



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

**Office of Healthcare Inspections**

**Report No. 14-01708-123**

## **Healthcare Inspection**

# **Staffing and Patient Care Issues West Palm Beach VA Medical Center, West Palm Beach, Florida**

**February 12, 2015**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations:**

**Telephone: 1-800-488-8244**

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## Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to complaints about staffing and patient care issues in the medical intensive care unit (MICU) at the West Palm Beach VA Medical Center (facility), West Palm Beach, FL.

We substantiated the allegation that senior nursing management and nursing officers of the day had an inappropriate understanding of the staffing methodology for safe staffing in the MICU. The staffing methodology process and plan required by the Veterans Health Administration to be in place by September 30, 2011, had not been fully implemented at the time of our visit in April 2014.

We did not substantiate the allegation that insufficient staffing in the MICU caused orders to be missed, and we could not substantiate the allegation that floating (temporary reassignment to another nursing unit) of the MICU staff caused delays in blood transfusions or inappropriate/unsafe hand off communication.

We substantiated the allegation that understaffing in the MICU contributed to an increase in patient falls and that the number of falls from October through March fiscal year (FY) 2014 exceeded the total number of falls for FY 2013. We did not substantiate that two falls resulted in patient injury.

We substantiated the allegations that unnecessary and frequent floating of the MICU staff contributed to the departure of several experienced registered nurses (RN) and that frequent floating and changes of assignments of MICU RNs and health technicians occurred.

We did not substantiate the allegation that an RN was sent to a telemetry floor so as to free up an RN on that floor to do paperwork for the telemetry nurse manager. We substantiated the allegation that nursing staff were sent to areas and given assignments where they did not feel either comfortable or competent. We did not substantiate the allegation that, to prevent the use of overtime, a staff member who was still being oriented to the facility and position was required to sit with suicidal patients.

We did not substantiate the allegation that insufficient staffing caused difficulty in covering the additional duties of the MICU RN staff due to a lack of specific shifts or occasions this may have occurred. However, we noted that the MICU staffing was frequently less than the established staffing requirements, and the staff member who would have been responsible for performing any additional duties was often floated to another unit.

We did not substantiate the allegation that the step down unit (a unit for less acutely ill patients) was opened and closed every 2 days in October and November 2013. We substantiated the allegation that one RN was left alone in the step down unit on four occasions in October and November. We did not substantiate that the RN had to leave the patients and unit unattended.

We substantiated the allegation that nursing staff documented their concerns about unsafe staffing in writing, but the paperwork “never seemed to make it past nursing service” to the appropriate person or department. The facility’s process for reporting incidents was not set up to ensure that incidents were reported to the Patient Safety Manager as required.

We also found that the facility policy for prevention of falls and injuries was not being followed.

We recommended that the Facility Director ensure that senior leadership and nursing managers fully implement the Veterans Health Administration Nurse Staffing Methodology Plan, as required; evaluate the medical intensive care and step down units’ patient mix, staffing plan, patterns of floating, physical layout, and unit assignments for opportunities for improvement and take necessary action; strengthen patient incident reporting processes to ensure that patient incidents or safety concerns are reported promptly to the patient safety manager; and require nursing staff to perform and document fall risk assessments as required.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 12–18 for the Directors’ comments.) We consider recommendation 4 closed. We will follow up on the planned actions for recommendations 1–3 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 to assess the merit of allegations of inadequate staffing and patient care issues in the medical intensive care unit (MICU) at West Palm Beach VA Medical Center (facility), West Palm Beach, FL.

## Background

The facility is a tertiary care facility with 181 acute care beds that provides a broad range of medical, surgical, and psychiatric inpatient care, as well as primary and specialty care outpatient services. The facility is part of Veterans Integrated Service Network (VISN) 8 and serves a veteran population of 56,677 unique patients.

The facility's MICU includes 8 beds in a 14-bed unit; the remaining 6 beds are designated as step down beds for less acutely ill patients. The patient population includes medical and surgical patients who are critically ill, require close monitoring, and have complex care needs.

### Nurse Staffing Methodology

The Veterans Health Administration (VHA) required all facilities to implement a nationally standardized staffing methodology process to determine the numbers and types of nurse staffing needs for all inpatient units by September 30, 2011.<sup>1</sup> The recommended process included a systematic collection of a minimum set of core evidence-based data to support staffing decisions and a foundation of professional judgment, critical thinking, and flexibility with an emphasis on patient outcomes. Staffing needs were to be individualized to specific clinical settings and not rely solely on ranges and fixed staffing models, staff to patient ratios, or prescribed patient formulas.

VHA's staffing methodology directive required each nursing unit to convene a panel of staff who worked on the unit that was representative of all nursing roles, including registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants. The unit-based panels were to analyze staffing needs and make recommendations for the target nursing hours per patient day<sup>2</sup> (HPPD) needed per unit. A second panel, the facility-based expert panel, comprised of facility staff knowledgeable about making staffing decisions based on system factors, reviewed the recommendations and forwarded them to the Nurse Executive for his/her approval and the facility Director's endorsement.<sup>3</sup>

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<sup>1</sup> VHA Directive 2010-034, Staffing Methodology for VHA Personnel, July 19, 2010, page 2.

<sup>2</sup> HPPD is a staffing calculation method that is derived from the number of hours of nursing care expected to be provided on a hospital unit compared to the number of patients on that unit during a 24-hour period.

<sup>3</sup> Staffing Methodology for VHA Nursing Personnel Guidebook, Version 3/31/2011, page 32.

The nurse staffing methodology replaced the previously used patient classification system, which was outdated, did not account for complexity of care, and was based on staff to patient ratios.

### **VHA National Center for Patient Safety Fall Prevention Guidelines**

The VHA National Center for Patient Safety Fall Prevention and Management Aid provides guidance for a systematic assessment for determining patients' risk for falling and recommends interventions. Fall risk assessments should be done when the patient is initially admitted, there is a change in status, the patient is transferred to a new location, and prior to patient discharge. The guideline includes tools for post fall assessment, fall risk level, interventions, and documentation. Furthermore, the guideline states that if a patient is not at risk for falling based on assessment, interventions should still be implemented to protect the patient from extrinsic fall risk factors such as the presence of clutter, spills, and electrical cords. These guidelines are reflected in the facility's fall and injury prevention policy.

### **Allegations**

The OIG received an anonymous complaint with multiple allegations concerning staffing in the MICU, increased risks to patient safety, increased patient falls, and a hostile work environment. The allegations are summarized as follows:

- Senior nursing management and nursing officers of the day (NODs) have an inappropriate understanding of the staffing methodology for safe staffing in the MICU; false calculations have been used to determine MICU staffing, and the staffing numbers have been covered up and not addressed by nursing leaders.
- Insufficient nurse staffing in the MICU compromised patient safety and quality of care. Specifically:
  - A change in nursing assignments in the middle of the shift caused an interruption in patient care, missed orders, a delay in blood transfusions, and inappropriate/unsafe hand off communication.
  - Understaffing in the MICU and cancelling patient fall prevention programs resulted in two falls that caused patient injury and the number of falls so far in fiscal year (FY) 2014 exceeded the total number of falls for the entire FY 2013.
- Unnecessary and frequent floating<sup>4</sup> of the MICU staff has led to the following:
  - Departure of several experienced RNs, making the turnover rate the highest since the facility opened in 1995.

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<sup>4</sup> "Floating" refers to temporarily assigning staff to work in another unit or area of patient care in a facility.

- An RN was sent to one area, then pulled to another 30 minutes after getting report.
  - An RN was sent to the telemetry floor to free up an RN on that floor to do paperwork for the telemetry nurse manager.
  - The nursing staff were sent to areas and given assignments they were not competent in or comfortable with (for example, psychiatric and long-term care unit). Specifically, they were not familiar with medications and care documentation used on these units.
  - To prevent the use of overtime, new staff (still in orientation) were required to sit with suicidal patients.
  - MICU RNs experienced difficulty in covering their additional duties, including responding to medical emergencies all over the hospital and recovering patients when the post-anesthesia unit was closed.
  - The NOD did not provide assistance or record events when there were two simultaneous codes<sup>5</sup> and a threatening family member was present in the MICU. The NOD came after the family was removed by the police, only to request that an RN float to another unit.
- The step down unit<sup>6</sup> was opened and closed every 2 days in October and November 2013 and was staffed by only one RN. The RN would have to leave the patients unattended to seek help or find a witness for a narcotic waste.
  - The nursing staff documented and submitted their concerns about unsafe staffing, but the documentation was not sent by nursing leadership to the appropriate service for review.
  - The nursing staff and MICU manager have been exposed to a hostile work environment created by current nursing administration leaders when they advocate for patient safety and safe staffing levels, and past managers left the position due to an unwillingness to tolerate the verbal abuse and work environment.

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<sup>5</sup> A cardiopulmonary arrest requiring resuscitation by a team of trained medical personnel.

<sup>6</sup> A unit that generally has less acutely ill patients than an intensive care unit.

## Scope and Methodology

We conducted a site visit April 7–9, 2014. During this site visit we interviewed MICU staff nurses, the unit manager, the staffing coordinator, senior nurse managers, the Chief of Staff, a Quality Management (QM) staff member, and an NOD. We also toured the MICU and step down unit.

We reviewed VHA and facility policies and procedures, nurse competency records, staffing data, internal reports, fall aggregated data, peer reviews, the electronic health records (EHRs) of selected patients, and other relevant documents.

We did not address the allegations related to hostility in the workplace as they were beyond the purview of the OIG Office of Healthcare Inspections review.

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: Nurse Staffing Methodology

We substantiated the allegation that senior nursing management and nursing officers of the day had an inappropriate understanding of the staffing methodology for safe staffing in the MICU. We did not substantiate the allegations that false calculations have been used to determine MICU staffing and that staffing numbers have been covered up and not addressed by nursing leaders.

Although VHA mandated that a staffing methodology based on HPPD be approved by the facility Director and implemented by September 30, 2011, we found that the required processes of developing a staffing methodology through unit and facility expert panels was not begun until June 2013, and the facility Director did not approve the initial staffing methodology plan until September 24, 2013. Onsite interviews revealed that the process was not fully implemented, and a dual system to determine staffing needs for all nursing units was being used. While unit staffing patterns were being retroactively evaluated using the required staffing methodology process, we found that a staffing grid (a chart that prescribed how many nurses were to be assigned to a specific unit by shift) based on the old classification system of staff to patient ratios was still being used to determine staffing needs.

We were given copies of an “old” grid and a modified grid that the NOD was currently using, both of which appeared to be based on the outdated patient classification system of staff to patient ratios to adjust daily staffing needs. Managers and NODs were confused about which grid was the most current, correct one. We were told that electronic data entry for the grid currently being used was difficult, could only be updated by one person at a time, and if the required HPPD staffing data and the unit census by shift were not updated, then staffing data reports were inaccurate.

A “new” grid and FY 2014 staffing methodology plan were given to us onsite but had not been implemented at the time of our visit. We were told that the staffing formulas and calculations for the “new” grid had been changed to reflect the current staffing methodology plan; however, no one was able to demonstrate this to us.

We reviewed daily assignment sheets and staffing data analysis for the MICU from October 2013 through March 2014. We determined that the discrepancies in actual staffing provided, when compared with staffing needs, were related to the difficulty in reconciling data from two different staffing processes but did not find evidence of use of false data or intentional manipulation of staffing data to cover up staffing shortages. We noted that the patient mix in the MICU (8 of the 14 beds were designated for MICU patients, and 6 beds were for step down patients) contributed to the difficulty in calculating staffing needs for the unit.

## **Issue 2: Compromised Patient Safety Due to Insufficient Staffing in MICU**

We did not substantiate the allegation that insufficient staffing in the MICU caused orders<sup>7</sup> to be missed. We were not provided with information or documentation of specific patients who had missed orders. We noted that an EHR of an MICU patient who had fallen had several deficiencies related to the required renewal of orders for restraint use and observation level by the ordering provider but did not find evidence that nursing staff did not follow all written orders.

We could not substantiate the allegation that floating of the MICU staff caused delays in blood transfusions or inappropriate/unsafe hand off communication. Although the MICU nursing staff and managers interviewed expressed their concerns that staff shortages, frequent floating, miscommunication, and frequent changes in assignment caused delays in patient care, they were unable to provide specific patient incidents or documentation related to these allegations.

We substantiated the allegation that understaffing in the MICU contributed to an increase in patient falls and that the number of falls from October through March FY 2014 exceeded the total number of falls for FY 2013. The MICU had one patient fall in FY 2013. Five falls occurred in the first 2 quarters of FY 2014. According to the HPPD staffing data and variance reports,<sup>8</sup> four of the five falls occurred when MICU staffing was below the required HPPD. We were also told that health technicians<sup>9</sup> assigned to the MICU had the responsibility of checking on patients frequently to prevent patient falls. When the decision was made to use the technicians elsewhere in October 2013, falls increased within 2 months. However, other aspects of a fall prevention program, including use of bed and chair alarms and hourly rounds by staff, remained in place.

We did not substantiate the allegation that two patient falls resulted in serious injury to two patients. Reported falls data from October 2013 through March 2014 showed that the MICU had five falls; however, according to their EHRs, none of these patients suffered serious injuries.

## **Issue 3: Problems Related to Floating of MICU Staff**

We substantiated the allegation that unnecessary and frequent floating of the MICU staff has led to the departure of several experienced RNs. The unit's nurse manager confirmed that at least three RNs transferred to other areas to avoid being floated. Data from the facility's strength and turnover rate report from December 2012 through September 2013 reflected that the facility hired 12 nurses to work in the MICU. We were told that this was in anticipation of opening a 6-bed step down unit; however, the

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<sup>7</sup> Orders refer to written directions for medications, treatments and/or instructions prescribed by a provider for a patient.

<sup>8</sup> Variance reports show when staff is floated to other units, and any other changes in patient care assignments on a given unit.

<sup>9</sup> Unlicensed nursing personnel, also known as nurse assistants.

unit was not opened when planned, resulting in overstaffing of the MICU. Consequently, the MICU nursing staff were required to float to other units frequently, resulting in eventual loss of some nursing staff. At the time of our visit, the unit had nine vacancies for RNs.

We substantiated the allegations of frequent floating and RN within-shift assignment changes in the MICU. Review of MICU staffing data and patient assignments by shift from January 2013 through March 2014 showed evidence of frequent floating of MICU nurses to other units, even when the staffing levels for the MICU were below HPPD targets.<sup>10</sup> In addition, we found several instances when MICU staff were floated outside of the unit, yet staff from another unit were floated to the MICU for the same shift.

We could not substantiate the allegation that an RN was sent to a telemetry floor so as to free up an RN on that floor to do paperwork for the telemetry nurse manager. While the daily nursing assignment reports showed that staff were frequently floated to the telemetry unit, we could not corroborate that the reason they were floated was for staff to perform functions other than direct patient care, and none of the staff we interviewed could provide us with further information.

We substantiated the allegation that nursing staff were sent to areas (such as psychiatric and long-term care units) and given assignments they did not feel competent in or comfortable with due to the special needs of patients in those areas. Daily nursing assignment reports reflected that from January through June 2013 and August through December 2013, nursing staff were frequently required to float to medical/surgical, telemetry, psychiatry, emergency department, post anesthesia care unit, hospice, and long-term care units to perform direct patient care. We reviewed the competency documentation for nine RNs and did not find evidence that the staff were oriented or cross-trained to other units that had different patient populations, medications, or other unique needs. The MICU nurse manager requested that the NODs not send the MICU nurses to the psychiatry or long-term care units to administer medications because the MICU staff voiced concerns about that type of assignment. At the time of our visit, the NODs were complying with that request.

We could not substantiate the allegation that, to prevent the use of overtime, new staff had to sit with suicidal patients. We reviewed the HPPD report from January 2013 through March 2014 and the daily schedule/staffing and variance reports from January 1, 2013, through January 11, 2014, and found only one incident in which a nursing assistant was assigned to float to the emergency department to do a one-to-one observation for a suicidal patient. At the time of this assignment, the employee had been orienting for nearly 3 months.

We did not substantiate the allegation that insufficient staffing caused difficulty in covering the additional duties of the MICU RN staff because we were not provided with specific incidences or data that the MICU staff were unable to perform additional duties

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<sup>10</sup> HPPD targets refer to a range of acceptable staffing levels on a unit.

as needed. However, the daily nursing assignment and variance reports from January 1, 2013, through January 11, 2014, showed that MICU nurses were frequently floated to other units, even though their HPPD requirements were below target. We also noted that the unit facilitator (charge nurse) was often floated. Since the unit facilitator was expected to perform the extra duties as needed, other nursing staff, who already had full patient assignments, were expected to perform those duties.

We did not substantiate that the NOD did not respond when needed. None of the nursing staff or managers we interviewed were aware of any concerns of this nature.

We did not substantiate the allegation that the step down unit was opened and closed every 2 days in October and November 2013. We were told that the step down unit was opened October 10, 2013, and daily staffing data reflected that the unit was staffed on all shifts for 2 months in October and November and has remained open.

We substantiated the allegation that one RN staffed the step down unit on four occasions in October and November; however, we could not substantiate that the RN had to leave the unit and patients unattended to get a witness for a narcotic waste. According to the staffing plan, two nurses should be present in the unit at all times.

During our tour of the step down unit, we observed that this unit is physically separated and not easily visible from the MICU. The physical isolation of the unit and insufficient staff assignments could potentially compromise patient safety.

#### **Issue 4: Patient Incident Reporting Process Issues**

We substantiated the allegation that the nursing staff documented their concerns about unsafe staffing in writing, but the documentation of concerns may not have been reported or routed to the appropriate service.

We learned onsite that the facility does not have a system in place to track reports of patient incidents or safety concerns from the point of initiation. Local patient safety policy requires that the first employee who learns of or witnesses an incident involving actual or potential harm to a patient is to initiate a patient incident worksheet (PIW). Staff are expected give the PIW to their nurse manager, who, we were told, can choose to do his or her own fact-finding and then send the PIW to the appropriate senior nursing manager and that sometimes the PIW “disappears into the system.” The senior nursing manager is then supposed to send the PIW to the QM Service.

The FY 2013 service-level review and QM report data for the MICU did not reflect that any staffing-related issues had been received by the QM Service. We confirmed with the Associate Chief of QM that PIWs are documented on paper and not tracked until they are received in Nursing Service and routed to QM, so there is no way to know when PIWs have been initiated but not reported or routed properly.

## **Issue 5: Additional Finding**

During our review, we found inconsistent documentation of fall risk assessments. Local policy for the prevention of falls and injuries requires that nursing staff perform and document fall risk assessments in the EHR, using a specific template, for all patients upon admission, transfer, change in condition, and after a fall occurrence. Completion of the assessment assists with identification of measures needed to prevent initial or recurring falls.

We reviewed the EHRs of all six patients who had a fall in the MICU during FY 2013 and the first 2 quarters of FY 2014. We found that the EHRs did not have documentation that required fall risk assessments had been done for one patient on admission, three patients upon transfer to other locations within the facility, and one patient with a change in condition.

## **Conclusions**

We substantiated the allegation that senior nursing management and NODs had an inappropriate understanding of the staffing methodology for safe staffing in the MICU. The staffing methodology process and plan required by VHA to be in place by September 30, 2011, had not been fully implemented at the time of our visit. We could not substantiate the allegation that false calculations have been used for MICU staffing or that the numbers had been covered up and not addressed by nursing leaders. The lack of full implementation of the staffing methodology required by VHA, coupled with the persistent use of an older, outdated staffing “grid,” has led to confusion, inaccurate data, and frustration of nursing staff and managers. Furthermore, applying the current staffing methodology processes and evaluating staffing data in the MICU is complicated by the fact that the MICU has “step down” patients that do not require the level of nursing care that the more critically ill MICU patients require.

We did not substantiate the allegation that insufficient staffing in the MICU caused orders to be missed, and we could not substantiate the allegation that floating of the MICU staff caused a delay in blood transfusions or inappropriate/unsafe hand off communication.

We substantiated the allegation that understaffing in the MICU contributed to an increase in patient falls and that the number of falls as of March FY 2014 exceeded the total number of falls for the entire FY 2013. The MICU had one patient fall in FY 2013, and five falls in the first 2 quarters of FY 2014. However, we did not substantiate the allegation that two patient falls resulted in serious injury to the patients.

We substantiated the allegations that floating of the MICU staff has led to the departure of several experienced RNs and that there was frequent floating and changes of assignments of RNs. The frequent assignment changes and floating of staff to other units causes a high level of dissatisfaction with staff and makes it difficult to ensure continuity of care.

We did not substantiate the allegation that an RN was sent to telemetry floor so as to free up an RN on that floor to do paperwork for the telemetry nurse manager.

We substantiated the allegation that nursing staff were sent to areas and given assignments that were outside their competencies and comfort level. The MICU nursing staff were frequently floated to medical/surgical, telemetry, psychiatric, emergency room, post anesthesia care unit, hospice, and long-term care units. However, at the time of our visit, we were told when MICU staff floated to psychiatric or long-term care units they were no longer required to administer medications.

We did not substantiate the allegation that to prevent the use of overtime, new staff had to sit with suicidal patients.

We did not substantiate the allegation that insufficient staffing caused difficulty in covering the additional duties of the MICU RN staff; however, we noted that MICU staffing was frequently under the target HPPD, and the person who would have been responsible for performing the additional duties was often floated to another unit.

We did not substantiate the allegation that the step down unit was opened and closed every 2 days in October and November. The unit was opened and staffed on all shifts after October 10, 2013.

We substantiated the allegation that one RN was left alone in the step down unit on four occasions in October and November. We did not substantiate that the RN had to leave the patients and unit unattended.

We substantiated the allegation that the nursing staff documented their concerns about unsafe staffing in writing, but the documentation of concerns may not be reported or routed to the PSM as required.

We also found that the facility policy for prevention of falls and injuries was not being followed.

## Recommendations

1. We recommended that the Facility Director ensure that senior leadership and nursing managers fully implement the VHA Nurse Staffing Methodology Plan as required.
2. We recommended that the Facility Director ensure that senior leadership and nursing managers fully evaluate the medical intensive care and step down units' patient mix, staffing plan, patterns of floating, physical layout, and unit assignments for opportunities for improvement and take necessary action.
3. We recommended that the Facility Director ensure that patient incident reporting processes be strengthened so that all patient incidents or safety concerns are reported promptly to the patient safety manager.

4. We recommended that the Facility Director ensure that nursing staff perform and document fall risk assessments as required.

## VISN Director Comments

**Department of  
Veterans Affairs**

## Memorandum

**Date:** December 3, 2014

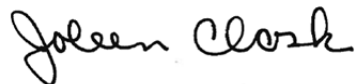
**From:** Director, VA Sunshine Healthcare Network (10N08)

**Subj:** **Draft Report**—Healthcare Inspection—Staffing and Patient Care Issues,  
West Palm Beach VA Medical Center, West Palm Beach, Florida

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

Thank you for your onsite review and recommendations. The VISN appreciates your consultation.

Corrective action plans have been established and actions completed as outlined and detailed in the attached report.



Joleen Clark, MBA, FACHE

Attachment



## Facility Director Comments

**Department of  
Veterans Affairs**

## Memorandum

**Date:** December 2, 2014

**From:** Director, West Palm Beach VA Medical Center (548/00)

**Subj:** **Draft Report**—Healthcare Inspection—Staffing and Patient Care Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida

**To:** Director, VA Sunshine Healthcare Network (10N08)

West Palm Beach VA Medical Center (WPB VA MC) would like to thank the Office of Inspector General (OIG) Team for the recommendations based on their assessment during the on site visit conducted April 7-9, 2014.

The Staffing Methodology for VHA Nursing Personnel (Directive 2010-034) was first implemented at WPB in 2011-2012.

During initial implementation, Nurse Managers (NM) Nurses and Nursing Officers of the Day (NOD) were educated on the methodology via staff meeting and in-services. Staffing Methodology templates were utilized to assess and determine staffing levels for ICU, inpatient acute, and long-term care units. However, recommendations were not submitted by unit-based panels nor were they reviewed by a Facility Expert panel as required by the directive.

In June of 2013, a Staffing Methodology compliance self-assessment was completed just prior to the retirement of the former Nurse Executive which identified gaps in the full implementation of the directive.

In September 2013, a coordinator was appointed as a collateral duty, and a Nurse Executive consultant from Miami VA was brought in to evaluate the process and assist in implementation improvements. In 2013-2014, the process was completed in accordance with the directive and the related HPPD targets for all inpatient settings were approved.

A number of factors impacted the implementation of a clear and consistent process for monitoring and demonstrating HPPD targets including; the use of a complex data collection tool for monitoring HPPD requirements, the existence of a “mixed” patient population within the facilities 14 bed ICU prompted by the need for acute care bed capacity, and the rotation of a number of Chief Nurses as Acting pending the recruitment of a new Nurse Executive.

Following the appointment of a new Nurse Executive in December of 2013, it was identified that the process and tool/grid being used to monitor ongoing compliance with staffing methodology implementation required modification. Both the process and tool have been modified, all Chief Nurses, Nurse Managers, and NODs have been educated on its use, and it was fully implemented on May 16, 2014.

Decision has been made to limit occupancy within the facilities 14 bed ICU to ICU admissions in order to ensure consistency of staffing and monitoring of HPPD requirements.

Inpatient staffing variances are monitored and reported daily to ensure the implementation of ongoing adjustments and the facility Staffing Methodology Coordinator has been relocated to the office of the Nurse Executive. The OIG met with the Coordinator at the time of the visit and they have full confidence in her ability.


An internal review of staffing assignments and time cards reflecting staff available within the MICU at the time of the five falls referenced in the report does not correlate with conclusion that these falls occurred as a result of decreased staffing levels.

Attempts are made to minimize the detail / floating of staff away from their primary unit of assignment so as not to adversely impact staff satisfaction and/or retention, however details do occur based on variations of Nursing Care requirements throughout the Medical Center. Although staff discomfort is appreciated, detail staff are only assigned functions within their competency levels.

The 2014-2015 Staffing Methodology review for inpatient areas was repeated using the required converter tools to derive Nursing Hours per Patient Day (NHPPD) and associated staffing levels. NHPPDs derived from these reviews were agreed upon by Facility Expert Panel members including our Staffing Methodology Coordinator, Chief Nurses, HR Representative and the Associate Director for Patient Care Services.

An Administrative Investigation Board (AIB) was initiated on February 10, 2014 to investigate allegations of workplace harassment in the MICU. The final report did not substantiate allegations of workplace harassment.

Our goal is to deliver the best care to our Veterans each and every day focusing on Quality, Safety, and Value and we appreciate the OIG Team's consultative and collaborative approach in helping us to meet our goal.



Charleen R. Szabo, FACHE

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 Recommendations

**Recommendation 1.** We recommended that the Facility Director ensure that senior leadership and nursing managers fully implement the Staffing Methodology Plan as required.

Concur

Target date for completion: 05-16-2014

Facility response: Under the Guidance of the Medical Center Director, the national Directives for Staffing Methodology (VHA Directive 2010-034 July 19, 2010) were initially implemented on September 20, 2013. After implementation, the approved HPPD was changed on the current NOD grids. All Nurse Managers and NOD's were involved and educated on changes made through the Staffing Methodology process. The initial NOD grid was identified to be erroneous at times in the reflection of the HPPD reported. Once this was identified the new NOD grid was developed. May 16, 2014 the new NOD grid was initiated, implemented and education was provided throughout nursing services, to include Nurse Managers and NOD's. This process has been accurate and simplified to prevent errors and confusion. Variances and HPPD are monitored by shift and discussed every morning to include Staffing Methodology Coordinator, Chief Nurses and ADPCS.

The second round of Staffing Methodology was completed and signed off on as of October 3, 2014. All changes are completed on the NOD grids and will be implemented for use as of November 01, 2014. NOD's were educated on all changes made through the Staffing Methodology process on October 22, 2014. All aspects of the Staffing Methodology process and expectations were defined and discussed in its entirety to all current NOD's involved in daily staffing. Ongoing training and education will be provided until all of leadership is completely comfortable and share the same understanding for the Staffing Methodology process.

Request for closure based on the full implementation date of September 20, 2013. Second year of Staffing Methodology process completed as of October 03, 2014.

**Recommendation 2.** We recommended that the Facility Director ensure that senior leadership and nursing managers fully evaluate the medical intensive care and step down units' patient mix, staffing plan, patterns of floating, physical layout, and unit assignments for opportunities for improvement and take necessary action.

Concur

Target date for completion: 01-17-2015

Facility response: The Nurse Manager remains involved in all assessments of the MICU such as staff mix and unit staffing plans. A unit based expert panel was developed for Staffing Methodology in the MICU that supported their requests for specific staffing needs based on acuity. Hours per patient day (HPPD) for the MICU were developed with the use of an essential (ONS) converter tool which established their required staffing levels and needed staff mix for the MICU and step-down. The converter tool included a permanent Unit Facilitator (code blue team) on all shifts to ensure flow and safety was addressed by one RN without a patient assignment. The Staffing Methodology process included a MICU unit based expert panel consisting of 11 people of different shifts and disciplines for both the initial Staffing Methodology implementation for FY'14 and the second round of Staffing Methodology completed October 03, 2014 for FY'15. All Staffing Methodology aspects including the HPPD were reviewed and signed off on through the Facility Expert Panel to include Chief Nurses, ADPCS, Fiscal, HR, AFGE and Staffing Methodology Coordinator. The HPPD was established with the assistance of the MICU Nurse Manager and Unit based expert panel. MICU has successfully stayed within the required HPPD since the development of the new NOD grid on May 16, 2014. The MICU continues to show on average a 0.50 surplus in HPPD. A Narrative summary was provided by the unit based expert panel and Nurse Manager (required by Directives) for Staffing Methodology during both the initial Staffing Methodology process and the recently completed Staffing Methodology.

The step down (6 bed unit) was established due to frequent diversion and bed unavailability issues at the WPB VAMC. With collaboration of the MICU Nurse Manager and MICU staff the decision was made to have MICU staff cross cover, the 6 bed unit, (when staffing permitted) to prevent the floating throughout the facility. A complete analysis was done on all possible staffing scenarios based on HPPD and multiple ADC's to ensure their current staffing levels could sustain the unit safely. The 6 bed unit was opened on January 17, 2014. It was agreed upon that this was a suitable way to fully utilize the staff with a higher competent skill mix and was intended to rebuild some morale issues identified.

**Recommendation 3.** We recommended that the Facility Director ensure that patient incident reporting processes be strengthened so that all patient incidents or safety concerns are reported promptly to the patient safety manager.

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Target date for completion: 01-01-2015

Facility response: WPB is currently developing an electronically entered Patient Incident Worksheet (PIW), where the initial reporting portion identifying what happened (actual event) or what could have happened (near miss) is summarized in a standardized reporting tool. This tool will be accessible using a desktop icon and its use will be mandated in the revision of MCM 548-99-259 Patient Incident Review Program. The MCM will be posted when all staff have been educated on the mandated changes.

When the recorder completes the initial findings electronically and requests the report to print, the report will print on the printer requested by the person reporting the incident and it will automatically print on the network printer for the Patient Safety Manager (PSM). This will ensure all initial reports for incidents that are reported using the mandated PIW will be printed in real time to the PSM. This will allow the PSM to review the initial statement and complete the Safety Assessment Code (SAC) identifying the probability and severity of injury to each event timely.

Until this new system is fully implemented, the Associate Director of Patient Care Services has advised that the PIWs go directly to Quality Management and then the follow-up actions will be directed by the Chief of Staff back to Nursing through QM.

**Recommendation 4.** We recommended that the Facility Director ensure that nursing staff perform and document fall risk assessments as required.

Concur

Target date for completion: In place at the time of survey

Facility response: The Safe Patient Handling/ Falls Coordinator has monitored Fall Risk documentation compliance using the Morse Fall Scale for the past five years. For FY14, the lowest compliance score was 97 percent in September and the highest compliance score of 99 percent was seen in February, May, June, July, and August and the remaining six month's compliance was at 98 percent. Overall compliance for FY14 was 98 percent.

Currently, the Safe Patient Handling/ Falls Coordinator reports to the Environment of Care Committee. Beginning January 2015, the Falls Prevention Committee will report up to the Environment of Care Committee.

Request for closure based on supporting documentation provided.

## **Office of Inspector General Contact and Staff Acknowledgments**

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