Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues and Staffing Deficiencies John J. Pershing VA Medical Center Poplar Bluff, Missouri

Report No. 08-02516-178 **July 29, 2009**

VA Office of Inspector General
Washington, DC 20420

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections reviewed allegations regarding complaints that the John J. Pershing VA Medical Center (the medical center), Poplar Bluff, MO, failed to hire a psychiatrist in a timely manner causing delays in patient care, and that nursing staff transported patients requiring one-to-one nursing care by government vehicle to another VA medical center 3 hours away without reliable means of communication in the event of an emergency.

We substantiated the allegation that the inability of the medical center to hire a psychiatrist in a timely manner led to delays in patient care. The medical center had not had a full-time psychiatrist since November 15, 2006, despite aggressive recruitment activities. The position was very difficult to fill due to the rural location of the medical center and the lack of an affiliation with a major medical center. The position was finally filled in July 2008. This had largely eliminated the delays in patients' obtaining mental health appointments. In addition, the medical center was in the process of hiring a new Program Manager for Mental Health. That position was filled March 1, 2009, when a clinical psychologist was hired.

We substantiated that licensed practical nurses (LPNs) were transporting patients who required one-to-one nursing care to another VA medical center 3 hours away with no reliable means of communication. Medical center leadership recognized these issues and purchased satellite phones, a medical bag with basic first aid equipment, and barriers to place between the front and back seat. Since our site visit, the medical center has a new Acting Director who, upon learning of the process, contracted with the local ambulance company; they started transporting these patients on April 1, 2009.

We found that the new Behavioral Health Lab Supervisor and the new LPNs in the mental health clinic lacked appropriate training in the treatment of mental health patients and governing policies and procedures. All personnel have since received training in the care of the mental health patient, to include an introduction to the Behavioral Health Lab concept and management of disruptive patients. In addition, the Supervisor of the Behavioral Health Lab has completed supervisory training, and new policies and procedures for the Behavioral Health Lab and the mental health clinic had been implemented.

We made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network 15

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues and Staffing Deficiencies at the John J. Pershing VA Medical Center, Poplar Bluff, Missouri

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding complaints that the John J. Pershing VA Medical Center (the medical center), Poplar Bluff, MO, failed to hire a psychiatrist in a timely manner causing delays in patient care. Also it was alleged that nursing staff transported patients requiring one-to-one nursing care by government vehicle to another VA medical center 3 hours away without reliable means of communication in the event of an emergency. The purpose of this review was to determine whether these allegations had merit.

Background

The medical center is a non-affiliated facility located in Poplar Bluff, MO. It is 150 miles south of St. Louis, MO, and 156 miles north of Nashville, TN. Poplar Bluff has a population of about 17,000, and the medical center service area supports about 50,000 veterans. The medical center has 18 acute medical beds and 40 extended care beds. Tertiary care support is provided by VA medical centers located in St. Louis and Columbia, MO; Memphis, TN; and Little Rock, AR. Four community based outpatient clinics (CBOCs) in Cape Girardeau, West Plains, and Farmington, MO; and in Paragould, AR, provide primary care and mental health services. Subspecialty service needs are met by local fee basis consultants and referrals to tertiary care facilities and through telehealth. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Scope and Methodology

We conducted a site visit August 20–24, 2008. Prior to our visit, we interviewed the complainants via telephone. During our site visit, we interviewed staff familiar with the

mental health clinic, and we reviewed staffing documents, relevant policies and procedures, and patient medical records.

Results

Issue 1: Staffing Deficiencies

We substantiated the allegation that the inability of the medical center to hire a psychiatrist in a timely manner led to delays in patient care.

The medical center had not had a full-time psychiatrist since November 15, 2006. Psychiatric coverage was met through the use of contracted psychiatrists, tele-mental health, a part-time VA psychiatrist, and a psychiatric nurse practitioner. In November 2006, the medical center received approval from the VISN to hire a full-time psychiatrist. Starting in February 2007, the medical center advertised for a full-time psychiatrist on USAJOBS, the Federal Government's official job site.[1] The posting lasted for 14 months but the medical center did not find a candidate. Starting in May 2008, the position was advertised in major newspapers throughout the United States and in seven major medical and psychiatric journals. In addition, the VA authorized the medical center to use various financial incentives to successfully hire a psychiatrist. The position was very difficult to fill due to the rural location of the medical center and the lack of an affiliation with a major medical center.

The psychiatrist position was finally filled in July 2008, and the new psychiatrist had been on the job for 2 weeks at the time of our visit. In addition, the medical center was in the process of hiring a new Program Manager for Mental Health. That position was filled in March 1, 2009, by a clinical psychologist. Medical center staff reported that the hiring of the psychiatrist had largely eliminated the delays in patients' obtaining mental health appointments.

We identified a period from November 20 to December 30, 2007, when there was no mental health provider with prescriptive authority available to see patients. The VA CBOC psychiatrist who saw a majority of the mental health patients had to take emergency leave out of the country. This drastically reduced the number of mental health providers available to see patients. Also, because of the provider's absence, the nurse practitioner who provided clinical care for patients was unable to prescribe medications. State law[2] prohibits nurse practitioners from prescribing medications if they fail to maintain a geographic proximity with their supervising physician.

[1] http://www.usajobs.gov/.
[2] Mo. Rev. Stat. §334.104 (2008).

The mental health clinic cancelled or rescheduled most of the appointments during this timeframe. This led to delays in patients' getting medications refilled and delays in seeing a mental health provider. We reviewed the records of 60 patients whose appointments had been cancelled and rescheduled and found that 24 patients had new appointments scheduled within 3 months, 24 had appointments scheduled between 3 and 6 months, and 12 had appointments beyond 6 months.

The medical center attempted to cover staff shortages using a part-time VA psychiatrist and tele-mental health. In addition, a refill clinic led by a pharmacist was established, and patients could obtain refills if they had no reported side effects to the medication, had taken the medication as ordered, and had a primary care doctor at the medical center. We reviewed the medical records for 10 patients who had their appointments cancelled in December 2007 and from August 2008 to January 30, 2009. We did not find any documentation that appointments had been cancelled by the clinic, and follow-up appointments were within the timeframe recommended by the provider.

Issue 2: Patient Transportation

We substantiated that licensed practical nurses (LPNs) were transporting patients who required one-to-one nursing care to another VA medical center 3 hours away with no reliable means of communication.

The medical center sends patients to the local community hospital when they require acute inpatient mental health services that the medical center cannot provide. If patients agree to voluntary admission to an inpatient psychiatric facility, the medical center will transport these patients to the St. Louis VA Medical Center, which is 3 hours away. The local Poplar Bluff ambulance service was unwilling to transport these types of patients, reportedly because it would leave the entire town with only one ambulance for all other emergencies for a 6-hour or greater period of time. In order to transport these patients to St. Louis for care, the medical center sends the patient with an LPN as an escort in a government car with a driver. The trip to St. Louis involves a drive on a two-lane highway through remote countryside where there is approximately 80 miles without cell phone coverage. There is no barrier for protection, separating the LPN escorting the patient and the driver from the patient, in the event that the patient's behavior becomes erratic. The patient and the LPN sit in the back of the car. If at any time during the drive the patient requests to be let out, the driver must let him or her out; this seldom happens.

LPNs reported they had not been trained in emergency procedures for handling a patient who becomes agitated or violent and did not have any basic first aid equipment for use during transport. The previous Program Manager for Mental Health stated that there had not been any adverse incidents during these transports. If the medical staff slated to escort or drive the patient feel that the patient is too dangerous to transport, they can refuse to complete the transport.

Medical center leadership recognized these issues and purchased satellite phones, a medical bag with basic first aid equipment, and barriers to place between the front and back seat. Since our site visit, the medical center has a new Acting Director, who upon learning of the process set up a contract with the local ambulance company which started transporting these patients on April 1, 2009.

Issue 3: Staff Training and Policy Development

We found that the new Behavioral Health Lab[3] Supervisor and the new LPNs in the mental health clinic lacked appropriate training in the treatment of mental health patients and governing policies and procedures.

The medical center had staffed the mental health program with 23 people, under the direction of a Program Supervisor for Mental Health; this had been a licensed clinical social worker who had 18 years of mental health clinical social worker experience. The staff of 22 included nurse practitioners, psychologists, clinical social workers, registered nurses and LPNs (10 of whom were added in the 6 months prior to our visit). Many of the new staff, including the Supervisor of the new Behavioral Health Laboratory, had no mental health experience. With the increase in staff and the addition of a new program, there was also a need to develop new policies and procedures and to orient and train staff. This had not been accomplished.

During a telephone interview with the new Acting Medical Center Director on April 9, 2009, the Acting Director stated that all personnel had received training in the care of the mental health patient, to include an introduction to the Behavioral Health Lab concept and management of disruptive patients. In addition, the Supervisor of the Behavioral Health Lab had completed supervisory training. New policies and procedures for the Behavioral Health Lab and the mental health clinic had been implemented.

Conclusions and Comments

The medical center took reasonable actions to hire a psychiatrist; however, due to the remote location of the medical center, this process took more than a year. This led to delays in patient care. We make no recommendations as the situation has been resolved by hiring a psychiatrist. We also found that patient transports were occurring in vehicles lacking appropriate first aid and safety equipment and with no reliable means of communication. The medical center has resolved these issues. Lastly, we identified a need for the medical center's new Supervisor of the Behavioral Health Lab and the new LPNs in the Mental Health Clinic to receive training in care of patients with mental

[3] A Behavioral Health Laboratory is a mental health assessment unit; Poplar Bluff VAMC's Behavioral Health Lab is an outpatient program which serves only that facility.

health disorders and for policies and procedures for the mental health clinic and Behavioral Health Lab; the training and policies have been completed. We made no recommendations in this report.

Comments

The VISN and Medical Center Directors agreed with our findings and conclusions. (See Appendixes A and B, pages 6 and 7).

(original signed by Dana Moore, Ph.D., Deputy Assistant Inspector General for Healthcare Inspections for:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 9, 2009

From: Director, VA Heartland Network, VISN 15 (10N15)

Subject: **Healthcare Inspection – Quality of Care Issues and Staffing Deficiencies at the John J. Pershing VA Medical Center, Poplar Bluff Missouri.**

To: Director, Washington DC, Regional Office (54DC)

I have reviewed the issues outlined in the draft report and will use this as an opportunity for improvement in these areas.

(Original signed by :)

James R. Floyd, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 9, 2009

From: Acting Medical Center Director, John J. Pershing VA Medical Center

Subject: **Healthcare Inspection – Quality of Care Issues and Staffing Deficiencies at the John J. Pershing VA Medical Center, Poplar Bluff Missouri.**

To: Director, Veterans Integrated Service Network (10N16)

Thank you for the opportunity to review the draft report from the VA Office of the Inspector General (OIG), Office of Healthcare Inspections, regarding the site review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri, on August 20-24, 2008. The review did not generate any recommendations.

(Original signed by :)

Judy K. McKee, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Nelson Miranda, Director Washington, DC, Regional Office (54 DC) 202-461-4665
Acknowledgments	Donna Giroux Randall Snow

Appendix D

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