Administrative Closure
Alleged Patient Safety Issues
The Villages Outpatient Clinic (573/GI)
The Villages, FL, USA
MCI# 2012-04621-HI-0456

The VA Office of Inspector General (VA OIG) Office of Healthcare Inspections (OHI) received allegations from a complainant regarding patient safety concerns at The Villages Outpatient Clinic (OPC), The Villages, FL.

The complainant alleged that:

- Staff in the mental health clinic (MHC) had been told not to document certain information in patient's medical records, such as abnormal vital signs (i.e. high blood pressure), critical patient statements (i.e. expressions of suicidiality), and clinical reminders.

- Staff in the MHC were concerned that not all patients had their vitals taken, particularly when Mental Health technicians were asked to perform clerical duties.

- MHC staff had been instructed to wait until a physician was done with a patient session before reporting critical events to that provider.

- Unqualified personnel had been asked to perform tasks beyond their scope, such as patient triage or writing MHC standard operating procedures.

- Patients were not processed appropriately, with some patients turned away without being seen.

(b)(3):5 U.S.C. App 3 (IG Act):(b)(6):

We interviewed the complainant by phone on October 15, 2012. We interviewed the (b)(6),(b)(7)(C) by phone on October 24, 2012, and again, while on site, on November 5, 2012. A second (b)(6),(b)(7)(C) was interviewed by phone on October 25, 2012, and again, while on site, on November 5, 2012. During our onsite visit, other clinical, administrative, and leadership staff in the OPC with knowledge of the MHC operations were also interviewed. This included the Program Support Assistant (PSA), Nurse Practitioner, and Medical Director for the MHC. On November 6, 2012, we interviewed the Acting Director for the Mental Health Service Line at the parent facility (Malcolm Randall VA Medical Center, Gainesville, FL).

Interviews revealed that (b)(3):5 U.S.C. App 3 (IG Act):(b)(6):
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reviewed the Position Descriptions (PDs) of the technicians and found that everything they had been asked to do, and their day-to-day work duties, were within their PD.

(b)(3): 5 U.S.C. App 3 (IG Act); (b)(6):

(b)(3): 5 U.S.C. App 3 (IG Act); (b)(6): We substantiated that at times, patients in the MHC may not have had vital signs taken when health technicians were detailed to cover clerical assignments. We found that no harm occurred as a result, and providers in the MHC told us that they could take vital signs themselves if warranted.

(b)(3): 5 U.S.C. App 3 (IG Act); (b)(6):

(b)(3): 5 U.S.C. App 3 (IG Act); (b)(6): We reviewed the electronic health records of these patients which did not support statements made by the (b)(6),(b)(7)(C) that patients had been harmed. We were also told that since this complaint, an additional PSA has been hired in the MHC, substantially decreasing the occasions in which health technicians are pulled away from their patient care role.

We did not substantiate the remainder of the above allegations.

Prior to our site visit, OPC management, staff and union representatives met on September 13, 2012, to discuss staff concerns. Management provided clarifying guidance to several of the staff's concerns. The AGFE union representative remains involved with the case (b)(6): We found that this is a (b)(6): and not a patient safety issue.

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