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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center

New York

HEALTHCARE INSPECTION | REPORT #17-03347-293 | SEPTEMBER 18, 2018

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations from several sources made in 2017 regarding inadequate long-term care nurse staffing and quality of care issues in the Community Living Centers (CLC) at the Northport VA Medical Center (Facility), New York. The OIG reviewed the following allegations:

- Nursing leaders were aware of staffing shortages in the CLCs.
    - The nurse staffing shortages were addressed by the use of float[1] staff and voluntary and mandated overtime (OT).
    - The use of float staff and OT to manage staffing shortages placed CLC residents[2] at a higher risk for adverse events.[3]
- Administrative nurses (nurses working outside of direct patient care) were ordered (by leadership) to feed and bathe CLC residents.
- CLC managers were pressured by Facility leaders to accept admissions when staffing was below the minimum level of nursing hours per patient day (NHPPD), jeopardizing the safety of CLC residents.
- CLCs were closed to admissions, and residents were transferred to acute care inpatient units due to a lack of staffing.

The OIG substantiated that nursing leaders were aware of staffing shortages in the CLCs and confirmed the use of float staff and OT to address staffing shortages. However, due to the many variables that contribute to the delivery of safe patient care, OIG inspectors were unable to substantiate or not substantiate that the use of float staff and OT to manage staffing shortages placed residents at a higher risk for adverse events.

The Facility CLCs had a chronic lack of nurse staffing. This was in part due to the delayed filling of vacant positions through new hires or redistribution of nursing staff and the lack of approval for increased full-time employee equivalents in response to nurse staffing methodology expert

[1] Float staff are nursing staff that are pulled from one unit in the Facility to cover a shift staffing shortage on another unit.

[2] Veterans who reside in a CLC are typically referred to as residents. For this report, veterans residing in the CLCs are referred to as "CLC residents" or "residents."

[3] For this report, adverse events are defined as a resident death, fall with major injury, or a clinical event that led to a resident needing a higher level of care.

panel[4] recommendations. Other contributing variables to a lack of nurse staffing included Nursing Service's preference in hires and staff's routine and atypical[5] leave. The Facility lacked an adequate number of permanent staff to meet the NHPPD; therefore, to meet staffing demands, the Nursing Service relied on OT and floating existing nursing staff. The Facility failed to consider or utilize alternative staffing strategies.

The OIG found the Facility lacked accountability and processes to identify and monitor excessive OT[6] use by an individual or unit. Federal employees are expected to be good stewards of government funds. OIG inspectors' review of the data indicated that the OT funding exceeded the cost associated with filling the vacant positions. In addition, even if the current full-time employee equivalent ceilings were met, staffing to the NHPPD would continue to require OT or other alternative staffing strategies.

The OIG found that staffing shortages were present, and the Facility Directors and nursing leaders were aware of the shortages in 2016 and 2017. In July 2017, Veterans Integrated Service Network (VISN) 2[7] leaders learned the extent of the CLC nurse staffing shortage when nursing leaders reached out to the VISN for input on their response to an oversight body regarding CLC related concerns. Awareness of the Facility staffing shortages at the VISN level, coupled with the presence of new Facility leadership, resulted in focused attention and action on the issue.

The OIG substantiated that nurses assigned to administrative, non-patient care roles were utilized to provide nursing care, including feeding and bathing. This happened in July and August 2017. Administrative nurses provided nursing care, assisted with passing medication, and provided coverage for continuous observation over a limited period of time when concerns about nurse staffing levels were heightened. The OIG inspectors did not find evidence of deficiencies in the administrative nurses' work or that the administrative nurses who covered in the CLCs performed work outside of the position description for a registered nurse.

The OIG substantiated that previous Facility leaders pressured CLC managers to accept admissions when the nurse staffing on the unit would be inadequate to provide the expected level

[4] "An expert panel is an advisory group comprised of individuals with in-depth knowledge of evidence-based factors impacting staffing needs at the point of care. The panel is best-suited to make judgments to deliver recommendations regarding staffing levels and overseeing outcome analysis and modifications to staffing recommendations." VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

[5] Routine leave may include annual leave and sick leave. Atypical leave, for the purpose of this report, is any leave outside annual and sick leave.

[6] VA Handbook 5011/23, Hours of Duty and Leave, November 20, 2012, defines OT for full-time employee equivalents as each hour of work in excess of 40 hours in a workweek or in excess of eight hours in a day, whichever is the greater number of OT hours. For the purposes of this review, excessive OT was defined as staff working 40 hours of OT or greater within a two week pay period (1.5 full-time employee equivalents).

[7] The VISN Director told the OIG that each facility is expected to manage their day to day operations, budget, and staffing. Once notified of the CLC staffing shortages, the VISN had a duty to respond and assisted the facility in resolving the situation.

of care for additional residents, which potentially jeopardized the safety of current residents. However, CLC nurse managers stated that they no longer experienced pressure to accept admissions when staffing was below safe levels. They specifically identified the new Facility leadership team—Director, Acting Chief of Staff, and Acting Nurse Executive (Associate Director for Patient Care Services)—assembled in August 2017 as catalysts for this change.

The OIG substantiated that, at times, the CLCs were closed to admissions. However, OIG inspectors did not substantiate that residents were being transferred to acute care inpatient units due to lack of CLC staffing. CLC nurse managers told OIG inspectors that, under the new leadership, patient census and acuity and available staffing were taken into account when considering admissions.

The OIG made three recommendations related to CLC nurse staffing and recruitment, alternate staffing, and OT management.

Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 25–28, for the Directors' comments.) We will follow up on the planned actions until they are completed.

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Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

CFO	Chief Financial Officer
CLC	Community Living Center
EHR	electronic health record
FTE	full-time employee equivalents
FY	fiscal year
HR	human resources
NA	nursing assistants
NHPPD	nursing hours per patient day
NOD	Nurse Officers of the Day
ONS	Office of Nursing Service
OT	Overtime
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations from several sources made in 2017 regarding inadequate long-term care nurse staffing and quality of care issues in the Community Living Centers (CLC) at the Northport VA Medical Center (Facility), New York.

Background

The Facility is part of Veterans Integrated Service Network (VISN) 2 and provides medical, surgical, psychiatric, rehabilitative, and long-term care. In fiscal year (FY) 2016, the Facility served more than 31,000 patients and had a total of 381 operating beds, including 173 inpatient beds, 38 domiciliary beds, and 170 CLC beds.

CLCs

The Facility CLCs provide short- to long-term care to residents,[8] with a variety of medical conditions, who need assistance with activities of daily living[9] as well as skilled nursing or medical care. The CLCs provide rehabilitation services and other specialty programs for residents. CLC staff provide patient-centered care tailored to each resident's needs and preferences. The Facility has four CLCs in two buildings. Residents are assigned to a CLC based on their medical conditions and individual care needs.

[8] Veterans who reside in a CLC are typically referred to as residents. For this report, veterans residing in the CLCs are referred to as "CLC residents" or "residents."

[9] VHA Handbook 1142.01 states "Activities of Daily Living include: grooming, bathing, dressing, personal hygiene, toileting, eating, and mobility." This may also include transfers from one location to another (moving in bed, sitting, and standing).

Building 92:

- CLC 1 has a maximum capacity of 41 residents and provides long-term,[10] palliative,[11] and dementia care.
- CLC 2 has a maximum capacity of 41 residents and provides long-term and palliative care.

Building 8:

- CLC 3 is a locked unit with a maximum capacity of 30 residents.[12]
- CLC 4 has a maximum capacity of 22 residents and provides palliative and respite care[13] as well as sub-acute rehabilitation.

Facility Leadership Changes

The Facility had key leadership changes during the course of this review, which are detailed in Figure 1 below:

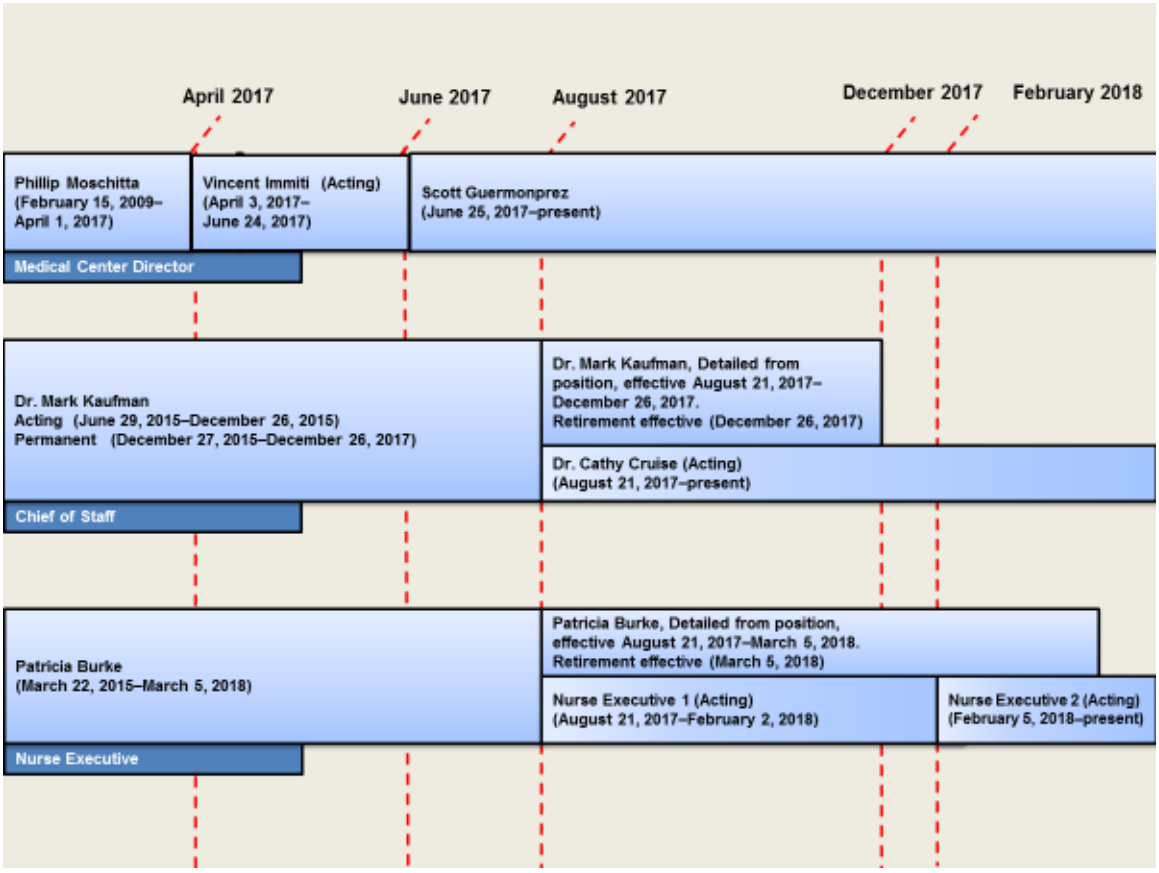

Figure 1. Relevant Facility Senior Leaders from January 2017 through June 2018.
Source: VA OIG analysis of Facility documents.

Nurse Staffing Methodology

Veterans Health Administration (VHA) provides a standardized method for determining direct patient care nurse staffing levels on the varied units providing inpatient care.[14] The methodology is based on an analysis of multiple variables, including patient needs, staff responsibilities, and professional judgment. These variables are used to recommend staffing levels that support safe and effective patient care. The nurse staffing plans outline nurse staffing levels and skill mix[15] by unit.[16] The methodology allows a facility to calculate the nursing hours per patient day (NHPPD) by nursing unit.

NHPPD refers to the number of nursing care hours needed to manage the patient workload. This measure reflects the number and mix of nursing staff needed to accomplish the direct care for the residents on the unit. Examples of direct care responsibilities are nursing assessment, planning, treatment, preparation time, medication orders and administration, nursing rounds, and resident teaching.

Nurse Staffing and Patient Outcomes

There is a considerable literature base examining the relationships between nurse staffing and patient outcomes, adverse events, and quality of care.[17] OIG inspectors reviewed literature examining patient and shift level data for relationships between understaffed nursing shifts and

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[10] "Long term care refers to a continuum of medical and social services designed to support the needs of people living with chronic health problems that affect their ability to perform everyday activities. It includes traditional medical and social services as well as housing." McCall, N. "Who Will Pay for Long Term Care?" Health Administration Press, January 1, 2001.

[11] "Palliative care is specialized medical care for people with serious illness focusing on providing relief from the symptoms and stress and improve quality of life." https://getpalliativecare.org/whatis/. (The website was accessed on July 12, 2017.)

[12] CLC 3 is a specialized locked unit for residents who wander, exhibit aggressive behaviors, present elopement risks, show significant cognitive impairment, or exhibit other high-risk behaviors.

[13] VHA Handbook 1140.02 defines respite care as "a distinct VA program with the unique purpose of providing temporary relief for unpaid caregivers from routine care giving tasks, thus supporting caregivers in maintaining the chronically ill veteran in the home."

[14] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This directive was in place for the events described in this report. The directive was rescinded and replaced by VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017 and contains the same or similar language regarding nurse staffing methodology.

[15] Skill mix refers to the percentage of patient care provided by the different skill and educational levels (Registered Nurse, Licensed Practical Nurse, and Nursing Assistant) of nurses on a unit.

[16] United States Government Accountability Office (GAO), *VA Healthcare: Actions Needed to Ensure Adequate and Qualified Nurse Staffing,* GAO-15-61 (October 16, 2014).

[17] Patrician, P, et al., "Twenty years of staffing, practice environment, and outcomes research in military nursing." *Nursing Outlook* 65(5S) (2017, October): S120-S129.

adverse patient outcomes. The literature supported the conclusion that understaffed nursing shifts have a higher rate of nurse-sensitive[18] outcomes.[19] Due to the complexities of the relationships and the wide variability in medical care settings, the data can be difficult to distill into clear guidelines for nurse staffing levels.[20] Research shows that simple prescribed nurse-to-patient ratios fail to capture relevant factors for determining the nurse staffing levels needed to mitigate risk and optimize patient outcomes.[21] Some studies have identified the use of NHPPD as a preferable measure for determining appropriate staffing because application of NHPPD methodologies at a unit level accounts for important moderating factors, such as patient acuity[22] or complexity and intervention levels.[23]

Overtime

VA Handbook 5011[24] defines overtime (OT) for full-time employee equivalents (FTE) as each hour of work in excess of 40 hours in a workweek or in excess of eight hours in a day, whichever is the greater number of OT hours. OT is considered a means to be used only under conditions where on-duty personnel cannot perform operations through planned coverage during their regular workweek. Supervisory personnel must obtain proper approval from authorizing managers prior to allowing an employee to work OT. Management is authorized to prescribe limitations as necessary to provide control and prevent abuse of OT. To ensure the continuity of patient care, managers can require personnel to work mandatory OT.[25]

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[18] A Nurse-sensitive outcome is an "adverse patient outcome that can be used as an indicator of the quality of nursing care. Some examples of outcomes are: surgical wound infection, urinary tract infection, ulcers, pneumonia, and deep vein thrombosis." Twigg D, Gelder L & Myers H (2015). The impact of understaffed shifts on nurse-sensitive outcomes. Journal of Advanced Nursing, 71(7), 1564-1572.

[19] Twigg et al (2015). West, Gordon, Patrician, Patricia A. and Loan, Lori, "Staffing Matters-Every Shift: Data from the Military Nursing Outcomes Database can be used to demonstrate that the right number and mix of nurses prevent errors," *American Journal of Nursing* 112, no. 12 (December 2012): 22-27.

[20] Leary, A, et al. Mining routinely collected acute data to reveal non-linear relationships between nurse staffing levels and outcomes. BMJ Open. 2016 Dec 16;6(12); Needleman J, Buerhaus P, et al. Nurse-staffing levels and the quality of care in hospitals. N Engl J Med. 2002 May 30;346(22):1715-22; Patrician et al, (2017); Stalpers D, et al. Associations between characteristics of the nurse work environment and five nurse-sensitive patient outcomes in hospitals: a systematic review of literature. Int J Nurs Stud. 2015 Apr;52(4):817-35.

[21] Leary et al. (2016); Min et al (2016); Spilsbury K, Hewitt C, Stirk L & Bowman C. The relationship between nurse staffing and quality of care in nursing homes: a systematic review. *Int J Nurs Stud*. 2011 Jun; 48(6):732-50.; Twigg et al. (2011).

[22] Acuity can be described in terms of "the care burden the patient brings to medical or nursing staff in terms of time, skill, mental concentration and surveillance required to meet patient needs." Brennan, C. & Daly B. Patient Acuity: a concept analysis. *Journal of Advanced Nursing*. 65(5), 114-1126.

[23] Min et al (2016); Twigg et al. (2011).

[24] VA Handbook 5011/23, *Hours of Duty and Leave*, November 20, 2012.

[25] VA Handbook 5011/23.

Continuous Observation[26]

Continuous observation by "sitters" has been described as a strategy for attempting to ensure the safety of at-risk patients[27] through continuous surveillance. Most hospitals in the United States utilize continuous observation, and the literature on this practice outlines that reliance on continuous observation by sitters presents a major and rising cost concern.[28] Geriatric-psychiatry units in particular may have increased costs from reliance on continuous observation, as research shows that conditions characterized by marked cognitive impairments, such as dementia, delirium, and psychosis, are associated with higher costs for sitter use.[29] Research also suggests that understaffing is a characteristic that has been associated with increased use of, and therefore higher costs for, use of sitters.[30] The rising costs of reliance on continuous observation, coupled with lack of evidence for improved outcomes, has prompted increased attention and research on alternative strategies for effectively managing at-risk patients while reducing the use of sitters.[31]

Allegations

The OIG initially became aware of concerns related to nurse staffing levels in the CLCs at the Facility from an anonymous complainant while conducting another inspection of patient care concerns in the Facility's CLCs. Shortly thereafter, the OIG received an email from a liaison to the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, as well as an email from an employee at the Facility, outlining additional concerns associated with nurse staffing in the CLCs. The OIG team responsible for the original inspection, in conjunction with the OIG Hotline Team, discussed the concerns and determined that a formal review was warranted. The specific concerns identified or alleged included:

- Nursing Leaders were aware of staffing shortage in the CLCs.

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[26] According to Facility Memorandum 118.04, *Continuous Visual Observation of Patients by Nursing Service Personnel*, April 9, 2015, continuous observation is also referred to as special observation, constant observation, and one-to-one.

[27] In this context, the term at-risk patient refers to patients presenting with potentially dangerous behaviors, such as suicidality, wandering or elopement risk, aggressive behaviors, or high agitation, or who are interfering with medical therapies, such as pulling out lines or tubes. Rochefort et.al.

[28] Rochefort et al., Worley et al., Solimine et al., Dewing, Laws, D. & Crawford, C, Alternative Strategies to Constant Patient Observation and Sitters. *J Nurs Adm*. 2013 Oct; 43(10):497-501; Tzeng et al.; Rausch, D. & Bjorklund, P., Decreasing the costs of constant observation. *J Nurs Adm*. 2010 Feb; 40(2):75-81; Rape, C., Mann, T., Schooley, J. & Ramey, J., Managing Patients with Behavioral Health Problems in Acute Care. J Nurs Adm. 2015 Jan; 45(1):7-10; Ray, R., Perkins, E., Roberts, P. & Fuller, L., The impact of nursing protocols on continuous special observation. *J Am Psychiatr Nurses Assoc*. 2017 Jan/Feb; 23(1):19-27.

[29] Rochefort et al.

[30] Rochefort et al.

[31] Nadler-Moodie, et.al.; Worley et al.; Laws et al.; Rausch et al.; Rape et al.; Ray et al.

  - The nurse staffing shortages were addressed by the use of float[32] staff and voluntary and mandated OT.
  - The use of float staff and OT to manage staffing shortages placed CLC residents at a higher risk for adverse events.[33]
- Administrative nurses (nurses working outside of direct patient care) were ordered (by leadership) to feed and bathe CLC residents.
- CLC managers were pressured by Facility leaders to accept admissions when staffing was below the minimum level of NHPPD, jeopardizing the safety of CLC residents.
- CLCs were closed to admissions and residents are being transferred to acute care inpatient units due to lack of staffing.

[32] Float staff are nursing staff that are pulled from one unit in the Facility to cover a shift staffing shortage on another unit.

[33] For this report, adverse events are defined as a resident death, fall with major injury, or a clinical event that led to a resident needing a higher level of clinical care.

Scope and Methodology

The OIG initiated the review on September 19, 2017, and conducted a site visit at the Facility October 16–20, 2017.

The following documents for FYs 2016 and 2017 were requested and reviewed by the OIG: Joint Commission standards and reports, Long-Term Care Institute policies, Occupational Safety and Health Administration reports, relevant VHA and Facility policies and procedures, nurse staffing methodologies and nurse staffing plans, NHPPD data, human resources (HR) gains and losses reports, vacancy tracking logs, Electronic Patient Event Report data, Facility fact-finding documents, Facility meeting minutes, and nursing schedules. The OIG reviewed over 8,600 Facility emails from January 1, 2017, through September 21, 2017.

The OIG interviewed staff from VHA's Office of Nursing Service (ONS), the VISN Director, VISN Chief Financial Officer (CFO), VISN HR Officer, Facility Director, Facility Acting Chief of Staff, Facility Acting Associate Director of Patient Care Services, Facility CLC nurse managers, Facility CFO, Facility Risk Manager, Facility Nurse Officers of the Day (NOD), Facility HR staff, and the Facility nurse recruiter. The OIG interviewed by telephone staff members who were not available during the onsite visits.

One complainant was anonymous. As such, some aspects of the review were limited by the inability to clarify allegation intent or request additional information regarding the specifics of an allegation.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to substantiate or not substantiate an allegation when the available evidence is insufficient to determine whether or not an alleged event or action took place.

The OIG 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: Nursing Leaders' Awareness of Staffing Shortages in the CLCs

The OIG substantiated that nursing leaders were aware of staffing shortages in the CLCs and confirmed the use of float staff and OT to address staffing shortages. However, due to the many variables that contribute to the delivery of safe patient care, OIG inspectors were unable to substantiate or not substantiate that the use of float staff and OT to manage staffing shortages placed residents at a higher risk for adverse events.

Determination of Staffing Need

Nurse Staffing Methodology - NHPPD

Nursing leaders are responsible for the most substantial patient care work force of the Facility. Nursing leaders establish a cohesive and collaborative nursing care team to improve quality in nursing care. VHA uses a standardized staffing methodology to determine the NHPPD and appropriate number of direct care nursing personnel by each patient care unit. Each VA facility is expected to establish staffing levels that provide a mix of nursing staff, from Nursing Assistants (NAs) to Registered Nurses (RNs), to meet patient care needs.[34] Adequate staffing contributes to safe patient care.

For FYs 2016 and 2017, each CLC nurse manager completed the recommended nurse staffing methodology to determine the staff needed to meet the target NHPPD and presented this data to Facility leaders. Ideally, the Facility Director documents approval or disapproval of the NHPPD and allocation of staff to meet target levels. Table 1 shows the staff on board and staff needed for FY 2016 and FY 2017 to reach NHPPD, as determined through the staffing methodology process. In FYs 2016 and 2017, the then-Facility Director, Mr. Moschitta, failed to provide approval or disapproval of the CLC staffing plans and the additional staff needed to meet the recommended NHPPD.

Staffing methodology is an important step in the management of HR as it provides the organization with a mechanism to determine the number and type of nursing positions necessary to staff each nursing unit. Organizational charts depict agreed upon authorized FTE and are utilized by HR for staff hiring and fiscal service for budget allocation. At the time of the OIG's review, the organizational chart for Nursing Service was out of date and failed to reflect the authorized number and type of nursing positions. In discussions with the OIG, the current Director, Mr. Guermonprez, shared his intention to have the organizational chart updated.

Table 1. CLC FTE Needed per Staffing Methodology, FTE On Board, and Vacancies for FY 2016 and FY 2017

Unit Location	FY 2016 FTE Needed	FY 2016 FTE On Board	FY 2016 Vacancies	FY 2017 FTE Needed	FY 2017 FTE On Board	FY 2017 Vacancies
CLC 1	33.9	35.2	-1.3	34.5	30	4.5
CLC 2	36.5	31.5	5	37.5	31.3	6.2
CLC 3	28	28.4	-0.4	28	26.4	1.6
CLC 4	24.7	21.7	3	24.7	21.7	3
Totals	123.1	116.8	6.3	124.7	109.4	15.3

Source: VA OIG analysis of Facility data

Nurse managers relied on a staffing tool that calculates the NHPPD based on the number and mix of nursing staff assigned to each unit on a shift by shift basis. From October 2016 to the middle of February 2017, the staffing tool was programmed with an NHPPD of 6.0 for CLCs 1, 2, and 3, and 7.0 for CLC 4, in accordance with the expert panel's[35] recommendations. In February 2017, at the direction of the Nurse Executive (Associate Director for Patient Care Services) Ms. Burke, a nursing administrator reprogrammed the staffing tool with an NHPPD of 5.5 for all CLC's, contrary to the expert panel's recommendations. Altering the target NHPPD up or down has a direct impact on the number of staff required to meet the NHPPD targets. Lowering the NHPPD required fewer staff to reach the target NHPPD. Ms. Burke was unavailable for interview, so the OIG inspectors were not able to determine the rationale for reducing the NHPPD below the levels recommended by the expert panels for each unit.

To determine if CLC nurse staffing met NHPPD targets as set by the expert panels, the OIG reviewed the NHPPD of the four CLC units for 75 randomly selected days from October 1, 2015, through September 30, 2016, in FY 2016 and from October 1, 2016, through June 4, 2017, in FY 2017. The Facility fell below the target staffing levels on the four CLC units. See Tables 2 and 3 below.

[34] VHA Directive 2010-034.

[35] VHA Directive 2010-034 states, "An expert panel is an advisory group comprised of individuals with in-depth knowledge of evidence-based factors impacting staffing needs at the point of care. The panel is best-suited to make judgments to deliver recommendations regarding staffing levels and overseeing outcome analysis and modifications to staffing recommendations."

Table 2. Estimated CLC Nursing Hours per Patient Day in FY 2016 (Sample size = 75 days)

Unit Location	Target	Mean	95% Confidence Interval	Estimates Below Target?
CLC1	6	4.48	(4.409, 4.551)	Yes
CLC2	6	4.61	(4.507, 4.714)	Yes
CLC3	6	4.53	(4.449, 4.618)	Yes
CLC4	7	6.55	(6.314, 6.779)	Yes

Source: VA OIG Biostatistics analysis of Facility data

Table 3. Estimated CLC Nursing Hours per Patient Day in FY 2017 (Sample size = 75 days)

Unit Location	Target[36]	Mean	95% Confidence Interval	Estimates Below Target?
CLC1	6	4.01	(3.954, 4.074)	Yes
CLC2	6	3.90	(3.836, 3.962)	Yes
CLC3	6	4.27	(4.193, 4.341)	Yes
CLC4	7	6.00	(5.822, 6.179)	Yes

Source: VA OIG Biostatistics analysis of Facility data

OIG inspectors interviewed staff from VHA's ONS to understand VHA's expectation regarding management of NHPPD. Interviewed staff reported that variances from NHPPD will occur and noted that nationally there has been no endorsement as to an acceptable level of variance from NHPPD. ONS staff further stated that understaffing of NHPPD should not be routine and is not a sustainable approach. ONS staff had knowledge of other VA facilities setting variance levels in past years; however, those were usually within 10 percent of the NHPPD recommended by the expert panel. They also noted that facilities that operate with limited staffing have little room for variance. Therefore, they emphasized the importance of identifying alternative staffing resources in advance to avoid patients' adverse events and to support staff satisfaction.

Throughout OIG's review of FYs 2016 and 2017 staffing data, the level of authorized variance at the Facility ranged from 60 to 80 percent of the target NHPPD. A 2013 Facility Nursing Service

[36] In February 2017, at the direction of the Nurse Executive, Ms. Burke, a nursing administrator reprogrammed the staffing tool with an NHPPD of 5.5 for all CLC's. The OIG used the expert panel NHPPD target numbers; however, only one CLC was above the Nurse Executive's NHPPD of 5.5.

memorandum[37] directed the NODs[38] to ensure that at no time should the NHPPD fall below 60 percent of the hours of care within a 24-hour period. This direction remained in place until May 2017 when Ms. Burke rescinded it. In OIG interviews, nursing personnel reported that the new authorized variance was changed from 60 to 80 percent of the target NHPPD. In August 2017, Nurse Executive 1 was appointed as Acting Nurse Executive. Nurse Executive 1 directed the NODs and nurse managers to use the target NHPPD only as a guideline and to use their clinical judgement, knowledge, and experience as well when staffing units. This approach allowed NODs and nurse managers greater flexibility to utilize their clinical expertise to make informed, real-time decisions about staffing needs on their units.

Impact of Staff Leave

The ability to reach NHPPD targets relies on available staff resources. In addition to vacancies, routine[39] and atypical[40] staff leave impact available staffing resources. Staff members can be on leave for a number of reasons. When a staff member is on extended leave, managers cannot hire new staff to fill that vacancy, and current staff may have to cover additional work in the absence of their colleague. Figure 2 shows the number of CLC staff on atypical leave by pay period for the past two FYs.

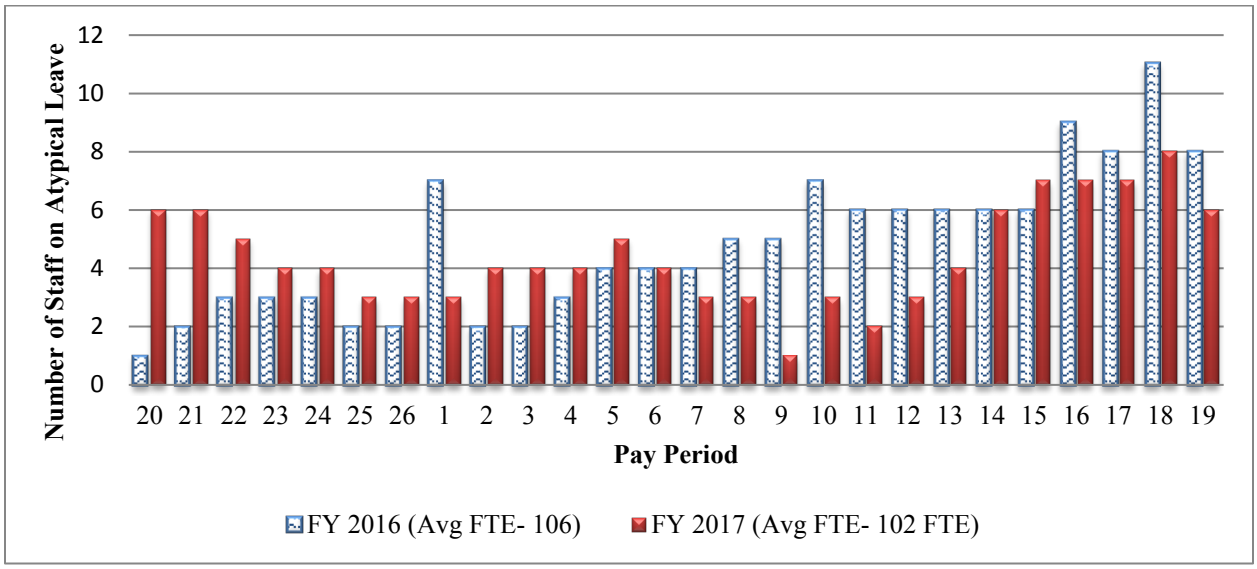

Figure 2. CLC Staff on Atypical Leave FY 2016 and FY 2017 by Pay Period
Source: VA OIG analysis of Facility data

[37] Facility Nursing Service Memorandum A-7, *Nursing Service Staffing*, November 6, 2013.

[38] NODs are a team of RNs that are part of the Nursing Service and provide administrative support Facility wide 24 hours a day, 7 days a week.

[39] Routine leave may include annual leave and sick leave.

[40] In this report, atypical leave is any leave outside annual and sick leave.

Staff vacancies and staff on atypical leave were contributory elements resulting in too few nursing employees to meet the NHPPD targets for the CLCs.

Nursing Leaders' Response to Staff Shortages

When a facility lacks sufficient FTE to adequately staff the units, common practice is for nursing leaders to utilize any or all of the following staffing strategies: intermittent staff, temporary agency staff, and patient census reduction. The OIG team learned that prior to August 2017, the Facility lacked a pool of intermittent staff or agency staff to be utilized, and most often relied upon current staff working OT. In August 2017, intermittent staff became available for use in the CLCs.

Nurse managers, in partnership with the NODs, are responsible for assessing and scheduling daily staffing to provide safe patient care. The unit nurse managers and the NODs take into account a combination of factors including NHPPD, acuity of the patients in the census, and the availability of staff.

In situations where staffing is low and the NHPPD threshold is not met, the NOD is responsible for staffing the units. Options for staffing included redistributing staff across units and identifying staff to work unscheduled hours (stay late or come in). NODs told OIG inspectors that due to staff on leave and vacant positions, it was often necessary to use voluntary or mandated OT to meet the minimum NHPPD, regardless of whether the variance was set at 60 or 80 percent of the target.

OT

VA Handbook[41] states OT is considered a means to be used only under conditions where operations cannot be performed through planned coverage by on duty personnel during their regular workweek. The process of approving and monitoring OT use varied throughout FYs 2016 and 2017.

From April 2017 through July 2017, Ms. Burke limited staff to 24 hours of voluntary OT per pay period. When staff reached their maximum voluntary hours of OT they could be mandated to work additional OT if justified by patient care needs. NODs, rather than the nurse managers, approved and tracked the number of hours of OT for each employee in order to comply with this rule. Staff reported the mandated OT was disruptive to their personal lives and a point of dissatisfaction with their job. Staff stated that they were mandated to work OT at times when other staff members, who had not been mandated, were willing to volunteer.

Prior to May 2017, the NODs had the authority to approve OT if necessary to reach the minimum NHPPD for each unit and each shift without getting the approval of the nurse

[41] VA Handbook 5011/23.

managers or nursing leaders. In May 2017, the NODs received direction by Ms. Burke to contact her directly to get authorization for OT use. Within a few days, the directions changed and the Associate Chiefs of Nursing Service were responsible for OT authorization. After a few weeks, directions again changed and nurse managers could grant OT authorization. With the arrival of Nurse Executive 1 in August 2017, NODs again received the authority to approve OT as necessary for each unit and each shift without getting prior approval from nurse managers or the Associate Chiefs of Nursing Service.

To gain an understanding of the extent of OT use, the OIG reviewed CLC OT hours for FYs 2016 and 2017. As Figure 3 shows, the Facility continuously used OT, with an increase noted in FY 2017. The total hours of OT were 19,991 in FY 2016 and 39,953 in FY 2017.

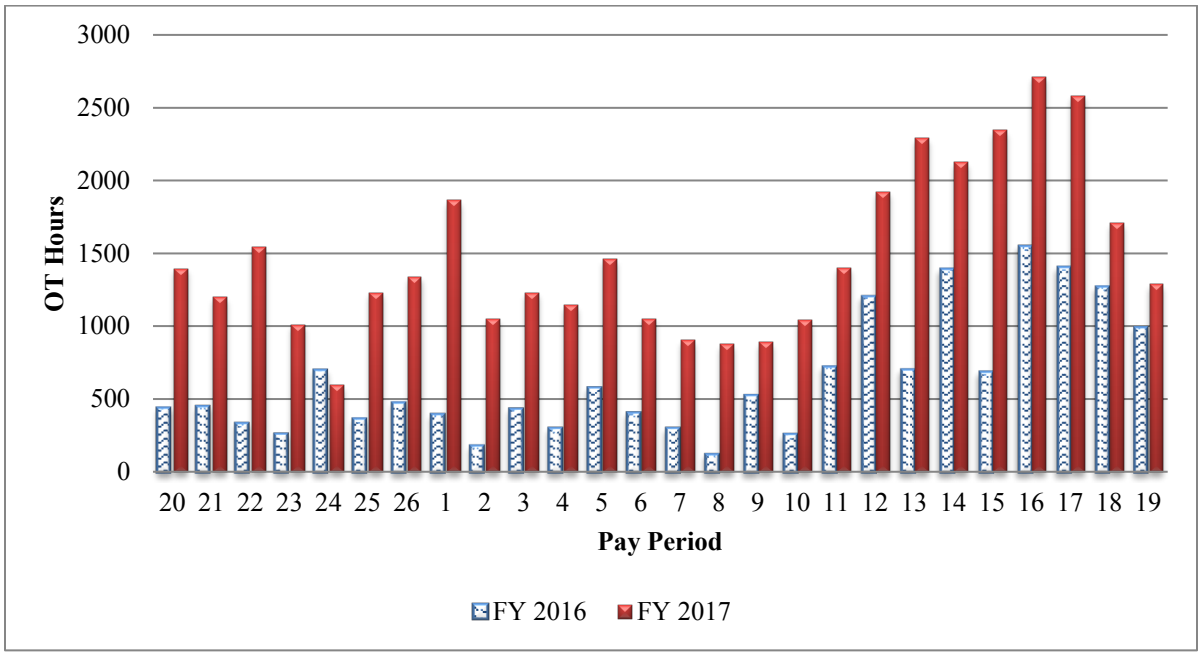

Figure 3. CLC Staff OT Hours FY 2016 and FY 2017 by Pay Period
Source: VA OIG analysis of Facility CLC Daily Staffing Sheets

From FY 2016 to FY 2017 total nurse staffing hours in the CLCs rose by an average of 501 hours per pay period. The number of nursing staff scheduled dropped by an average of 332 hours. Nursing OT increased by an average of 833 hours per pay period over the same time period.

An increase in the use of continuous observation for management of at-risk residents was one explanation CLC managers provided for the increase in OT. The Facility's use of continuous observation increased by an average of 886 hours per pay period from FY 2016 to FY 2017. OT

hours showed a 0.77 correlation[42] with continuous observation hours, indicating a strong relationship between these variables. (See Figure 4.)

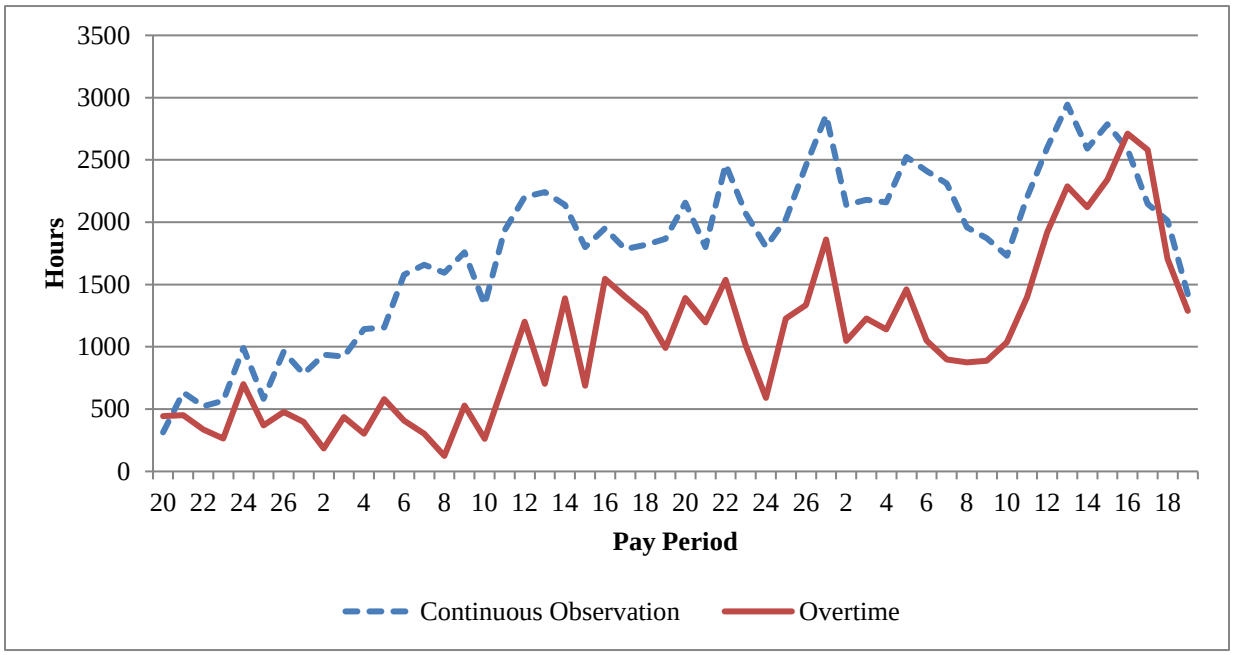

Figure 4. CLC Overtime and Continuous Observation FY 2016 and FY 2017 by Pay Period
Source: VA OIG analysis of Facility data

The FY 2016 total OT cost in the CLCs was $730,953. The FY 2017 total OT cost doubled from that of FY 2016 and was $1,493,395.

OT Oversight

It is the responsibility of Facility leaders to manage their overall budget and OT. The OIG interviewed VISN leaders to gain an understanding of their awareness of OT use at the Facility. The OIG team learned that the VISN generates monthly financial reports for each facility that includes aggregate OT data. Facility leaders also had access to the monthly financial reports.

At the Facility level, the CFO had access to payroll data, including OT hours and cost. Facility Fiscal Service staff routinely looked at aggregate OT use and projected the impact on the annual Facility budget. The CFO told OIG staff that the FY 2016 Facility-wide OT cost totaled $4.6 million. The then-Facility Director, Mr. Moschitta, set the Facility FY 2017 cap for OT cost at $2 million. Actual Facility FY 2017 OT expenditures were near $4.7 million, with Nursing

[42] Correlation is a statistical measurement of the relationship between two variables. Correlations can range from -1 to +1. Correlations are positive when both variables increase or decrease together. Correlations are negative when one variable decreases as the other increases. A correlation of zero shows no relationship between the variables, while correlations approaching -1 or +1 show strong relationships between the variables. Correlational statistics show relationships, but do not prove that changes in one variable causes changes in the other. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3576830/ (The website was accessed on May 30, 2018.)

Service accounting for approximately one-third of the total. In addition to Fiscal Service, Ms. Burke had access to OT information and, according to the CFO, was at one point preparing nursing OT reports for Mr. Moschitta.

Operationally, the Facility nurse managers are responsible for certifying the timecards for nursing staff working OT shifts. The Facility lacked an automated process for tracking OT use by individual nursing staff members. Therefore, nurse managers had no mechanism to alert them if one of their unit nursing personnel worked excessive OT.[43] Nurse managers reported that some staff volunteered for OT on other units without needing the approval of their unit nurse manager. Nurse managers were typically unaware of the additional hours of OT worked by their staff member(s) until after the fact. Because the nurse managers were not the only authority approving OT for their staff member, the nurse managers were unaware of who was working what shifts and where outside of the staff member's normal shift. In interviews, the OIG was told that neither the Associate Chief of Nursing Service nor the nurse managers received OT use reports for their respective areas.

A review of payroll data for CLC nursing staff identified that the top 10 percent of OT payouts were for staff who worked 48 hours or more of OT within a two-week pay period, with the top two percent of payouts reflecting staff who worked more than 80 hours OT within the pay period.

The Facility lacked processes to monitor and manage OT use. Throughout interviews with Facility leaders, NODs, and nurse managers, the OIG found no indication that those responsible for authorizing use of OT had real time knowledge of the extent to which each employee was working OT hours in excess of their scheduled tour. Front line leaders lacked the tools to manage OT use, and the Facility leaders had not implemented alternative solutions to the use of OT.

Alternative Staffing Strategies[44]

Alternative staffing strategies commonly used in VA medical centers include use of intermittent staff, temporary agency staff, and fee basis employees to supplement permanent staff. The Facility utilized permanent FTE as float staff to fill gaps in daily staffing, but the demand for the float staff was greater than the supply. In November 2016, Mr. Moschitta gave approval to hire 10 RNs and 10 NAs as intermittent nursing staff.[45] This approved intermittent nursing pool did not come to fruition until August 2017. Once the intermittent staff were on board, unit requests

[43] For the purposes of this review, excessive OT was defined as staff working 40 hours of OT or greater within a two week pay period or 1.5 FTE. OIG inspectors determined that 15 percent of the OT payouts for CLC nursing were made for staff who worked excessive OT.

[44] The OIG team chose to use the term "Alternative Staffing Strategies" to describe those methods commonly used in VA medical centers to supplement permanent staff.

[45] Intermittent nursing staff are hired specifically to fill in where units are short staffed. They are not permanently assigned to a specific unit or service but rather go where needed on a shift-by-shift basis.

for intermittent staff were filled on a first come, first serve basis. Nurse Executive 1, in acknowledgement of the CLC staffing shortages, altered the process and gave the CLC units priority. The OIG found no evidence that the Facility leaders pursued or used other alternative staffing options prior to the hiring of intermittent staff in August of 2017 to help address the CLC staffing shortages.

Mismanagement of CLC Nurse Staffing

Federal employees are expected to be good stewards of government resources. The OIG found a mismanagement of CLC nurse staffing by senior leaders.

Failure to Fill CLC Nursing Positions Identified as Needed

As shown in Table 1, the four CLC units had nursing staff vacancies. These vacancies reflected staff identified as necessary to reach target NHPPD as recommended by the expert panel. To understand decisions related to these vacancies, the OIG reviewed Facility hiring efforts. In an interview with VISN leaders and Facility HR staff, the OIG learned that the Nursing Service had automatic approval to recruit for and fill positions vacated throughout FYs 2016 and 2017. OIG inspectors reviewed a list of nursing vacancy announcements from FYs 2016 and 2017 documenting HR's ongoing recruitment efforts. Prior to April 2017, these recruitment efforts were slowed by the requirement that new nursing staff complete the hiring process before the Facility Resource Management Committee granted approval of a start date. Once issued, the start date may have been several months in the future, causing portions of the new nursing staff onboarding[46] packet to expire, requiring renewal and further delays. The addition of Resource Management Committee approval within the hiring process was contrary to the intent of automatic approval to fill nursing positions. For instance, a member of the nursing leadership team told OIG inspectors of an RN and an NA who were interviewed and selected in January 2017 and given a start date in July 2017. This delay in hiring often resulted in the loss of selected applicants who took other jobs.

As an additional challenge, HR identified Nursing Service's use of preferred qualifications above minimum standards to filling vacant nursing positions. For example, the Nursing Service preferred to hire RNs with a Bachelor of Science in Nursing and five to seven years of experience despite the minimum standard for hire in the VA being RNs with an Associate degree in Nursing and no post-degree experience.

[46] Onboarding is the term used to describe the process of bringing a new employee into the organization. https://www.govloop.com/community/blog/the-difference-between-onboarding-and-orientation/. (The website was accessed on November 27, 2017.)

The OIG looked at the Facility nursing gains and loss data[47] to determine whether or not the Facility staff made progress in filling vacant nurse positions in an effort to reach their FTE ceiling. The change in nursing FTE for the Facility across FYs 2016 and 2017 was insignificant. The rate of gains was similar to the rate of loss, with a net loss of 1.58 FTE over the two-year span. Thus, the Facility had no appreciable gain in nursing FTE to allocate toward strengthening the nurse staffing levels in the CLCs to meet target NHPPD.

Given the nursing vacancies and the high cost of OT, OIG staff analyzed data to determine the cost of hiring staff compared to the cost of OT. Analysis of the data indicated that the funding spent on OT exceeded the cost associated with filling the vacant positions.[48] For example, Figure 5 shows that in FY 2016 the money spent on OT could have funded 5 RNs or 8.75 LPNs or 12.25 NAs.

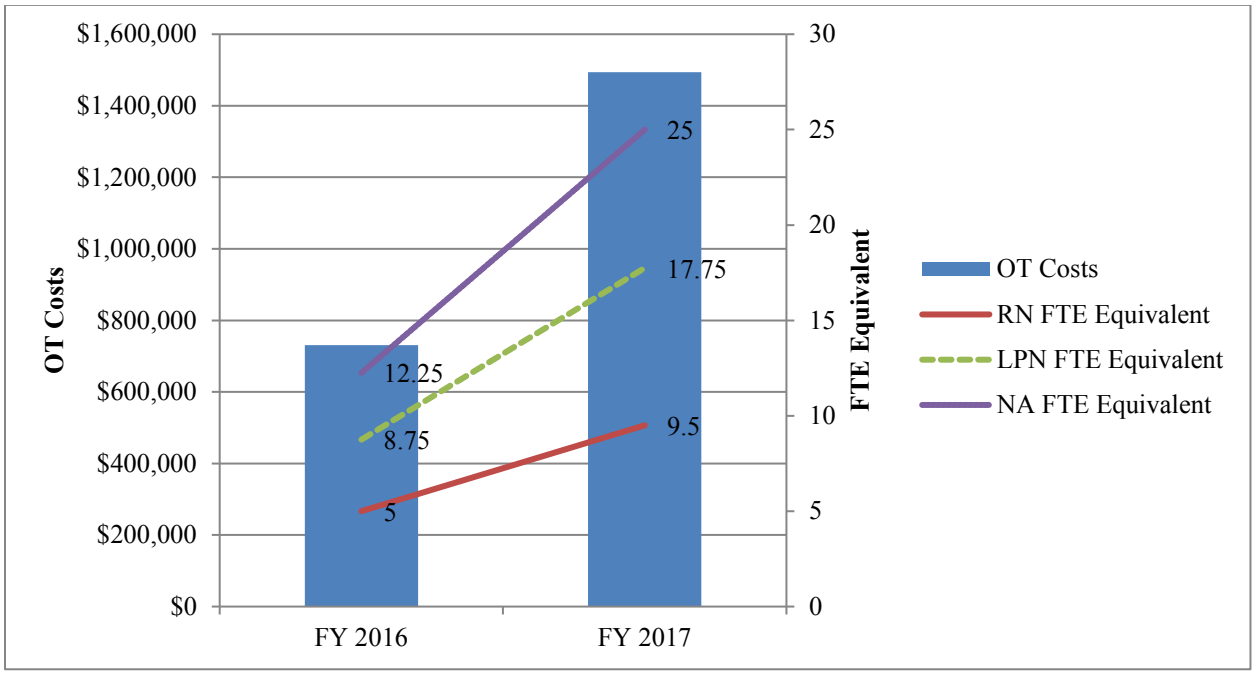

Figure 5. CLC Nursing Overtime Costs and FTEs that Could Have Been Funded with OT Dollars for FY 2016 and FY 2017
Source: VA OIG analysis of Facility data

Impact on Patients

A variety of contributory factors can impact patient outcomes and quality of care, including the environment of care, availability of supplies, clinical expertise, and staff resources. In isolation, an organization utilizing OT and float staff to offset reduced staffing availability does not present

[47] Gains data is the number of new employees starting at a facility and the loss data is the number of employees who left the facility and are no longer working there.

[48] As noted in Table 1, vacancies totaled 6.3 FTEs in FY 2016 and 15.3 FTEs in FY 2017.

a risk to patients. Based on OIG inspectors' review of Facility root cause analysis, fall data, Electronic Patient Event Report data, and Fall Prevention committee minutes, the OIG was not able to directly attribute to staffing issues the adverse events that were reviewed.

In June 2017, Mr. Guermonprez was appointed as Facility Director, and in August 2017, the Chief of Staff, Dr. Kauffman, and Ms. Burke were detailed out of the Facility and Dr. Cruise and Nurse Executive 1, respectively, assumed their roles. The new leadership team conducted a review of CLC staffing and OT use and identified a number of initiatives to improve staffing and patient outcomes.

After reviewing OT use, Facility staff determined that some staff worked back-to-back shifts (doubles) and that at times they were assigned to a full shift on continuous observation during their second shift. To reduce the possibility of fatigue during continuous observation, leaders implemented requirements that no staff member shall work continuous observation on the second shift of a double shift and that staff will rotate on and off continuous observation assignments every two hours.

New leadership members also began implementation of alternative strategies to offset use of continuous observation, and therefore OT, in the CLCs. In an effort to reduce the use of continuous observation, Mr. Guermonprez met with staff and explored alternatives that may allow residents to be more actively engaged in common areas of the unit, allowing for more frequent observation by staff. Recreation Therapy engaged in this process resulting in an increase in therapeutic activities available to residents. Managers initiated a plan to move away from the use of a centralized nursing station on the CLC units in favor of a structure in which nursing staff spend more time in common areas closer to residents. Facility leaders identified resources to support this change, such as increased availability of computers on wheels on the units, which allowed nursing staff to access charts and complete documentation while in common areas and residents' rooms.

Facility leaders identified an effect on staffing caused by having CLC staff escort residents to medical appointments across the Facility's campus. Leaders are considering the feasibility of using the escort pool from the on campus medical center to provide the necessary escorts for CLC residents.

New Facility leaders are taking steps to reduce the use of OT while continuing to address the needs of the patients.

Issue 2: Administrative Nurses were Ordered to Feed and Bathe CLC Residents

The OIG substantiated that nurses assigned to administrative, non-patient care roles, were ordered (by leadership) to provide nursing care, including feeding and bathing. These

administrative nurses provided nursing care and coverage for CLC residents on continuous observation over a limited period of time.

In July 2017, Ms. Burke shared her concerns regarding CLC nurse staffing levels with VISN leaders. In order to maintain situational awareness, the VISN Director, Dr. McInerney, requested that Ms. Burke communicate with her on a daily basis confirming that adequate staffing was in place. Nursing personnel told OIG staff that one of the strategies deployed by Ms. Burke to ensure adequate staff and reach the target staffing levels was to float RNs from administrative positions to cover patient care. VISN leaders reported they had been involved in discussions about the possibility of reassigning administrative nurses to clinical care but did not have knowledge of this practice taking place.

In July and August 2017, administrative nurses provided nursing care, assisted with passing medication, and provided coverage for continuous observation. Some administrative nurses expressed concerns with this process and requested information regarding the training they would receive prior to providing the care, as many of them had not recently worked in direct patient care. The OIG did not find evidence that Facility leaders asked the reassigned administrative nurses to perform work outside of the position description for an RN. In addition, the OIG found no reports of patient incidents or medication errors while the administrative RNs provided patient care.

Issue 3: CLC Managers were Pressured by Facility Leaders to Accept Admissions when Staffing was Below the Minimum Level of NHPPD, Jeopardizing the Safety of CLC Residents

The OIG substantiated that previous Facility leaders pressured CLC managers to accept admissions when CLC managers' assessments determined nurse staffing on the unit would be inadequate to provide the expected level of care for additional residents; therefore, potentially jeopardizing the safety of residents.

VHA policy[49] states "[a]ll admissions to the CLC must be properly assessed for appropriateness of admission by a CLC-based admission coordinator, team, or CLC leader." The policy further states "The ultimate decision about an admission is to be made by the VA CLC medical director in collaboration with the designated CLC nurse leader."[50]

Facility leaders had pressured CLC managers to accept admissions at times when the unit's staffing was insufficient to increase patient census while providing an adequate level of care.

[49] VHA Handbook 1142.02, *Admission Criteria, Service Codes, And Discharge Criteria For Department Of Veterans Affairs Community Living Centers*, September 12, 2012. This handbook was scheduled for recertification on or before the last working day of September 2017 and has not been recertified.

[50] VHA Handbook 1142.02.

CLC nurse managers shared examples of being pressured to accept new admissions despite advising leaders of concerns given the nursing staff and acuity of the residents at the time.

A review of one example provided by staff confirmed that nurse staffing at the time of the admission was less than 75 percent of the target NHPPD for the unit. In this case, the CLC nurse manager informed the Chief of Staff, Dr. Kaufman, about the concern that the already limited available staffing was insufficient to manage a new admission with multiple medical needs, but Dr. Kaufman instructed the nurse manager to accept the admission. The CLC nurse manager told the OIG that this admission strained the capacity of the available staff, diverted staff time from other residents, and prevented optimal management of the combined needs of all residents on the unit. The nurse manager stated that staff felt distressed by the admission of this high acuity resident as it impacted staff's time with another resident on the unit for end-of-life care.

VHA policy also states that "[a] CLC with necessary resources can choose to admit veterans outside of normal working hours on a case-by-case basis."[51] The policy details specific requirements that must be met for this to occur. Requirements include stipulations that a "CLC-based admission coordinator, team, or CLC-based designee must have evaluated the veteran for appropriateness of admission and determined that the CLC has the nursing resources and program competencies to accept the admission outside of normal working hours" and that the veteran is "medically and psychiatrically stable."[52] The policy also requires that "there is a clearly designated and readily available medical provider" and that "there is evidence of adequate nurse staffing."[53]

A CLC nurse manager provided another example of leaders' pressure to accept an admission. In this example, the CLC unit nurse manager was pressured to accept a weekend admission, a practice outside of normal procedure due to staffing levels and resident needs. The nurse manager said that the admission was for a resident whose care needs were not best suited to that CLC unit or in alignment with the available staffing, including the lack of physician staffing on the unit at that time. The CLC nurse manager said in a discussion with Ms. Burke that the unit was close to its maximum and was later advised by Ms. Burke that the unit would not receive any admissions until Monday. The CLC nurse manager noted that the resident in question was initially intended for admission to a different CLC unit better suited to the resident's care needs; but, was instead admitted to the unit on a Saturday, when the CLC nurse manager was not present to participate in the decision to admit. The CLC nurse manager did not identify who made the final decision to admit the patient to the unit. The CLC nurse manager described the resident as presenting with high-intensity needs due to psychiatric issues as well as medical issues. The CLC nurse manager noted that the resident's behavior and care needs upon

[51] VHA Handbook 1142.02.

[52] VHA Handbook 1142.02.

[53] VHA Handbook 1142.02.

admission necessitated assignment to continuous observation by staff as a safety precaution. Despite the resident having needs that exceeded the admission criteria for that particular CLC unit, the resident remained on that unit for a number of months and required continuous observation throughout the admission, which necessitated additional staff resources.

CLC nurse managers told the OIG that they have noted positive changes under the new Facility leaders. CLC nurse managers stated that under the new leadership team, Nurse Executive 1 and the Acting Chief of Staff, Dr. Cruise, census, patient acuity, and available staffing were discussed when considering admissions. CLC nurse managers further stated that they no longer experienced pressure to accept admissions when staffing was below safe levels. They specifically identified the new leadership team assembled in August 2017 that included the Facility Director, Scott Guermonprez, Nurse Executive 1, and Dr. Cruise as catalysts for this change.

Issue 4: CLCs were Closed to Admissions and Residents were Transferred to Acute Care Inpatient Units Due to Lack of Staffing

The OIG substantiated that at times the CLCs were closed to admissions; however, the OIG did not substantiate that residents were transferred to acute care inpatient units due to lack of CLC staffing. Review of emails related to CLC closures confirmed that from late July through early September 2017, CLC units were closed to admissions due to nurse staffing levels. OIG inspectors confirmed CLC closures during interviews with CLC staff. A CLC nurse manager told OIG inspectors that Ms. Burke put a hold on admissions while staffing in the CLCs was examined. The same nurse manager indicated that the unit had few beds affected by this temporary hold because the unit was close to capacity at that time.

In July of 2017, Ms. Burke reached out to the VISN for input on her response to an oversight body regarding CLC related concerns and in doing so notified Dr. McInerney of the possibility that nurse staffing was critically low and may be unsafe for residents. Dr. McInerney responded by proposing to set up a VISN incident command response and look at the possibility of moving residents to alternative long-term care facilities in the area. After the VISN's discussion of such measures and re-assessment of the status of staffing in the CLCs, leaders determined that the staffing levels in the CLCs were safe and the VISN incident command response was not required. No CLC residents were transferred to acute care inpatient units as a result of nurse staffing levels.

Conclusion

The OIG substantiated that nursing leaders were aware of staffing shortages in the CLCs, and OIG inspectors confirmed the use of float staff and OT to address staffing shortages. However, due to the many variables that contribute to the delivery of safe patient care, the OIG was unable to substantiate or not substantiate that the use of float staff and OT to manage staffing shortages placed residents at a higher risk for adverse events.

The Facility CLCs had a chronic lack of nurse staffing. This was in part due to the delayed filling of vacant positions (through new hires or redistribution of nursing staff) and the lack of approval for increased FTE in response to nurse staffing methodology expert panel's recommendations. Other contributing variables to a lack of nurse staffing included Nursing Service's preference in hires and staff's routine and atypical leave. The Facility lacked an adequate number of permanent staff to meet the NHPPD; therefore, to meet staffing demands, Nursing Service relied on OT and floating existing nursing staff. Prior to the hiring of intermittent staff in August 2017, the Facility failed to utilize alternative staffing strategies.

The OIG found the Facility lacked processes to identify and monitor excessive OT use by individual or unit. Federal employees are expected to be good stewards of government funds. The OIG found a lack of accountability for managing OT expenditures. OIG inspectors' data review indicated that the OT funding exceeded the cost associated with filling the vacant positions. In addition, even if the current FTE ceilings were met, staffing to the NHPPD would continue to require the use of OT or other alternative staffing strategies.

The OIG found that staffing shortages were present and the Facility Directors and nursing leaders were aware of the shortages in FYs 2016 and 2017. In July 2017, VISN leaders learned the extent of the nurse staffing shortage when nursing leaders reached out to the VISN for input regarding an oversight body for CLC related concerns. Awareness of the Facility staffing shortages at the VISN level, coupled with the presence of new Facility leadership, resulted in focused attention and action on the staffing issue.

The OIG substantiated that nurses, assigned to administrative, non-patient care roles, were ordered (by leaders) to provide nursing care, including patients' feeding and bathing. This occurred in July and August 2017. Administrative nurses provided nursing care, assisted with passing medication, and provided coverage for continuous observation over a limited period of time during which concerns about nurse staffing levels were heightened. The OIG inspectors did not find evidence of deficiencies in their work or that the administrative nurses who covered in the CLCs were asked to perform work outside of the position description for an RN.

The OIG substantiated that previous Facility leaders pressured CLC managers to accept admissions at times when the nurse staffing on the unit was inadequate to provide the expected level of care for additional residents, which potentially jeopardized the safety of current residents. CLC nurse managers stated that they no longer experienced pressure to accept

admissions when staffing was below safe levels. They specifically identified the new Facility leadership team (Director, Acting Chief of Staff, and Nurse Executive 1) assembled in August 2017 as catalysts for this change.

The OIG substantiated that at times the CLCs were closed to admissions. However, OIG inspectors did not substantiate that residents were being transferred to acute care inpatient units due to lack of CLC staffing. CLC nurse managers told OIG inspectors that the new Facility leaders, the Associate Chief Nursing Services, and the Acting Chief of Staff discussed census, patient acuity, and available staffing when considering admissions.

The OIG made three recommendations.

Recommendations 1–3

1. The Northport VA Medical Center Director completes a full review of Community Living Center nurse staffing to ensure authorized full-time employee equivalents align with census and recommended nursing hours per patient day and that modifications (if any) are reflected on the Nursing Service organizational chart.

2. The Northport VA Medical Center Director continues efforts to recruit and hire for Community Living Center nursing vacancies and ensures that, until optimal staffing is attained, alternate staffing strategies are consistently available to meet resident care needs.

3. The Northport VA Medical Center Director reviews and identifies processes that improve management of overtime practices to ensure quality of care and responsible use of financial resources and determines if actions need to be taken.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 20, 2018

From: Network Director (10N2)

Subj: Healthcare Inspection—Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the CLC at the Northport VA Medical Center, New York

To: Director, Seattle Regional Office (54SE)

VHA Management Review Services

I have reviewed and concur with the Office of Inspector General's findings and recommendations and the responses and actions initiated by Northport VAMC. Thank you for the opportunity to review our processes to ensure that we continue to provide exceptional care for our Veterans.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA FACEP
Network Director

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 17, 2018

From: Interim Director, VHA VISN 2 Northport New York #632

Subj: Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Center, Northport VA Medical Center, New York

To: Director, Seattle Regional Office (54SE)

VHA Management Review Services

I have reviewed and concur with the Office of Inspector General's findings and recommendations and the responses and actions initiated by Northport VAMC.

Thank you for the opportunity to review our processes to ensure that we continue to provide exceptional care for our Veterans.

(Original signed by:)

Cathy Cruise, MD
Interim Medical Center Director
VAMC Northport NY VISN 2

Comments to OIG's Report

Recommendation 1

The Northport VA Medical Center Director completes a full review of Community Living Center nurse staffing to ensure authorized full-time employee equivalents align with census and recommended nursing hours per patient day and that modifications (if any) are reflected on the Nursing Service organizational chart.

Concur.

Target date for completion: September 30, 2018

Director Comments

Organizational Charts for the four CLCs were reviewed, updated, and signed in March 2018. Medical Center Leadership agreed to fill all vacancies to approved ceilings. Staffing methodology is currently being conducted with an anticipated completion date of September 30, 2018. Staffing methodology is updated annually and as needed and used as a guideline in establishing Nursing Hours Per Patient Day (NHPPD). Organizational charts are reviewed annually and additionally if there are changes in programming. Updated organizational charts will be formulated once all newly established positions are approved.

Census and acuity for each CLC unit are reviewed and analyzed daily by the Nursing Leadership to ensure staffing levels are appropriate for respective units. Variables that impact the need for nursing staff include severity of patient condition, complexity of care, nursing skill level, skill mix of staff, and actual or projected change in census.

Recommendation 2

The Northport VA Medical Center Director continues efforts to recruit and hire for Community Living Center nursing vacancies and ensures that, until optimal staffing is attained, alternate staffing strategies are consistently available to meet resident care needs.

Concur.

Target date for completion: September 30, 2018

Director Comments

Direct Hire Authority was authorized by Leadership to the Resource Board for nurse staffing to achieve 100% of staff based on approved organizational chart and staffing methodology. Alternative staffing strategies have been explored and developed to ensure appropriate staffing levels. Strategies for success include:

- Use and expansion of float pool
- Cross-train nursing staff for LTC to ensure adequate staffing
- Use of intermittent staff
- Recruitment of 20 Universal Workers to assist in ADLs and Light Housekeeping
- Hiring of transporters to drive and escort Residents to appointments thus eliminating the need for staff to leave the unit
- Flexible scheduling to provide additional staff during peak hours such as meal time and medication passes
- Establishment of an Adult Day Care Program encompassing a multidisciplinary approach to providing care to the Veteran
- Development of an RN Clinical Coordinator Role, providing oversight, education, and support for WHEN hour Staff.

Recommendation 3

The Northport VA Medical Center Director reviews and identifies processes that improve management of overtime practices to ensure quality of care and responsible use of financial resources and determines if actions need to be taken.

Concur.

Target date for completion: September 30, 2018

Director Comments

A task force has been authorized to review and identify processes to decrease overtime. Overtime is approved by Nurse Managers along with NODs. Internal controls are utilized to review overtime by T&L biweekly and by employee name as needed. Strategies for reduction include:

- Daily review of special status observations and provide potential alternatives
- Purchase of Telesitter which will visualize multiple high-risk Residents via monitoring device eliminating need of 1:1 staffing to ensure patient safety
- Explore nurse turnover rates to decrease costs and timeframes of new hires
- Cross-train core group of staff to work in multiple areas to ensure competence.

OIG Contact and Staff Acknowledgments

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