Administrative Closure
Healthcare Inspection, Alleged Medical /Surgical Unit Staffing Deficiencies, Charles George Veterans Affairs Medical Center, Asheville, North Carolina.

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to review allegations made by a complainant that patient care was compromised due to inadequate nurse staffing on a medical/surgical unit at the Charles George VA Medical Center (the facility) in Asheville, N.C.

A complainant alleged that during a Joint Commission (JC) February 2011 site visit, the facility used overtime to increase nurse staffing to one nurse caring for three patients. The usual nurse staffing on this unit was reportedly 1 nurse caring for 5 patients on day shift and 1 nurse caring for 10 patients during the night shift. The complainant alleged that because of this staffing, patients are not turned, hygienic care[1] is neglected, and the infection rate is higher than usual.

We conducted telephone interviews during June 22–July 14, 2011, with VA Central Office personnel, the facility Associate Director, and the facility Associate Director for Patient Care Services. We reviewed relevant VHA, VA, and facility policies and procedures. In addition, we reviewed nurse staffing documents, certified time sheets, infection rates, medication error rates, acquired pressure ulcer rates, fall occurrences, and other administrative documents. We reviewed medical records of 20 patients admitted on the medical/surgical unit during February 2011.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

The medical/surgical unit (the unit) is an 18–bed unit providing post-surgical care to patients following cardiac, urological, and general surgery procedures. In addition, the unit provides care to patients diagnosed with congestive heart failure and general medical conditions.

The unit staffing needs are individualized to specific clinical settings and do not rely solely on fixed staffing models. At the time of our review, VHA was implementing a new directive that had been instituted July 2010.[2] All facilities were required to fully implement the directive no later than September 30, 2011. The staffing methodology used in this directive requires the "...systematic collection of a minimum set of core evidence-based data to

[1] Hygienic care encompasses oral care, skin care, cares after incontinence and clean linens and environment.
[2] VHA released VHA directive, 2010–034, *Staffing Methodology for VHA Nursing Personnel, July 19, 2010.*

support staffing decisions and a foundation of professional judgment, critical thinking, and flexibility, with an emphasis on patient or resident outcomes."[3] The staffing methodology provides formulas for determining long range planning and budget projections for staffing. In addition, it defines the steps a facility must take to determine the appropriate levels of nursing staff at all points of care. The directive eliminates the use of the "...1980's VA patient classification system in Automated Management Information System (AMIS), also known as VISN Workload Measurement (VWM), as it is an outdated system and does not accurately measure the complexity of care. Additionally, the directive "finds no other evidence-based patient acuity data is currently known or available for acute care."[4]

Under this methodology, nursing staff and the nurse manager from each unit are part of a unit based expert panel. This panel gathers and analyzes evidenced-based data on factors impacting direct patient care on their unit. Using this data, they project the required number of Nursing Hours Per Patient Day (NHPPD). Once approved by the facility expert panel, this becomes the target for NHPPD on this unit. However, other factors may impact this target, such as changes in patient condition, treatments, discharges and admissions, one to one care, nursing illness, and requested time off. Data on changes to the NHPPD target is collected and used to adjust the daily and annual predictions of NHPPD.

The facility's local nurse staffing Standard Operation Procedure (SOP)[5] states that it is the nurse manager's responsibility to identify shift-to-shift nursing shortages and to ensure there is adequate staffing to care for their unit's patients. The facility policy on Special Work Assignment Teams (SWAT) provides guidance on using nursing reserve pools to cover shortages on the unit when there are insufficient nursing personnel assigned to the unit.

Issue 1: Staffing

We did not substantiate the allegation that overtime was granted to increase nurse staffing to one nurse caring for three patients during a JC February 2011 site visit. We reviewed the medical/surgical unit's daily assignments, certified time sheets, and the NHPPD. During the week of the JC site visit, nurse staffing on days was one nurse caring for four or five patients; on nights, it was one nurse caring for eight patients. We did not find any instances of one nurse caring for three patients during February. We found that the facility used overtime for patients requiring one on one observation, or to alleviate personnel situations such as sick call, or when a nurse resigned. We did not find an increase in the use of overtime or the SWAT team during the week of the JC visit. We found that the unit nurse manager adjusts staffing based on the needs of patients and the

[3] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010
[4] VHA Directive 2010-034
[5] Charles George VA Medical Center SOP 3.8 *Work Scheduling and Time Planning,* January 2011

availability of unit nursing personnel to fill vacancies due to employee absence or increased patient care needs. When unit staff cannot fill in, SWAT team members assist with patient care on the unit.

Medical Records Review

We reviewed the nursing documentation for 20 patients to evaluate the frequency of patient evaluations. According to local policy, nursing documentation in the medical record is required at least once every 24 hours.[6] However, the facility policy states that documentation every 8 hours is preferred and is necessary when there is a significant change in the patient's condition or diagnosis, when the patient transfers to another area of the facility, changes level of care, after invasive procedures, or when there is a need to observe more closely than usual or patient response to an intervention.

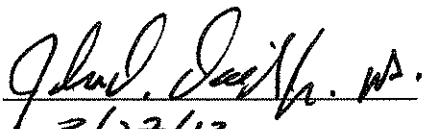
Every medical record we reviewed was in compliance with the local documentation policy. All records contained documentation of nursing reassessments of patient condition at least every 24 hours. Sixteen of the 20 medical records contained documentation of nursing reassessments every 8 hours.

Issue 2: Patient Care

We did not substantiate the allegations that because the number of patients assigned to one nurse was greater than three, patients were not appropriately turned, patients did not receive proper hygienic care, or that the facility's infection rate was higher than usual.

We reviewed the facility bloodstream infection rate data and found that there was no increase during February 2011. In addition, we found no increase in the fall rate or the acquired pressure ulcer rate.

We did not substantiate the allegation that overtime was granted to meet nurse staffing of one nurse caring for three patients on a medical/surgical unit during a JC site visit. We found no instances of a nurse caring for only three patients or for more patients then established ratios, and found no increase in the facility infection rate. We made no recommendations.

Approved  3/27/12

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[6] Nursing Service SOP 4.3(57), *Nursing Documentation in Acute Care*, January 2011.