



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

Office of Healthcare Inspections

Report No. 13-00670-540

Healthcare Inspection

Follow-Up Review of the Pause in Providing Inpatient Care VA Northern Indiana Healthcare System Fort Wayne, Indiana

September 29, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an oversight review to follow up on recommendations OIG made in the published report, *Healthcare Inspections—Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana, Report No. 13-00670-262*, issued on August 28, 2014. The purpose of the review was to evaluate the progress VA Northern Indiana Healthcare System's Fort Wayne campus (facility) has made in implementing the action plan outlined in response to the 2014 report. Our review was limited to the Healthcare System's Fort Wayne campus.

Originally in November 2012, Senator Joe Donnelly and Congressman Marlin Stutzman requested the OIG conduct an inspection about the suspension (pause), initiated in October 2012, of all inpatient admissions at the facility. The pause was part of Veterans Integrated Service Network 11 proactive risk management decisions that were warranted based on clinical and administrative circumstances affecting the facility at the time.

In January 2014, an acute 16 bed medical unit with telemetry capability was operational; however, the Intensive Care Unit (ICU) remained closed. In July 2014, the official date to reopen the ICU as a Level 4 had not been established. On October 22, 2014, the facility reopened the ICU with two beds and in December increased the number of beds to four.

During our onsite visit in April 2015, we found that the facility continued to support 16 medical beds with telemetry capability and 4 ICU beds. We determined that Veterans Integrated Service Network 11 and facility leadership had completed actions to reopen the ICU and taken actions to actively recruit and hire staff to fill leadership and qualified clinical positions. We also determined that nursing leadership assessed the utilization of the nursing staff to systematically plan assignments.

In summary, we found that Veterans Integrated Service Network and facility leadership exercised oversight and implementation of corrective actions to resolve the conditions identified in the 2014 report. The facility is now admitting patients to the acute medical unit and the ICU. We made no further recommendations.

Comments

The Acting Veterans Integrated Service Network and VA Northern Indiana Healthcare System 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 conducted an oversight review to follow up on recommendations OIG made in *Healthcare Inspection—Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana, Report No. 13-00670-262*, issued on August 28, 2014.¹ The purpose of the review was to evaluate the progress VA Northern Indiana Healthcare System's (VANIHCS) Fort Wayne campus has made in implementing the action plan outlined in response to the 2014 report.

Originally in November 2012, Senator Joe Donnelly and Congressman Marlin Stutzman requested the OIG to conduct a review related to the October 2012 suspension of inpatient admissions at the facility.

Background

VANIHCS consists of two campuses located in Fort Wayne and Marion, IN, and is part of Veterans Integrated Service Network (VISN) 11. The Fort Wayne campus (facility) provides outpatient primary care and inpatient medical services.

In October 2012, the facility implemented a suspension (pause) of all inpatient admissions at the facility. The pause was part of the VISN's proactive risk management based on clinical and administrative circumstances that affected the facility at the time. The pause involved only the facility. At that time, the facility had 22 medical beds with some telemetry capability and 4 Intensive Care Unit (ICU) beds for a total of 26 authorized beds. In fiscal year (FY) 2012, the average daily census (ADC) was 15.7 inpatients for the medical unit and 1.9 inpatients for the ICU.

The VISN's active oversight role in implementing the pause and its continued review of the facility's progress to reopen the ICU was essential in addressing administrative and clinical actions to ensure quality health care delivery. The VISN and the facility implemented a phased-in process to return the facility to operational status for inpatient services and the reopening of a Level 4 ICU.² In the 2014 OIG report, we noted that the facility was not at full capacity nor at normal operations. At that time, the facility had 16 medical beds with telemetry capability on the acute medical unit; however, the ICU remained closed.

In our 2014 report, we recommended that:

- The VISN Director ensure continued monitoring and implementation of actions for reopening of the ICU.

¹ <http://www.va.gov/oig/pubs/VAOIG-13-00670-262.pdf>

² Almenoff, P., Sales, A., Rounds S., et al. *Intensive care services in the Veterans Health Administration*. Chest 2007, 132:1455–62.

- The VISN Director and the Facility Director ensure continued recruitment efforts to hire qualified key leadership and qualified clinical staff.
- The Facility Director ensure that nursing leadership assess the utilization of nurse staffing to systematically plan assignments during times when the acute medical unit's census is low.

Scope and Methodology

Our review was limited to operations at the Fort Wayne campus of VANIHCS. The review period for this inspection was April 6–May 27, 2015.

We conducted an onsite review April 14–15, 2015. We interviewed the VISN 11 Acting Network Director and the VISN 11 Chief Medical Officer. We also interviewed VANIHCS leadership to include the VANIHCS Director; VANIHCS Interim Director; Fort Wayne Acting Associate Director; Acting Assistant Director; Chief of Staff (COS); Acting Associate COS for Acute Medicine/Deputy COS; Chief of Surgery; Directors for the Emergency Department, ICU, and the Hospitalists; Associate Director for Patient Care Services; Resource Manager for Patient Care Services; ICU Nurse Manager; Chief of Quality Management; Assistant Chief of Human Resources; Public Affairs Officer; and the Customer Service Manager. We reviewed VHA and facility administrative documents, policies and procedures, quality management documents, patient advocate records, and other relevant documentation.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was 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.

Inspection Results

Issue 1: ICU Level of Care

In our 2014 report, we recommended that the VISN ensure continued monitoring and implementation of actions for the reopening of the ICU. During the present review, we determined the VISN and the facility took corrective actions to reopen the ICU.

On October 22, 2014, the facility reopened the Level 4 ICU with two beds, and on December 3, the bed capacity was increased to four. The ICU ADC from October 22, 2014, to March 30, 2015, was 1.05 inpatients. During our onsite visit April 14–15, 2015, the ICU bed census was 4 inpatients.

The facility had 16 medical beds with telemetry capability on the acute medical unit in April 2015. The unit's ADC increased after the ICU was reopened in October 2014. The ADC was 2.3 inpatients in FY 2013 and 4.8 inpatients in FY 2014. From October 1, 2014 to March 30, 2015, the ADC was 8.7 inpatients. The medical bed census was 10 inpatients on April 14, 2015, and 15 inpatients on April 15, 2015.

In FY 2014, the facility transferred 2,453 patients who required care beyond the scope of services provided by the facility to Non-VA Care.³ From October 2014 to March 2015, the facility transferred 1,213 patients to Non-VA Care. Facility leadership stated that although the facility has resumed admitting inpatients, including to the ICU, some patients will continue to receive Non-VA Care because some specialty services are not provided at the facility, such as neurosurgery.

We also determined through discussion with the Customer Service Manager that the facility did not receive any complaints related to inpatient care access from March 2014 through March 2015.

Issue 2: Qualified Clinical Staff

In our 2014 report, we recommended that the VISN Director ensure that efforts continue to recruit qualified clinical staff to provide care. During the present review, we determined corrective actions were taken to recruit and hire qualified clinical staff.

We found that VISN and facility leadership made active recruitment efforts to hire qualified clinical staff. Since March 2014, the facility reported hiring 25 physicians representing various services, including cardiology, emergency, hospitalists, primary care, psychiatry, and fee-basis.⁴ Facility leadership told us that the success in physician hiring might be due, at least in part, to the facility's addition of a full-time physician recruiter.

³ Non-VA care is used when VA medical facilities are not feasibly available, <http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/>.

⁴ Personnel appointed on a fee-basis contract and provide services on the facility's premises.

Since March 2014, the facility hired 27 registered nurses (RNs). Nursing leadership stated the ICU was fully staffed with 12 skilled, full-time RNs and 4 medical technicians.

Issue 3: Recruitment and Appointment of Leadership Positions

In our 2014 report, we recommended that the VANIHCS Director ensure that efforts continue to recruit qualified staff for vacant leadership positions. During the present review, we determined that corrective actions were taken to recruit and hire qualified staff for leadership positions.

We determined that administrative and clinical leadership positions were filled including the Deputy COS; Directors for the Emergency Department, Hospitalists, and ICU; the Associate COS Primary Care; and nursing leadership positions. Facility leadership stated that the facility hired qualified, skilled staff and that the stability of leadership has improved. Although select leadership and management positions continued to be vacant, such as the Associate Director and Chief of Extended Care, the facility was actively recruiting.

Issue 4: Utilization of the Nursing Staff to Systematically Plan Assignments

In our 2014 report, we recommended that the VANIHCS Director ensure that nursing leaders assess the utilization of the nursing staff to systematically plan assignments during times when the acute medical unit's census is low. During the present review, we determined that corrective actions were taken to assess utilization of nursing staff.

Nursing leadership reported implementing a software package in October 2014 that assists in tracking direct and indirect patient care hours by nursing service for the planning and deployment of staff. For the period when the acute medical unit's census was low, from October 2014 through March 2015, the acute medical unit deployed nursing staff to various other assignments in the facility for a total of 2,561 hours.

Conclusions

VISN and facility leadership took appropriate actions to reopen the ICU. The official reopening date of the facility's ICU occurred on October 22, 2014. Recommendation 1 is closed.

VISN and facility leadership took actions to actively recruit and hire leadership positions and qualified clinical staff. The facility ensured the appropriate level of clinical staff to reopen the Level 4 ICU. Both physicians and nurses have been hired under recent hiring initiatives. Recommendations 2 and 3 are closed.

Nursing leadership implemented a software package to assess the utilization of the nursing staff to systematically plan assignments. Recommendation 4 is closed.

In summary, VISN and facility leadership exercised oversight and implementation of corrective actions to resolve the conditions identified in the 2014 report. The facility is now admitting patients to the acute medical unit and the ICU. We made no further recommendations.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: August 19, 2015

From: Director, Veterans in Partnership VISN 11 (10N11)

Subj: Healthcare Inspection—Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana

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

1. Please find the attached response to Healthcare Inspection—Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana.
2. If you have any questions, please contact Carol M. Jones, RN, Chief Quality, Safety & Values/Chief Nurse Officer at 734-222-4300.



ROBERT P. McDIVITT, FACHE/VHA-CM
Acting VISN 11 Network Director

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 19, 2015

From: Director, VANIHCS, Fort Wayne, IN (610A4/00)

Subj: Healthcare Inspection—Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana

To: Director, Veterans in Partnership VISN 11 (10N11)

1. This memorandum serves as concurrence with the Office of Inspector General's report and notification of closure for the four recommendations received as a result of the Follow-Up Review of the Pause in Providing Inpatient Care at the Fort Wayne Campus of VA Northern Indiana Healthcare System.

2. I appreciate the opportunity to review our processes to improve the care to our Veterans.

Sincerely,



Denise M. Deitzen
Director, VA Northern Indiana Health Care System

OIG Contact and Staff Acknowledgments

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