeming_Prepub_June2014.pdf. Accessed July 7, 2016.

³⁰ The JC may recommend Contingent Accreditation when a health care organization has successfully abated an immediate threat to life situation.

³¹ <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>. Accessed July 7, 2016.

condition, and after a fall occurrence.³² Additionally, the FHCC's fall risk protocol requires that staff develop individualized fall prevention plans for patients.

We found the following issues with Patient A's Morse Scale Notes:

- Morse Scale Notes were chronologically inaccurate.
- Calculated Morse Scale scores were inaccurate.
- Morse Scale Notes were not completed post (after) falls.
- Monthly Morse Scale Notes were not completed.

Nursing staff are responsible for documenting patients' fall risk in FHCC Morse Scale Notes. Four Morse Scale notes were completed within the 10 days prior to the patient's fall in early 2015. Three of the four notes linked a "Date of Note" more than 2 months before the note was signed, rendering the fall risk assessments contained in each note outdated. Additionally, these three notes referred to Morse Fall Scale scores that were calculated after the "Date of Note," making the notes chronologically inaccurate. These date inaccuracies made it impossible to reliably interpret changes in the patient's fall risk level over time.

The patient's Morse Fall Scale scores of 15 and 35 in early 2015 were not consistent with the patient's condition at the time. We determined that the Morse Fall Scale score should have been 75:

- Falling within 3 months = 25,
- Secondary Diagnosis = 15,
- Impaired Gait = 20, and
- Forgets Limitations = 15.

The Morse Scale Notes signed in early 2015 all documented that high fall risk prevention measures had been implemented despite low fall risk scores. Morse Scale notes were not documented for Patient A's two falls in late 2014. On both occasions, Patient A was found in the bathroom, away from his/her wheelchair. At the time of the 2015 fall, Patient A fell onto the floor while reaching for an item near his/her bed, breaking his/her right hip.

FHCC staff failed to evaluate the patient's fall risk after the two falls in late 2014 and were not conducting monthly fall-risk assessments or implementing fall prevention measures prior to the third fall in early 2015 that resulted in Patient A's right hip fracture. Analyzing and learning from acute falls, and recognizing that risks for falls can change in a CLC is part of a continuous improvement process in a Falls program. Patient A's fall in early 2015 might have been prevented if post-fall and/or monthly fall risk

³² FHCC Joint Policy Instruction No.118-2014-12, *Fall Prevention and Management Program*, January 9, 2015.

assessments had been performed and appropriate fall prevention measures implemented as required by policy.

CLC Patient Fall Increase: While we substantiated that CLC patient falls increased during FY 2014, we found CLC patient falls decreased in FY 2015.³³ Prior to our review, FHCC leadership identified the increase in CLC patient falls and implemented an action plan to reduce them, which included staff education on fall prevention, patient assessment, and the use of tools for fall prevention.

Issue 3: Suicide Prevention

We did not substantiate that FHCC staff mishandled the suicides of two individuals. (See Patient B and Patient C below.) We did not substantiate that the FHCC suicide rate was unusually high.

Patient B: We did not substantiate that FHCC staff mishandled Patient B's suicide. The veteran died on the FHCC's property in 2014; the coroner ruled the death was a suicide. We reviewed FHCC documents related to the event and interviewed the Suicide Prevention Coordinators. We determined the veteran had not sought nor received VHA medical or mental health services and was not an FHCC patient. We found no indication the veteran's interactions with the FHCC contributed to events that led to his death.³⁴

Patient C: We could not substantiate that FHCC staff mishandled a Navy recruit's suicide in 2014 because we were unable to identify Patient C using the information provided. Our attempts to identify Patient C included interviewing a complainant and FHCC staff and reviewing all issue briefs created during and around the relevant timeframe in 2014.

Suicide Rate: We did not substantiate that the FHCC suicide rate was unusually high. We compared the 2014 FHCC suicide rate data to the VISN and National VHA user suicide rates. The FHCC's 2014 suicide rate was 22.0 per 100,000 users of VHA services. The VISN 12 suicide rate was 29.9 per 100,000 users of VHA services, and the National suicide rate was 39.0 per 100,000 users of VHA services in 2014.³⁵ We also reviewed the FHCC suicide prevention policy and compared it to VHA Suicide

³³ Due to the protected status of specific IPEC information, we do not discuss specific FHCC falls data collected by IPEC in order to comply with 38 U.S.C. 5705. VHA Directive, *Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents*, November 7, 2008. "Focused Reviews (including but not limited to...Inpatient Evaluation Center (IPEC)...which address specific issues (usually of major consequences to patient care processes and outcomes) or specific incidents (usually involving a discrete episode of care), and which are designated by the responsible office at the outset of the review as protected by 38 U.S.C. 5705, and its implementing regulations, are considered confidential.

³⁴ The patient was on the premises of the VAMC to undergo a compensation and pension benefits exam, which did not indicate clinical concerns requiring urgent follow-up.

³⁵ The comparative data was used not to infer statistical meaning but to gauge, in-general, the local FHCC user suicide rate relative to the VISN and National VHA user suicide rates.

Prevention Program requirements.^{36,37,38} The FHCC policy included all required VHA elements.

Issue 4: ED

We substantiated that on seven occasions the ED was left unattended by a qualified physician when ED physicians left the ED to perform emergency airway management in other FHCC care areas; however, we did not find any evidence that this interrupted the timely delivery of patient care. We substantiated that the ED did not have clerical staff support on weekends and most weekdays during the dayshift; however, we determined the ED clerical support staffing schedule did not conflict with VHA policy and did not negatively affect the timely delivery of patient care.

We did not substantiate that the ED LOS for admitted patients was long or that ED transfer rates were high. We substantiated that primary care providers referred Navy recruits to the ED for non-emergent care needs; however, we determined the practice was permitted under the EA to ensure recruits were ready for deployment at any time. We determined the EHR computer system and/or patterns of ED bed utilization did not negatively affect the FHCC's ability to meet ED LOS performance metrics.

ED Staffing: We substantiated that the ED was left unattended by a qualified physician when physicians left the ED to perform emergency airway management in other FHCC care areas. VHA Handbook 1101.04 requires that a qualified physician is present in the ED at all times, and the physician is not to be responsible for any inpatient activities except under select conditions, which are not applicable to this FHCC.³⁹ We reviewed ED physicians' schedules and the EHRs of patients who required airway management outside of the ED from January 1, 2015 through January 6, 2016. We found that ED providers left the ED unattended by a qualified physician to perform airway management on seven occasions.

We substantiated that the ED did not have clerical staff support on weekends and most weekdays during the dayshift; however, we determined the ED clerical support staffing schedule did not conflict with VHA policy because it did not negatively affect the timely delivery of patient care.

VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, requires that EDs and Urgent Care Centers are

³⁶ FHCC Joint Policy Instruction, No. 116-2015-08, *Suicide Prevention Procedures for Veterans, Military Members, and Dependents*, January 20, 2015.

³⁷ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, this handbook was scheduled for recertification by the last working date of September 2013. Although it was amended November 16, 2015, the recertification date was not reset with the amendment.

³⁸ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014.

³⁹ VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010. This handbook was scheduled for recertification on or before the last working day of August 2015 but has not yet been recertified.

provided with sufficient support services to ensure consistent delivery of timely care.⁴⁰ The Directive recognizes the important role support staff (including clerical services) play in ensuring patients receive timely care.⁴¹ However, the Directive does not identify any critical support staff who must be on station nor require support staff presence during all hours of operation. Rather, the Directive requires that sufficient support services must be provided to ensure that patients receive timely care. Because the ED met or exceeded FY 2015 LOS performance metric thresholds, we determined FHCC ED clerical support staffing practices did not negatively affect the timely delivery of patient care. (See Table 2.)

ED LOS and Boarding Rates: We did not substantiate that the ED LOS for admitted patients was long. We also determined ED boarding rates did not exceed the VHA ED performance thresholds.

VHA establishes ED performance metric goals (targets) and minimum standards (thresholds). FY 2015 performance metric targets and thresholds discussed in this review are displayed in Table 1. The ED met or exceeded VHA ED performance metrics for LOS and boarding thresholds during FY 2015.

⁴⁰ VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010. This directive was current at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1101.05(2) *Emergency Medicine*, September 2, 2016, amended March 7, 2017. Both directives have the same or similar language regarding ED personnel.

⁴¹ VHA Directive 2010-010, 4(e) states that the Chief of Staff and Nurse Executive are responsible for (5) “Providing sufficient support services to the ED and UCC to ensure that necessary and appropriate care can be consistently delivered to patients in a timely fashion. It is recognized that additional staff, such as health care technicians, paramedics, licensed practical nurses (LPNs), nurses’ aides, patient support assistants (PSA), pharmacists, and clerical staff, provide important supportive roles in the ED. NOTE: The use of such additional staff is supported and encouraged.” The current 2016 directive also supports and encourages the use of additional staff.

Table 1. FY 2015 VHA ED Targets and Thresholds and FHCC, VISN 12, and VHA National ED Performance Metrics

	Total Patient LOS	Discharged Patient LOS	Admitted Patient LOS	Percent Patients Boarded More Than 4 Hours
FY 2015 VHA Target	<=*200 minutes	<=150 minutes	<=240 minutes	<=10 percent
FY 2015 VHA Threshold	>=**300 minutes	>=210 minutes	>=360 minutes	>=25 percent
FHCC	165 minutes+	149 minutes+	282 minutes^	5.1 percent+
VISN 12	167 minutes+	140 minutes+	275 minutes^	10.3 percent^
VHA National	182 minutes+	154 minutes^	312 minutes^	14 percent^

Source: VHA Support Service Center EMMT Report, October 1, 2014–September 30, 2015.
 *Less than or equal to. **More than or equal to. +Green: Above Target. ^Yellow: Between the target and the threshold.

ED Transfer Rate: We did not substantiate that the ED transfer rate was high. The FHCC’s FY 2015 transfer rate was 1.1 percent, which was less than the 1.4 percent National FY 2015 transfer rate.

Navy Recruit ED Non-Emergency Care: While we substantiated that primary care providers referred Navy recruits to the ED for non-emergent care needs, we determined the practice was allowed under the EA to ensure recruits are ready for deployment at any time. FHCC leadership acknowledged that Navy recruits were, at times, referred to the ED for routine care because of the FHCC’s unique requirement to ensure mission readiness at all times. We determined the practice did not negatively affect the FHCC’s ED’s ability to meet LOS performance metrics. (See Table 1.)

Issue 5: Medical/Surgical Unit LOS

We did not substantiate that the medical/surgical unit LOS was long. The FHCC’s FY 2015 medical/surgical unit LOS was 2.48 days, which was less than the VISN 12 and National averages. During the same time period, VISN 12 and National FY 2015 averages were 3.28 and 3.12, respectively.⁴²

⁴² The average LOS reported represents the average number of days each patient stayed within the selected nursing unit type.

Issue 6: Hand Hygiene

We substantiated that nurses did not consistently follow proper hand-hygiene practices. VHA and FHCC policy requires that health care workers’ hand-hygiene practices are monitored for adherence to VHA handwashing policy.^{43,44} The FHCC established thresholds for hand hygiene compliance and monitored for compliance as required. With the exception of ED nurses in FY 2016, FHCC nurses on the medical/surgical unit, ICU, and ED did not meet the established threshold for hand hygiene compliance in FY 2014, FY 2015, and FY 2016. (See Table 2.)

Table 2: FHCC Nurse Hand Hygiene Data

Acute Care Areas	FY 2014 Percent Results	FY 2014 Percent Threshold	FY 2015 Results	FY 2015 Threshold	FY 2016 Results	FY 2016 Threshold
Medical/Surgical Unit	50%	73%	55%	75%	65%	75%
Intensive Care Unit	71%	80%	79%	83%	83%	87%
ED	81%	89%	69%	85%	86%	80%

*Source: FHCC Nursing Hand Hygiene data, October 2014–September 2016.
Green: Met the threshold. Red: Did not meet the threshold.*

Issue 7: ADIS Qualification

We did not substantiate that the ADIS lacked the required education and experience to qualify for the position.

The ADIS is the direct line supervisor for the medical/surgical unit and ICU nurse managers. The ADIS qualification requirements listed in the position’s Functional Statement included the following minimum education and experience qualification requirements: a Master’s Degree in Nursing or related health-care field and 2–3 years of experience in progressively responsible leadership assignments. The incumbent earned a Master’s Degree in Nursing in 2009 and had over 10 years of progressively responsible leadership experience prior to assuming the role of ADIS in 2015.

Issue 8: Other Quality of Care Allegations

We did not substantiate 10 of the 13 poor patient care allegations. We substantiated that an outpatient mental health clinic patient, who required one-to-one staff observation, left the FHCC and was deemed missing; however, we determined the

⁴³ VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011. This VHA Directive expired February 29, 2016 and has not yet been updated.

⁴⁴ FHCC Policy Instruction No.OOQ-2012-07, *Hand Hygiene Practices*, April 30, 2012.

patient was not harmed and was later admitted for inpatient care.⁴⁵ (See Patient D discussed below.) We could not substantiate the two remaining allegations because we did not receive sufficient information from the complainants to identify one of the patients or to identify the other patient's specific timeframe or episode of care. We were able to identify this patient, but the complainants could not provide specific information regarding the time frame for the alleged mismanagement of medical and psychiatric care. We reviewed this patient's EHR and did not find documentation of instances of mismanagement or poor care; however, without specifics to examine, we could not determine if we completely addressed the allegation.

Patient D: Based on the EHR review, we learned a staff member was assigned to watch Patient D one-to-one because the patient was assessed to be "at risk" for self-harm. However, the patient refused to stay in the outpatient mental health clinic, despite the assigned staff member's encouragement to remain. When Patient D left the clinic, staff contacted the VA police who located Patient D and brought him/her to the ED unharmed. Patient D was later admitted for inpatient care.

Conclusions

This review addressed a variety of allegations regarding poor quality of care at the FHCC covering the period January–July 2015. We focused the review on allegations that could have directly threatened patient safety if substantiated. In general, we did not review allegations of non-compliance with FHCC policies or failed leadership practices unless we could establish a direct relationship between those concerns and threats to patient safety. We did not address complainants' concerns that GAO addressed in its February 2015 report. We referred complainants who alleged retaliation and intimidation by leadership to the Office of Special Counsel.

We substantiated that the HBPC program's accreditation status was "threatened" in March 2015. However, the HBPC program attained accreditation status prior to our review.

We substantiated that a CLC patient who fell and fractured his/her hip in early 2015 had an inaccurately low Morse Fall Scale assignment. In addition, we found Morse Fall Scale Notes in the patient's EHR were chronologically inaccurate and not completed monthly and after falls as required. We also substantiated that CLC patient falls increased during FY 2014; however, prior to our review, FHCC leadership identified the increase in CLC patient falls and implemented an action plan to reduce them which included staff education on fall prevention, patient assessment, and the use of tools for fall prevention. CLC patient falls decreased in FY 2015.

⁴⁵ A missing patient is an "at-risk patient who disappears from the patient care areas (on VA property), or while under control of VHA." 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.

We did not substantiate that FHCC staff mishandled the suicides of two individuals. We also did not substantiate that the FHCC suicide rate was unusually high. For 2014, we found that the FHCC suicide rate of 22.0 per 100,000 users of VHA services was lower than the VISN and VHA National suicide rates, which were 29.9 and 39.0 respectively.

We substantiated that on seven occasions the ED was left unattended by a qualified physician when ED physicians left the ED to perform emergency airway management in other FHCC care areas; however, we did not find any evidence that this interrupted the timely delivery of patient care. We substantiated that the ED did not have clerical staff support on weekends and most weekdays during the dayshift; however, we determined the ED clerical support staffing schedule did not conflict with VHA policy because it did not negatively affect the timely delivery of patient care. We did not substantiate that the ED LOS for admitted patients was long or that ED transfer rates were high. We substantiated that primary care providers referred Navy recruits to the ED for non-emergent care needs; however, we determined the practice was permitted under the 2010 EA to ensure recruits were ready for deployment at any time.

We did not substantiate that the medical/surgical unit LOS was long. We substantiated that nurses did not consistently follow proper hand-hygiene practices. We did not substantiate that the ADIS lacked the required education and experience to qualify for his/her position.

We substantiated that an outpatient mental health clinic patient, who required one-to-one staff observation, left the FHCC and was deemed missing; however, we determined the patient was not harmed and was later admitted for inpatient care.

We made three recommendations.

Recommendations

1. We recommended that the Captain James A. Lovell Federal Health Care Center Director ensure that patients in the Community Living Center receive appropriate fall risk ratings and individualized fall intervention plans.
2. We recommended that the Captain James A. Lovell Federal Health Care Center Director ensure compliance with Veterans Health Administration policies on Emergency Department provider coverage.
3. We recommended that the Captain James A. Lovell Federal Health Care Center Director ensure compliance with Veterans Health Administration and Captain James A. Lovell Federal Health Care Center policies on hand hygiene practices.

Morse Fall Scale

Morse Fall Scale

Fall Risk is based upon Fall Risk Factors and it is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, at change of condition, transfer to new unit, and after a fall.

Variables		Score	
History of Falling	no	0	_____
	yes	25	
Secondary Diagnosis	no	0	_____
	yes	15	
Ambulatory Aid	None/bed rest /nurse assist	0	_____
	Crutches/cane/walker	15	
	Furniture	30	
IV or IV access	no	0	_____
	yes	20	
Gait	Normal/bed rest/wheelchair	0	_____
	Weak	10	
	Impaired	20	
Mental status	Knows own limits	0	_____
	Overestimates or forgets limits	15	
Total		_____	

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⁴³ Morse Fall Scale is from the VA National Center for Patient Safety, Falls Toolkit, Website, <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>. Accessed July 7, 2016.

Morse Fall Scale

Safety Factors

- Maintain bed in low position, bed alarm when needed
- Call bell, urinal and water within reach.
Offer assistance with elimination needs routinely
- Buddy system
- Wrist band identification
- Ambulate with assistance
- Do not leave unattended for transfers / toileting
- Encourage patient to wear non-skid slippers or own shoes
- Lock bed, wheelchairs, stretchers and commodes

Assessment

- Assess patient's ability to comprehend and follow instructions
- Assess patient's knowledge for proper use of adaptive devices
- Need for side rails: up or down
- Hydration: monitor for orthostatic changes
- Review meds for potential fall risk (HCTZ, Ace inhibitors, Ca channel blockers, B blockers)
- Evaluate treatment for pain

Family/Patient Education

- PT consult for gait techniques
- OT for home safety evaluation
- Family involvement with confused patients
- Sitters
- Instruct patient/family to call for assistance with out-of-bed activities
- Exercise, nutrition
- Home safety (including plan for emergency fall notification procedure)

Environment

- Room close to nurses station
- Orient surroundings, reinforce as needed
- Room clear of clutter
- Adequate lighting
- Consider the use of technology (non-skid floor mats, raised edge mattresses)

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 29, 2017

From: Director, VA Great Lakes Health Care System (10N12)

Subj: Healthcare Inspection—Quality of Care and Other Concerns,
Captain James A. Lovell Federal Health Care Center, North Chicago,
Illinois

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed the document and concur with the recommendations.
2. Corrective action plans have been established as detailed in the attached report. If additional information is needed, please contact my office at (708) 492-3200.



Renee Oshinski
VISN 12 Network Director

FHCC Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 29, 2017

From: Director, Captain James A. Lovell Federal Health Care Center (556/00)

Subj: Healthcare Inspection—Quality of Care and Other Concerns,
Captain James A. Lovell Federal Health Care Center, North Chicago,
Illinois

To: Director, VA Great Lakes Health Care System (10N12)

1. Attached is the Captain James A. Lovell Federal Health Care Center's response to the Office of Inspector General's report. I want to express my appreciation to the OIG survey team for their professional and comprehensive review.
2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans, active duty patients and families.
3. For any questions, please contact Survey Accreditation Facilitator @ 224-558-5986.



Stephen R. Holt, MD, MPH, MSNRS
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Captain James A. Lovell Federal Health Care Center Director ensure that patients in the Community Living Center receive appropriate fall risk ratings and individualized fall intervention plans.

Concur

Target date for completion: Completed on August 2016

FHCC response: FHCC implemented a weekly standardized fall prevention Gemba walk beginning January 2015 for every patient care area to ensure the utilization of individualized patient fall intervention plans. The facility has also conducted an annual Fall Aggregate review and Falls summit since 2015. Weekly tracers were implemented to ensure that the patients are receiving appropriate fall risk ratings and individualized fall intervention plans. Audits of Morse Scale Score and individualized fall intervention plans were implemented. Results demonstrated compliance with established 90% target:

Morse Scale Score

February 2016	52/52 = 100%
March 2016	55/55 = 100%
April 2016	53/53 = 100%
May 2016	58/61 = 95%
Jun 2016	49/53 = 92.4%
July 2016	54/54 = 100%

Individualized fall intervention plans

February 2016	133/133 = 100%
March 2016	131/131 = 100%
April 2016	101/111 = 91%
May 2016	109/109 = 100%
Jun 2016	104/104 = 100%
July 2016	101/101 = 100%

OIG Comment: based on information received, we consider this recommendation closed.

Recommendation 2. We recommended that the Captain James A. Lovell Federal Health Care Center Director ensure compliance with Veterans Health Administration policies on Emergency Department provider coverage.

Concur

Target date for completion: December 2017

FHCC response: FHCC is working to strengthen its staffing plan to have in-house licensed independent practitioners provide Emergency Department coverage when the ED provider responds to a code to perform emergency airway management in other FHCC care areas.

Recommendation 3. We recommended that the Captain James A. Lovell Federal Health Care Center Director ensure compliance with Veterans Health Administration and Captain James A. Lovell Federal Health Care Center policies on hand hygiene practices.

Concur

Target date for completion: December 2017

FHCC response: FHCC implemented action plans including Infection Control Practitioners daily rounding and weekly tracers to monitor compliance, provide just-in-time training and post the compliance results in clinical areas resulting in consistent improvement in hand hygiene compliance. Actions will continue until the 80% target is attained and sustained.

OIG Contact and Staff Acknowledgments

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