United States General Accounting Office

GAO

Report to the Honorable
Charles S. Robb, U.S. Senate

September 1993

VA HEALTH CARE

Labor Management and Quality-of-Care Issues at the Salem VA Medical Center

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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-250915

September 23, 1993

The Honorable Charles S. Robb
United States Senate

Dear Senator Robb:

On April 14, 1992, you asked us to conduct an investigation at the Salem, Virginia, Department of Veterans Affairs (VA) Medical Center to determine what could be done to (1) restore confidence in the facility and (2) ensure that high-quality patient services are provided. Just before we received your request, the bodies of two patients had been found on the grounds of the facility, and employee union representatives had alleged that poor-quality patient care was being provided at the center due to nursing shortages, employee stress, and poor staff morale.

In performing this review, we examined selected aspects of the center's quality assurance program, reviewed the nursing care being provided in various psychiatric and medical/surgical units, and identified initiatives being taken by hospital management to address identified problems. The scope of our work and methodology are discussed in more detail in appendix I.

We also met with more than 160 individuals at the medical center—medical center staff, managers, and patients; members of the employees union and union leaders; families of patients; representatives of veterans service organizations; and external groups who deal with the medical center—to obtain their perspectives on the center's problems. The results of these interviews are discussed in appendix II.

Background

VA's Salem Medical Center is a 525-bed full-service facility. It provides acute medical, surgical, and psychiatric care; intermediate care; long-term psychiatric care; nursing home care; and hospice care. It acts as a referral center for other VA facilities in Virginia, West Virginia, Tennessee, and Washington, D.C., for acute and long-term psychiatric care. The Salem facility serves approximately 113,000 veterans in 25 counties of western Virginia. In March 1993, it employed 69 physicians, 228 registered nurses, 117 licensed practical nurses, and 169 nursing assistants.

In 1989, the medical center director, who had been at the center for 17 years, died. His position was filled in 1989 by an individual who immediately instituted changes in the way the medical center was

managed and directed. A new chief of staff was appointed in 1990, and a new chief nurse and an associate director were appointed in 1991. In early 1992, the employee union representing some medical center employees openly challenged medical center management and the decisions that it had made. When the union did not obtain what it considered an acceptable response from management, it initiated a local media campaign to publicly air employee grievances. The union actively sought the firing of the medical center director, chief of staff, and chief nurse.

The discovery of two bodies on the grounds of the center in March 1992 brought the facility to the attention of the national media. In addition to considerable negative publicity, the center was also subjected to reviews by several internal VA organizations: the regional office, Medical Inspector, and Inspector General. Subsequently, the medical center director was transferred to a VA regional office in April 1992. On June 15, 1992, a new director was assigned to the Salem facility. On the same day, the new director requested the chief of staff's resignation. The chief of staff was later reassigned to a regional office and ultimately terminated from VA employment on September 22, 1992. The chief nurse transferred to another VA hospital in September 1992.

Results in Brief

The new medical center director is restoring both staff and public confidence in the management of the facility and has begun to address quality-of-care issues. He has addressed many of the labor-management issues confronting the facility and is taking action to reduce nurse staffing shortages that have had a detrimental effect on the quality of care being provided. But more needs to be done. For example, nurse staffing shortages continue, medical records are incomplete, some psychiatrists are not seeing their patients regularly, and certain psychiatrists and nurses are not performing essential functions, such as taking patient histories upon admission, assessing patient needs, and providing discharge planning before a patient is released into the community. These problems are resulting in poor quality care for some patients. Further, the center's quality assurance program needs improvement. Management should ensure that this program objectively and systematically monitors and evaluates and continuously improves the quality and appropriateness of the services delivered.

New Management Has Improved the Medical Center's Work Environment

During our first visit to the Salem, Virginia, Medical Center, from April 27 to May 1, 1992, many facility employees were demoralized and highly agitated. Union and management conflicts were rampant, negative publicity about the facility was routinely appearing in the local media, nursing staff were under severe stress due to shortages of personnel, and some physicians were considering terminating their employment at the center. Since his appointment in June 1992, the medical center director has initiated a number of actions to address these and other issues confronting the center and has attempted to restore the confidence of the center's staff in the management of the facility.

Personnel directly involved with the facility, such as individual nurses and physicians, the union president, and the dean of the University of Virginia Medical School, told us in November 1992 that employee stress levels had been reduced and morale at the center had substantially improved since our first visit. They attributed most of the improvement to the individual efforts of the medical center director. Veterans service organizations, such as the American Legion, Disabled Veterans of America, and Paralyzed Veterans of America, also expressed satisfaction with the manner in which the center was currently being managed. In addition, a January 1993 report by VA's Region I Office stated that center staff members were responding positively to the medical center director's leadership and noted that the director had shifted the center's focus from labor-management problems to patient care.

The director's initiatives have included:

- recommending personnel changes in key management positions;
- seeking the staff's opinions and perspectives on issues confronting the center;
- meeting with the media to discuss important medical center issues;
- elevating the chief of nursing to the level of full participation in the hospital's management team;
- increasing the authorized number of nursing staff that can be employed at the facility and actively recruiting and hiring additional nursing staff to meet the new staffing levels;
- evaluating and making changes, where appropriate, to the staffing levels in patient units to increase the nurse-to-patient staffing ratios; and
- reestablishing an effective working relationship with the university that provides the facility with resident physicians.

Appendix III contains more information about these initiatives.

Improvements Are Needed in the Medical and Nursing Care Provided to Patients

The quality of care being received by some patients in the Salem Medical Center needs substantial improvement. In terms of medical care, some of the efforts by center psychiatrists do not meet requirements established by the medical center's bylaws. Specifically, in two acute-care psychiatric units, we found that two psychiatrists were not assessing patients' physical and psychological status on admission to the unit; developing patient treatment plans; providing ongoing evaluation of patients; or performing discharge planning. Further, we found no indication that patients on these units were receiving psychotherapeutic services, such as individual, group, or community therapy. However, the center is addressing performance problems of these individuals and is hiring additional psychiatrists for these units.

The nursing care provided in seven inpatient units we visited also needs improvement. This care does not meet the nursing standards of the American Nurses' Association (ANA) or the accrediting criteria of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). More specifically, our review of patient records, interviews with nurses and patients, and general observations on the patient units revealed continuing problems in patient assessment, nursing diagnosis, treatment care plans, intervention and evaluation, and discharge planning. This situation was primarily due to chronic staffing shortages over the past several years. But we also found that many nursing staff are not complying with nursing standards and criteria when providing patient care. Some nurses indicated that they did not have sufficient time to adhere to applicable nursing standards, while others said that they believe additional in-service education is needed. (Appendix IV contains additional information on the medical and nursing care provided in certain patient units of this facility.)

Quality Assurance Efforts Need to Be Strengthened

The medical center's quality assurance program needs substantial improvement. We as well as VA regional office personnel found that quality assurance activities are not adequately documented, minutes of quality assurance meetings are incomplete, and hospital service departments are not reporting the results of their quality assurance initiatives to the center's Quality Management Office. Further, we identified problems through a medical records review, such as the lack of written justification for restraints,[1] lack of treatment plans, and the failure to provide therapy to psychiatric patients, that were not being identified by quality assurance personnel. This situation was due in large part to (1) the lack of previous

[1]Restraints are usually leather arm straps, leather leg straps, or a waist belt used as a temporary measure to prevent patients from harming themselves or others or seriously disrupting the therapeutic environment.

top management support for quality assurance and its failure to develop an effective center-wide quality assurance program, (2) an inadequately staffed and trained quality assurance group, and (3) hospital staff who have been unresponsive in complying with requirements to fully document the care being provided to the facility's patients.

In January 1993, the regional office conducted a mock survey of the facility to determine if it was ready for an accreditation survey by a JCAHO review team scheduled for July 1993. The regional office found that the center had made significant progress in meeting JCAHO standards when compared to the findings of an earlier review in March 1992. However, the review team also found that much work needed to be done. For example, the regional office report noted that the medical center policy on providing nursing care should be formalized as soon as possible and that nursing policy on documentation should expand on the standards of nursing practice. The report also stated that the documentation of the nursing process should be more consistent, reflecting congruency between the nursing assessment, patient care plans, and progress notes. In addition, the report noted that the inconsistencies in documentation were most evident in acute psychiatry. Further, the report stated that some units maintain separate nursing and physician notes and suggested that the staff consider charting unified progress notes.

Many of the nursing and psychiatric care problems that we and VA regional office review teams found could have been identified earlier if the medical center's quality assurance program was functioning effectively. But because of limited staffing and expertise and the lack of strong management support for an effective center-wide quality assurance program, these problems have continued. Recent changes in staff and program emphasis represent movement in the right direction. However, continued strong medical center management support is critical to the success of the program to identify and correct future problems. (See app. V for further details.)

Recommendations

We recommend that the Secretary of Veterans Affairs direct VA's Under Secretary for Health to require the Salem Medical Center Director to:

- review the psychiatric care being provided at the facility and take the necessary actions to ensure that it meets medical center bylaws.

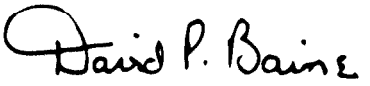
- identify the learning needs of the nursing staff and implement in-service education programs to reinforce the need to comply with nursing standards and criteria.
- adequately staff the quality assurance office and require that quality assurance findings developed by that office be reviewed and analyzed on a center-wide basis.
- require service chiefs to enforce requirements calling for complete and accurate medical records.

Agency Comments

In a letter dated August 5, 1993, the Secretary of Veterans Affairs agreed with our recommendations and recognized that additional action to effect improvement in those areas identified by our office is needed. He also believes that actions undertaken and planned by Salem VA Medical Center management are responsive to our report recommendations. (See app. VI.)

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, copies will be sent to appropriate congressional committees; the Secretary of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties. We will also make copies available to others upon request. If you have any questions about this report, please call me at (202) 512-7101. Other major contributors are listed in appendix VII.

Sincerely yours,



David P. Baine
Director, Federal
Health Care Delivery Issues

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Abbreviations

AFGE	American Federation of Government Employees
ANA	American Nurses' Association
APA	American Psychiatric Association
HCFA	Health Care Financing Administration
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
VA	Department of Veterans Affairs

Scope and Methodology

On April 14, 1992, Senator Charles S. Robb asked us to investigate the Department of Veterans Affairs' Salem, Virginia, Medical Center to determine what could be done to (1) restore confidence in the facility and (2) ensure that high-quality patient services are provided. This investigation was prompted by the discovery of the bodies of two missing patients on the medical center grounds and by concerns of the hospital employees that the center was providing poor-quality patient care due to nurse staffing shortages, employee stress, and poor staff morale.

We initially responded to this request by sending a five-member team to the center to interview management, union, and clinical staff to determine what the problems at the center were. During this effort, the team also talked with every patient, patient family member, or staff member who wished to talk to them, and met with the former director and chief of staff to obtain their perspectives on the issues and problems facing the medical center.[1] From April 27 to May 1, 1992, more than 160 individuals spoke with us about the facility. The results of this effort were discussed with VA's Under Secretary for Health and the Acting Medical Center Director in May 1992. We also provided this information to the new Medical Center Director in a meeting on June 15, 1992.

On the basis of information obtained during our interviews, we focused our review in four areas: (1) actions taken or planned by the new medical center director to address identified problems; (2) the quality of nursing care being provided to patients in psychiatric and other selected patient units; (3) the quality of care being given by psychiatrists; and (4) the effectiveness of the center's quality assurance program.

To determine what actions were being taken to address issues confronting the Salem VA Medical Center, we (1) requested that the new medical center director provide us with a list of initiatives he had undertaken since his arrival to address problems confronting this facility; (2) interviewed nurses, physicians, union representatives, quality assurance personnel, and representatives of the University of Virginia Medical School (which maintains an affiliation agreement with the hospital) to determine if they thought there has been any change in the working environment at this facility since the new medical center director was appointed; (3) observed the staffing arrangements in selected units as well as the care being provided to patients on these units and compared our October 1992 observations with those from our April, June, and July 1992 visits; and

[1]In April 1992, the former medical center director was transferred to a regional office. In June 1992, the former chief of staff was relieved of all responsibilities at the center and on September 22, 1992, his employment with VA was terminated.

(4) reviewed supporting documentation and interviewed medical center personnel to determine whether some of the initiatives cited by the medical center director had been implemented.

A registered nurse on our staff evaluated the quality of nursing care by (1) direct observation of the care provided to patients on seven patient units; (2) review of 35 patient records, 5 from each of the seven patient units; (3) interviews with patients about their hospital stays and; (4) discussions with nursing staff on our observations and patient record findings. Our evaluation of nursing documentation was made using standards and criteria developed by the American Nurses' Association and Joint Commission on the Accreditation of Healthcare Organizations.

To determine whether psychiatrists were adequately performing and documenting their work, we screened physician documentation for 20 patient records on four psychiatric units using standards and criteria developed by the American Psychiatric Association (APA), the Health Care Financing Administration (HCFA), and VA. We discussed our findings with the medical center's Chief of the Psychiatry Service and reviewed performance data on certain psychiatrists who were not performing their work in accordance with professional standards to determine what action the center was taking to correct the situation.

Our review of the medical center's quality assurance program consisted of monitoring the results of ongoing VA regional office quality assurance reviews and examining selected aspects of the center's program. Specifically, we reviewed the results of regional office surveys conducted in March, June, and September 1992, and January 1993. Each of these reviews was designed to determine what the center needed to do to pass a JCAHO accreditation survey in July 1993. We also examined three quality assurance monitors (morbidity and mortality, autopsy, and restraints) to determine how effectively the center was performing these functions.

To evaluate the morbidity and mortality monitor, we collected a sample of morbidity and mortality reviews conducted by the surgical and medical services over a 24-month period to determine if quality-of-care problems were being identified and, if so, whether any action was being taken to resolve them.

Our review of autopsies consisted of examining the center's policies and procedures on the subject and determining whether they were being followed. We collected data on (1) the number of hospital deaths from

April 1991 through September 1992 and (2) the number of autopsies performed during this period.

Our review of the restraints monitor consisted of an examination of applicable policies and procedures, observations of how restraints are used on the units, an examination of the patient records to determine if the use of restraints was properly authorized and documented, and an examination of the minutes from the Psychiatry Service's quality assurance meetings to verify that the service monitored the use of restraints. Our review of patient records was made using screening criteria from APA and HCFA.

During our initial interviews with center personnel in April 1992, several questions were raised about the operations of the center's pharmacy. We did not perform any work in this area because VA's Inspector General had assigned a team to review pharmacy personnel and management issues at the Salem facility. The Inspector General's report was issued on July 15, 1993.

We conducted our review from April 1992 through February 1993 in accordance with generally accepted government auditing standards. We met with the medical center's director in January 1993 to inform him of the findings of the review and have updated information in this report as appropriate.

Results of Initial Interviews Conducted at the Salem VA Medical Center

At our first visit to the Salem, Virginia, Medical Center, from April 27 to May 1, 1992, many facility employees were demoralized and highly agitated. Union/management conflicts were rampant, negative publicity resulting from the discovery of two corpses on the center's grounds was routinely appearing in the local media, nursing staff were under severe stress due to shortages of personnel, some physicians were considering terminating their employment at the center, and resident physicians were signing petitions calling for the resignation of the chief of staff.

Management of the facility was also in transition. The director had been reassigned to a regional office position and an acting director had been appointed. Further, the union, while pleased with the removal of the director, was still calling for the resignation of the chief of staff and the chief of nursing. While much of the concern expressed by medical center staff was directed at management, the recently transferred medical center director, chief of staff, and chief of nursing each believed that a major problem at the facility was the staff's inability and unwillingness to change the way they were performing their work.

During this visit, we made ourselves available to meet with staff, patients, and patient family members. Most of the interviews conducted were not initiated by us. Although some interviewees made positive comments about the facility, a significant majority complained about how the facility was being managed and operated. To provide balance, we also obtained the perspectives of the previous medical center director, chief of staff, and chief of nursing and have incorporated their comments as appropriate. The following is a summary of what key groups at the facility told us.

Physicians Attribute Much of Center's Problems to Poor Management

Service chiefs and physicians we interviewed attributed many of the center's problems to the personal management styles and practices of the previous director and the former chief of staff. They described the two as stubborn and dictatorial and said that they had forced the facility to move too far, too fast. The physicians readily acknowledged that many of the changes the director and chief of staff were trying to implement, including expanding the psychiatric residency program from 2 to 4 years, expanding geriatric services, and increasing the emphasis on outpatient care, were good ideas and were needed. But they objected to what they perceived to be a management style that alienated physicians, nurses, and other staff and fostered confrontation with the union. In their opinion, the previous director and chief of staff often failed to achieve effective staff

participation in decisionmaking. This resulted in limited buy-in by the staff who ultimately were required to implement change.

Physicians also told us that the facility was functioning in an atmosphere of tension and distrust. They stated that some physicians were threatening to look for employment outside the facility and potential recruits were reconsidering previous commitments to join the staff. The physicians believed that the medical center could not continue for much longer without losing critically needed staff. However, the physicians believed that patients were generally receiving good medical care. But this was occurring only through the extraordinary efforts and personal commitment of individual staff members. In fact, the physicians believed that there was a very real potential for quality-of-care problems if the management situation at the facility did not improve soon. They also told us that they thought the facility would possibly fail its upcoming Joint Commission on the Accreditation of Healthcare Organizations accreditation survey.

Nursing Staff Concerned About the Consequences of Staff Shortage

Nursing staff were concerned primarily with (1) the effects nursing shortages were having on both staff and patients and (2) the perception that management was giving preferential treatment to some members of the nursing staff.

Nurses told us that staff shortages had resulted in long work hours, increased stress on the staff working those hours, and low morale. Registered nurse-to-patient ratios as low as 1 to 27 were cited on some units and shifts. Nurses also told us that staff shortages resulted in patient care that provided for the essentials but which some described as rudimentary and in some cases unsafe for patients and staff. Nurses also alleged that in some instances therapeutic treatments were not provided to psychiatric patients, at least one physician was not providing care to patients, and recreational and social activities were very limited due to the lack of staff available to provide them. We were also told that because of shortages nurses were often reassigned to work on units that were clinically unfamiliar to them.

Several nurses also identified what they believed to be unequal treatment of nursing personnel on the units. Specific examples included: (1) reassignment of eight highly skilled staff from a busy acute care unit to special programs, such as the day hospital, which left the original unit understaffed; (2) admission of overflow medical and surgical patients to

psychiatric and oncology units without increases in nursing personnel; (3) assignment of staff from closed long-term care units to psychiatry or acute medicine where they did not know how to care for the patients; and (4) the perception by nursing staff that those who raised concerns about staff shortages or assignments were often ignored, punished, or labeled as troublemakers by management.

Some nurses were also concerned about the lack of nurse education programs within the facility. The center's nurse education program was described as very limited in scope and not meeting the needs of the facility's employees. For example, we were told that in some cases nurses were assigned to care for patients with conditions for which they had no training.

Nursing staff also told us that the chief nurse acted on the premise that nurses should be able to work in any medical specialty area. They indicated that after some of the nursing staff refused to work in areas for which they did not have the clinical skills, the Nursing Service attempted to administer a competency test. They also stated that because of the competency testing, the regular staff development program for evaluating and updating skills was put aside to provide for remedial education programs. However, in response to pressure from the employee union and others, the competency testing was terminated within a month.

The performance of the chief of nursing during this period received mixed reviews by the nursing staff we interviewed. Some registered nurses were supportive of her efforts to address nursing issues. Others, however, believed that some of the initiatives she undertook to improve nursing were ill-conceived and had negative effects on nursing staff. Specific examples cited included: (1) an attempt to hide a camera in the day room of a psychiatric unit to monitor for potential incidents of patient abuse and (2) implementation of a competency test.

The chief of nursing told us that when she arrived at Salem in 1991 she found a number of problems ranging from the lack of a clear delineation of functional responsibilities to unusually high incidents of patient injuries on some units. Other troubling areas included problems in the performance levels of some nursing staff, a lack of nursing education opportunities, overuse of sick leave, lack of control over drugs and supplies, and what she considered to be a high rate of medication errors. Of equal significance to her, however, was the staff's general resistance to change.

The chief of nursing stated that she was also concerned about the effects these problems were having on the quality of patient care and she concluded that some type of nurse competency evaluation should be conducted to identify training needs among the staff and to demonstrate staff proficiency. To address this problem, she designed and partially implemented a competency testing program for nurses. The program was terminated because of union and staff resistance. The chief nurse told us that she installed a video camera in the day room of one of the psychiatric units to determine why a high incidence of patient injuries was occurring on the unit. To investigate, management decided to try surveillance.

Union Representative Contends That Management Exacerbated Nursing Problems

In April 1992, the president of the center's local employee union said that she was actively seeking the resignation of the medical center's director, chief of staff, and chief nurse. She told us that her concerns were twofold: nurse staffing shortages and ineffective management. Specifically, she told us that staff shortages had been allowed to accumulate since 1990 and nurse-to-patient ratios were allowed to decrease to unacceptable levels. As a result, nursing staff had experienced increasing stress and low morale. She stated that management had compounded the problem by failing to replace nurses as they retired and by moving nurses from patient care roles to administrative positions without providing replacements.

The president of the union also indicated that management supported several initiatives that the union believed were inappropriate. For example, the union opposed the medical center's support of a VA-proposed rural health initiative that would have allowed VA physicians to treat nonveteran patients. She stated that the union believed this proposal was inappropriate in an environment where the medical center did not have enough physicians to treat its own veteran patients. The union also opposed management's implementation of its nurse competency testing program because of questions about the need for such a program and fear over how testing results would be used against nursing staff. Because of the level of distrust with management within the center at the time it was implemented, this program was viewed with a high level of suspicion by most who would be tested.

A union press release stated that because persistent union efforts to address these problems with the center's management had been fruitless and communication had become ineffective, the union decided that the only recourse available to get their message heard was to go to the local media.

Quality Assurance Program Allegedly Understaffed and Minimally Effective

Personnel we interviewed that were either assigned to or had knowledge of the center's quality assurance program described it as being seriously hampered by (1) inadequate staffing, (2) insufficient staff with experience and training to perform required tasks, and (3) minimal support by center management and hospital services. For example, we were told by the quality assurance coordinator that only three staff were assigned to the Quality Management Office in October 1991 and that management had reassigned one of these staff to other temporary duties. In her opinion, this level of staffing was inadequate to perform the quality assurance functions necessary in a facility the size of Salem.

Some quality assurance activities were allegedly not being performed as required. For example, quality assurance plans were not updated in 1991, as required by medical center policy, and hospital-wide quality assurance reviews were not being performed in such areas as morbidity and mortality. We were also told that although some good quality assurance activities were taking place in some services, there was no structure to those activities and they were not being coordinated with the Quality Management Office for overall trending and analysis purposes. Further, some hospital services were resisting suggestions made by quality assurance personnel to correct identified deficiencies. Quality assurance staff told us that without major changes in the quality assurance program the medical center would not pass its next JCAHO accreditation survey.

Individual Perspectives Provided to the Review Team

Patients and families who requested interviews with us were most often concerned about specific aspects of their own or their relatives' cases. These interviews concerned situations in which physicians did not see patients as frequently as the patient or family thought they should or the patient was not making desired progress.[1]

Comments made by other center employees, including administrative and support personnel, focused on the shortage of staff within the center and the resulting stress and low morale it had caused. Comments were also made about difficulties employees were experiencing in getting needed education. Employees noted that confidentiality between personnel service and employees had been broken on some occasions and that trust levels were low. Several interviewees stated that they feared retribution from management if they questioned the way the hospital was being

[1]In later meetings with patients and family members, additional concerns were raised, such as patients being passed from one physician to another with little or no continuity of care, the lack of appropriate contact with family members, and uncooperative behavior of employees with both patients and their families.

managed. Some interviewees also raised questions about how some personnel decisions were made at the facility.

Perspectives of the Former Medical Center Director and His Chief of Staff

The former medical center director and chief of staff viewed their appointments in 1989 and 1990, respectively, to the Salem Medical Center as a mandate for implementing change. Thus, they aggressively pursued their initiatives and viewed staff resistance as unnecessary delaying tactics and an indication that they had to press the staff even harder. They also expressed frustration with what they believed was a lack of support and honesty from regional and central office officials in failing to share information about conflicts and problems they heard about the facility.

Comments From the Former Medical Center Director

The former medical center director told us that when he came to the center in 1989, he found a facility needing improvement in a number of areas, including quality assurance, resident supervision, psychiatry, pharmacy, and budget stabilization. He characterized his style of managing change as "total quality management" but admitted that if after being given several opportunities the staff did not implement changes he believed were needed he became "directive."

The director stated that during his 3-year tenure, the center had made a number of changes of which he and the center's staff could be proud. Some of those mentioned included increasing the psychiatric residency program from 2 to 4 years; attracting excellent physicians from the affiliated university, some of whom were board-certified in both psychiatry and medicine; moving ahead with the construction of and the eventual move to a new addition designed to house medicine, surgery, and outpatient services; supporting the VA-proposed rural health initiative, which would have allowed the center to provide services to nonveterans and for veterans to receive care from non-VA providers; and adding new services, such as laparoscopy, adult day care, hostel, and upgraded outpatient care.

The director stated that in retrospect he believes that the changes undertaken at the center had been too much too fast for the staff to efficiently implement. He also said that he recognized that the staff had no past experience in implementing the rapid change expected of them and this created much of the turmoil experienced in the facility.

Comments From the Former Chief of Staff

The former chief of staff stated that when he came to the medical center in November 1990, he found a facility needing to achieve 10 years of change in 2 years. He identified a number of changes needed, including expanding the ambulatory program and geriatric services, strengthening the nursing program, and controlling the pharmacy budget. He stated that one of the major driving forces behind his desire for rapid change in these areas was the realization that the facility would likely be scheduled for a JCAHO accreditation survey in 1993, and he was convinced that the facility as it existed at that time would fail.

The chief of staff described his management style as one of team-building and pointed to the changes made in the previous 18 months as evidence of the effectiveness of that style. He stated that before he initiated changes in any area, he consulted with experts within VA who helped set objectives and plan change. He indicated that his efforts to make changes in several areas were met with strong resistance and that to achieve goals in a very short time he used his position on several occasions to force action on his initiatives.

Management Is Addressing Staff Concerns

Employee morale at the Salem Medical Center has substantially improved since our first visit to the facility in April 1992. Much of this can be attributed to the actions of the new medical center director. Since his appointment in June 1992, the director has implemented a number of initiatives designed to (1) enhance communication between facility management and staff, (2) improve the working conditions of nursing staff, and (3) address identified problems.

Actions to Improve Communications Between Medical Center Staff and Management

The current medical center director has sought to open the lines of communication between staff and management and establish himself as an agent for change. His initial activities included meeting with the full union membership to explain his management style and answer their questions. He also invited small groups of medical center staff members to meet with him to discuss issues of concern to them. These actions received a positive response from the staff.

The director and the president of the American Federation of Government Employees (AFGE) at the facility have met on several occasions to establish lines of communication and to address common issues and problems. The director told us that he used these meetings to establish a fair and professional rapport with the union. The president of AFGE told us that since the new director's arrival, the working atmosphere in the center has greatly improved. She stated that the director emphasizes dealing effectively with people and maintains a policy that any topic can be openly presented and discussed. She stated that issues and complaints are given a fair hearing and there is now more of a spirit of compromise within the medical center.

The director has also conducted orientation and consultation meetings with each of the service chiefs, held group meetings with all other physicians, met with employees in their units and work areas, and visited waiting areas and units to assess patient satisfaction. The director told us that during these meetings and activities he attempted to demonstrate a personal concern for the employees, show his appreciation for work well done, and emphasize his intent to maintain an open door policy in which all employees feel free to share thoughts and concerns with him.

Medical center staff members, including the interim chief of staff and the president of the union, told us that the director's initiatives have been very successful in restoring a stable environment to the medical center and that his actions have been viewed very favorably by medical center employees.

They were appreciative of his open door policy and his fairness in considering problems brought to his attention. They indicated that employee attitudes in the facility have changed significantly since his arrival and that there is now more of a spirit of compromise.

Efforts Have Been Made to Improve the Working Conditions of Nursing Staff

The director has made an effort to correct the nursing shortage that has existed at the medical center for the past several years. Specifically, he has developed and implemented a recruiting program to fill nursing vacancies and has increased the number of authorized nursing positions. In July 1992, Salem initiated a nurse recruitment program with a goal of hiring 50 registered nurses and 32 licensed practical nurses by July 1, 1993. In September 1992, the recruiting goal for registered nurses was increased to 72 positions, and 24 nurse assistant positions were also added. As of March 8, 1993, Salem had hired 63 registered nurses, 28 licensed practical nurses, and 29 nurse assistants. However, between July 1, 1992, and March 8, 1993, Salem lost 15 registered nurses, 5 licensed practical nurses, and 3 nurse assistants. This resulted in net gains of 48 registered nurses, 23 licensed practical nurses, and 26 nursing assistants.

The nurse recruitment program focuses on identifying qualified candidates and streamlining and improving the hiring process. It includes help-wanted advertisements in the local and regional newspapers, direct mailings to all registered nurses and licensed practical nurses who live within a 250-mile radius of the medical center, open houses at the medical center, center officials' participation in job fairs, and an internal recruiting bonus program. Under the bonus program, employees are given $250 if they refer a registered or licensed practical nurse to Salem and that person is hired. An additional $250 is given to the referring employee if the new employee is still working 6 months later. Also, at the end of each calendar year the employee making the most successful referrals is awarded an additional $1,000 bonus. As of March 1993, 14 employees had received bonuses totaling $5,500 for referring 18 nurses for employment.

On September 29, 1992, the staffing levels increased for registered nurses from 215 to 240, for licensed practical nurses from 85 to 116, and for nurse assistants from 156 to 176. The following table shows the number of nurses authorized and on board as of July 13, 1992, and March 8, 1993, by type of nursing position.

Table III.1: Comparison of Authorized Nursing Positions With Filled Nursing Positions in July 1992 and March 1993

	July 1992		March 1993	
Nurse positions	Authorized	On duty	Authorized	On duty
Registered	215	203	242	228
Licensed practical	85	101	119	117
Assistants	156	148	176	169

Although recruiting goals could put the center's on-duty strength over the authorized ceiling, based on past experience, center officials assumed a 25-percent turnover rate for registered and licensed practical nurses between July 1, 1992, and June 30, 1993.

Identified Problems in Several Areas Are Being Addressed by the Medical Center Director

The new medical center director has taken action to address problems in several areas that have been identified to him. These areas include relations with the medical center's university affiliate, veterans service organizations, and the media; staffing of certain psychiatric units; and locating missing patients. He has also elevated the role of the chief of nursing to a position on his management team and has had the opportunity to fill several key positions on the medical center staff.

Many of the director's initial actions focused on strengthening relationships with those groups affiliated with the facility's operation. For example, one of his first meetings was with the Dean of the University of Virginia School of Medicine. The purpose of this session was to improve a relationship that had been deteriorating over the previous 18 months primarily due to differences over management styles. Both the medical center director and the dean of the medical school told us that these meetings were very successful in reestablishing good lines of communication between the two organizations.

The director also met on several occasions with veteran service organizations, such as the American Legion, Disabled American Veterans, and Paralyzed Veterans of America, to share information and receive advice. The director increased the frequency of meetings with these organizations to once a month instead of quarterly, and he characterized the response to speeches made before these groups as creating "unusual support" for the medical center.

Comments from representatives of these veterans service organizations concerning the atmosphere at the medical center under the new director have been positive. Representatives told us that the new director has

opened channels of communication and has been responsive to their needs.

Other efforts have been directed toward improving the public image of the facility. Upon arrival, the director met with the editorial staffs of the local television stations and newspapers to help ensure that information about the center is presented fairly and within the proper perspective. According to the director, this has resulted in much more balanced reporting on the medical center that has helped increase public confidence as well as improve employee morale.

To help alleviate some of the staffing shortages that psychiatric units were encountering, in July 1992, the director combined two units that had been serving psychiatric patients with similar types of dementia and behavior problems. By consolidating the two units, approximately 17 staff members were made available for reassignment to the consolidated psychiatric unit and other units that were experiencing shortages. These changes, plus the authorization of additional positions in fiscal year 1993, have resulted in improved nurse-to-patient ratios.

The director also expanded the medical center's top management team from three members (the director, associate director, and chief of staff) to four by adding the chief of nursing. He told us that he took this action because he believes that nurses, who represent the largest group of employees in the medical center, should be represented in the decision-making process of the center. He indicated that he had used this management approach effectively in the medical center where he had previously served as director.

A significant number of changes in key personnel positions have also occurred since the new director was appointed. Vacancies in these positions resulted from employee transfers to other assignments within the Salem facility, other VA facilities, another federal agency, and terminations due to separation or death. Each of these positions has been filled, at least on an interim basis, as shown in the following table.

Table III.2: Changes in Key Medical Center Personnel

Position	Date position filled	Status of change
Chief of Staff	06/30/92	Interim
Quality Assurance Coordinator	08/24/92	Permanent
Labor Relations Representative	09/06/92	Permanent
Chief of Police	10/18/92	Permanent
Chief Nurse	11/01/92	Permanent
Chief of Personnel	11/16/92	Permanent

The selection process for a permanent chief of staff has been completed, and a new chief of staff was selected in June 1993.

Measures Are Being Taken to Enhance the Center's Capability to Locate Missing Patients

Patients leaving the facility without the approval or knowledge of medical center personnel has been one of the most explosive issues Salem officials have faced. When the medical center director was assigned to the Salem facility in June 1992, a new patient-search policy had just been implemented. This policy defined procedures to be followed when a patient is reported as missing. In December 1992, the body of another missing patient was found on the grounds of the facility. This spurred the director to consider and implement additional measures to prevent patients from leaving undetected and to help find patients once they are reported missing.

In addition to preparing new search procedures for missing patients, center management determined that certain areas adjacent to the facility should be cleared of underbrush to eliminate hiding places and to make the grounds easier to search. These areas were cleared during the summer of 1992. In 1992, management also determined that new fencing was needed to prevent patients from wandering into wooded areas and out of sight. The fencing was installed in February 1993.

Under the director's guidance, the center also identified other security measures that have been implemented or are being considered to help reduce the instances of patient elopements or to help find missing patients quicker. The center has added spotlights to police search vehicles; required patients, known to be elopement risks, to wear color-coded wrist bracelets; refined the checklist used in searching for missing patients to better assign responsibility for search zones; installed flood lights around the center grounds; and arranged for search assistance from local counties

in the form of a search dog unit and volunteer search groups. Another measure being considered is the purchase of electronic alert bracelets.

Improvements Are Needed in the Medical and Nursing Care Provided to Patients

The quality of care received by some patients in the Salem VA Medical Center remains in need of substantial improvement. In the two short-term acute-care psychiatric units we visited, we found in many instances that patients' physical and psychological status were not assessed on admission to the unit, patients were without treatment plans, and no ongoing evaluation of patients or discharge planning was done. Also, patients on these units were not receiving active psychotherapeutic services, such as individual, group, or community therapies, or any of the other supportive therapies, such as art or music therapy. This situation was occurring because (1) certain psychiatrists were not providing care according to VA standards and (2) there were not sufficient numbers of psychiatrists, psychologists, psychiatric nurse specialists, social workers, and other multidisciplinary staff.

The nursing care provided in each of the seven patient units we visited also needs improvement. The care we reviewed did not meet nursing standards established by either the American Nurses' Association or criteria used by the Joint Commission on the Accreditation of Healthcare Organizations. In particular, for the cases we reviewed, nurses were not assessing the problems or needs of patients, planning for care, providing ongoing monitoring or evaluation of the response to nursing care, or providing discharge planning. This situation was due in large part to chronic staffing shortages. However, some staff did not provide complete nursing services, even when there was sufficient staffing. As a result, patients were at risk of having adverse outcomes.

Some Psychiatric Patients Were Not Receiving Active Medical Treatment

Acutely ill psychiatric patients were not receiving the level of services or active treatment necessary for in-patient short-term hospitalizations (under 30 days). Salem medical staff bylaws require that psychiatrists who admit patients to the acute short-term in-patient setting provide: (1) a written admission history, physical, diagnosis, and treatment plan for the patient; (2) ongoing monitoring and evaluation of the patient's response to medication and other treatments or therapies; and (3) a plan for the continued care of the patient upon discharge to the community. But our review of the medical charts of 10 patients in two acute care psychiatric units (five records from each unit) using a Health Care Financing Administration quality screen, discussions with staff, and personal observations, showed that certain attending psychiatrists were not performing these functions regularly. In addition, staff told us that often patients were not seen or adequately monitored by these physicians. They

also told us that patients received no therapies other than medications and, for some, kinesitherapy.[1]

Most patients hospitalized on the two acute care short-term units we visited were not receiving a complete medical history, physical examination, diagnostic testing, and treatment for symptoms that precipitated their admission to the VA. For example, our review of 10 patient records showed that 3 did not have notations of the circumstances leading to the patient's admission, the patient's chief complaint, or the reason for admission; 8 did not contain a relevant social history or any data from the patient's family or significant others; 9 did not specify the treatment modalities to be used; 10 did not cite any short-term and/or long-term treatment goals or reassessment dates; 9 did not contain progress notes indicating patient response to treatment; and 5 contained no indication that any discharge planning had been made for the patient. (See fig. IV.1 for additional data on our medical record review.)

The results of our medical record review represent more than just documentation problems. Nursing staff assigned to these units repeatedly stated that these functions were not being performed. The chief of psychiatry said that he was aware that certain psychiatrists were not providing required services and told us that he was counseling the involved physicians. Further, we also found that neither of the two short-term acute-care psychiatric units were providing structured therapeutic programs to patients. When we visited one patient unit, we noted that patients were sitting in the dayroom or were outside smoking. There were no signs of ongoing therapeutic activities during our visits.

We discussed our observations with nursing staff assigned to these units who told us that there were no therapeutic activities provided, only kinesitherapy. As a possible consequence, some of the patients in our review were readmitted to the acute care unit within 21 days after discharge.

The medical center's failure to assure that its standards and bylaws are being followed can have adverse consequences for the patient. The following is an example of what can happen when ongoing monitoring and evaluation of a patient's condition and treatment is not effectively carried out:

[1]The treatment of diseases by movement or exercise.

- We noted in a patient record that the nursing staff found that a female patient had a breast mass. A mammogram was ordered by the psychiatrist and performed in mid-August 1992 at a local hospital. The record indicates that over the next 2 months, the patient often screamed, cried, and expressed fears that she was going to die from cancer. During our review of the patient's record in mid-October 1992, we noted that the mammography results had not been obtained. We provided this information to the nursing staff and the new unit psychiatrist. Until we took this action, no one had reviewed the progress notes to determine (1) if this patient's concerns had any basis in reality and (2) the findings of the mammography.

The problems we identified on these units were occurring because (1) certain psychiatrists were not providing care as required by the medical center bylaws and (2) there are insufficient numbers of psychiatrists, psychologists, nurse specialists, social workers, and other multidisciplinary staff to provide needed therapy. The chief of psychiatry told us that five new psychiatrists would be hired by June 1993. In addition, he said that he was trying to hire more psychologists.

Care Was Improving on Extended-Stay Psychiatric Units

The quality of care provided in the two extended-stay psychiatric units we visited improved from the time of our first visit in April 1992. At that time, the number of nursing personnel available to staff both units was considered by the nurse managers and nurse practitioners working on these units to be inadequate. On one unit, the physical condition of the premises was poor and patients were not receiving appropriate care. In that unit there was only one part-time psychiatrist assigned to 38 patients, there were no doors on the toilet stalls or curtains on the shower area, and a strong smell of urine permeated the area. Further, patients on this unit were dressed in hospital gowns with open backs and were wearing a waterproof canvas diaper with a disposable inner pad. The diapers fit poorly around the patients' legs, and urine leaked out on the floor, creating a fall hazard for patients and personnel. The nurse practitioner and the nurse manager for this unit were particularly concerned about this situation and sought our assistance in improving the conditions. We subsequently discussed the situation with the acting director of the facility.

Our observations in October 1992 indicated that conditions on both units had improved. Each had more staff assigned and restrictions were placed on the types of patients that were admitted to the units. For example, one

unit admitted only patients with Alzheimer's disease or related dementias. Previously this unit had accepted the overflow medical/surgical and psychiatric patients from other units as well as dementia patients. In addition, patients who were previously given canvas diapers were provided disposable diapers and thus able to wear street clothes. Bathrooms had been improved to provide for privacy and safety.

We noted on the Alzheimer's unit the presence of a multidisciplinary team approach to patient care planning; that is, a team consisting of the geriatric nurse practitioner, members of the nursing staff, social worker, physician, physical and occupational therapy staff, and the dietician who work with the patient and families to plan patient care and specific treatment related actions (therapeutic interventions).

The result of such teamwork was noted in the chart of a patient with Alzheimer's disease who was very combative. The team worked with the family, staff, and patient and was able to change the patient's behavior by implementing several changes, such as providing the patient with his own room and personal furniture (he had been throwing other patients out of lounge chairs) and putting him in charge of certain tasks. The staff also approached this patient in a nonthreatening manner, which further decreased his combativeness.

Nursing Care Needs Improvement

The nursing care provided on seven patient care units we visited (four psychiatric, two medical, one surgical) needs substantial improvement. ANA and JCAHO standards and criteria reflect the nursing process that consists of (1) a systematic assessment of a patient's need for nursing care, including the need for continued care after discharge to the community; (2) a nursing diagnosis; (3) a plan for nursing intervention to meet the patient's needs while in the hospital and a discharge plan; (4) implementation of the plan; and (5) a reassessment of the patient's condition and response to therapy and nursing interventions.[2] JCAHO also requires that there be "sufficient qualified nursing staff members to meet the nursing care needs of patients throughout the hospital." However, our interviews with nursing staff, observations of the nursing care provided to patients, and a review of 35 patient records demonstrate that the nursing staff generally were not complying with nursing standards and criteria in providing patient care. As a result, many patients were admitted without

[2]See, Carol Taylor, Carol Lillis, and Priscilla LaMone, Fundamentals of Nursing: The Art and Science of Nursing Care (Philadelphia, J.B. Lippincott, 1989), pp. 245-249.

adequate assessments of their needs and subsequently discharged without planning for continued care.

Our review of 35 patient records showed that the majority of the nursing staff were not assessing, planning, implementing, or evaluating nursing patient care. For example, of the 20 psychiatric patient records we reviewed, 20 did not have complete nursing assessments, 11 did not contain a plan to meet the patients' nursing needs, and 14 did not record patient response to nursing interventions. (See fig. IV.2 for additional data on our patient record review.) Initially, we also noted that no therapeutic community group meetings, led by nursing or any other staff, were being held on the short-term acute-care psychiatric units (in October 1992 nurses were beginning to lead community meetings on one short-term unit).

Our review of 15 patient records on three medical surgical units identified similar nursing process problems. However, in these units we also found the nurses' notes were charted separately from physician and other disciplines' progress notes.[3] This creates a disconnect in communication that can lead to serious consequences for the patient when important observations are missed because the information is located somewhere else in the chart.

In July 1992, in a memorandum to the medical center's resources advisory committee, the chief nurse stated that nursing documentation of patient care was unacceptable and did not meet internal or external standards. She further stated that 60 percent of the time the registered-nurse-to-patient ratio on the acute psychiatric units was 1 to 38 and only a maintenance type of care existed on these units. She noted that the private sector had a 1 to 15 registered-nurse-to-patient ratio. With respect to medical surgical nursing, the chief nurse stated that the patients' severity of illness had progressively increased in recent years on these units and additional staffing was needed to meet JCAHO requirements. In September 1992, the medical center director approved hiring more nursing staff.

Although inadequate staffing may have played a significant role in the problems in nursing care, nursing assessment skills must also be enhanced. The chief nurse stated that such enhancements are needed to appropriately evaluate patients and prevent crisis in code situations (cardiac arrest) in all areas of the hospital. Several nursing staff also told

[3]On the four psychiatric units all members of the health care team wrote consecutive progress notes in the same section of the chart.

us that in-service education in areas such as orientation, clinical assessment, and discharge planning was lacking. Further, individuals who applied for continuing education programs were refused the opportunity because they could not be released from their duties.

When nursing assessments are not properly done, major problems or potential problems may be overlooked. For example, in assessing a patient's mental status on psychiatric, medical, and/or surgical units, the nurse should be aware of any factors that may be predictive of mental confusion or alterations in mood, such as: (1) age; (2) diagnosis and understanding of prognosis; (3) certain medications; and (4) changes in blood serum chemistries and arterial blood gases, especially for patients diagnosed as having some form of chronic obstructive pulmonary disease. When such factors go unaddressed in assessment or planning of care, situations may arise where patients wander off the units or become so agitated that they leave the unit against medical advice and may come to harm.

Nursing standards and criteria also require involvement of the patient in assessing, planning, implementing, and evaluating his or her care. In speaking with selected patients on these units we found that they knew very little about the nature of their illness, the medications they were taking, or how they would manage their care once they left the hospital.[4] In addition, the nurses knew little about the discharge planning resources available to them, and several nurses stated that discharge planning was the social worker's responsibility. However, JCAHO criteria state that discharge planning is a nursing responsibility. When discharge planning does not take place, patients are returned to the community with inadequate information or resources and may regress instead of recover. For example, the wife of a recently discharged patient called our office in April 1993 because her husband, who was dying, had been discharged to his home with an open decubitus ulcer (bed sore) on his lower back. The wife received no instructions on care of the ulcer and had not been referred to home care by the nursing staff or anyone else.

Many of the patients who come to the Salem Medical Center are elderly and when they are discharged are more likely to need services such as Meals on Wheels, home health nursing, physical therapy, and assistance with treatments that must be continued at home. The medical center has an office for two public health nurses from Roanoke City's public health

[4]In a July 1992 memorandum to the chairman, Resources Advisory Committee, the chief nurse noted that patient education programs are needed to provide proactive nursing practice and keep the patient in a state of wellness.

department. These nurses assist staff with planning the discharge for patients living in Roanoke and also for patients living outside of the city. None of the staff we spoke with knew of this service.

We presented this information to nursing administration at a meeting attended by the nurse managers of the seven units, the associate chief nurses for the relevant areas, the associate chief nurse for administration and quality assurance, and the chief nurse. They agreed with our findings. We also presented the information to the director and his executive staff and service chiefs.

Figure IV.1: Results of GAO's Review of the Quality Screening of 10 Psychiatric Patient Records

- Patient Assessment:
  a. 3 charts did not note the onset of illness, the circumstances leading to admission, the patients' chief complaint, or the reason for admission.
  b. 4 charts did not cite an admission or provisional diagnosis, including intercurrent diseases, plus psychiatric diagnosis.
  c. 4 charts did not include a physical examination and 1 chart had an inaccurate physical examination recorded.
  d. 6 charts did not have an assessment of mental status including an assessment of risk behavior, such as (1) danger to self and others, (2) self-care abilities, (3) affect, (4) perceptual disorders, and (5) cognitive fluctuations.
  e. 8 charts did not provide a relevant social history or any data from patient family or significant others.
- Treatment Planning:
  a. 5 charts did not include a diagnosis consistent with the treatment plan and findings.
  b. 10 charts did not cite short-term and long-range treatment goals or reassessment dates.
  c. 6 charts did not provide a plan for addressing behaviors that presented a risk to the patient and/or to others.
  d. 9 charts did not specify the treatment modalities to be used.
  e. 7 charts did not document any psychiatric or medical treatments, referrals, or other therapies.
- Ongoing Monitoring and Evaluation of Patient Status:
  a. 7 charts did not indicate any ongoing monitoring or evaluation of the treatment plan.
  b. 8 charts did not address special problems, behaviors or behavioral inconsistencies through ongoing evaluation of the treatment plans.
  c. 9 charts did not contain progress notes indicating patient response to therapy and treatment (medication was the only therapy provided).

- Medications:

  7 charts did not meet the screen for appropriate renewal of medications or evaluation of patient response to medications (after October 1, 1992, 2 of these charts had appropriate notations written by a new physician assigned to the unit).

- Physical and Mechanical Restraints:

  a. In 5 out of 8 charts where restraints were used, there was a physician order but not for every use, the use was not justified by the physician and there was no exploration of the use of less restrictive devices nor for the behavioral criteria necessary for termination.

  b. 1 chart did not indicate adequate supervision by staff while the patient was in restraints.

  c. 1 chart did not have a nursing summary every shift while patient was in restraints.

  d. 2 charts did not have a physician note assessing the need for continued use of restraints every 24 hours.

- Discharge Planning:

  5 charts indicated no discharge planning by the physician.

Figure IV.2: Results of GAO's Nursing Audit of 35 Patient Records

1. Assessment:
   a. 30 charts had incomplete or no assessments.
   b. Data collection sheets were used and were present on most charts but only 5 charts had assessments derived from the data collected. In addition, the data collection sheets were often incomplete, and 2 sheets contained inaccurate information.
   c. 26 charts contained no information from patient families and significant others.
   d. 13 charts either had no nursing diagnosis or the nursing diagnosis was not based on the identified patient care needs.
   e. The nursing notes for 28 charts did not indicate collaboration with the physician staff and other disciplines. The nursing notes on the medical-surgical units are separate from the physician progress notes.
   f. 21 charts did not reflect goals derived from the nursing diagnosis and/or were not made in concert with the patient, patient's family or other health care disciplines.
2. Plan:
   a. 25 charts did not have a nursing care plan that included priorities for nursing action. The records also lacked specifics as to who was responsible for carrying out the plan, and did not indicate whether the plan was communicated to the patient and/or family.
3. Implementation:
   a. 26 charts did not document nursing actions such as teaching, discharge planning, counseling, or guiding group therapies, or patient responses to such actions. Medications and vital signs were consistently charted.
4. Evaluation and Reassessment:
   a. 31 charts did not contain patient responses to nursing interventions or progress toward goals identified in the care plan or patient problem list.

Quality Assurance Program Needs to Be Strengthened

Every VA hospital is required to have a quality assurance program in place through which the care provided to patients is monitored, evaluated, and improved. Quality assurance program activities include examining and identifying the important aspects of care, collecting and organizing data, identifying quality-related problems and their causes, correcting these problems, and following up to see whether the problems recur.

At the time of our review in 1992, the quality assurance program in the Salem Medical Center was not achieving these objectives because staff in the Quality Management Office lacked the expertise to conduct an effective quality assurance program. In addition, the program did not have the full support of hospital management, and medical staff were not responsive to fulfilling documentation requirements.

Regional Reviews Showed That the Center Did Not Meet Fundamental Quality Assurance Requirements

VA regional office assessments of the quality assurance program conducted in March, April, June, and September 1992 found that (1) the center was not meeting fundamental JCAHO accreditation requirements with respect to documenting and reporting quality assurance activities and (2) the hospital administration did not emphasize quality assurance activities. Further, in a January 1993 mock JCAHO accreditation survey conducted by VA officials, the region found that while the center had made progress in correcting some of the deficiencies identified in the reviews conducted in 1992, problems still remained.

During its March 1992 visit, the regional review team found that the medical center was generally addressing VA quality assurance and JCAHO accreditation requirements. However, the regional team concluded that a lack of communication between center management and the medical staff was hampering medical center programs and compromising compliance with the quality assurance standards designed to identify opportunities for improving patient care services.

In April 1992, a more comprehensive review of the center's quality assurance program was conducted by regional office staff and additional problems were identified. Specifically the review found that although a quality assurance committee structure was in place, the clinical executive board[1] and several quality assurance committees were not discharging their responsibilities. The team also found that the minutes from meetings of the surgical and anesthesia service were poorly documented and did not

[1]The board is comprised of the chiefs of professional services and other key clinical staff. It coordinates, evaluates, and improves patient care programs and makes recommendations to top hospital management.

show consistent follow-up on recommendations that were made. Further, they found little evidence that quality management data from quality assurance activities was merged to present an overall picture. The regional team cited the latter as an overall facility-wide problem that stemmed from a poorly organized quality management office and inexperienced staff.

During this review, the regional team also found that the surgical service's quality management plan[2] was poorly structured and would not meet JCAHO standards. While the team acknowledged that the service conducted several excellent activities, such as morbidity and mortality reviews and surgical infection control, the documentation and data required to support these activities were either not prepared or were poorly presented. The regional team praised the surgical service's morbidity and mortality conference, citing an excellent exchange among the participants, but noted that the information that resulted from the conferences was not channelled into the center-wide quality management processes.

In June 1992, a follow-up visit by the regional team focused on the medical center's ability to meet JCAHO standards in areas such as medical staff monitoring and evaluation, surgical case review, nursing care, pathology services, and surgery and anesthesia. The team reported that the facility was not prepared for the upcoming July 1993 JCAHO survey and could not meet basic quality assurance program documentation requirements. Other areas cited as deficient included the structure of quality assurance committees and the reporting of quality assurance data to center management.[3]

According to the region's report, the situation was exacerbated by the staff's lack of knowledge of fundamental JCAHO requirements, which in turn inhibited the center from conducting a viable quality assurance program. The report further stated that (1) the Quality Management Office lacked direction and was not accomplishing the necessary technical support and coordination to conduct a successful quality assurance program that corrects identified deficiencies and (2) prompt remedial actions were necessary to prepare Salem for their upcoming JCAHO accreditation survey.

[2]A written quality management plan identifies the mechanisms for monitoring and evaluating the quality and appropriateness of care provided at a facility. Each hospital service develops its own written plan, which is integrated into a facility-wide plan.

[3]Quality assurance data such as morbidity and mortality reviews must be collected for at least 12 months before a JCAHO survey to receive an acceptable score.

At the conclusion of the June 1992 review, the regional team recommended that the medical center take immediate action to provide appropriate direction, technical training, and staff support to comply with JCAHO standards. The team also recommended that responsibility for the Quality Management Office be transferred from the chief of staff to the medical center director and that appropriate mechanisms be developed to ensure effective communication between the chief of staff and the medical staff.

In September 1992, the regional team conducted another follow-up visit to determine the medical center's progress in correcting previously identified deficiencies. The team also reviewed the organizational structure of the quality assurance program. The team found that the medical center had hired an experienced quality management coordinator who was implementing changes where needed. The team also noted that after discussions with the new medical center director, associate director, and acting chief of staff, it was confident that quality management efforts would now have the complete support of top management.

The regional team also found that substantial progress had been made in correcting problems previously identified in medical services, ambulatory care, and medical records. However, the quality management staff had experienced only limited success in getting service chiefs involved in quality assurance activities. The regional team noted that the medical staff was eager to provide quality patient care but was not enthusiastic about documenting the provision of this care. As a result, the team noted that documentation was often deficient. The team concluded that the staff's attitude reflected the perception that documentation is an intrusion and someone else's responsibility.

In January 1993, the regional team conducted a mock accreditation survey to determine the center's compliance with JCAHO standards. The survey report indicated that the center had made significant progress in meeting JCAHO standards when compared to the first review in March 1992, but noted that much work must still be done. In the team's opinion, this would be a formidable task given that JCAHO requires a 1-year record of compliance in order to comply with its standards.[4] But the team reported that it was particularly impressed with the quality management unit at the facility and concluded that they had grown through adversity and were favorably responding to new leadership.

[4]JCAHO surveyed the Salem Medical Center in July 1993.

GAO's Review Identified Problems With Center's Quality Assurance Program

Our review of selected aspects of the center's quality assurance program showed that certain quality assurance monitoring activities need to be improved. From October 1990 to January 1992, the Office of Quality Management was understaffed and quality assurance activities were limited. Further, when additional staff were assigned in February 1992, they lacked knowledge in fundamental quality assurance requirements and did not have the experience needed to conduct a fully effective program. As a result, the center's quality assurance program foundered. For example, at the time of our review, morbidity and mortality reviews conducted by the medical and surgical services were not analyzed to determine if medical center practices or procedures were resulting in unnecessary deaths or illnesses. In addition, physicians did not always document important patient information, such as patient responses to treatment or the justification for the use of restraints. Finally, the autopsy rate had declined significantly from September 1991 to September 1992, but no action was taken to determine why this decline had occurred.

The Quality Management Office is responsible for integrating quality assurance activities throughout the facility, monitoring these activities, educating staff in quality assurance requirements, and providing technical support to carry them out. But at the time of our review quality assurance data were not always analyzed and shared on a facility-wide basis because some hospital services were not providing appropriate data to quality assurance personnel. Further, few attempts to analyze quality assurance data for trends were being made, and guidance and technical support to departments and services was limited because of the lack of experience and knowledge of Quality Management Office staff.

JCAHO requires that relevant results from quality assurance activities be used to study and improve processes that affect patient care outcomes. To do this, however, relevant results must be communicated to the Quality Management Office for evaluation to identify trends and patterns of patient care and opportunities to improve it. However, the medical and surgical services did not share the results of morbidity and mortality[5] reviews but kept them filed in the service.

During mortality and morbidity reviews, physicians discuss the appropriateness of care provided and any unusual circumstances related to the case. As a result of these discussions, a determination is made as to whether the death could have been attributable to improper medical

[5]Morbidity reviews are performed in instances of adverse events, such as infections or other complications, that are unrelated to the natural course of the disease or illness.

procedures and practices. The center's medical service reviewed two patient deaths per month that occurred within the service. The surgical service conducted morbidity amd mortality reviews on all deaths occurring within that service each month. But the results of these reviews were not reviewed and analyzed by the Quality Management Office because the services did not provide the resulting information to that office.

Both VA policy and JCAHO standards require that the use of restraints be reviewed regularly by both psychiatric physicians and nursing staff to ensure that such use is appropriate, clinically justified, and judiciously prescribed. Documentation in patient records should include the justification for using restraints, the efforts made to calm the patient before using restrictive measures, prior interventions, and patient response. But our review of medical records in October 1992 showed that the use of restraints was not always justified in medical records, as VA requires. In our review of psychiatric patient records, two out of eight charts indicating use of restraints contained no justification for use. In addition, five charts did not have a physician note justifying continued use of restraints beyond 24 hours.

The psychiatry service is aware that its psychiatrists are not always adequately documenting the use of restraints. During 1991, as part of the service's quality assurance efforts, the chief of the service reviewed the medical records of all patients who had been placed in restraints three or more times in a week or for more than 24 hours. The chief stated that his review showed that physicians do not always properly document the use of this medium of care, and he counseled them on several occasions about the deficiency. The service's 1991 quality assurance meeting minutes also documented deficiencies in medical records regarding the use of restraints. For example, the minutes of the April and September 1991 meetings state that physicians were not recording a justification for their use of restraints in some of the medical records.

Autopsies provide important information on discrepancies between clinical diagnoses and postmortem findings. These data provide quality assurance personnel with an indicator of the quality of care being provided at the facility. Our analysis of autopsy data showed that the rate of autopsies performed at the facility significantly declined from 1991 to 1992.

Table V.1: Comparison of the Number of Deaths With the Number of Autopsies Performed

Period	Number of deaths	Number of autopsies	Autopsy rate
04/01 - 09/30/91	143	31	21.68
10/1/91 - 3/31/92	156	23	14.74
04/01 - 09/30/92	161	22	13.66

Between January 1 and August 29, 1992, the medical center conducted 29 autopsies. Autopsy findings are graded into five categories, but findings may be applicable to more than one category. Of the 29 autopsies performed, there were no major disagreements between premortem and postmortem diagnosis; 7 of the 29 autopsies were categorized as a "major unsuspected or additional diagnosis," which is used to identify an additional illness that was not the primary cause of death and would not have altered the patient's treatment; and 10 others were categorized as "significant clarification of differential diagnosis," which means that the attending physician was unsure of the patient's medical problem. The differential diagnosis category is used when one or more illnesses may be present in the cause of death but diagnostic tools do not allow the physician to differentiate among them. Twenty-one autopsies confirmed or verified the major diagnosis and one autopsy was categorized as indeterminate.

The interim chief of staff was concerned about the declining autopsy rate but was not sure why it declined. He said that the laboratory had sufficient resources to perform many more autopsies than were currently being done.

To reverse the declining autopsy rate, the interim chief of staff stated in September 1992 that he would require service chiefs to stress the importance of autopsies. He said that the center has not established an autopsy rate goal but that he will monitor the number performed in 1993 and will take steps to assure an increase.

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

AUG 5 1993

Mr. David P. Baine
Director Federal Health Care
Delivery Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Baine:

This is in response to your draft report, **SALEM VA MEDICAL CENTER: Labor-Management Relations Improved But Quality of Care Problems Need To Be Corrected** (GAO/HRD-93-108). This report reviews selected aspects of the center's quality assurance program; nursing care being provided in various psychiatric and medical/surgical units; and identified initiatives being taken by hospital management to address problems. I concur with the recommendations in the report and I am confident that the actions already taken and those planned by the medical center personnel will not only address your concerns, but will also result in continuous improvement in the quality and appropriateness of care provided by the medical center.

I believe the efforts undertaken and planned by the medical center are responsive to your recommendations. Enclosure (1) details actions taken on the recommendations, and Enclosure (2) suggests some technical changes to the report. Thank you for the opportunity to comment on this report.

Sincerely yours,

Jesse Brown

Jesse Brown

Enclosures
JB/grj

Enclosure (1)

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT, **SALEM VA MEDICAL CENTER: Labor Management Relations Improved but Quality of Care Problems Need to Be Corrected**
(GAO/HRD-93-108)

GAO recommends that I direct the Under Secretary for Health to require the Salem Medical Center Director to:

-- **review the psychiatric care being provided at the facility and take the necessary action to assure that it meets medical center by-laws.**

Significant actions have been taken to improve the psychiatric care being provided at Salem. The medical center has hired eleven full time and four part time psychiatrists in the last two years. Five of the new employees were Chief Resident graduates; four are either double-board certified or double-board eligible in medicine and psychiatry; one has sub-specialty qualifications in geriatric psychiatry; one has special expertise in addictionology; another has expertise in sleep disorders; and one employee was the recipient of the Laughlin Fellow (awarded for outstanding promise in psychiatric research). Additional staff in psychology, social work and nursing have also improved the quality of care provided. These enhancements, plus a major focus on the activities and therapies provided to patients and the interdisciplinary coordination of these areas, have improved Salem's psychiatric care. Emphasis on documentation, policy and review of care provided has resulted in more effective monitors and improved quality assurance activities.

-- **identify the learning needs of the nursing staff and implement in-service education programs to reinforce the need to comply with nursing standards and criteria.**

Medical center management has addressed the learning needs of nursing staff through a coordinated consideration of staffing; nursing processes; standards; physician/nursing collaboration; nursing climate; and education. This coordinated approach has resulted in meeting the learning needs of staff while providing the framework for focusing on the complete nursing environment. This approach has led to significant and ongoing improvements in all of the identified problem areas.

-- **adequately staff the quality assurance office and require that quality assurance findings developed by that office are reviewed and analyzed on a facility-wide basis.**

Enclosure (1)

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO GAO DRAFT REPORT, SALEM VA MEDICAL CENTER: Labor Management Relations Improved but Quality of Care Problems Need to Be Corrected
(GAO/HRD-93-108)
(Continued)

The quality management office is now staffed with 15 full time employees (there were three in 1991). The increase in staff has allowed for significant overall improvement in the scope and depth of the Quality Assurance program at the medical center. There are regular reviews of Quality Management (QM) findings at the service level, the Quality Improvement Board, and appropriate executive committees. In addition, the QM Coordinator plays a major role in communications with top management at the medical center.

-- require service chiefs to enforce requirements calling for complete and accurate medical records.

Major emphasis by the Chief of Staff on enforcing the requirements for complete medical records, and the support of Service Chiefs and Medical Administration Service in this effort, have significantly improved the quality and timely preparation of medical records. Acquisition of new equipment and outside transcription services have been instrumental in improving record management, as has development of the primary care team concept. In addition, the medical center has established a task force to resolve other medical record issues. The results of the medical center's efforts are such that the number of delinquent medical records has been reduced to 29%, well within the 50% Joint Commission on Accreditation of Healthcare Organization criteria.

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