OMI Review for the Under Secretary for Health
Veterans Affairs Medical Center
Reno, Nevada
April 24, 2012
2011-D-1352

Executive Summary

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate quality of care and patient safety concerns at the Department of Veterans Affairs (VA) Sierra Nevada Health Care System, Reno, Nevada (hereafter, the Medical Center). The VA Sierra Pacific Network (VISN 21) and the Medical Center requested an in-depth review of wide-ranging complaints from the Medical Center's American Federation of Government Employees (AFGE) union president, involving patient safety and care delivery concerns. The OMI conducted site visits to the Medical Center on October 3-6 and October 24-27, 2011.

A. Primary Care (PC)

Allegation

Poor staffing results in poor continuity of care and poor access to care. Providers have increased their workload to meet performance measures.

Summary of Conclusions

Continuity of care in the PC clinic could be improved. The incomplete implementation of the Patient Aligned Care Team (PACT) staffing model may be a contributing factor. Closed encounter information may result in a loss of clinical information, which may represent a potential threat to patient safety and continuity of care. A number of clinical staff members sampled had not received annual performance evaluations for the past 3 years.

Recommendations

The Medical Center should:

1. Develop a plan with metrics to improve and measure continuity of care in the PC clinic. Consider tracking and trending the percentage of care provided outside of a single provider, and tracking and trending the number of Veterans followed in PC without an assigned provider as continuity metrics.
2. Review the delivery of PC to identify gaps in continuity of care, and evaluate against PACT staffing.
3. Develop a plan with metrics to improve and measure clinical staff recruitment, hiring, and retention.
4. Develop a plan to ensure that all staff members have timely performance evaluations.

VISN 21 should:

1. Evaluate the Medical Center's administrative closure of encounters and take appropriate action.
2. Evaluate the failure to complete annual performance evaluations at the Medical Center and take appropriate action.

B. Social Work Services for Primary Care Clinic

Allegation

The PC social work service is understaffed. Social workers were not hired because the money was spent on PACT teamlet training instead.

Summary of Conclusions

The Medical Center is not in compliance with the current model for PACT team social work coverage; however, the workload documentation provided to the OMI does not support the hiring of additional social workers. The Medical Center appropriately funded PACT training for the PC staff.

Recommendations

The Medical Center should:

5. Improve workload documentation for social work.
6. Review the current staffing patterns and take appropriate action to ensure the appropriate distribution of social work resources in PC.

C. Emergency Department (ED)

Allegation

The ED is inadequately staffed with physicians. There are long wait times in the ED due to poor access to primary care. ED patients often leave without being seen.

Summary of Conclusions

The ED workload has increased, particularly in the third quarter of FY 2011. Patient flow from the PC and urgent care clinics may have contributed to this increase. The ED physician staffing may be inadequate to address the increased workload.

Recommendations

The Medical Center should:

7. Develop and implement a plan addressing the increased workload in the ED. The plan should include a review of the number of ED physicians and support staff. The plan should also address the apparent increase in patient flow from PC.
8. Contact patients who leave the ED without being seen and encourage them to take the appropriate action based upon their clinical concerns. This information should be tracked and trended.

D. Pain Management

Allegation

The Medical Center lacks pain management resources. The pain management program does not comply with the first step of the pain management strategy outlined in the VHA directive on pain management.

Summary of Conclusions

The Medical Center is not providing pain management oversight as required in VHA Directive 2009-053, specifically in early pain recognition and effective treatment. In addition, there is no evidence that the Medical Center is evaluating pain management activities, is evaluating clinical competence in pain management, or developing a pain management strategy by growth of the existing pain management resources, as required by the Directive. Finally, the Medical Center collects data on patient satisfaction and overall pain management, but the Pain Task Force (PTF) does not review this data. Neither the PTF nor the Pain Panel (PP), is chartered in a Medical Center policy. Also, the mission of the PTF is not documented in a Medical Center policy.

The Medical Center does not provide timely access to pain management specialists as required in the second step of VHA Directive 2009-053 that mandates a step-approach to pain management. In a facility where the prescription of oral narcotics is consistently high (see the discussion of oral narcotic prescribing below) and where there are no pain specialists on staff, nine pain management fee-basis consultations on six different Veterans in 10 months appears low. In addition, in five of the six Veterans who had requests for a fee-basis consultation with a pain management specialist, the time to get the consultation approved was more than 30 days. In two cases, the request for fee-basis pain management consultation has not been approved by the drafting of this report, and in two cases, the request for fee-basis pain management consultation took 90 days.

Recommendations

The Medical Center should:

9. Develop a plan to improve access to pain management services as described in step two of VHA Directive 2009-053. This improvement should include comparing the number of pain management consults completed at facilities of similar complexity, increasing the number of patients who are referred for pain management consultation, if appropriate, reducing the time for fee-basis pain management consultation approval, and monitoring the results of the improvements.
10. Charter the PTF and the PP in an appropriate policy.
11. Ensure compliance with pain management oversight requirements as outlined in VHA Directive 2009-053.

E. Narcotics Prescribing

Allegation

Primary care providers prescribe more oral narcotics than other VA health care facilities. Leadership pressures primary care providers to give Veterans oral narcotics to keep complaints down.

Summary of Conclusions

Providers prescribe some oral narcotic medications at a rate higher than providers at other facilities in VISN 21 and providers at other facilities of comparable complexity. The facility offered no explanation for this finding. The OMI found no evidence that leadership attempted to pressure providers to prescribe narcotics to keep the number of patient complaints down.

Recommendations

The Medical Center should:

12. Develop a quality improvement and drug utilization review of its pain management strategy, including review of an appropriate number of complex pain management patient records each month, making recommendations about narcotic prescription practices, and followup on implementation.
13. Educate providers on the appropriate management of patients with complex pain management conditions. This should include a review of pain management strategy, and clarification of the roles of the PTF and PP.
14. Monitor the rates of patients receiving opiates and opiate prescription refills. Complete a comparative analysis of facilities of similar size and complexity.

F. Pharmacy

Allegation

The Outpatient Pharmacy takes as long as 4 hours to fill prescriptions for Veterans discharged from the hospital.

Summary of Conclusions

Most patients discharged from inpatient care take less than 4 hours from the time a discharge order is entered until that patient picks up his discharge medications. In a minority of patients, it may take 4 hours or longer; however, this time includes activities that are not under the control of the pharmacy.

Recommendations

The Medical Center should:

15. Continue in its efforts to reduce the time between entry of the discharge order into the inpatient medical record and the dispensing of discharge medications. As the discharge process involves a number of disciplines, the groups addressing this issue should be multidisciplinary and include the Pharmacy Service.
16. Monitor the time from discharge order entry to medication pickup as part of this continuing review.

G. Hospitalist Service

Allegation

The hospitalist service is understaffed. The hospitalist work schedule is too demanding.

Summary of Conclusions

The OMI found no evidence that patients suffered adverse outcomes due to hospitalist shortage or scheduling. Because the Medical Center has not defined its needs for hospitalists in a plan, the OMI is unable to determine whether the current staffing level and provider schedule meets the facility's needs.

Recommendation

The Medical Center should:

17. Develop a comprehensive plan to determine the needs of the hospitalist service, implement the plan, and monitor its implementation.

H. Surgical Services: Otolaryngology Clinic

Allegations

Veteran 7's treatment for recurrent head and neck cancer was delayed by an unnecessary second opinion during which time the tumor grew to such an extent that it became inoperable.

Veteran 8's care was delayed because of an unnecessarily lengthy approval process for fee-basis care.

The skin biopsy clinic, run in the otolaryngology (ear, nose, and throat or ENT) clinic by the nurse practitioner assigned there, was canceled without reason, causing delays in treatment for patients with skin cancer.

Summary of Conclusions

Veteran 7's treatment for recurrent head and neck cancer was unnecessarily delayed between 6 and 8 weeks by the request for a second opinion from the San Francisco ENT consultant. Although this Veteran's treatment was delayed, it is not possible to determine whether the delay contributed to the Veteran's death.

Although not adversely affecting Veteran 8's favorable outcome, the treatment for his cancer was delayed by 5 or 6 weeks while the Chief of Staff (COS) and the ENT consultant exchanged comments with each other in this Veteran's medical record about the appropriateness of the positron emission tomography (PET) scan.[1]

Although the skin biopsy clinic run by the advanced practice nurse (APN) was abruptly suspended, there is no evidence that any patient's care was adversely affected by this decision. The COS has responsibility to ensure that every practitioner in the Medical Center has the appropriate education, training, and experience to exercise the privileges or scope of practice granted by the facility. In this instance, the decision to suspend the skin biopsy clinic pending clarification of the practitioner's credentials to perform skin biopsies was reasonable. Better communication with the providers directly involved with the skin biopsy clinic might have expedited reinstatement of the clinic.

Recommendations

The Medical Center should:

18. Develop a time standard and a process to ensure timely approval of requests for care outside of the VA medical system, particularly for requests involving diseases, like cancer, for which rapid treatment is critical.
19. Conduct an institutional disclosure about the delay in care with Veteran 7's family and with Veteran 8.

[1] PET scanning is an imaging technique that uses positively charged radioactive particles to detect subtle changes in metabolism and chemical activities.

I. Outpatient Mental Health Clinic

Allegations

The Mental Health Clinic (MHC) has not offered individual psychotherapy since December 2010.

Patients are assigned a "principle mental health care provider" who does not provide direct patient care, but rather coordinates the care that a patient may receive.

High-risk patients are often seen by a nurse who has no training in psychotherapy.

Summary of Conclusions

The OMI did not find evidence of any patients receiving recommended individual psychotherapy of eight or more sessions after December 2010, either through the MHC or other available resources like fee-basis care. MHC vacancies are contributing to the inability of the Medical Center to provide individual psychotherapy of eight or more sessions. The Medical Center is not providing transportation for patients between the MHCs on the remote and main campuses.

Veterans are receiving appropriate, initial mental health assessments by appropriately trained staff, but not within the 14-day time frame as required by the VHA Handbook 1160.01: *Uniform Mental Health Services in VA Medical Centers and Clinics*.

In some instances, clinical mental health providers may serve in dual roles as a principle mental health provider and as a mental health therapist, in order to meet the requirements of the aforementioned handbook.

The MHC registered nurse (RN) is providing followup for high-risk patients. The MHC RN does not have the credentials, clinical competencies, or necessary clinical guidance in the form of a protocol to provide this service.

Recommendations

The Medical Center should:

20. Determine whether there are any current patients with unmet individual psychotherapy needs of eight or more sessions and address any needs that are found.
21. Develop and implement a plan to meet individual psychotherapy needs of eight or more sessions, and monitor its implementation. The plan should address continued recruitment for MHC vacancies. On a quarterly basis, the monitor should track the number of consults to the MHC for individual psychotherapy, the actual number of encounters for individual psychotherapy, the total number of patients receiving this care, and the number of patients receiving individual psychotherapy on fee-basis. Communicate the availability of individual psychotherapy of eight or more sessions to those working in other MHS specialties.
22. Review the practice of using mental health care providers as principle mental health

providers, and ensure patients receive appropriate initial mental health assessments within the 14-day time frame as required by VHA Handbook 1160.01: *Uniform Mental Health Services in VA Medical Centers and Clinics*.

23. Ensure high-risk patients are followed up by a provider with the proper credentials and clinical competencies, or with the appropriate clinical guidance.
24. Review the care of patients who received followup by the MHC RN for the past 6 months and take any necessary action to ensure appropriate management.

J. Locked Inpatient Psychiatric Unit

Allegations

The inpatient psychiatric ward environment does not provide for patient's serious medical needs such as wall oxygen, call-light system, intravenous therapy, and hospital beds. In addition, the bathrooms are prison-like, the furniture is uncomfortable, heavy, and spartan.

The inpatient psychiatric unit is being used to house elderly, chronic, demented patients, in addition to younger patients with acute psychiatric illnesses.

There is a lack of patient comfort supplies so that inpatient psychiatric unit staff purchase needed items with their own money. The patients on the unit do not have access to a telephone.

The inpatient psychiatric unit is understaffed.

Summary of Conclusions

Patients on the inpatient psychiatric unit have their medical needs met either on the unit or by transfer to a medical unit. The furniture and bathrooms are appropriately designed to maximize patient safety on a high-risk, locked, inpatient psychiatric unit, often at the expense of style and aesthetics.

Community Living Center (CLC) residents with unmanageable behaviors are admitted to the inpatient psychiatric unit when they cannot be transferred to another appropriate care facility. The admission of these CLC residents to the inpatient psychiatric unit represents a reasonable solution for the safety of the CLC residents, hospital patients, and staff. The CLC residents on the inpatient psychiatry unit at the time of the OMI site visit did not have a treatment plan recognizing their special needs. Although the inpatient psychiatric unit is an acute unit with a short average length-of-stay, there is an inadequate number of groups and activities on the unit. Some patients will benefit from additional activities and structure.

Basic comfort items were not regularly provided to the inpatient psychiatric unit because the unit staff was not familiar with the proper ordering process. The inpatient psychiatric staff removed the telephone for valid safety reasons but provided a cellular telephone, an adequate alternative.

The actual number of available nursing staff is below the authorized staffing ceiling. Nursing is not participating in the required interdisciplinary treatment team meetings.

Recommendations

The Medical Center should:

25. Ensure that the CLC residents admitted to the inpatient psychiatric unit for behavioral control have a treatment plan that addresses their individual therapeutic, physical, and social needs.
26. Develop and implement a plan to initiate recovery-oriented activities and groups to meet the needs of the patients on the inpatient psychiatric unit.
27. Analyze the nature of the patient-on-staff assaults and provide staff with necessary training based upon findings.
28. Ensure that patients on the inpatient psychiatric unit get appropriate comfort items.
29. Ensure that patients have appropriate access to a telephone and are aware that it is available for their use.
30. Review the current staffing patterns to ensure the appropriate distribution of nursing resources on the inpatient psychiatric unit.
31. Ensure that an RN participates in the interdisciplinary treatment team meetings.

K. Intensive Care Unit (ICU)

Allegation

There is a staffing shortage in the ICU. The ICU management has counseled the RN staff for not giving medications on time.

Summary of Conclusions

The OMI found no evidence of adverse patient outcomes due to ICU nurse staffing shortages. The ICU is not staffed to its authorized ceiling; although, based on the current workload and patient mix, staffing may be adequate. There have been significant delays in hiring RNs for the ICU. ICU nurses risk losing their specialized skills and competencies by frequently caring for lower complexity telemetry patients. In addition, routine placement of telemetry patients in the ICU solely for monitoring, may be an inefficient use of the ICU. The lack of a monitor technician in the ICU reduces the number of RNs available for direct patient care. The Medical Center does not have a policy defining admission criteria for the ICU or the other inpatient units. The increase in staff injuries may be a reflection of the staff shortages. All ICU RNs who received counseling were appropriately counseled.

Recommendations

The Medical Center should:

32. Review the current ICU staffing plan, taking into account the patient mix, and use of monitor technicians, and take action based on the review.
33. Develop and implement a plan to treat patients who require only telemetry monitoring on the medical-surgical unit.
34. Shorten the time it takes to fill RN vacancies in the ICU.
35. Develop an admission criteria policy for all inpatient units.
36. Review RN injuries in the ICU and take appropriate action.

L. Physical Therapy

Allegation

Physical therapy is understaffed. Physical therapy consults were automatically approved for 6 weeks of fee-based therapy. Durable medical equipment (DME) is no longer dispensed by physical therapy on a walk-in basis with delays in completion of consultations. CLC residents electively used their own Medicare benefits to seek community physical therapy services.

Summary of Conclusions

Physical therapy was critically understaffed during the summer of 2011, causing curtailment of most routine services, causing the referral of total joint operations to the community, and causing delays in access to outpatient physical therapy services. The Medical Center did not respond in a timely manner to predictable reductions in physical therapy staffing. Responding to the staffing shortage, the Medical Center did approve a group of physical therapy consultations from the electronic waiting list (EWL) to the community for fee-based care. In the absence of the timely anticipation of staffing losses, the OMI feels this was a reasonable method to provide access to care. Although providing walk-in physical therapy consultation for DME services is preferred, scheduling consultations was an acceptable option during this staffing shortage. CLC residents had their physical therapy services severely curtailed. As a result, one resident left the CLC to receive rehabilitative physical therapy services in his home; however, the OMI did not determine how his services were paid. The OMI found no occasion where a CLC resident used a Medicare benefit to obtain physical therapy services.

Recommendation

The Medical Center should:

37. Develop and implement a comprehensive plan that accounts for staff fluctuations and meets the rehabilitative and physical therapy needs of patients throughout the health care system.

M. Respiratory Therapy

Allegation

Frequently, there is a 2-hour period of time where there is only one registered respiratory therapist (RRT) to cover all beds in the hospital and CLC. The RRT that is scheduled to go off duty has to stay to assist with respiratory care. During times when there are multiple medical emergencies, coverage is inadequate, putting patients at risk. The intermittent RRTs are rarely available to work.

Summary of Conclusions

The OMI did not find evidence that the quality of care was negatively impacted by respiratory therapy staffing. There is frequently a 2-hour block of time during when only one RRT is on duty for the entire Medical Center, which was not able to provide a staffing plan for respiratory therapy services.

Recommendation

The Medical Center should:

38. Develop and implement a respiratory therapy staffing plan to ensure quality and safety.

N. Community Living Center (CLC)

Allegations

The CLC nurse staffing is inadequate, impacting resident falls, resident-on-resident and resident-on-staff violence, and there is a lack of activity and therapies for residents. The CLC is misallocating Hospice and Palliative Care Program funds.

Too many dementia residents are on psychotropic medications, and it may take an RN up to 2 hours to administer 200 medications between 9:00 a.m. and 11:00 a.m.

Nurses are required to perform respiratory treatments and to do tracheostomy care, and tracheostomy care supplies are not available.

Summary of Conclusions

Although the CLC authorized nurse staffing is adequate, the actual number of available nursing staff providing day-to-day resident care is inadequate. The number of CLC staff injured during resident care increased from the previous year. There was no evidence of a trend in resident-on-resident violence. The CLC has a higher prevalence of falls when compared to VISN 21 and VHA nationally. It is unclear whether the current CLC escort program is well suited to the needs of the CLC, which often requires residents to be transported and monitored by nursing staff. The OMI substantiated the lack of CLC resident activities and the overall lack of physical activity for nearly all CLC residents. The OMI believes that understaffing contributes to a lack of resident activity and has caused the dining room to close. With their greater care needs, the Hospice and Palliative Care residents require a higher nurse staffing level than CLC residents. Due to the current staffing methodology, both program needs may not be met. The allegation of misallocation of funds in the Hospice and Palliative Care Program should be investigated by the appropriate authority.

There is a high rate of CLC residents on more than nine prescribed medications when compared to VISN 21 and VHA nationally. There is a higher percentage of prescribed total psychotropic medications in CLC residents than in national and state of Nevada nursing home populations. Medication administration times may be in excess of 2 hours, and there may be more than 200 medications to administer during that time.

CLC nurses provide respiratory care in accordance with their competencies and certifications. The OMI found no evidence of a shortage of tracheostomy supplies.

Recommendations

The Medical Center should:

39. Develop and implement a plan, with Human Resources Division, to bring CLC nurse staffing to their authorized staffing levels. This plan should include human resource targets and accountability to achieve expedient staffing goals.
40. Reduce and monitor the diversion of CLC nurse staff to other units and implement consistent assignment of nursing staff for residents.
41. Develop and implement a plan to reduce resident falls and continue to monitor.
42. Develop and implement a comprehensive plan to improve the frequency and variety of resident recreational activities including weekends, holidays and off-shifts.
43. Develop and implement a CLC Restorative Care Program including a dining program.
44. Develop and implement a plan to identify Hospice and Palliative Care nurse staffing needs using casemix and RUGs data.
45. Conduct ongoing multidisciplinary reviews of resident medications, including the indications, dosage, and side effects of prescribed medications, and monitor appropriately.

VISN 21 should:

3. Investigate the alleged misallocation of Hospice and Palliative Care Program funds.

O. Operating Room (OR)

Allegation

Poor staffing in the OR and Supply Processing and Distribution (SPD) has resulted in delayed surgical start times during after-hour cases, RNs having to pick up supplies from SPD, and RNs having to sterilize surgical equipment. Not all radiology technicians are trained to use fluoroscopy equipment in the OR, resulting in delays in care.

Summary of Conclusions

The OMI found no impact on the quality of care or surgical services due to the delay of delivery of equipment or instruments from SPD during off-tour shifts. The OMI found no impact on the surgical quality of care related to availability of fluoroscopy services in the OR.

Recommendation

None.

P. Pathology and Laboratory Medicine Services (P&LMS)

Allegations

Poor staffing in P&LMS caused delays in the lab picking up specimens on the inpatient unit. There is a delay in picking up blood products by the inpatient unit once the unit has been notified by P&LMS that it is ready.

The histology exhaust hood is improperly vented.

Summary of Conclusions

The P&LMS is at its authorized personnel ceiling. From information the OMI gathered in interviews, there was no evidence of deficiencies in laboratory services as a result of P&LMS staffing. The Medical Center does not monitor the time it takes the laboratory to draw blood on inpatient units, or the time it takes to pick up a specimen from the inpatient unit, but there is no VHA requirement to monitor these times. In October 2011, the average pickup time for blood products by the unit nursing staff was greater than 1 hour; however, there is no VHA standard for this pickup time. Although the Medical Center reports the histopathology and autopsy room exhaust hoods venting into the facility air supply has been corrected, and reports acceptable levels of formaldehyde in the work area air, the strong odor of formaldehyde present during the OMI tour of the histopathology laboratory causes concern that the hoods may still not be used consistently by employees.

Recommendations

The Medical Center should:

46. Review the process for laboratory draws and specimen collection and take appropriate action.
47. Review the process for blood pickup from the laboratory and take appropriate action.
48. Consider automating the exhaust hoods in histopathology laboratory and autopsy room so that the hoods function whenever employees are in this work area.

Q. Additional Findings

The OMI is concerned that there is inconsistent professional oversight of nursing practice across the Medical Center, which may have a negative impact on the overall quality and safety of patient care provided by the Nursing Service. The OMI is concerned that one nurse educator for the entire Medical Center is insufficient to meet the education and training needs of the nursing staff.

The number of staff injuries and patient falls on the medical-surgical unit may be a reflection of the staff shortages. There are multiple staffing vacancies that need to be filled on the medical-surgical unit. The lack of a monitor technician in the medical-surgical unit may reduce the number of RNs available for direct patient care.

Recommendations

The Medical Center should:

49. Develop and implement a comprehensive plan to ensure nursing practice standards are met consistently throughout the health care system. This plan should address the education and training needs of nurses in the Medical Center and documentation of competencies.
50. Assess the need for additional nurse educators and take action as appropriate.
51. Review the current medical-surgical staffing plan, and use of monitor technicians, and take appropriate action based on the review.
52. Review causes of patient falls on the medical-surgical unit and develop a plan to reduce the rate.
53. Review causes for the increased staff injuries on the medical-surgical unit and develop and implement a plan to reduce them including appropriate training and preventive measures.

Table of Contents

I. Introduction

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate quality of care and patient safety concerns at the Department of Veterans Affairs (VA) Sierra Nevada Health Care System, Reno, Nevada (hereafter, the Medical Center). The VA Sierra Pacific Network (VISN 21) and the Medical Center requested an in-depth review of wide-ranging complaints from the Medical Center's American Federation of Government Employees (AFGE) union president, involving patient safety and care delivery concerns.

II. Facility Profile

Part of VISN 21, the Medical Center provides primary and secondary care to approximately 120,000 Veterans in northern Nevada and northeastern California. The Medical Center has approximately 1,200 employees and provides acute inpatient and outpatient primary care (PC) and specialty services. In fiscal year (FY) 2011, there were 64 inpatient beds, with 4,147 admissions, and over 331,800 outpatient visits, serving 29,319 unique patients. The Medical Center also has a 60-bed Community Living Center (CLC) that includes 12 hospice beds. The Medical Center is categorized as a moderately complex facility, a Medical Care Group (MCG) 2. [2]

The PC service line operates several clinics at the Medical Center's main facility in Reno, Nevada, and four community-based outpatient clinics (CBOCs) in Fallon and Minden, Nevada, and Auburn and Susanville, California, and one rural outreach clinic in Winnemucca, Nevada.

The Medical Center has academic affiliations providing medical and allied health training with the University of Nevada School of Medicine, Reno, and the East Bay Surgical Program at the University of California, San Francisco.

III. Methods

The OMI team consisted of the Deputy Medical Inspector for National Quality Assessment (a physician), a Medical Investigator (a physician), three Clinical Program Managers (two registered nurses (RN) and an advanced practice nurse (APN)), a Mental Health Investigator (a clinical psychologist), the Special Assistant to the Medical Inspector, and the Chief, VA CLCs. The OMI conducted site visits to the Medical Center on October 3-6 and October 24-27, 2011.

On October 3, the OMI held an entrance briefing with the Medical Center Director, Chief of Staff (COS), Associate Director, Associate Director for Patient Care Services/Nurse Executive, Chief, Quality Management, and the Patient Safety Manager. During the course of both site visits, the team toured all of the inpatient units including the intensive care unit (ICU), the inpatient psychiatric unit, the PC outpatient areas, the emergency department (ED), the clinical and histopathology laboratories, and the CLC.

[2] Facilities are categorized according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions and administrative complexity. Facilities are classified into three levels with Level 1 representing the most complex facilities, Level 2 moderately complex facilities, and Level 3 the least complex facilities.

The OMI met with the AFGE union president and a union steward. We met with more than 80 employees, representing the following clinical areas: PC, ED, ICU, pharmacy, respiratory therapy, physical therapy, clinical laboratory, mental health, CLC, and engineering and industrial hygiene. The interviewees included front-line employees, supervisors, and Medical Center leadership. In addition to meeting with these employees, we conducted a session open to anyone with a concern.

The OMI reviewed the documents listed in Appendix A.

The OMI compared the narcotics prescribing practices among national, VISN 21, and Medical Center providers. A description of the methods of this comparison is found in Appendix B.

We conducted exit briefings on October 6 and October 27, 2011, with VISN 21 and Medical Center leadership.

The OMI circulated this review to VISN 21, the Medical Center, and selected VA and VHA offices for comment. The OMI has incorporated comments into the final review as appropriate.

IV. Findings

A. Primary Care (PC)

Allegation

1. Poor staffing results in poor continuity of care and poor access to care. Providers have increased their workload to meet performance measures.

Findings

PC is provided throughout VHA by Patient Aligned Care Teams (PACT). PACT is a team-based model of health care led by a PC provider (a physician or an APN), who enables continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The team is responsible for providing all of a patient's health care needs or appropriately coordinating care with other qualified professionals.

A PACT is composed of teamlets consisting of a PC provider, an RN care manager, a clinical associate such as a licensed practical nurse (LPN), a medical assistant (MA) or health technician, and a clerk. Each PACT teamlet is supported by a team composed of clinical pharmacists, social workers, nutritionists, and behavioral health specialists. Each teamlet cares for a panel of approximately 1,200 patients.

There is a total of 26 teamlets at the Medical Center. At the time of the site visits, the following postions were vacant: four PC providers, one RN, four LPNs, four clerks, and nine social workers.

Several providers informed the OMI that up to 50 percent of their clinic appointments were filled with Veterans who were either unassigned to a teamlet, or who had not been reassigned from teamlets without providers. The OMI was also informed that Veterans are often sent to the urgent care (UC) clinic and the ED as a result of an inability to accommodate all patients in primary care. To address these provider vacancies, locum tenens and VA employee physicians assumed clinical care for Veterans without assigned providers.[3] For each PC appointment, these Veterans were scheduled to see the next available provider rather than being reassigned to another panel. This occurred frequently, resulting in Veterans seeing multiple providers. Because of personnel shortages, the RNs, LPNs, and clerks were shared among teamlets.

The quality and performance data for the Medical Center as reported in the Aspire and LINKS databases met or exceeded the target for all outpatient measures.[4] The Medical Center was recently recognized by the Joint Commission for attaining and sustaining excellence on accountablility measure performance as one of 20 VA medical centers and one of 405 facilities nationwide as a Top Performers on Key Quality Measures™. The program is based on data reported about evidence-based clinical processes for certain conditions, including heart attack, heart failure, pneumonia, and surgical care. The FY 2011 All Employee Survey (AES) scores are more than one standard deviation below the VA mean in the leadership category and for overall employee satisfaction.

In FY 2011, the percentage of new patients seen in the PC clinics within 14 days of the desired clinic date was 86.4 percent, the national target is 83 percent; the percentage of established patients seen in the PC clinics within 14 days of the desired clinic date was 93.3 percent, the national target is 94 percent.[5] In FY 2010 and FY 2011, the Medical Center advertised continuously to recruit physicians for all six clinical sites.

VHA Directive 2009-002, *Patient Care Capture,* requires the capture of all outpatient encounters. Staff reported to the OMI that over 4,500 outpatient encounters had been administratively closed in August and September 2011, and therefore the data may not have been captured as required. In addition to the non-compliance with the directive, only the author can view the clinical notes associated with the closed encounters, and notes are not available for quality review or oversight.

The OMI also found that performance evaluations for six PC clinical staff were not completed in FY 2008, FY 2009, or FY 2010. The Joint Commission identified similar findings with performance evaluations during their April 2010 survey.

[3] Locum tenens physicians temporarily fulfill the duties of another physician when that physician is absent, or when a practice is short-staffed.
[4] Aspire is a web-based dashboard that documents quality and safety goals for all VA hospitals. LINking Knowledge & Systems (LINKS) is a dashboard that documents outcomes measures for acute care, ICU, outpatient, safety, and annual measures.
[5] *New and Established Patient Wait Times for Completed Appointments*, VHA Support Service Center (VSSC), U.S. Department of Veterans Affairs.

Conclusions

- Continuity of care in the PC clinic could be improved. The incomplete implementation of the PACT staffing model may be a contributing factor.
- Closed encounter information may have resulted in a loss of clinical information; that is a potential threat to patient safety and continuity of care.
- A number of clinical staff members sampled had not received annual performance evaluations for the past 3 years.

Recommendations

The Medical Center should:

1. Develop a plan with metrics to improve and measure continuity of care in the PC clinic. Consider tracking and trending the percentage of care provided outside of a single provider, and tracking and trending the number of Veterans followed in PC without an assigned provider as continuity metrics.
2. Review the delivery of PC to identify gaps in continuity of care, and evaluate against PACT staffing.
3. Develop a plan with metrics to improve and measure clinical staff recruitment, hiring, and retention.
4. Develop a plan to ensure that all staff members have timely performance evaluations.

VISN 21 should:

1. Evaluate the Medical Center's administrative closure of encounters and take appropriate action.
2. Evaluate the Medical Center's failure to complete annual performance evaluations and take appropriate action.

B. Social Work Services for Primary Care Clinic

Allegations

1. The PC social work service is understaffed.
2. Social workers were not hired because the money was spent on PACT teamlet training instead.

Findings

The PACT model recommends that every two PACT teamlets be supported by one social worker. The Medical Center currently has 3 FTEE social workers and 1 social work assistant covering the 26 teamlets.

The OMI asked for the workload and was told that the workload is undocumented and could not be provided. The OMI was shown the schedule for one PC social worker, which demonstrated

approximately 90 percent of the scheduled time for booking appointments was available.

The OMI review of PACT funding documentation showed appropriate expenditures to support the PACT mission.

The PC staff did not identify any specific cases where the quality of care was negatively impacted. In addition, PC providers denied that there were gaps in social work services.

Conclusions

- The Medical Center is not in compliance with the current model for PACT team social work coverage; however, the workload documentation provided to the OMI team does not support the hiring of additional social workers.
- The Medical Center appropriately funded PACT training for the PC staff.

Recommendations

The Medical Center should:

5. Improve workload documentation for social work.
6. Review the current staffing patterns and take action to ensure the appropriate distribution of social work resources in PC.

C. Emergency Department (ED)

Allegations

1. The ED is inadequately staffed with physicians.
2. There are long wait times in the ED due to poor access to primary care.
3. ED patients often leave without being seen.

Findings

The ED is aligned under the Department of Medicine, not the division of PC which includes the PC and UC clinics. Patients may be transferred to the ED from other clinical locations within the Medical Center, in addition to arriving by ambulance or personal vehicle.

For the first through third quarters of FY 2011, the Medical Center reported an 11.55 percent increase in ED encounters when compared to those of FY 2010. The missed opportunity rate of all patients who left the ED against medical advice or without being seen is as follows:

	FY 2010	FY 2011
1st Quarter	3 %	2 %
2nd Quarter	3 %	4.2 %
3rd Quarter	2 %	6.45 %

The number of patients whose length of stay exceeded 6 hours has nearly doubled from 8.16 percent in the first through third quarters of FY 2010 to 16.19 percent in the first through third quarters of FY 2011.[6] The average daily census for the ED is 50-65 patients; 70 percent of all ED visits occur between the hours of 9 a.m. and 6 p.m. The busiest days of the week are Monday through Wednesday.

Around 3 p.m. on weekdays, which is the middle of the ED day shift and near the end of the PC clinic day, the ED physicians report a predictable influx of patients transferred from the PC and the UC clinics that began in early FY 2011. Even though the daytime ED staff manages as many patients as possible, usually there are 10-20 patients remaining to be seen after the 7 p.m. ED physician hand-off.

The ED is authorized 5.8 physicians and 1 APN with all positions filled. In interviews, the ED physicians recommended daily staffing of two physicians on the 7 a.m. to 7 p.m. shift, one physician on the 7 p.m. to 7 a.m. shift, and the APN from 11 a.m. until 9 p.m. on weekdays. They made this recommendation to expeditiously manage the predictable influx of patients from PC and UC clinics. On the day shift, the physician staffing may drop to one physician because a second physician is not available.

The ED physicians told the OMI that from April 2011 to the present, they were discouraged from requesting leave so that two physicians would be available for ED staffing. However, the OMI review of the time and leave records from this time period for three ED physicians showed that each had been granted leave.

Additionally, the ED physicians report that physicians and RNs answer all incoming telephone calls because there is no clerk assigned in the ED to perform this function.

The ED staff did not identify any specific cases where the quality of care was negatively impacted. However, the OMI learned that patients leaving the ED without being seen were not being contacted for followup at any time after leaving the ED, although there is no VHA or Medical Center policy requiring the facility to do so.

The Medical Center leadership plans to realign the UC clinic under the Department of Medicine to better serve patients seeking urgent or emergent care.

Conclusions

- The ED workload has increased, particularly in the third quarter of FY 2011. Patient flow from the PC and UC clinics may have contributed to this increase.
- The ED physician staffing may be inadequate to address the increased workload.

[6] ED length of stay is defined as the time from patient arrival to time of discharge.

Recommendations

The Medical Center should:

7. Develop and implement a plan addressing the increased workload in the ED. The plan should include a review of the number of ED physicians and support staff. The plan should also address the apparent increase in patient flow from PC.
8. Contact patients who leave the ED without being seen and encourage them to take the appropriate action based upon their clinical concerns. This information should be tracked and trended.

D. Pain Management

Allegation

1. The Medical Center lacks pain management resources. The pain management program does not comply with the first step of the pain management strategy outlined in the VHA Directive 2009-053, *Pain Management*.

Findings

On October 28, 2009, VHA outlined a stepped approach to pain management in VHA Directive 2009-053, *Pain Management*. The first step envisions the management of common pain conditions in the PC setting, requiring the development of a competent PC provider team including behavioral health. The second step requires timely access to specialty consultation in pain medicine, physical medicine and rehabilitation, and other pain specialties. The facility director is responsible for ensuring that the objectives of the VHA National Pain Management Strategy, initiated in November 1998, are met, including the establishment of a multidisciplinary pain management committee, implementation of a stepped model of pain care, evaluation of outcomes and quality of pain management, and development of clinical competence and expertise in pain management.

In November 2009, the Medical Center issued its supporting pain management policy.[7] At this time, the Medical Center also established the Pain Task Force (PTF) and the Pain Panel (PP).

The PTF is a multidisciplinary committee consisting of 15 permanent members and chaired by the Assistant Chief of Staff (ACOS) for PC. The PTF's mission is to support the PC-based PP and to tackle system issues related to pain management, although neither the PTF nor its mission is mentioned in the Medical Center's pain management policy. This group meets monthly. The Medical Center reports that the PTF is responsible for assuring that the facility complies with VHA Directive 2009-053, including the coordination of annual pain management training for clinical staff, the evaluation of the quality and outcome of pain management activities, the evaluation of patient satisfaction with overall pain management, and the evaluation of clinician competence and expertise in pain management. The PTF communicates pain management standards to staff by the PTF staff members taking this information back to their clinical section

[7] VA Sierra Nevada Healthcare System 11AC-06, *Management of Pain,* November 2009.

meetings. The PTF coordinates the annual pain management training for the clinical staff by participating in national VHA pain management calls. The PTF works with the VISN 21 pain management group on the development of policies and the implementation of pain management guidelines by participating in monthly conference calls. The PTF also follows the guidelines written in the VA/DoD Clinical Practice Guidelines: *Management of Opioid Therapy for Chronic Pain*, by incorporating these guidelines into local policies.

Although not addressed by the PTF, Patient Advocate Reports for January 1 through June, 30, 2011, show 47 complaints that Veterans experienced a delay in getting pain medications and 41 complaints that Veterans experienced problems with pain.

The PTF has not been involved in implementation of procedures for early pain recognition and prompt effective treatment, evaluation of the quality and outcome of pain management activities, evaluation of patient satisfaction with overall pain management (even though the Patient Advocate data are available), or the development of a coordinated and comprehensive pain management strategy by growth of existing pain management resources. The OMI found no evidence that the pain management oversight tasks not being done by the PFT, are performed by another Medical Center committee as is required by policy.

The PP is a multidisciplinary committee of six permanent members and chaired by a PC physician. The Medical Center policy on pain management says that the mission of the PP is to provide interdisciplinary consultation to PC providers if a provider requests pain management recommendations on an individual patient with a complex pain management condition. This group meets twice a month. The PP records its recommendations in the patient's medical record. Between January 1 and November 2, 2011, the PP issued 63 consultations.

The Medical Center does not have a specifically trained pain medicine or physical medicine and rehabilitation specialist on staff. Between January 1 and November 1, 2011, nine consultations for pain management on six different Veterans were approved for fee-basis. The OMI reviewed these pain consultations.

Veteran 1: On (b)(6) 2011, Veteran 1 had a consultation to the PP entered in his medical record for back pain thought to be inoperable by a neurosurgeon. The neurosurgeon recommended a pain pump, and the consultation to the PP written by a PC provider asked that the Veteran be referred for evaluation for that pump.

On (b)(6) 2011, based on review of the Veteran's record, the PP recommended attendance at a chronic pain course scheduled to begin in (b)(6) 2011; the PP did not interview the Veteran.

On (b)(6) 2011, the request for referral for evaluation for a pain pump was discontinued. On (b)(6) 2011, the Veteran was seen by a PC physician who was not his PC provider. That physician noted the Veteran's wife was angry about the invitation to the pain course when she believed the neurosurgeon had recommended a pain pump. The PC physician increased the Veteran's pain medication patch and said he would pursue having the Veteran seen by a pain physician.

On (b)(6) 2011, the PC physician added another pain medication and wrote that the Veteran needed to follow up with a different neurosurgeon for a second opinion about his back.

On (b)(6) 2011, in a PP note, the chairman of that committee said he would submit a consultation for the pain pump. Two consultation requests for the pain pump were submitted on (b)(6) one to the ACOS for PC and one to the Chief of Medicine. Both were referred to the Medical Center's COS, and on May 31, the COS wrote that this Veteran's case would need telehealth or an interfacility consultation with the Palo Alto VA Medical Center (hereafter, Palo Alto) to see whether they agreed with the plan and whether they could place the pump. This request was forwarded to Palo Alto on June 7, and a day later they responded that their pain clinic did not manage pain pumps.

On (b)(6), 2011, the PC physician saw the Veteran who told him he had not gotten the pain pump evaluation.

On (b)(6) 2011, the PC physician submitted another consultation for the Veteran to be evaluated for a pain pump.

On (b)(6) 2011, an APN covering for the PC physician noted that the Veteran's pain medication should be tapered, and that he or she would refer the Veteran to the PP. On October 31, a clinical pharmacy specialist recommended that the Veteran be referred to a pain management specialist.

On (b)(6) 2011, another PC physician entered a new referral to a pain management specialist for consideration of a pain pump. On November 3, the COS asked that Palo Alto be contacted again for their opinion on this management strategy.

Veteran 2: On (b)(6) 2011, a PC physician requested a fee-basis consultation with a pain specialist for Veteran 2. On (b)(6) the COS approved the request. On (b)(6) the ACOS recommended holding this request based on a multidisciplinary staff meeting of Veteran 2's caregivers. On (b)(6) the COS reiterated the need for the pain consultation.

Veteran 3: On (b)(6) 2011, Veteran 3's urologist requested a pain management consultation. This fee-basis request was approved on the same day, and the authorization was mailed to the Veteran the next day.

Veteran 4: On (b)(6) 2011, Veteran 4's PC provider entered a request for a pain management consultation on fee-basis. On November 4, the request was placed on hold pending review by the PP based on a note that all pain management patients are to be seen and reviewed by the PP, and the PP, in turn, would issue the fee-basis consultation for approval by the COS. The PP chart review was scheduled for (b)(6)

Veteran 5: On (b)(6) 2010, the Chairman of the PP placed a referral for Veteran 5 to see a local provider to manage an intrathecal pain pump on fee-basis since the Medical Center did not manage pain pumps. On (b)(6), the COS asked that VA Northern California Health Care System at Mather, California, be consulted to see whether that facility could handle the pain

pump. No action was taken on this request; however, a subsequent request entered into Veteran 5's medical record on (b)(6) 2011, was approved the next day.

Veteran 6: On (b)(6), 2011, Veteran 6's PC physician requested a physical therapy consultation for management of his chronic pain condition. Veteran 6 saw the fee-basis physical therapist (PT) on (b)(6). On (b)(6), the PC physician entered a PP consultation. On (b)(6) the PC physician noted that the consultation to the PP had been sent and that the PP should consider a fee-basis pain management consultation. On (b)(6) the PP reviewed Veteran 6's medical record, recommending a fee-basis consultation for pain management among five other pain management recommendations. On (b)(6) the PC physician entered a consultation to a pain management specialist on fee-basis. The consultation was approved on (b)(6)

Conclusions

- The Medical Center is not providing pain management oversight as required in VHA Directive 2009-053, specifically in early pain recognition and effective treatment. In addition, there is no evidence that the Medical Center is evaluating pain management activities, is evaluating clinical competence in pain management, or developing a pain management strategy by growth of the existing pain management resources, as required by the Directive. Finally, the Medical Center collects data on patient satisfaction and overall pain management, but the PTF does not review these data.
- Neither the PTF nor the PP is chartered in a Medical Center policy. Also, the mission of the PTF is not documented in a Medical Center policy.
- The Medical Center does not provide timely access to pain management specialists as required by the second step of VHA Directive 2009-053. In a facility where the prescription of oral narcotics is consistently high (see the discussion of oral narcotic prescribing below) and there are no pain specialists on staff, nine pain management fee-basis consultations on six different Veterans in 10 months appears low. In addition, in five of the six Veterans who had requests for a fee-basis consultation with a pain management specialist, the time to get the consultation approved was more than 30 days. In two cases, the request for fee-basis pain management consultation had not been approved by the November 14 drafting of this report, and in two cases, the request for fee-basis pain management consultation took 90 days.

Recommendations

The Medical Center should:

9. Develop a plan to improve access to pain management services as described in step two of VHA Directive 2009-053. This improvement should include comparing the number of pain management consults completed at facilities of similar complexity, increasing the number of patients who are referred for pain management consultation, if appropriate, reducing the time for fee-basis pain management consultation approval, and monitoring the results of the improvements.
10. Charter the PTF and the PP in an appropriate policy.

11. Ensure compliance with pain management oversight requirements as outlined in VHA Directive 2009-053.

E. Narcotics Prescribing

Allegations

1. PC providers at the Medical Center prescribe more oral narcotics than other VA healthcare facilities.
2. Medical Center leadership pressures PC providers to give Veterans oral narcotics to keep complaints down.

Findings

The OMI reviewed prescribing data for oral narcotics from the VHA Decision Support System and National Patient Care Database for the Medical Center, VISN 21, all MCG 2 facilities, and all VA medical centers. We selected commonly prescribed outpatient opioids: acetaminophen with codeine, acetaminophen with oxycodone, codeine, fentanyl (patches), hydromorphone, methadone, morphine, and oxycodone. From October 2009 to June 2011, the monthly rate of prescription fills and refills for each of the eight different medications is displayed in Appendix C. We have included separate prescribing trend lines for the Medical Center, VISN 21, MCG 2 facilities, and all VA medical centers.

In six of eight medications selected for this analysis, the Medical Center's providers prescribed oral narcotics at a higher rate than those at other VHA and MCG 2 facilities. In one of the two remaining medications (acetaminophen with codeine), the Medical Center's providers prescribed at a lower rate than VHA nationally, but at a similar rate as MCG 2 facilities. In the remaining medication (codeine), the Medical Center's providers prescribed at a lower rate.

The Medical Center tracks the number of opiate prescription fills and the number of patients receiving opiates. Although these numbers have remained stable in FY 2010 and 2011, the rate of prescription fills and rate of patients receiving opiates is not monitored, making comparison with other facilities difficult.

None of the providers interviewed by the OMI said leadership pressured them to prescribe unwarranted narcotics to keep the number of patient complaints low.

Conclusions

- Providers prescribe some oral narcotic medications at a rate higher than providers at other facilities in VISN 21 and providers at other facilities of comparable complexity. The facility provided no explanation for this finding.
- The OMI found no evidence that leadership attempted to pressure providers to prescribe narcotics to keep the number of patient complaints down.

Recommendations

The Medical Center should:

12. Develop a quality improvement and drug utilization review of its pain management strategy, including review of an appropriate number of complex pain management patient records each month, making recommendations about narcotic prescription practices, and following up on implementation.
13. Educate providers on the appropriate management of patients with complex pain management conditions. This should include a review of pain management strategy, and clarification of the roles of the PTF and PP.
14. Monitor the rates of patients receiving opiates and opiate prescription refills. Complete a comparative analysis of facilities similar in size and complexity.

F. Pharmacy

Allegation

1. The Outpatient Pharmacy takes as long as 4 hours to fill prescriptions for Veterans discharged from the hospital.

Findings

The Medical Center reported that medications dispensed to patients discharged from the hospital are initially reviewed by the inpatient pharmacy provider who performs the medication reconciliation with the patient's outpatient medications, and counsels the patient. These tasks routinely take up to 45 minutes. When the reconciliation and counseling tasks are complete, the outpatient pharmacy technician fills the prescriptions. An outpatient pharmacist reviews the filled prescriptions, after which a dispensing pharmacy technician dispenses them to the patient. In FY 2011, the Medical Center reported that the average time to fill all outpatient prescriptions, including the processing of discharge prescriptions by the outpatient pharmacy providers, was less than 30 minutes.

The Medical Center chartered multidisciplinary systems redesign groups to streamline the discharge process in 2009, 2010, and 2011.

The 2011 group measured the length of time from entry of the order for discharge medications to the patient's leaving the unit in a sample of 31 patients. The average time was 2 hours and 48 minutes with a range from 49 minutes to 6 hours. Five of the 31 patients had a time of over 4 hours. The group noted that non-pharmacy discharge activities such as discharge counseling by the ward staff, clearing the ward, and clearing the business office, occur before the discharge medications are picked up by the patients. These non-pharmacy activities may extend the time between when the discharge order is entered and when the medication is picked up by the patient.

Conclusion

- Most patients discharged from inpatient care take less than 4 hours from the time a discharge order is entered until that patient picks up his discharge medications. In a minority of patients, it may take 4 hours or longer; however, this time includes activities that are not under the control of the pharmacy.

Recommendations

The Medical Center should:

15. Continue in its efforts to reduce the time between entry of the discharge order into the inpatient medical record and the dispensing of discharge medications. As the discharge process involves a number of disciplines, the groups addressing this issue should be multidisciplinary and include the Pharmacy Service.
16. Monitor the time from discharge order entry to medication pickup as part of this continuing review.

G. Hospitalist Service

Allegations

1. The hospitalist service is understaffed.
2. The hospitalist work schedule is too demanding.

Findings

A hospitalist is a physician who primarily provides inpatient care; hospitalists are usually trained in internal medicine, and may work independently, or oversee as an attending physician the clinical education of medical students, interns, and resident physicians. While their primary duties revolve around the front-line provision of medical care, additional duties may relate to performance and quality, patient safety, and continuous clinical improvement. Most hospitalists work exclusively within the inpatient setting; however, some clinical assignments include clinic coverage to close gaps in continuity of care between inpatient and outpatient care.

The hospitalist service at the Medical Center consists of two teaching inpatient teams that each include a hospitalist, one senior medical resident physician, and two junior medical resident physicians. The current hospitalist schedule consists of 14 consecutive days on the inpatient medical team, followed by 7 consecutive days of outpatient clinic, and then 7 consecutive days off-duty. The hospitalist's inpatient duties include daily rounds at the patient bedside, teaching sessions with the resident physicians, and attending physician coverage for clinical concerns both during the daytime, and as the on-call physician on evenings, nights, weekends, and holidays. The hospitalist physicians do not provide coverage for the inpatient surgical unit or ICU. Resident physicians take in-house calls. The 24-hour coverage includes a day tour in the facility, and evening, night, and weekend calls from home.

There were three hospitalists assigned to the service; however, one hospitalist resigned, effective October 2011. There are two hospitalists remaining to cover the two inpatient medical teams. Hospitalist recruitment efforts continue. Other physicians fill in for the attending hospitalists on the unassigned inpatient medical teams.

In interviewing physician and nursing staff, the OMI could find no evidence of patient harm or reduced quality of care due to hospitalist staffing.

On the first site visit, the OMI asked the Medical Center for a plan that addressed the needs of the facility and the duties of the hospitalists; this plan has not yet been received.

Conclusions

- The OMI found no evidence that patients suffered adverse outcomes due to hospitalist shortage or scheduling.
- Because the Medical Center has not defined its needs for hospitalists in a plan, the OMI is unable to determine whether the current staffing level and provider schedule meets the facility's needs.

Recommendation

The Medical Center should:

17. Develop a comprehensive plan to determine the needs of the hospitalist service, implement the plan, and monitor its implementation.

H. Surgical Services

Otolaryngology (ENT) Clinic

Allegation

1. Veteran 7's treatment for recurrent head and neck cancer was delayed by an unnecessary second opinion during which time the tumor grew to such an extent that it became inoperable.

Findings

Veteran 7: In (b)(6) 2007, this (b)(6)-year-old Veteran was diagnosed with cancer in his left (b)(6). He completed radiation and chemotherapy for the cancer in (b)(6) 2007. The Veteran was thought to be disease free until he developed swelling under his left jaw in (b)(6) 2009. Recurrence of the cancer was confirmed by a biopsy on (b)(6) 2009.

On (b)(6) 2009, the ENT specialist at the Medical Center discussed the biopsy results with the Veteran, who agreed with the recommendation to be referred to the ENT clinic at Palo Alto.

On (b)(6) 2009, the Veteran was seen in the ENT Clinic at Palo Alto where the treatment plan included magnetic resonance imaging (MRI), positron emission tomography (PET), and discussion of the Veteran's case at the next Stanford University Tumor Board meeting (hereafter, Tumor Board).[8] The fee payment approval request for this Tumor Board consultation was submitted on (b)(6) and approved by the Medical Center's COM on (b)(6).

On (b)(6) 1, 2009, the Tumor Board recommended a modified radical neck dissection. Because the tumor involved the carotid artery, the Board felt part of that artery might have to be resected, along with intraoperative radiation therapy.

The Veteran's medical record reflects that the Chief, ENT, at Palo Alto submitted a request for surgical and radiation care at Stanford University, consistent with the Tumor Board recommendation of (b)(6) 2009. On (b)(6) the Medical Center asked for an estimated cost to determine who would be the approving official, because the COS approves all requests over $20,000. On (b)(6) Palo Alto responded that the cost for intraoperative radiation therapy would be about $30,000, and 6 weeks of radiation therapy would cost $60,000 to $70,000. On October 7, the COM asked that the request be referred to the COS, and said that an alert about this request had been sent to the COS. On (b)(6) the Palo Alto fee-basis office asked "Any news?" on this request.

On (b)(6) 2009, the Veteran was seen in the ENT clinic at the San Francisco VA Medical Center (hereafter, San Francisco), where the ENT consultant agreed that the plan laid out by Palo Alto was reasonable. In addition, San Francisco stated they could perform the modified radical neck dissection, but were not prepared to resect the Veteran's carotid artery or provide intraoperative radiation therapy. San Francisco recommended followup with Palo Alto for the surgical therapy recommended by the Tumor Board.

On (b)(6), 2009, the COS approved the request for Veteran 7 to be treated according to the treatment plan articulated by Palo Alto.

On (b)(6) 2009, the Veteran was seen at Palo Alto, where the results of a computerized tomography (CT) scan done the day before were compared to the results of an (b)(6) 2009, scan.[9] The new scan reflected significant growth of the cancer with probable invasion of the skin. Palo Alto opined that the Veteran's cancer was no longer even possibly resectable and referred the Veteran for palliative radiation and chemotherapy.

On (b)(6) the Veteran was admitted to the Medical Center for poor nutritional intake and discharged on (b)(6) after treatment with a percutaneous endoscopic gastrostomy

[8]MRI is a technique that uses a magnetic field and radio waves to create detailed images of the organs and tissues within the body. PET scanning is an imaging technique that uses positively charged radioactive particles to detect subtle changes in metabolism and chemical activities.

[9]CT combines a series of x-ray views taken from many different angles to produce cross-sectional images of the bones and soft tissues inside the body.

tube placement. In [redacted] 2010, the Medical Center's ENT felt the Veteran was eating very well and gaining weight.

On [redacted] 2011, the Veteran's family contacted the Medical Center asking for information on hospice and end-of-life care. On [redacted], the family notified the Medical Center that the Veteran had died in a local private hospital.

Conclusions

- Veteran 7's treatment for recurrent head and neck cancer was unnecessarily delayed for 6 to 8 weeks by the request for a second opinion from the San Francisco ENT consultant.

Although not explicitly stated in the Veteran's medical record, the unstated reason for the request for the second opinion was to see whether the extensive procedure recommended by the Tumor Board could be performed by another VA facility instead of the private facility. This important and necessary determination, however, could and should have been accomplished more quickly, without requiring the Veteran to make what turned out to be an unnecessary trip to San Francisco.

- While this Veteran's treatment was delayed, it is not possible to determine whether the delay contributed to the Veteran's death.

With the treatment course received, the Veteran lived for more than 1 year after the palliative radiation and chemotherapy were begun, and for nearly 18 months after initial discovery of the recurrence, a substantial survival for a recurrent tumor. Further, had a CT scan been obtained in October 2009, when the surgery would have been considered without the delay of a second opinion, evidence of tumor spread might have been identified then. With an earlier CT scan, the Veteran's tumor might have been determined inoperable 2 months before that determination ultimately was made in December 2009. An earlier CT scan might have made the Tumor Board recommendation for surgery moot in October rather than December.

Allegation

2. Veteran 8's care was delayed because of an unnecessarily lengthy approval process for fee-basis care.

Findings

Veteran 8: On [redacted] 2009, [redacted]-year-old Veteran 8 was seen in the Medical Center's ENT clinic for a several month history of [redacted]. Total left vocal cord paralysis was documented. On that same day, a CT scan showed a throat mass suggestive of malignancy. On [redacted] the mass was biopsied; however, pathologic examination of the biopsy specimen did not document cancer. On [redacted] a PET scan was ordered.

Veteran 8's medical record reflects that the PET scan was originally scheduled for [redacted] 2009, at the VA Northern California Healthcare System facility in Sacramento, California (hereafter,

Sacramento). The medical record states the Veteran did not appear for the (b)(6) appointment; however, it states he tried to cancel the appointment through the Medical Center, not through Sacramento.

On (b)(6) 2009, the Veteran returned to ENT at the Medical Center. The note written by the ENT consultant states he was unaware that the Veteran had not gotten the PET scan he ordered in (b)(6) He re-ordered the PET scan with the request that it be done in the Reno area, because the Veteran said he could not travel to Sacramento.

On (b)(6), 2009, as documented in the Veteran's medical record, the COS asked why the Veteran could not travel to Sacramento because he had indicated previously that he had traveled there on personal business. The COS also asked why the ENT consultant ordered the PET scan rather than some other diagnostic test. Finally, the COS recorded his suggestion that oncology be consulted.

On (b)(6) 2009, ENT responded in the Veteran's medical record that the PET scan was needed to differentiate between an active lesion and a treated one and that the Veteran was willing to travel, but could not drive and also had an infirm wife who could not drive.

On (b)(6), 2009, the COS reiterated his request to have an oncology consultation on the merit of the PET scan.

On (b)(6), 2009, after discussion with the Chief of Surgery, the COS approved the PET scan request and, again, asked to have the Veteran seen by oncology.

On (b)(6), 2009, the oncology consultant saw Veteran 8, recommending an urgent CT scan of the neck and, if there were no tumor progression, a PET scan prior to another biopsy.

On (b)(6) 2009, the repeat CT scan showed enlargement of the mass. The oncologist then recommended the PET scan to aid in the biopsy procedure by ENT.

On (b)(6) 2009, ENT commented that the PET scan was positive in the area of the mass.

On (b)(6) 2009, ENT performed a second biopsy, which did not reveal a diagnosis of cancer.

On (b)(6) 2010, an interventional radiologist performed an ultrasound guided fine needle biopsy. The pathology report, dated (b)(6) indicated a diagnosis suspicious for cancer.

On (b)(6) 2010, ENT opined that the Veteran was not a surgical candidate and referred him for radiation and chemotherapy with the diagnosis of squamous cell cancer. He began this therapy at the end of January, completing it in (b)(6) 2010.

On (b)(6) 2010, ENT saw Veteran 8, commenting that both vocal cords moved and his voice had completely returned. He continued to do well through (b)(6) 2011, the date of his most recent ENT appointment.

Conclusions

- Although not adversely affecting Veteran 8's favorable outcome, the treatment for his cancer was delayed by 5 or 6 weeks while the COS and the ENT consultant exchanged comments in this Veteran's medical record about the appropriateness of the PET scan.

Satisfying the COS's question about the necessity of the PET scan was appropriate. However, any question about the indication for the test and the Veteran's ability to travel to a more remote VA facility for that test should and could have been resolved in a more timely manner, without resorting to a protracted exchange in the medical record between the provider and the COS.

Recommendations

The Medical Center should:

18. Develop a time standard and a process to ensure timely approval of requests for care outside of the VA medical system, particularly for requests involving diseases, like cancer, for which rapid treatment is critical.
19. Conduct an institutional disclosure about the delay in care with Veteran 7's family and with Veteran 8.

Allegation

3. The skin biopsy clinic, run in the ENT clinic by the nurse practitioner assigned there, was canceled without reason causing delays in treatment for patients with skin cancer.

Findings

According to the ENT clinic staff, toward the end of 2007 and at the request of two part-time plastic surgeons, a skin biopsy clinic was begun and run by the APN working in the ENT clinic. In order to reduce the number of uncomplicated skin biopsy cases that were competing for their operating room time, the surgeons trained the APN to do shave and punch skin biopsies. The APN's scope of practice agreement recommended by the Medical Executive Council and approved by the Medical Center Director in May 2007, did not list skin biopsies as an approved procedure. The Chief of ENT is listed as the APN's collaborating physician in that scope of practice agreement. The OMI found no evidence that the APN requested approval to perform skin biopsies prior to March 2008. The APN related that she usually saw 70 skin biopsy patients per month.

According to the Chief of ENT and the APN, on January 14, 2008, the COS ordered the skin biopsy clinic canceled without prior discussion with either of them. The COS stated that his concern was that the scope of practice for the APN did not refer to skin biopsies, and, until the APN's scope of practice could be clarified, the skin biopsy portion of the APN's practice would need to be suspended.

In a March 24, 2008, memorandum addressed to the COS, the Chief of ENT outlined the rationale for the APN's performance of the skin biopsies and notes that the termination of the APN's biopsy clinic impacted the dermatology and general surgery section's ability to provide timely services, since those sections had to absorb responsibility for conducting necessary biopsies. On March 27, the Medical Executive Board recommended and the Medical Center Director approved, deferral of action on the APN's request to include skin biopsies in her scope of practice pending documentation of her training to do those procedures. On April 24, the Medical Executive Board recommended, and the Medical Center Director approved, the APN's scope of practice including performance of skin biopsies, based on the Chief of ENT's submission of evidence of her training.

On June 30, 2008, the skin biopsy clinic was reinstated. The APN related that she did not undergo any additional training or education, other than what she had completed before the clinic was opened in late 2007, prior to reinstatement.

The Medical Center reported that no patients were referred to a fee provider for a skin biopsy during the period when the APN skin biopsy clinic was discontinued. The OMI found no evidence that patients with skin cancer suffered delays in care resulting from this action.

Conclusions

- Although the APN's skin biopsy clinic was discontinued, there is no evidence that any Veteran's care was adversely affected by this decision.
- The COS has responsibility to ensure that every practitioner in the Medical Center has the appropriate education, training, and experience to exercise the privileges or scope of practice granted by the facility. In this instance, the decision to discontinue the skin biopsy clinic pending clarification of the practitioner's credentials to perform skin biopsies was reasonable. Better communication with the providers directly involved with the skin biopsy clinic might have expedited reinstatement of the clinic.

Recommendation

None.

I. Outpatient Mental Health Clinic

Allegation

1. The Mental Health Clinic (MHC) has not offered individual psychotherapy since December 2010.

Findings

All mental health resources and services are aligned under the Mental Health Service (MHS). The MHS is divided into 9 specialties including Integration into Primary Care, MHC, Post Traumatic Stress Disorder (PTSD) Clinic, Addictive Disorders Treatment Program, Behavioral

Medicine, Health Care for Homeless Veterans, Compensated Work Therapy, and Inpatient Psychiatry.

The Integration into Primary Care program is located in the PC clinic. The mission of this program is to provide mental health care to PC patients and to refer them to the appropriate mental health specialty clinic when necessary. This clinic is staffed by a psychiatrist, two psychologists, and an RN.

The remaining outpatient mental health services provide care along clinical specialties. However, the MHC treats patients who do not clinically fit into the other outpatient mental health specialty care programs. In particular, it provides longer-term and more intense therapy than the Integration into Primary Care program does. The MHC is authorized a staff of four psychiatrists, six psychologists, four social workers, one APN, and one RN. However, there are three psychologist and two social work positions vacant. The MHC provides psychological assessment and treatment, including individual therapy up to eight sessions, group therapy, and psychoactive medication management. The social workers and psychologists provide individual and group therapy. Psychiatrists diagnose mental illnesses and prescribe and monitor medication, but they do not routinely provide individual or group psychotherapy.

In August 2010, the MHC lost two psychologists and two social workers who did the majority of the individual psychotherapy of eight or more sessions. In September 2010, all MHS psychologists were assigned the additional duty of performing two compensation and pension examinations per week.

In December 2010, according to all mental health staff members interviewed by the OMI, the MHC stopped offering individual psychotherapy of eight or more sessions. The OMI was presented with two cases of Veterans whose mental health provider in the Integration into Primary Care program recommended individual psychotherapy of eight or more sessions. Interviews with their provider affirmed that the therapy was not received. In addition, the OMI could find no evidence in the electronic health record that individual psychotherapy of eight or more sessions was provided or offered via fee-basis. Further, we could find no evidence that fee-basis individual psychotherapy was offered to anyone since December 2010.

The MHC and the PTSD clinic are located approximately 5 miles from the main Medical Center campus. The MHC is scheduled to move into their new clinic location on the main campus in February 2012. The PTSD clinic will remain at the current remote location indefinitely. There is no shuttle service between the remote and main campus locations.

Conclusions

- The OMI did not find evidence of any patients receiving recommended individual psychotherapy of eight or more sessions after December 2010, either through the MHC or other available resources like fee-basis care. In addition, the OMI did not find evidence of individual psychotherapy of less than eight sessions provided on a fee-basis.
- MHC staffing vacancies are contributing to the inability of the Medical Center to provide individual psychotherapy of eight or more sessions.

- The Medical Center is not providing transportation for patients between the mental health clinics on the remote and main campuses.

Recommendations

The Medical Center should:

20. Determine whether there are any current patients with unmet individual psychotherapy needs of eight or more sessions and address any needs that are found.
21. Develop and implement a plan to meet individual psychotherapy needs of eight or more sessions, and monitor its implementation. The plan should address continued recruitment for MHC vacancies. On a quarterly basis, the monitor should track the number of consults to the MHC for individual psychotherapy, the actual number of encounters for individual psychotherapy, the total number of patients receiving this care, and the number of patients receiving individual psychotherapy on a fee-basis. Communicate the availability of individual psychotherapy of eight or more sessions to those working in the other MHS specialties.

Allegation

2. Patients are assigned a "primary mental health care provider" who does not provide direct patient care, but rather coordinates the care that a patient may receive.

Findings

On the day that the MHC receives an electronic consult, the RN screens the consult and schedules the Veteran to see a social worker or psychologist for a mental health intake appointment within 30 days. The social worker or psychologist performing the mental health intake examination can provide the care or refer the Veteran for group or individual psychotherapy in the MHC or other MHS specialties.

The OMI found that clinical mental health providers may serve in dual roles as a principle mental health provider and as a mental health therapist. This is consistent with the requirements in VHA Handbook 1160.01: *Uniform Mental Health Services in VA Medical Centers and Clinics*.

During interviews, the OMI learned that Veterans referred to the MHC by other mental health providers were not receiving the care those providers originally recommended. In October 2011, the MHC implemented an interdisciplinary treatment team assessment of these referrals to facilitate the development of an appropriate care plan in the MHC.

Conclusions

- Veterans are receiving appropriate initial mental health assessments by properly trained staff, but not within the 14-day time frame as required by VHA Handbook 1160.01: *Uniform Mental Health Services in VA Medical Centers and Clinics*.

- In some instances, clinical mental health providers may serve in dual roles as principle mental health provider and also as mental health therapist in order to meet the requirements of the Handbook.

Recommendation

The Medical Center should:

22. Review the practice of using mental health care providers as principle mental health providers, and ensure patients receive appropriate, initial mental health assessments within the 14-day time frame as required by VHA Handbook 1160.01: *Uniform Mental Health Services in VA Medical Centers and Clinics*.

Allegation

3. High-risk patients are often seen by a (b)(6) who has no training in psychotherapy.

Findings

In interviews with the MHC (b)(6), the OMI learned that (b)(6) does followup with high-risk mental health patients.

The MHC (b)(6) has experience as a mental health (b)(6) provider. (b)(6) has maintained her (b)(6) (b)(6) certification for over 10 years. However, the OMI could find no evidence that (b)(6) possesses advanced education or training in the assessment and treatment of mental health patients such as an APN would have. The OMI could find no evidence that (b)(6) follows up with high risk mental health patients under an approved treatment protocol.

The OMI did not find evidence that any Veteran's mental health care was negatively impacted by this assessment and followup process.

Conclusions

- The MHC (b)(6) is providing followup for high risk patients.
- The MHC (b)(6) does not have the credentials, clinical competencies, or necessary clinical guidance in the form of a protocol to provide this service.

Recommendations

The Medical Center should:

23. Ensure high-risk patients are followed by a provider with the proper credentials and clinical competencies, or with the appropriate clinical guidance.
24. Review the care of patients who received followup by the MHC RN for the past 6 months and take any necessary action to ensure appropriate management.

J. Locked Inpatient Psychiatric Unit

Allegation

1. The inpatient psychiatric ward environment does not provide for Veterans' serious medical needs such as wall oxygen, call-light system, intravenous therapy, and hospital beds. In addition, the bathrooms are prison-like, the furniture is uncomfortable, heavy and spartan.

Findings

The Medical Center operates a locked, 14-bed, acute inpatient psychiatric unit. The average length of stay ranges from 5 to 10 days.

During its tour of the Medical Center and in interviews with staff, the OMI learned that the inpatient psychiatric unit does not have wall oxygen, a call-light system, hospital beds, and does not provide intravenous therapy. While there is no requirement for call-lights on inpatient psychiatric units, these rooms do have two emergency alarms, one located in the bathroom and one located between the two patient beds. When activated, these alarms ring in the nurses' station, identifying the room.

Patients are medically cleared before admission to the inpatient psychiatric unit. If they have special medical needs they are not admitted to the inpatient psychiatric unit, but instead are admitted to the inpatient medical unit, where both their acute psychiatric and medical needs are met. Some home-based medical treatments can be accommodated by the nursing staff on the psychiatric unit. Patients developing acute medical illnesses while on the psychiatric unit, where their medical treatment needs cannot be met, will be transferred to the medical unit.

The OMI found evidence of frequent transfers from the inpatient psychiatric unit to the medical unit. There were 184 such transfers between FY 2009 and FY 2011.

The furniture in the patient rooms and in the day room has been replaced with specially designed furniture that reduces the patient's ability for self harm or for harming others. It is too heavy to be lifted or thrown. Beds are close to the floor so patients cannot crawl underneath or lift them. Bathrooms have also been redesigned to keep patients from harming themselves. The bathrooms were clean and neat, but austere in appearance. These changes meet the requirements to modify the inpatient psychiatric unit environment to minimize patient injuries to self or others.

Conclusions

- Patients on the inpatient psychiatric unit have their medical needs met either on the unit or by transfer to a medical unit.
- The furniture and bathrooms are appropriately designed to maximize patient safety on a high-risk, locked, inpatient psychiatric unit, at the expense of style and aesthetics.

Recommendation

None.

Allegation

2. The inpatient psychiatric unit is being used to house elderly, chronic, demented patients in addition to younger patients with acute psychiatric illnesses.

Findings

The locked inpatient psychiatric unit receives patients from the CLC who are not suited to be in the CLC due to unmanageable behavior. The Medical Center reports that there have been 17 admissions to the inpatient psychiatric unit from the CLC between FY 2007 and FY 2011. Three of those patients had a length of stay greater than 118 days. At the time of the OMI site visit, there were two demented patients from the CLC on the inpatient psychiatry unit awaiting guardianship determination and subsequent placement. These two patients have no individualized treatment plans focusing on their needs. They have not been off the unit since the time of their admission, one for as long as a year.

The OMI also learned that the only scheduled group is a psychotherapy group which is run by a psychology intern. The OMI found no evidence of any other inpatient activities.

The OMI could find no evidence in FY 2011 records of assaults by young inpatient psychiatric patients on elderly CLC residents who had been admitted to the inpatient psychiatric unit. Although there were eight patient-on-staff assaults in FY 2011, these data were not broken down by age.

Conclusions

- CLC residents with unmanageable behavior are admitted to the inpatient psychiatric unit when they cannot be transferred to another appropriate care facility. The admission of these CLC residents to this unit represents a reasonable solution for the safety of the CLC residents, hospital patients, and staff.
- The CLC residents on the inpatient psychiatric unit at the time of the OMI site visit did not have a treatment plan recognizing their special needs.
- Although the inpatient psychiatric unit is an acute unit with a short average length-of-stay, there is an inadequate number of groups and activities on the unit. Patients will benefit from recovery-oriented activities.

Recommendations

The Medical Center should:

25. Ensure that the CLC residents admitted to the inpatient psychiatric unit for behavioral control have a treatment plan that addresses their individual therapeutic, physical, and social needs.
26. Develop and implement a plan to initiate recovery-oriented activities and groups to meet the needs of patients on the inpatient psychiatric unit.
27. Analyze the nature of the patient-on-staff assaults and provide staff with necessary training based upon findings.

Allegation

3. There is a lack of patient comfort supplies so that inpatient psychiatry unit staff purchase needed items with their own money. The patients on the unit do not have access to a telephone.

Findings

The inpatient psychiatric unit staff has been buying items such as combs, shampoo, conditioner, toothpaste, clothing, and eye glasses because they were not aware that these items were available through other means. The OMI was told that they were receiving these supplies sporadically from Voluntary Services when financial donations to purchase these supplies were available. The Medical Center leadership told the OMI that this issue had been dealt with and resolved; they were surprised it had surfaced again.

The inpatient psychiatric unit leadership observed that a telephone booth located on the unit was a patient safety hazard, removed the telephone, and locked the door to prevent patient access. During FY 2011, the nursing staff purchased a cellular telephone for patient use.

Conclusions

- Basic comfort items were not regularly provided to the inpatient psychiatric unit because the unit staff was not familiar with the proper ordering process.
- The inpatient psychiatric staff removed the telephone for valid safety reasons but provided a cellular telephone, an adequate alternative.

Recommendations

The Medical Center should:

28. Ensure that patients on the inpatient psychiatric unit get appropriate comfort items.
29. Ensure that patients have appropriate access to a telephone and are aware that it is available for their use.

Allegation

4. The inpatient psychiatric unit is understaffed.

Findings

The inpatient psychiatric unit has an existing staffing ceiling of an RN nurse manager, 10 RNs, 3 LPNs, and 4 NAs. There is one vacancy each for an RN, LPN and NA.

Every Thursday, an interdisciplinary team meeting is held of staff members caring for patients on the inpatient psychiatric unit to develop, review, and modify treatment plans. Required to attend this meeting are the psychiatrist, the psychologist, the medical resident physician, an RN, the suicide prevention officer, and the social worker. RN attendance is crucial because the RN has daily, direct contact with the patients, and their observations are necessary for treatment planning. The meetings take place off of the unit. Because an RN must be present on the unit at all times, there may not be an RN available to attend the meeting when there is only one on duty, the current staffing pattern.

In interviews, the inpatient psychiatric unit staff did not identify any specific cases where the quality of care was negatively impacted.

Conclusions

- The actual number of available nursing staff is below the authorized staffing ceiling.
- Nursing is not participating in the required interdisciplinary treatment team meetings.

Recommendations

The Medical Center should:

30. Review the current staffing patterns to ensure the appropriate distribution of nursing resources on the inpatient psychiatric unit.
31. Ensure that an RN participates in the interdisciplinary treatment team meetings.

K. Intensive Care Unit (ICU)

Allegations

1. There is staffing shortage in the ICU.
2. The ICU management has counseled the RN staff for not giving medications on time.

Findings

The ICU is a 12-bed, combined medical and surgical unit with an average daily census of 9.5 patients. The ICU has an authorized ceiling of 29 RNs, including the Nurse Manager, but there are currently 4.6 FTEE vacancies: the Nurse Manager position since January 2010; 2 RN

positions since April and October 2010; and, 1.6 RN positions since September 2011. There has been an acting Nurse Manager since January 2010.

Both the nursing leadership and nursing staff confirmed that the ICU routinely cares for patients requiring telemetry when beds are not available on the medical-surgical telemetry unit. [10] In FY 2011, 40 percent of the patients admitted met the complexity level for ICU care, while 60 percent met the complexity level for a medical-surgical telemetry unit, but not for an ICU. Because of this mix, RNs are not consistently working at their skill level.

The ICU currently does not have a monitor technician assigned to the unit.[11]

The Medical Center did not provide a current policy defining the admission criteria for inpatient units, including the ICU.

There were two reported RN injuries in FY 2010 and six in FY 2011. Six of the injuries were caused by lifting or repositioning patients.

Medical Center policy requires that within 2 hours of admission, nurses assess and document the effectiveness of pain medications given on an as-needed basis. In FY 2011, two counseling statements were give to ICU nurses for not complying with this policy.

None of the physician or nursing staff who were interviewed stated that a patient did not get the appropriate quality of care because of nursing staff shortages.

Conclusions

- The ICU is not staffed to its authorized ceiling, although based on the current workload and patient mix, staffing may be adequate.
- The OMI found no evidence of adverse patient outcomes due to ICU nurse staffing shortages.
- There have been significant delays in hiring RNs for the ICU.
- ICU nurses risk losing their specialized skills and competencies by frequently caring for lower complexity telemetry patients. In addition, routine placement of telemetry patients in the ICU solely for monitoring, may be an inefficient use of the ICU.
- The lack of a monitor technician in the ICU reduces the number of RNs available for direct patient care.
- The Medical Center does not have a policy defining admission criteria for the ICU or the other inpatient units.
- The increase in staff injuries may be a reflection of the staff shortages.
- All ICU RNs who received counseling were appropriately counseled.

[10] Telemetry is the continuous electrocardiographic monitoring of a patient's heart beat. In the absence of other conditions requiring intensive care, telemetry is typically provided on a medical-surgical unit. All ICU beds have telemetry and, therefore, can provide cardiac monitoring even though the patient might not otherwise need intensive care.

[11] A monitor technician is a person specially trained to observe and analyze a patient's heart rhythm through telemetry but does not have the other skills than RNs have.

Recommendations

The Medical Center should:

32. Review the current ICU staffing plan, taking into account the patient mix, and use of monitor technicians, and take action based on the review.
33. Develop and implement a plan to treat patients who require only telemetry monitoring on the medical-surgical unit.
34. Shorten the time it takes to fill RN vacancies in the ICU.
35. Develop an admission criteria policy for all inpatient units.
36. Review RN injuries in the ICU and take appropriate action.

L. Physical Therapy

Allegations

1. Physical therapy is understaffed.
2. Physical therapy consults were automatically approved for 6 weeks of fee-based therapy.
3. Durable medical equipment (DME) is no longer dispensed by physical therapy on a walk-in basis with delays in completion of consultations.
4. CLC residents electively used their own Medicare benefits to seek community physical therapy services.

Findings

In November 2010, the Medical Center had obtained authorization for five physical therapists (PT). From November 2010 through September 2011, the Medical Center had the following number of PTs available for duty:

Date	Staff PT	Contract PT	Total PT
November 2010	3	1	4
June 2011	2	1	3
August 2011	1	1	2
September 2011	0	1	1
Late September 2011	0	2	2

One staff PT resigned in June 2011, one retired in August, and one left in September on maternity leave.

The physical therapy electronic waiting list (EWL) went from 0 patients in the first part of May 2011 to a high of 194 patients in late August as shown in Appendix D. As of August 22, 2011, 123 patients had been waiting longer than 30 days from the desired date of care.

On August 29, 2011, the acting COS directed all patients on the physical therapy EWL be referred to the community on fee-basis for 6 weeks of therapy. The goal was to eliminate the backlog of patients on the EWL. The Medical Center could not provide the number of patients

referred to fee-basis providers under this directive; however, the total number of fee-basis physical therapy consultations doubled from 523 in FY 2010 to 1165 in FY 2011. The EWL for physical therapy visits decreased to zero by the end of September 2011. The OMI was told that at least 11 of these consultative requests were cancelled due to lack of specificity of diagnosis or the treatment required.

The OMI learned that the Medical Center usually did about three total joint operations per week. Because physical therapy services were not available for post-operative total joint patients, three total joint replacement operations were referred to the community on fee-basis in August 2011. The OMI also learned that one of the contract PTs would not provide care to inpatients, exacerbating the shortage of physical therapy services.

Prior to August 3, 2011, patients who required a physical therapy consultation for DME could often get the necessary physical therapy consultation on a walk-in basis.[12] Due to the reduction in staff, the physical therapy department could not accommodate walk-in consultation requests for DME, so these consultations were placed on the EWL.

The OMI was also told that physical therapy services for CLC residents were reduced from five times per week to once or less per week by August 2011.

The OMI learned that at least one CLC rehabilitation resident voluntarily left the CLC to have this care at home because rehabilitative physical therapy was not available in the CLC. The OMI was not able to determine how this resident paid for these services. Through interviews with CLC nursing staff, the OMI could not identify any other residents who may have used Medicare to pay for physical therapy services unavailable in the CLC.

Conclusions

- Physical therapy was critically understaffed during the summer of 2011, causing curtailment of most routine services, causing the referral of total joint operations to the community, and causing delays in access to outpatient physical therapy services.
- The Medical Center did not respond in a timely manner to predictable reductions in physical therapy staffing.
- Responding to the staffing shortage, the Medical Center did approve a group of physical therapy consultations from the EWL to the community for fee-based care. In the absence of the timely anticipation of staffing losses, the OMI feels this was a reasonable method to provide access to care.
- Although providing walk-in physical therapy consultation for DME services is preferred, scheduling consultations was an acceptable option during this staffing shortage.
- CLC residents had their physical therapy services severely curtailed. As a result, one resident did leave the CLC to receive rehabilitative physical therapy services in his home; however the OMI did not determine how these services were paid. The OMI found no evidence of a CLC resident using a Medicare benefit to obtain physical therapy services.

[12] DME is equipment like crutches or braces prescribed by physicians. Before this equipment is dispensed, consultation with physical therapy is often necessary to obtain measurements to appropriately fit the equipment to the patient.

Recommendation

The Medical Center should:

37. Develop and implement a comprehensive plan that accounts for staff fluctuations and meets the rehabilitative and physical therapy needs of patients throughout the health care system.

M. Respiratory Therapy (RT)

Allegations

1. Frequently, there is a 2-hour period during which there is only one registered respiratory therapist (RRT) to cover all beds in the hospital and CLC. The RRT that is scheduled to go off-duty has to stay to assist with respiratory care. During times when there are multiple medical emergencies, coverage is inadequate, putting Veterans at risk.
2. The intermittent RRTs are rarely available to work.

Findings

There are eight full-time RRTs and four intermittent RRTs to provide coverage 24 hours a day, 7 days a week. This respiratory care coverage extends to the ICU, the medical-surgical units, the CLC, and the ED. In addition, RRTs are expected to respond to rapid response calls for emergent or urgent care. The current staffing plan requires two full-time RRTs be assigned to each 12-hour shift.

Because coverage is provided by a combination of 10-hour and 12-hour shifts, one RRT will be on duty alone for 2 hours at least once a week. The OMI learned from the RT supervisor that routine RT treatments were not scheduled during this 2-hour block of time when only one RRT is on duty. The four intermittent RRTs only cover absences caused by leave, not this 2-hour staffing gap.

In interviews, the RT supervisor believed the current staffing is adequate. The Medical Director of RT concurred.

The OMI found no evidence that patients had experienced a reduction in the quality of repiratory therapy care due to RT staffing.

Although the OMI requested the RT staffing plan and workload for FY 2010 and FY 2011, we were provided staffing data for the month of July 2011 only.

Conclusions

- The OMI did not find evidence that the quality of care was negatively impacted by respiratory therapy staffing.
- There is frequently a 2-hour block of time during which only one RRT is on duty for the entire Medical Center.

- The Medical Center was not able to provide a staffing plan for respiratory therapy services.

Recommendation

The Medical Center should:

38. Develop and implement a respiratory therapy staffing plan to ensure quality and safety.

N. Community Living Center (CLC)

Allegations

1. The CLC nurse staffing is inadequate, impacting resident falls, resident-on-resident and resident-on-staff violence, and there is lack of activity and therapies for residents.
2. The CLC is misallocating funds provided to the Hospice and Palliative Care Program.

Findings

The CLC is a 60-bed unit; 48 beds offer skilled nursing care with a goal to provide rehabilitation, restoration, and maintenance of the resident's optimal level of functioning. A Respite Care Program provides short-stay services. The 12 remaining beds belong to the Hospice and Palliative Care services, where residents are provided with an appropriate level of care at the end of their lives.

The VA Office of Nursing Services developed a new nurse staffing methodology outlined in VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel,* that includes guidance on CLC staffing. The Directive stipulates that implementation should occur by September 30, 2011, in each facility at all points of care.

In the CLC setting, nursing hours per patient day (NHPPD) are the number of direct care hours provided by RNs, LPNs, and NAs to the resident over a 24-hour period and are related to the resident's care requirements. The types of nurse staff, the care model, resident functioning and health status, and health outcomes are critical factors to the NHPPD determination. The NHPPD are used to calculate the level and number of staff needed by the CLC. Resident outcomes sensitive to nurse staffing levels include pressure ulcers, falls, and intravenous infiltrations.

Resource Utilization Groups (RUGs) are used to determine resident health care needs, and to determine nurse staffing levels.[13] A higher RUG indicates a resident with a greater need for nursing or therapy services.

During OMI interviews, all non-supervisory nursing staff and other non-nursing staff in the CLC reported nursing staff shortages and could provide examples of impact on resident care. Staffing shortages were consistently reported for all shifts and all nursing positions (RN, LPN, NA).

[13] Resource Utilization Groups (RUGs) are metrics that measure the interdisciplinary resources required to care for a CLC resident.

Unscheduled leave, staff diverted to other units, and staff spending hours transporting and staying with residents while off the unit all contributed to staff absence on the unit. The OMI found that many interviewees were concerned about low staffing levels, fear of providing care in an unsafe environment, poor or limited communications with leadership, and an inconsistent approach by management in resolving staffing and leave abuse issues.

In FY 2010, there were 8 staff injuries related to patient care (21 percent of the Medical Center's total staff injuries related to patient care), and in FY 2011 there were 10 (21 percent). The OMI reviewed all CLC incident reports for FY 2011 and found one report of resident-on-resident violence. The Medical Center could not provide specific data on resident-on-staff violence.

From January 1, 2011, through August 30, 2011, the CLC nursing staff used an average of 259.25 hours per month of sick leave. The average number of sick leave hours per employee was 5.25 hours per month.

The FY 2012 CLC Executive Summary Budget Proposal, which projects the Medical Center's annual budget and staffing requirements, authorizes 58.4 FTEE for the CLC. The Proposal indicates that there were a total of 49.4 FTEE nursing staff in the CLC, but 8 staff were not available for duty (4 were on a light-duty detail and 4 were on family leave), leaving 41.4 FTEE to cover the unit, a 29 percent shortfall. Actual staffing numbers are chronically diminished by floating CLC personnel to other hospital units or by unexpected sick leave. One CLC staff member was carried on the schedule for at least 1 month while he or she was absent without leave, and a decision was made to work with human resources to take appropriate action. In FY 2011, the CLC lost 15 nursing staff, representing 30 percent of their 49.4 FTEE staff providing resident care. The CLC was able to hire 11 nursing staff for the same time period.

When a resident leaves the CLC for an appointment and it is clinically necessary for a trained health care individual to remain with him or her, an escort is not able to perform this function. While the OMI received information that there were two part-time escort positions assigned to the CLC, the OMI could not confirm whether these persons were suited for transport of CLC residents.

The CLC average daily census and average length of stay are shown below:

Fiscal Year	Average Daily Census (residents)	Average Length of Stay (days)
2009	55.1	Not Available
2010	56.3	69.3
2011	58.2	40.6

Data for admissions, discharges, ward days of care, turnover rate, and average daily census are indicators for increased workload for CLC staff (*FY 2012 CLC Executive Summary Budget Proposal*).

Based on data from October 1, 2010 through July 31, 2011, the Medical Center projected a requirement of 4.7 NHPPD for CLC residents. During its September 20-22, 2011 visit, the Long Term Care Institute Inc. found that the actual staffing level provided for 3.6 NHPPD.[14] The OMI found that in September 2011, the actual mean staffing level provided for 3.9 NHPPD with a range of 3.1 to 4.8 NHPPD.

[14] Long Term Care Institute, Inc. is a private company that performs quality monitoring services in long-term care for corporate and government agencies. See http://www.ltciorg.org/.

The Medical Center calculated its staffing requirements for the Hospice and Palliative Care beds to provide 8.31 NHPPD and documented this in its *CLC Executive Summary Budget Proposal for FY 2012.*

The National Center for Patient Safety (NCPS) reports the Medical Center's CLC fall rates as shown in the table below.[15]

Fiscal Year	Fall Rate
2008	7.0
2009	7.1
2010	8.4
2011	9.5

The NCPS's national pooled fall rate for long term care was 5.6. In addition, the monthly Medical Center's Quality Measure/Quality Indicator Report reflects a CLC FY 2011 average fall prevalence of 14.5 for the facility with an average fall prevalence of 9.8 and 11.6 for VISN 21 and VHA, respectively.

During the site visit, the OMI toured the CLC on a weekday between 2:30 p.m. and 3:30 p.m. We conducted a spontaneous survey of the number of residents in bed, finding that 37 of 43 CLC residents were in bed. Eight of nine hospice residents were in bed. We were advised that the activity staff member was not available and residents prefer to nap in the afternoon. The Medical Center's Quality Measure/Quality Indicator Report reflects that the prevalence rates of CLC residents who spend most of their time in bed or in a chair and residents with little or no activity is nearly double that of VISN 21 and VHA. On two other occasions, we observed only 15 residents in the dining room. In interviews with CLC staff members, the OMI learned that the dining room had been closed on at least two occasions because the nursing staff felt there was not enough staff to safely monitor the residents during meals. There is currently no restorative nursing program.

Residents are invited to current events twice weekly, may receive pet therapy weekly, and are scheduled for recreation fitness therapy once weekly. There are two recreation assistants available for 4 hours twice weekly, and there are no activities scheduled for weekends. During an OMI interview, we spoke to the newly-hired recreational therapist. She spoke of plans to introduce more activities, with a focus on therapeutic activity versus diversional activity. She attends the CLC Resident Council and plans to obtain feedback to use in her recreational therapy plan.

The OMI did not investigate the allegation of the misallocation of funds in the Hospice and Palliative Care Program.

Having recognized some of the challenges noted above, the *FY 2012 CLC Executive Summary Budget Proposal* includes quality goals with targets to reduce falls, to decrease the time residents spend in a bed or chair, and to reduce residents' loss of range of motion.

Conclusions

- Although the CLC authorized nurse staffing is adequate, the actual number of available nursing staff providing day-to-day resident care is inadequate.

[15] Fall rates are expressed in number of falls per patient bed days of care multiplied by 1,000.

- The number of CLC staff injured providing patient care increased from the previous year. There was no evidence of a trend in resident-on-resident violence.
- The CLC has a higher prevalence of falls when compared to those of VISN 21 and VHA nationally.
- It is unclear that the current CLC escort program is well suited to the needs of the CLC, which often requires residents to be transported and monitored by nursing staff.
- The OMI substantiated the lack of CLC resident activities and the overall lack of physical activity for nearly all CLC residents. The OMI believes that nurse understaffing contributes to a lack of resident activity and has caused the dining room to close.
- With their greater care needs, the Hospice and Palliative Care residents require a higher nurse staffing level than CLC residents. Due to the current staffing methodology, the needs of both programs may not be met.
- The allegation of misallocation of funds in the Hospice and Palliative Care Program should be investigated by the appropriate authority.

Recommendations

The Medical Center should:

39. Develop and implement a plan, with Human Resources Division, to bring CLC nurse staffing to its authorized staffing levels. This plan should include human resource targets and accountability to achieve expedient staffing goals.
40. Reduce and monitor the diversion of CLC nursing staff to other units, and implement consistent assignment of nursing staff for residents.
41. Develop and implement a plan to reduce resident falls and continue to monitor.
42. Develop and implement a comprehensive plan to improve the frequency and variety of resident recreational activities including weekends, holidays, and off-shifts.
43. Develop and implement a CLC Restorative Care Program including a dining program.
44. Develop and implement a plan to identify Hospice and Palliative Care nurse staffing needs using case mix and RUGs data.

VISN 21 should:

3. Investigate the alleged misallocation of Hospice and Palliative Care Program funds.

Allegation

3. Too many dementia patients are on psychoactive medications, and it may take an RN up to 2 hours to administer 200 medications between 9:00 a.m. and 11:00 a.m.

Findings

The OMI team asked the CLC to produce a list of those residents taking nine or more medications. They reported that 40 of 52 residents (77 percent) were taking 9 or more medications. The Medical Center's Quality Measure/Quality Indicator Report indicates that the CLC rate for residents who are on nine or more prescribed medications consistently exceeds

VISN 21 and VHA national rates. Through interviews, the OMI learned that the CLC leadership decided to divide medication administration into two, 2-hour medication passes per day, one in the morning and the other in the early evening. The OMI verified that medication administration can take 2 or more hours. While the pharmacy was unable to provide the OMI with data on the number of medications ordered for CLC residents during these two time frames, the number of residents with greater than 9 prescribed medications suggests that 200 medications or more may be given to the different residents during each medication pass, and medication administration may take more than 2 hours.

The same resident list showing 9 or more medications per resident also reported that 29 of 52 residents (56 percent) were on 1 to 3 psychoactive medications (antipsychotic, antidepressant, anti-anxiety, or hypnotic).[16]

For the fourth quarter of FY 2010 and the first and second quarters of FY 2011, the CLC reported a higher number of prescriptions for two of the four categories of psychoactive medications compared to state and national prescribing levels (Appendix E). The State of Nevada and national data are derived from nursing homes reporting to the Online Survey, Certification and Reporting (OSCAR) database.[17] The Medical Center uses the OSCAR data for quality improvement and provided the national and State data to the OMI.

Conclusions

- There is a high rate of CLC residents on more than nine prescribed medications compared to VISN 21 and VHA nationally.
- There is a higher percentage of prescribed total psychoactive medications in CLC residents than in national and State of Nevada nursing home populations according to data used by the Medical Center and provided to the OMI.
- Medication administration times may be in excess of 2 hours, and there may be more than 200 medications to administer during that time.

Recommendations

The Medical Center should:

45. Conduct ongoing multidisciplinary reviews of resident medications, including the indications, dosage, and side effects of prescribed medications and monitor appropriately.

[16] Antipsychotic medications treat psychosis; antidepressants treat depression; anti-anxiety medications treat nervousness and anxiety; and hypnotic medications induce sleep or deep relaxation.
[17] OSCAR is a compilation of all the data elements collected by surveyors during the certification process for participation in the Medicare and Medicaid programs.

Allegation

4. Nurses are required to perform respiratory treatments and to do tracheostomy care, and tracheostomy care supplies are not available.[18]

Findings

Through interviews and the CLC tour, the OMI learned that nurses do administer basic respiratory treatments such as providing prescribed inhalers. Nurses also perform tracheostomy care, which involves cleansing the tracheostomy site, and suctioning and cleansing the inner cannula. CLC nurses have certified competencies for these activities. Tracheostomy supplies are kept in an automated supply center, and the OMI could find no report of a shortage.

Conclusions

- CLC nurses provide respiratory care in accordance with their competencies and certifications.
- The OMI found no evidence of a shortage of tracheostomy supplies.

Recommendations

None

O. Operating Room (OR)

Allegations

1. Poor staffing in the OR and Supply Processing and Distribution (SPD) has resulted in delayed surgical start times during after-hour cases, RNs having to pick up supplies from SPD, and RNs having to sterilize surgical equipment.
2. Not all radiology technicians are trained to use fluoroscopy equipment in the OR, resulting in delays in care.

Findings

The OR has a total of 13.5 FTEEs that includes the nurse manager and 1 RN FTEE detailed to SPD. There are currently no staff vacancies. OR staff is available 24 hours a day, 7 days a week. SPD staff is not on-site during off-tour shifts; however, it was reported that staff are available via a call roster.[19]

To manage the equipment needs for emergency cases, the OR staff draws on pre-prepared instrument packs and flash sterilization. The packs are assembled by, and stored in, SPD and are

[18] A tracheostomy is a surgically placed opening in the throat for breathing, usually with a metal tube is placed in the opening to maintain patency. The tube, or inner cannula, and the tracheostomy site require cleaning and care; often, suctioning may be necessary.
[19] Off-tour shifts are evening, night, and weekend shifts.

available to OR staff at all times. SPD does not track off-tour shift access or signing out of equipment by OR staff. The RN staff from the OR said they infrequently have to obtain pre-prepared packs from SPD.

In FY 2011, there were 19 instances of flash sterilization, for a rate of approximately 1.58 flash sterilizations per month. All OR RNs are trained to do flash sterilization.

For the first 11 months of FY 2011, 6.2 percent of late surgical starts was due to equipment not being ready and 0.5 percent was due to instruments not being ready. However, the Medical Center does not track these events by whether they occur during the normal duty day or during off-tour shifts.

Thirteen of 15 radiology technicians are trained and current with their competencies to use fluoroscopy. During interviews, the OR staff indicated that they had no difficulty obtaining fluoroscopy services in the OR. They identified no quality of care issues regarding fluoroscopy.

Conclusions

- The OMI found no impact on the quality of care or surgical services due to the delay of delivery of equipment or instruments from SPD during off-tour shifts.
- The OMI found no impact on the surgical quality of care related to availability of fluoroscopy services in the OR.

Recommendation

None.

P. Pathology and Laboratory Medicine Services (P&LMS)

Allegations

1. Poor staffing in P&LMS caused delays in the laboratory picking up specimens on the inpatient unit.
2. There is a delay in picking up blood products by the inpatient unit once the unit has been notified by P&LMS that it is ready.
3. The histology exhaust hood is improperly vented.

Findings

The P&LMS is fully staffed to its authorized ceiling of 33.25 FTEE.

Laboratory personnel are available to draw blood and collect specimens from the inpatient units at 4:30 a.m., at 11:00 a.m., and at 9:00 p.m. Laboratory personnel carry cell phones for routine and emergency calls. When the OMI requested data on the time it takes laboratory personnel to respond to calls for drawing blood or collecting specimens, we learned the Medical Center had no data. However, there is no VHA requirement to collect data on the time it takes the

laboratory to perform these functions. Further, nursing leadership reported that they had not received complaints from inpatient nursing staff regarding the response time by laboratory personnel to arrive on the unit to draw blood or collect specimens.

Once the laboratory prepares the blood product for transfusion, the laboratory staff notifies the unit it is ready for pickup. The unit nursing staff is responsible for picking up the blood product and administering it within 30 minutes, according to VHA Handbook 1106.08, *Pathology and Laboratory Medicine Service Procedures*. If the patient does not need the transfusion urgently, the unit nursing staff may delay pickup until the staff is confident it can be infused within the 30 minute standard. VHA does not have a standard time requirement between the time of laboratory notification of blood product readiness and the time of nursing staff pick up.

The Medical Center reports that for October 2011, the average pickup time for blood products by unit nursing staff is:

Red blood cells: 18 cases, 80 minutes
Fresh frozen plasma: 9 cases, 63 minutes
Platelets: 3 cases, 139 minutes

All pathology laboratories use noxious chemicals to process tissue from biopsy specimens and autopsies. The area where these chemicals are used is equipped with exhaust hoods to protect employees from exposure; hoods should exhaust to the outdoors.

The P&LMS has two chemical exhaust hoods in the histopathology laboratory where tissue samples are processed, and one in the autopsy room. In the histopathology laboratory area, one hood is an integral part of the tissue sectioning equipment, while the other vents the chemical storage area.

In a memorandum of July 12, 2010, the Certified Industrial Hygienist reported that the engineers noticed the vents from the histopathology equipment and autopsy room hoods were being routed into the facility air handling unit rather than to the outside. This misrouting of the exhaust hood vents was corrected and the hoods recertified by July 20, 2010.

Industrial Hygiene Service measured a routine formaldehyde level on October 5, 2009, and found it was acceptable.[20] These levels were measured again on October 26, November 16, November 22, December 16, and December 21, 2010, and April 20, 2011, with all levels within the acceptable range.

During the OMI tour of the histopathology laboratory and the autopsy room, we detected a strong odor of formaldehyde in the histopathology laboratory. Neither of the two hoods in that laboratory were turned on during our visit. After the hood fan was turned on manually, the intensity of the odor dissipated. The OMI learned that the hoods are activated in the histopathology laboratory before measuring formaldehyde levels.

[20] Formaldehyde, a known carcinogen, is one of the most toxic chemicals used by laboratories for processing tissue samples. The danger is that it vaporizes and is inhaled by employees. Facilities routinely measure formaldehyde levels in the air where it is used.

Conclusions

- The P&LMS is at its authorized personnel ceiling. From information the OMI gathered on interviews, there was no evidence of deficiencies in laboratory services as a result of P&LMS staffing.
- The Medical Center does not monitor the time it takes the laboratory to draw blood on inpatient units or the time it takes to pick up a specimen from the inpatient unit, but there is no VHA requirement to monitor these processes.
- In October 2011, the average pickup time for blood products by the unit nursing staff was greater than 1 hour; however, there is no applicable VHA standard.
- Although the Medical Center reports the histopathology and autopsy room exhaust hoods venting into the facility air supply has been corrected, and that formaldehyde levels in the work area are at an acceptable level, the strong odor of formaldehyde present during the OMI's tour leads us to believe that the hoods are still not being used consistently by employees.

Recommendations

The Medical Center should:

46. Review the process for laboratory draws and specimen collection and take appropriate action.
47. Review the process for blood pickup from the laboratory and take appropriate action.
48. Consider automating the exhaust hoods in the histopathology laboratory and the autopsy room so that the hoods function whenever employees are in the work area.

Q. Additional Findings

Finding

In interviews, the OMI found that nursing staff in PC, ED, UC, and outpatient mental health, did not have nursing competencies. When the OMI asked to see the nursing competencies folders from staff in these areas, we were given blank template competency forms. The OMI reviewed the nursing competencies from the OR, CLC, ICU, and medical-surgical units and found them to be complete. Upon request, the Medical Center could not provide a comprehensive facility-wide plan for nursing education and training. The OMI learned that the Medical Center has one nurse educator for the entire health care system.

Conclusions

- The OMI is concerned that there is inconsistent professional oversight of nursing practice across the health care system, which may have a negative impact on the overall quality and safety of patient care provided by nursing service.
- The OMI is concerned that one nurse educator for the entire health care system is insufficient to meet the education and training needs of the nursing staff.

Recommendations

The Medical Center should:

49. Develop and implement a comprehensive plan to ensure nursing practice standards are met consistently throughout the health care system. This plan should address the education and training needs of nurses in the Medical Center and documentation of competencies.
50. Assess the need for additional nurse educators and take action as appropriate.

Findings

The current authorized staffing ceiling for the medical-surgical unit is 53.3 FTEE. There are 7.6 RN and 1 NA vacancies on the medical-surgical unit. In FY 2011, the Medical Center reported a total of 123 patient falls in the medical-surgical unit. The number of employee injuries on this unit increased from 10 in FY 2010 to 21 in FY 2011. The medical-surgical unit currently does not have a monitor technician to observe telemetry patients.

Conclusions

- The OMI is concerned by the number of staff injuries and patient falls on the medical-surgical unit; this may be a reflection of staff shortages.
- There are multiple staffing vacancies that need to be filled on the medical-surgical unit.
- The lack of a monitor technician in the medical-surgical unit may reduce the number of RNs available for direct patient care.

Recommendations

The Medical Center should:

51. Review the current medical-surgical staffing plan, and use of monitor technicians, and take appropriate action based on the review.
52. Review causes of patient falls on the medical-surgical unit and develop a plan to reduce the rate.
53. Review causes for the increases in staff injuries on the medical-surgical unit and develop and implement a plan to reduce them, including appropriate training and preventative measures.

V. List of Recommendations

The Medical Center should:

1. Develop a plan with metrics to improve and measure continuity of care in the PC clinic. Consider tracking and trending the percentage of care provided outside of a single provider, and tracking and trending the number of Veterans followed in PC without an assigned provider as continuity metrics.
2. Review the delivery of PC to identify gaps in continuity of care, and evaluate against PACT staffing.
3. Develop a plan with metrics to improve and measure clinical staff recruitment, hiring, and retention.
4. Develop a plan to ensure that all staff members have timely performance evaluations.
5. Improve workload documentation for social work.
6. Review the current staffing patterns and take action to ensure the appropriate distribution of social work resources in PC.
7. Develop and implement a plan addressing the increased workload in the ED. The plan should include a review of the number of ED physicians and support staff. The plan should also address the apparent increase in patient flow from PC.
8. Contact patients who leave the ED without being seen and encourage them to take the appropriate action based upon their clinical concerns. This information should be tracked and trended.
9. Develop a plan to improve access to pain management services as described in step two of VHA Directive 2009-053. This improvement should include comparing the number of pain management consults completed at facilities of similar complexity, increasing the number of patients who are referred for pain management consultation, if appropriate, reducing the time for fee-basis pain management consultation approval, and monitoring the results of the improvements.
10. Charter the PTF and the PP in an appropriate policy.
11. Ensure compliance with pain management oversight requirements as outlined in VHA Directive 2009-053.
12. Develop a quality improvement and drug utilization review of its pain management strategy, including review of an appropriate number of complex pain management patient records each month, making recommendations about narcotic prescription practices, and following up on implementation.
13. Educate providers on the appropriate management of patients with complex pain management conditions. This should include a review of pain management strategy, and clarification of the roles of the PTF and PP.
14. Monitor the rates of patients receiving opiates and opiate prescription refills. Complete a comparative analysis of facilities similar in size and complexity.
15. Continue in its efforts to reduce the time between entry of the discharge order into the inpatient medical record and the dispensing of discharge medications. As the discharge process involves a number of disciplines, the groups addressing this issue should be multidisciplinary and include the Pharmacy Service.
16. Monitor the time from discharge order entry to medication pickup as part of this continuing review.

17. Develop a comprehensive plan to determine the needs of the hospitalist service, implement the plan, and monitor its implementation.
18. Develop a time standard and a process to ensure timely approval of requests for care outside of the VA medical system, particularly for requests involving diseases, like cancer, for which rapid treatment is critical.
19. Conduct an institutional disclosure about the delay in care with Veteran 7's family and with Veteran 8.
20. Determine whether there are any current patients with unmet individual psychotherapy needs of eight or more sessions and address any needs that are found.
21. Develop and implement a plan to meet individual psychotherapy needs of eight or more sessions, and monitor its implementation. The plan should address continued recruitment for MHC vacancies. On a quarterly basis, the monitor should track the number of consults to the MHC for individual psychotherapy, the actual number of encounters for individual psychotherapy, the total number of patients receiving this care, and the number of patients receiving individual psychotherapy on a fee-basis. Communicate the availability of individual psychotherapy of eight or more sessions to those working in the other MHS specialties.
22. Review the practice of using mental health care providers as principle mental health providers, and ensure patients receive appropriate, initial mental health assessments within the 14-day time frame as required by VHA Handbook 1160.01: *Uniform Mental Health Services in VA Medical Centers and Clinics*.
23. Ensure high-risk patients are followed by a provider with the proper credentials and clinical competencies or with the appropriate clinical guidance.
24. Review the care of patients who received followup by the MHC RN for the past 6 months and take any necessary action to ensure appropriate management.
25. Ensure that the CLC residents admitted to the inpatient psychiatric unit for behavioral control have a treatment plan that addresses their individual therapeutic, physical, and social needs.
26. Develop and implement a plan to initiate recovery-oriented activities and groups to meet the needs of patients on the inpatient psychiatric unit.
27. Analyze the nature of the patient-on-staff assaults and provide staff with necessary training based upon findings.
28. Ensure that patients on the inpatient psychiatric unit get appropriate comfort items.
29. Ensure that patients have appropriate access to a telephone and are aware that it is available for their use.
30. Review the current staffing patterns to ensure the appropriate distribution of nursing resources on the inpatient psychiatric unit.
31. Ensure that an RN participates in the interdisciplinary treatment team meetings.
32. Review the current ICU staffing plan, taking into account the patient mix, and use of monitor technicians, and take action based on the review.
33. Develop and implement a plan to treat patients who require only telemetry monitoring on the medical-surgical unit.
34. Shorten the time it takes to fill RN vacancies in the ICU.
35. Develop an admission criteria policy for all inpatient units.
36. Review RN injuries in the ICU and take appropriate action.
37. Develop and implement a comprehensive plan that accounts for staff fluctuations and

meets the rehabilitative and physical therapy needs of patients throughout the health care system.

38. Develop and implement a respiratory therapy staffing plan to ensure quality and safety.
39. Develop and implement a plan, with Human Resources Division, to bring CLC nurse staffing to its authorized staffing levels. This plan should include human resource targets and accountability to achieve expedient staffing goals.
40. Reduce and monitor the diversion of CLC nursing staff to other units, and implement consistent assignment of nursing staff for residents.
41. Develop and implement a plan to reduce resident falls and continue to monitor.
42. Develop and implement a comprehensive plan to improve the frequency and variety of resident recreational activities including weekends, holidays, and off-shifts.
43. Develop and implement a CLC Restorative Care Program including a dining program.
44. Develop and implement a plan to identify Hospice and Palliative Care nurse staffing needs using case mix and RUGs data.
45. Conduct ongoing multidisciplinary reviews of resident medications, including the indications, dosage, and side effects of prescribed medications and monitor appropriately.
46. Review the process for laboratory draws and specimen collection and take appropriate action.
47. Review the process for blood pickup from the laboratory and take appropriate action.
48. Consider automating the exhaust hoods in the histopathology laboratory and the autopsy room so that the hoods function whenever employees are in the work area.
49. Develop and implement a comprehensive plan to ensure nursing practice standards are met consistently throughout the health care system. This plan should address the education and training needs of nurses in the Medical Center and documentation of competencies.
50. Assess the need for additional nurse educators and take action as appropriate.
51. Review the current medical-surgical staffing plan, and use of monitor technicians, and take appropriate action based on the review.
52. Review causes of patient falls on the medical-surgical unit and develop a plan to reduce the rate.
53. Review causes for the increases in staff injuries on the medical-surgical unit and develop and implement a plan to reduce them, including appropriate training and preventative measures.

VISN 21 should:

1. Evaluate the Medical Center's administrative closure of encounters and take appropriate action.
2. Evaluate the failure to complete annual performance evaluations at the Medical Center and take appropriate action.
3. Investigate the alleged misallocation of Hospice and Palliative Care Program funds.

Department of Veterans Affairs

Memorandum

Date: APR 2 2012

From: Medical Inspector (10MI)

Subj: Office of the Medical Inspector Predecisional Review for the Under Secretary for Health: Department of Veterans Affairs (VA) Sierra Nevada Health Care System, Reno, Nevada

To: Under Secretary for Health (10)

Thru: Principal Deputy Under Secretary for Health (10A)

1. Attached is the Office of the Medical Inspector (OMI) Predecisional Review for the Under Secretary for Health (USH): VA Sierra Nevada Health Care System (hereafter, the Medical Center), Reno, Nevada. The Veterans Integrated Service Network (VISN) 21: Sierra Pacific Network and the Medical Center requested an in-depth review of wide-ranging complaints from the President of the American Federation of Government Employees union local, regarding patient safety and care delivery at the Medical Center. The OMI conducted site visits on October 3-6 and October 24-27, 2011.

2. The OMI has received input on its investigation from the Medical Center, VISN 21, the Office of General Counsel, and select Veterans Health Administration Program Offices.

3. Following your review of the attached report, please indicate your approval in the signature block below. The OMI will then transmit the approved documents to the Deputy Under Secretary for Health for Operations and Management along with a request for the Medical Center to prepare an Action Plan to address the recommendations. If you have any questions/comments, I would be pleased to address them.

John R. Pierce, M.D.

Attachment

Approval of the Office of the Medical Inspector Predecisional Review for the Under Secretary for Health: VA Sierra Nevada Health Care System, Reno, Nevada.

Robert A. Petzel, M.D. Date 4/24/12

Appendix A

The following documents were reviewed in preparation of the report:

1. VA Sierra Nevada Health Care System, *Patient Care Services Staffing Plan,* June 1992
2. VA Sierra Nevada Health Care System, EL-00A-01, *Organizational Structure and Functional Elements,* May 2007
3. VA Sierra Nevada Health Care System, CC-111-57, *Assessment/Reassessment,* July 2008
4. VA Sierra Nevada Health Care System, *Patient Care Services Staffing Plan*, Revised March 2009
5. VA Sierra Nevada Health Care System, 018-07, *Hospice and Palliative Care,* October 2009
6. VA Sierra Nevada Health Care System, 04-20, *Fee-basis Process for Outpatient/Inpatient Services,* October 2009
7. VA Sierra Nevada Health Care System, 11AC-06, *Management of Pain*, November 2009
8. VA Sierra Nevada Health Care System, *Palliative Care Program Site Visit*, 2011
9. VA Sierra Nevada Health Care System, Patient Care Service Policy PCS-15, *Safety of Patients and Personnel,* June 2011
10. VA Sierra Nevada Health Care System, Patient Care Service Policy PCS-16, *Standards of Care and Practice*, June 2011
11. VA Sierra Nevada Health Care System, Patient Care Service Policy PCS-19, *Utilization of Staff Based on Patient Needs,* June 2011
12. VA All Employee Survey, *VA Sierra Nevada Health Care System*, FY09 – FY11
13. VA Sierra Nevada Health Care System, CLC Budget Proposal FY12: *Community Living Center Executive Summary*
14. VA Sierra Nevada Health Care System Documents:
    a) Competency and training
    b) Workload, staffing and scheduling plans and data
    c) Monitoring, work orders and maintenance checks
    d) Electronic waiting list data
    e) Fee data
    f) Fall data
    g) Patient Advocate data FY10 and FY11
    h) Human Resource documents
    i) Staff clinical privileges
    j) Clinical council and committee minutes
    k) Rapid Response data FY09-FY11
15. VHA Directive 2009-002, *Patient Care Capture*, January 23, 2009
16. VHA Directive 2001-053, *Pain Management*, October 28, 2009
17. VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities,* March 2, 2010
18. VHA Directive 2010-027*, VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010
19. VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel,* July 19, 2010
20. VHA Directive 2011-011, *Transfusion Verification and Identification Requirements for All sites,* March 4, 2011
21. VHA Handbook 1101.02: *Primary Care Management Module* (PCMM), April 21, 2009

22. VHA Handbook 1101.05: *Emergency Medicine Handbook,* May 12, 2010
23. VHA Handbook 1160.01: *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008
24. VHA Handbook 1106.08: *Pathology and Laboratory Medicine Service Procedures,* October 6, 2008
25. VHA National Center for Organizational Development (NCOD), *2011 VA All Employee Survey: VISN 21 Results and Findings*
26. VHA Executive Decision Memo, FY2008 Facility Complexity Level Model
27. VHA Office of Nursing Services intranet site: Staffing Methodology for VA Nursing Personnel, retrieved from http://vaww1.va.gov/nursing/staffing.asp
28. VHA Pain Management Strategy, November 1998, http://www.va.gov/PAINMANAGEMENT/VHA_Pain_Management_Strategy.asp,
29. Department of Veterans Affairs, VHA Support Service Center (VSSC), New and Established Patient Wait Times for Completed Appointments
30. VHA Survey of Healthcare Experiences of Patients (SHEP): *Inpatient Dimensions of Care Question-level Report,* FY11
31. VHA Survey of Healthcare Experiences of Patients (SHEP): *Outpatient Dimensions of Care Question-level Report*, FY11
32. VA-DoD Clinical Practice Guideline, *Management of Opioid Therapy for Chronic Pain*, May 2010
33. Department of Veterans Affairs and the American Federation of Government Employees, *2011 Master Agreement*, VA Pamphlet 05-68, P70450
34. Department of Veterans Affairs, Office of Inspector General, Combined Assessment Program, Report No. 09-03039-62: *Review of the VA Sierra Nevada Health Care System, Reno, Nevada*, January 14, 2010
35. Department of Veterans Affairs, Hospital Compare, VHA ASPIRE database and LINKS dashboard, http://www.hospitalcompare.va.gov/aspire/index.asp
36. Department of Veterans Affairs, VHA Support Service Center (VSSC), New and Established Patient Wait Times for Completed Appointments, http://vssc.med.va.gov/klf_default.asp
37. Department of Health and Human Services, Office of Inspector General, *Nursing Home Resident Assessment Quality of Care* (OEI-02-99-00040), January 2001
38. Department of Health and Human Services, Office of Inspector General, *Nursing Home Resident Assessment Resource Utilization Groups* (OEI-02-99-00041), January 2001
39. The Joint Commission report, *VA Sierra Nevada Health Care System*, April 2010
40. Centers for Medicare and Medicaid Services, Online Survey, Certification and Reporting (OSCAR) Database

Appendix B

A. Purpose

This summarizes monthly drug prescription fill rates for eight Schedule II drug/drug combinations at the Medical Center (also know in these slides as the Reno VAMC), and compares the rates with those from relevant VA medical center clusters (VAMCs). The Schedule II drugs/drug combinations that will be summarized are acetaminophen with codeine, acetaminophen with oxycodone, codeine, fentanyl, hydromorphone, methadone, morphine, and oxycodone. Monthly drug prescription fill rates are defined as the monthly number of drug prescription fills and refills per 1,000 unique patients, the time period summarized is from October 2009 to June 2011, and the Medical Center fill rates will be compared to those for VISN 21 VAMCs, Facility Complexity Level Group 2 (MCG 2) VAMCs, and the national summary for all VAMCs.

B. Methods and Data

The Schedule II drug data and number of unique patients were obtained from VHA Decision Support System (DSS) and National Patient Care Data Files. Total number of prescription fills and refills for all 249 unique Schedule II drugs present in the data from at least one of the following: the Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, or all National VAMCs. The drugs/drug combinations summarized were defined using this list as follows:

- **acetaminophen with codeine** are drug combinations with acetaminophen, codeine and, no other drugs in tablet form (IP Numbers: 30226, 30227, 30228, and 55790)
- **acetaminophen with oxycodone** are drug combinations with acetaminophen, oxycodone, and no other drugs in tablet form (IP Numbers 30835, 30836, 56275, 56276, 67237, and 68528)
- **codeine** in tablet form (IP Numbers 28578, 28579, 28580, and 63596)
- **fentanyl** in skin patch form (IP Numbers 33940, 33941, 33942, 33943, and 69586)
- **hydromorphone** in tablet form (IP Numbers 31019, 31021,46579, 63505, 93540, and 93541)
- **methadone** in tablet form (IP Numbers 28682, 28683, 28685, 28690, and 63498)
- **morphine** in tablet or capsule form (IP Numbers 28896, 28897, 28898, 28910, 28911, 28912, 28921, 45247, 45248, 45249, 62306, 62307, 63507, 63508, 63509, 63597, and 67249)
- **oxycodone** in tablet or capsule form (IP Numbers 32801, 41267, 41268, 41269, 45335, 46614, 49876, 59462, 63412, 63511, 63512, 63513, 72522, 72523, 72524, 73630, and 74104)

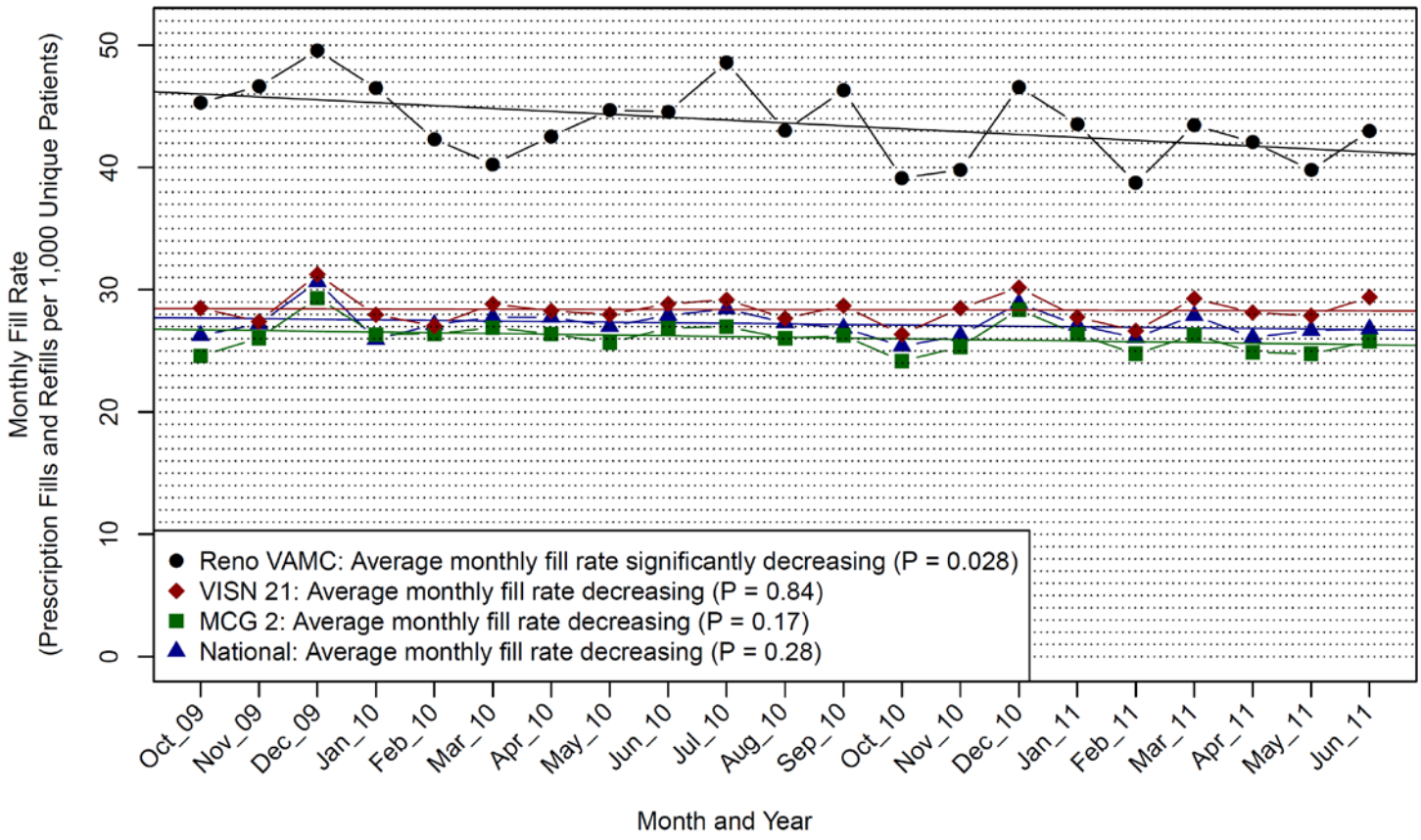
The monthly patient data used is the total number of unique patients (determined by unique social security numbers) that visited the particular VAMC or VAMC cluster at least one time in a given month. These data were obtained from the National Patient Care Database (Inpatient

Hospital Stays (PM), Outpatient Encounters (SE), and Extended Stays – Community Living Centers and DOMs (XM) data files).

The monthly fill rates are a measure of the number of drug prescription fills and refills per 1,000 unique patients. These were determined by dividing the number of monthly fills and refills for each drug/drug combination by the number of unique patients for that month and multiplying by 1,000. For each VAMC/ VAMC cluster and drug/drug combination the average fill rate trend over entire time period from October 2009 to July 2011 was calculated using the ordinary least squares method and is represented by the corresponding linear regression line. Whether the fill rate trend was increasing or decreasing was determined by the slope of the regression line, and the significance of the increase or decrease was tested using the usual t-test (H_0: the slope of the regression line is equal to 0 or the monthly fill rate is constant). For each drug/drug combination, the monthly fill rates for the four VAMC/VAMC clusters are plotted along with the fill rate trend in the accompanying plot summaries. The direction and significance of the trend are noted.

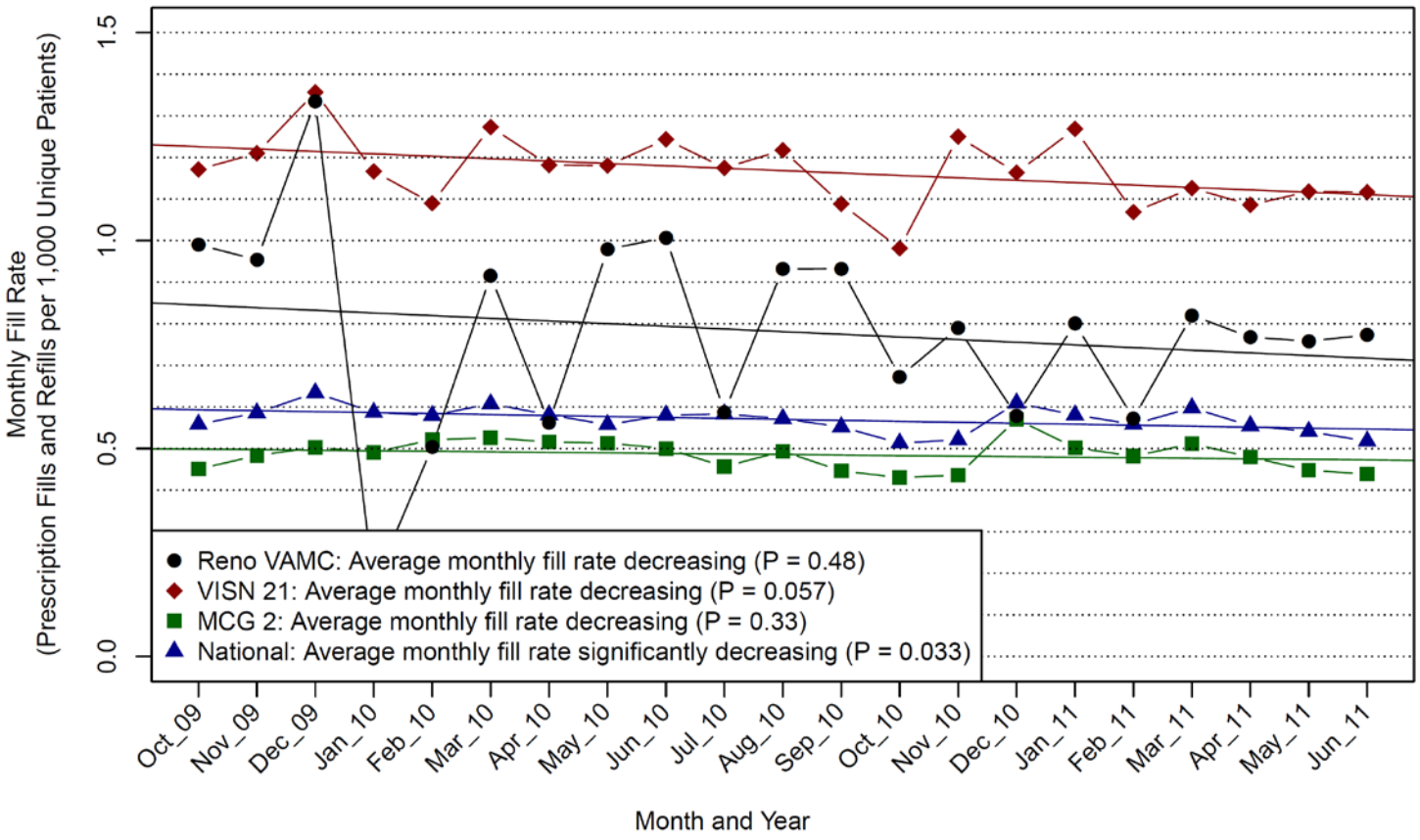
Appendix C

ACETAMINOPHEN with OXYCODONE
Monthly Prescription Fills and Refills Per 1,000 Unique Patients
Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, and All VAMCs Nationally



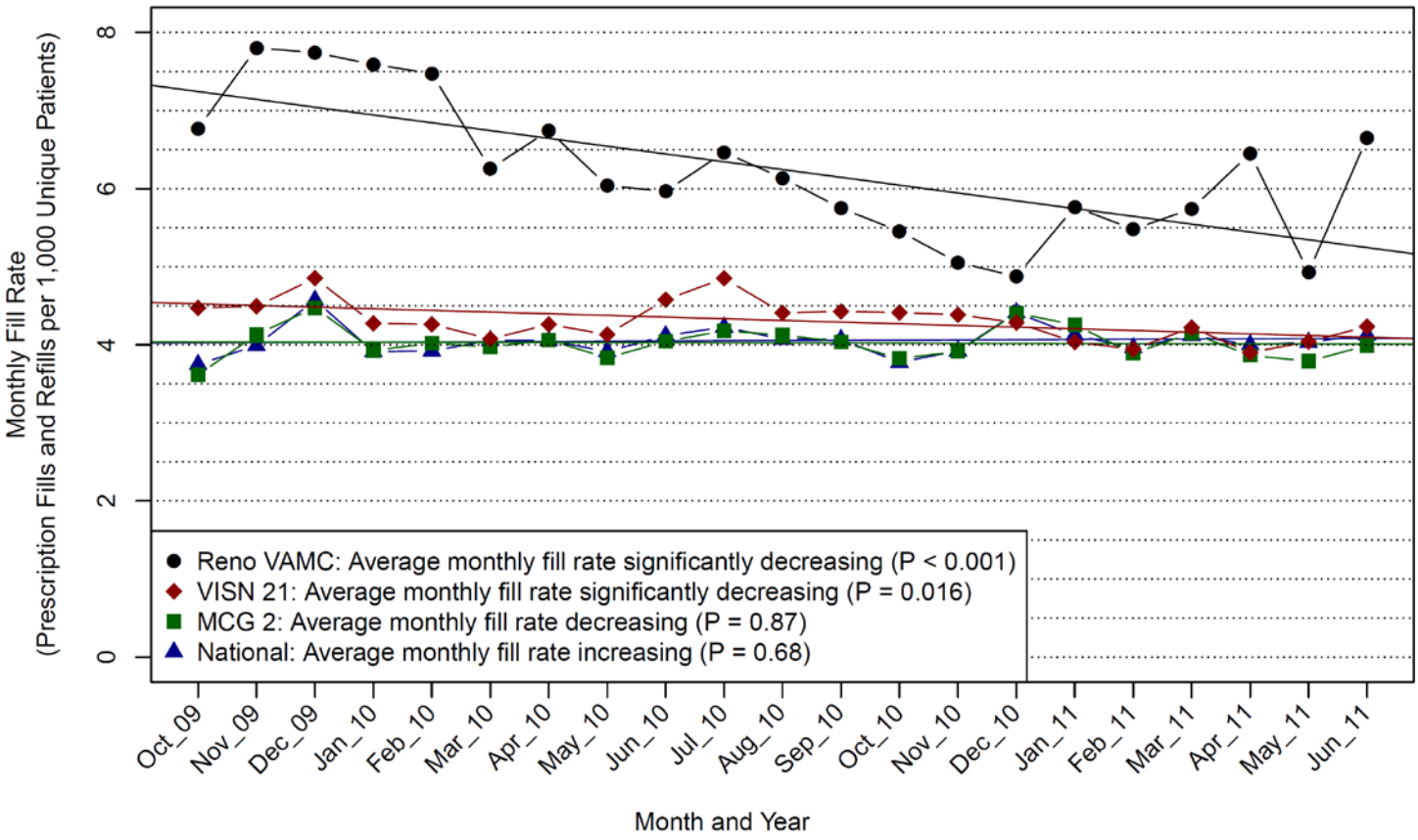
Data Sources: VHA Decision Support System (DSS) and National Patient Care Data Files
Prepared by: Office of the Medical Inspector (OMI)
Date: October 19, 2011

CODEINE
Monthly Prescription Fills and Refills Per 1,000 Unique Patients
Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, and All VAMCs Nationally



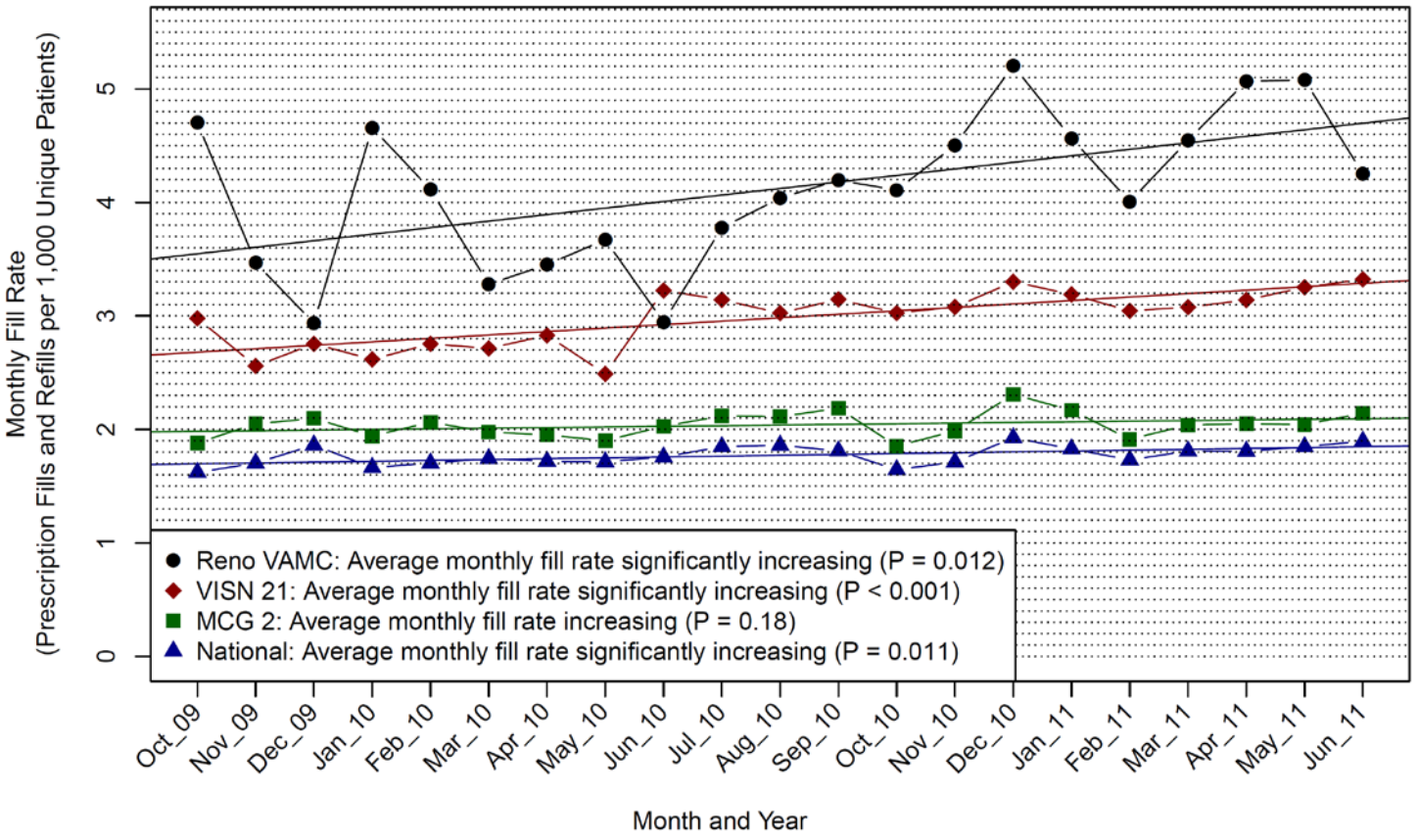
Data Sources: VHA Decision Support System (DSS) and National Patient Care Data Files
Prepared by: Office of the Medical Inspector (OMI)
Date: October 19, 2011

FENTANYL
Monthly Prescription Fills and Refills Per 1,000 Unique Patients
Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, and All VAMCs Nationally



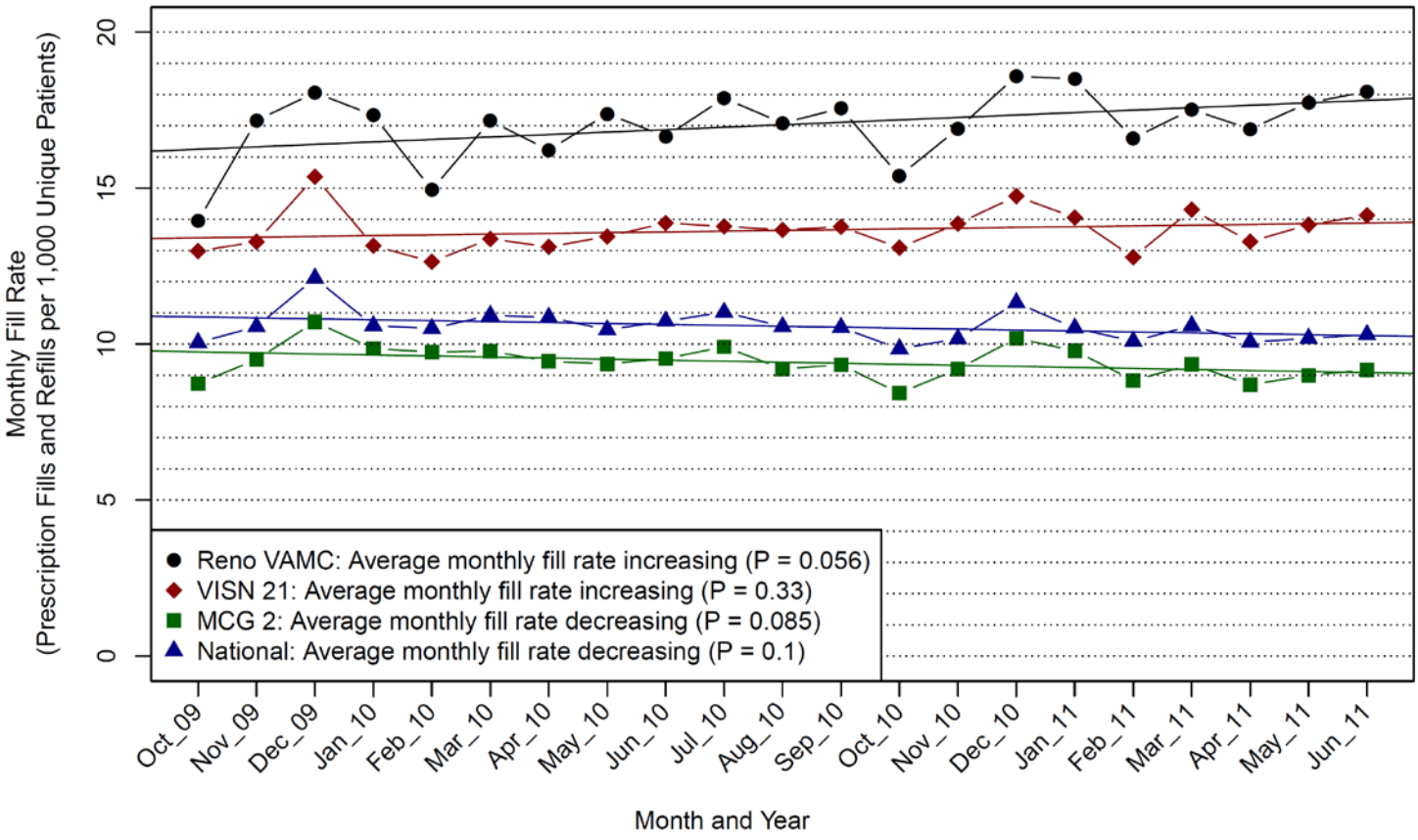
Data Sources: VHA Decision Support System (DSS) and National Patient Care Data Files
Prepared by: Office of the Medical Inspector (OMI)
Date: October 19, 2011

HYDROMORPHONE
Monthly Prescription Fills and Refills Per 1,000 Unique Patients
Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, and All VAMCs Nationally



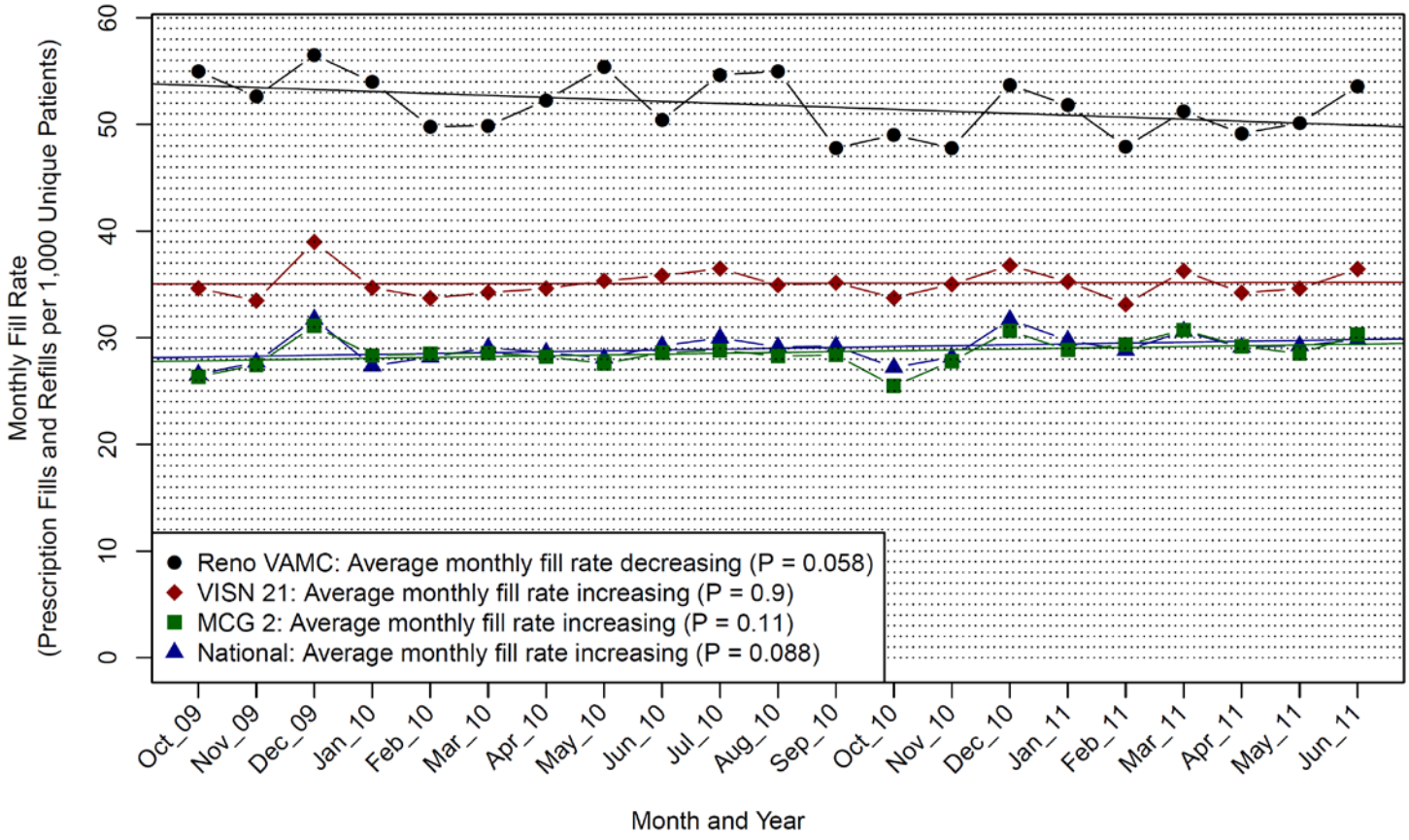
Data Sources: VHA Decision Support System (DSS) and National Patient Care Data Files
Prepared by: Office of the Medical Inspector (OMI)
Date: October 19, 2011

METHADONE
Monthly Prescription Fills and Refills Per 1,000 Unique Patients
Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, and All VAMCs Nationally



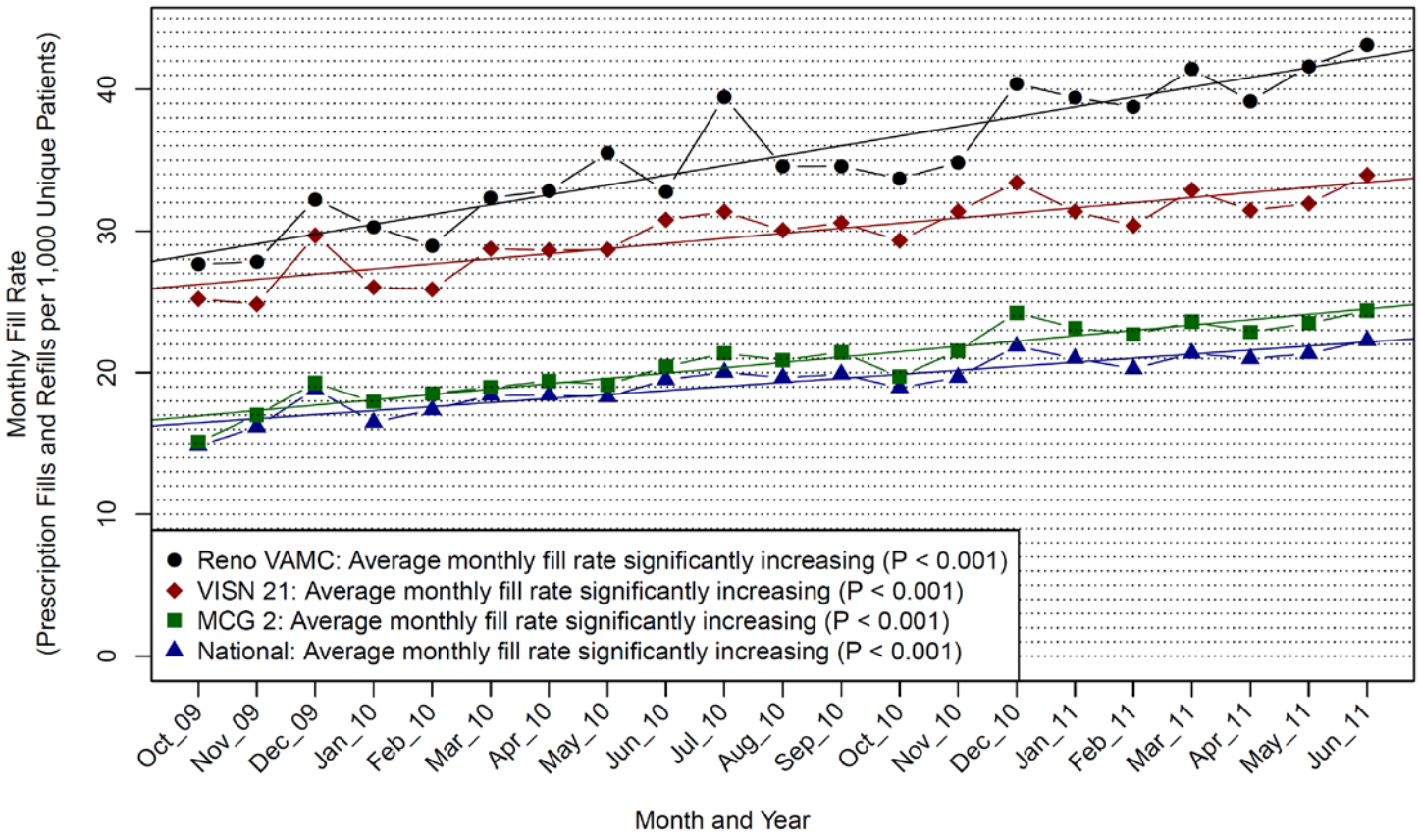
Data Sources: VHA Decision Support System (DSS) and National Patient Care Data Files
Prepared by: Office of the Medical Inspector (OMI)
Date: October 19, 2011

MORPHINE
Monthly Prescription Fills and Refills Per 1,000 Unique Patients
Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, and All VAMCs Nationally



Data Sources: VHA Decision Support System (DSS) and National Patient Care Data Files
Prepared by: Office of the Medical Inspector (OMI)
Date: October 19, 2011

OXYCODONE
Monthly Prescription Fills and Refills Per 1,000 Unique Patients
Reno VAMC, VISN 21 VAMCs, MSG 2 VAMCs, and All VAMCs Nationally



Data Sources: VHA Decision Support System (DSS) and National Patient Care Data Files
Prepared by: Office of the Medical Inspector (OMI)
Date: October 19, 2011

Appendix D

VA Sierra Nevada Healthcare System

Electronic Wait List (EWL) for Physical Therapy

Date	30-90 days	<30 days	Total
5/10/11	0	0	0
5/27/11	0	35	35
6/13/11	2	81	83
6/20/11	31	56	87
7/11/11	47	58	105
7/20/11	49	75	124
7/25/11	75	57	132
8/8/11	79	83	162
8/15/11	90	88	180
8/22/11	123	69	194
8/31/11	106	48	156
9/6/11	54	18	74
9/12/11	0	0	0

The first column shows the date the EWL data were collected, the second column shows the number of patients whose desired appointment date ranged from 30 to 90 days, the third column shows the number of patients whose desired appointment date was less than 30 days and the fourth column shows the total number of patients on the EWL.

Appendix E

Comparison of the Use of Psychotropic medications among VA Sierra Nevada Healthcare System (VASNHCS) Community Living Center (CLC) Residents and National and the State of Nevada Long Term Care Patients

Frequency of use: % of residents receiving	Any psychotropic %	Antidepressant Medication %	Antipsychotic Medication %	Anxiolytic Medication %	Hypnotic Medication %
VASNHCS CLC					
	73.0	**62.0**	18.5	16.0	0.6
4th Qt FY 10	**78.4**	**67.5**	21.7	17.7	3.4
1st Qt FY 11	**77.6**	**63.6**	18.3	18.9	1.8
2nd Qt FY 11					
National Data					
4th QT FY 10	65.1	47.7	**25.2**	20.1	7.5
1st Qt FY 11	65.1	47.7	**25.2**	**20.1**	7.5
2nd Qt FY 11	65.3	48.3	**25.2**	20.8	7.4
State of Nevada					
4th Qt FY 10	60.3	37.3	21.1	**20.2**	**15.0**
1st Qt FY 11	60.3	37.2	21.1	**20.1**	**15.0**
2nd Qt FY 11	59.8	36.4	21.6	**21.4**	**14.9**

Bolded percentages represent the greatest percent for that quarter.

These data were retrieved from the Medical Center's quarterly Quality Management/Quality Improvement report prepared by the CLC pharmacist.