COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

093760

B-133044

APR 14 1976

The Honorable W. Henson Moore
House of Representatives

Dear Mr. Moore:

Following your June 11, 1975, letter, we agreed to assess the following aspects of the administration of the New Orleans Veterans Administration (VA) Hospital:

--Space available for selected hospital services.

--Staff levels and qualifications for selected hospital services.

--Completeness of patient medical records and physician access to records.

--Medical staff committees' efforts to assure quality patient care.

Hospital officials acknowledge that longstanding problems identified in each area have hampered patient care. Their corrective efforts have been foiled by increasing workload, lack of resources, and lack of effective management action. They believe that appointing a new hospital director and a permanent chief of staff, along with the attention focused on the hospital by the temporary suspension of its accreditation, will strengthen the hospital's efforts to provide quality patient care.

INTRODUCTION

The New Orleans VA Hospital is a general medical and surgical hospital affiliated with Tulane University and Louisiana State University medical schools. The hopital has 581 operating beds--221 surgical, 298 medical, and 62 psychiatric.

As of July 1, 1975, the hospital was authorized 1,232 full-time-equivalent employees. Nursing service and medical administration service had the most employees--354 and 230, respectively. The hospital's funding in fiscal year 1976 is about $28 million.

~~707335~~
093760

MWD-76-119

The Joint Commission on Accreditation of Hospitals surveyed the hospital in February 1975 and suspended its accreditation in April. The major factors affecting the accreditation were

--multiple medical records deficiencies,

--a critical shortage of nurses, and

--several fire and safety hazards.

VA took action to correct some of the deficiencies mentioned above--primarily those concerning the fire and safety hazards, such as the need for more fire-resistive doors and for devices to protect the water supply from contamination. VA also began to reduce the backlog of incomplete medical records. In April 1975 VA appealed the commission's decision and the hospital was resurveyed in May and given a 1-year accreditation retroactive to the date of the earlier survey.

SPACE SHORTAGES

The New Orleans hospital does not have enough space to handle its patient load, particularly in outpatient, pharmacy, laboratory, and radiology services. Hospital officials said that the hospital does not meet VA space criteria for its medical care facilities. VA has no accurate data on the amount of space available at the New Orleans hospital, so we did not evaluate the extent of the deficiencies. However, according to hospital officials, the space occupied by the four services has remained virtually unchanged since 1970, while the services' workloads have increased, as shown in the following table.

Service (workload measurements)	FY 1970	FY 1975	Increase in workload	
			Total	Percent
Outpatient (visits)	70,114	189,495	119,381	170
Pharmacy (prescriptions)	123,212	323,697	200,485	163
Laboratory (tests)	a/439,576	1,298,257	858,681	195
Radiology (examinations)	50,451	63,758	13,307	26

a/Workload for FY 1971.

The radiology and laboratory chiefs said their services had not been affected by space deficiencies. The chief of pharmacy service said he does not have adequate drug storage or working space.

The chief of outpatient services said waiting areas are overcrowded and clerks' desks are in congested hallways. Sometimes several physicians, all seeing patients at the same time, share open examination rooms. Such arrangements may embarrass patients and can inhibit discussion. Several physicians in the outpatient clinics said space shortages have impaired medical services.

Corrective efforts

To ease the crowded conditions in outpatient and pharmacy services the New Orleans hospital has

--expanded working hours,

--moved some hospital services to leased facilities, and

--instituted such other measures as using the main lobby as an outpatient waiting area.

However, the constantly increasing workload has more than offset these efforts. VA plans to open an outpatient clinic in Baton Rouge, Louisiana, 90 miles from New Orleans, in 1977. Although this clinic will be able to handle about 18,800 patient visits annually, New Orleans hospital officials expect a continuing increase in outpatient visits to negate its effect.

The New Orleans hospital has considered two alternatives for constructing additional space but has no firm plans.

The Administrator of Veterans Affairs, in a June 1975 letter to the Veterans of Foreign Wars of the United States, recognized the need to modernize and expand many VA hospitals, including the one in New Orleans. He said that this hospital was working at maximum capacity under somewhat strained conditions, and although some preliminary plans had been made, higher VA priorities precluded scheduling construction of a replacement hospital.

STAFFING

Patient care at the New Orleans hospital has been compromised by a number of staffing problems, including staff

shortages, communication problems of foreign resident physicians, and impaired effectiveness in key medical positions due to interim appointments. Hospital officials indicated these problems have existed for some time, and most of them still existed at the time of our review, despite recent actions.

Nurses

As of October 14, 1975, the nursing service consisted of 377 full-time-equivalent employees--195 registered nurses and 182 licensed practical nurses and nursing assistants. The nursing staff appears to be well qualified, in that more than 50 percent are registered nurses. The hospital conducts continuing classroom and inservice training for all nurses.

VA Central Office and New Orleans hospital officials recognized that the number of nurses does not meet VA guidelines. Reports prepared by both groups show that present nurse staffing will not permit the hospital to meet patient care needs beyond the minimal level. (Minimal care means that only basic physical needs of the patient can be met.) Nevertheless, the chief of nursing service said the hospital had not tried to obtain the nursing staff needed for comprehensive care. (Comprehensive care includes assessing and attending to patients' psychological and emotional needs and educating them and their families about postdischarge self-care responsibilities.)

The number of nurses approved in the hospital's annual budget is decided by the hospital director. He is assisted in his budgetary appraisal of staffing levels by his service chiefs. For the past 3 fiscal years (1974-76) the chief of nursing told the director how many nurses were needed to immediately upgrade nursing care from minimal to comprehensive, as required by VA guidelines.

The following table shows that the staffing levels approved in the hospital's budgets have consistently been less than those requested by the chief of nursing service. The table also shows a widening gap between staffing levels approved in the budgets and comprehensive care requirements.

FY	Staff needed for comprehensive care	Staff approved by hospital director	Difference Amount	Difference Percent
1974	405	326	79	24
1975	428	342	86	25
1976	472	359	113	31

The appraisals for fiscal years 1974 and 1975 were determined by the nursing chief based upon her professional judgment. The 1976 appraisal was based on VA Central Office nurse staffing guidelines published in March 1975. In spite of the apparent nursing shortage, hospital management did not increase the nursing staff to the comprehensive care level.

The nursing shortage has rendered nursing care inadequate. For example:

--Nurses do not always maintain patients' medical records properly.

--Supervisory nurses cannot thoroughly oversee the quality of patient care or fulfill administrative responsibilities, because they must help with direct nursing.

--Hurrying nurses have incorrectly administered medications.

In addition, nurses can't properly attend to patients' psychological and emotional needs or educate patients or their families about postdischarge self-care responsibilities. The latter failure increases patients' chances of readmission. Finally, workload pressures can create morale problems which manifest themselves in absenteeism and turnover. Twenty-five percent of registered nurses at the New Orleans hospital quit in fiscal year 1975, compared to a VA-wide rate of 12 percent.

Physicians

As of September 30, 1975, the hospital employed 55 full-time and 38 part-time staff physicians and 78 residents. Of 93 staff members, 88 were either board certified or board eligible. Board certification or eligibility is a generally accepted standard of a physician's qualifications. Thus, the physician staff is apparently well qualified.

The hospital has, however, experienced certain problems in physician staffing, including (1) temporary vacancies in radiology and laboratory services, (2) use of foreign graduates as resident physicians, and (3) vacancies in key medical positions.

Staffing of radiology and laboratory services

Authorized staffing levels for radiology and the laboratory during fiscal years 1974 and 1975 generally met VA criteria. However, both services experienced staff shortages due to resignations and changes by some employees from full-time to part-time status. The service chiefs said that recruiting and retaining employees was difficult, due to VA's inability to match salaries offered by other hospitals.

The chief of the radiology service said that vacancies in his service had delayed the processing of radiology reports. The laboratory chief said that his service had been affected because

--laboratory technicians received less supervision,

--the service could perform fewer clinical procedures,

--liaison between laboratory service physicians and other hospital physicians was reduced, and

--quality control was weakened.

At the conclusion of our fieldwork only two positions were still vacant. Hospital officials said that recruiting radiologists and pathologists had been aided by legislation authorizing bonuses for VA physicians. 1/

Use of foreign resident physicians

For at least 15 years the New Orleans hospital has relied primarily on foreign graduates for residents in the hospital's medical service, because local medical schools

---

1/Veterans Administration Physicians and Dentists Pay Comparability Act of 1975, Pub. L. No. 94-123, Oct. 22, 1975.

have not agreed to provide the number of residents needed in the service. Nearly 90 percent of the resident physicians in the medical service have been graduates of foreign medical schools, with local medical schools providing the remainder.

According to hospital officials as well as officials from local schools, the foreign graduates generally have an inadequate command of English. Officials believe this factor has inhibited communications with both the hospital staff and patients and impaired patient care. For instance:

--Nurses frequently must clarify foreign graduates' written orders and oral instructions for nursing care. Also, patients frequently ask nurses to interpret the foreign graduates' oral comments or instructions.

--A hospital medical records supervisor estimated that 50 percent of all hospitalization summaries are dictated by foreign graduates whose poor diction makes transcription difficult.

--Medical school officials say that American graduates are hesitant to consult with foreign graduates.

Tulane officials recently agreed to provide resident physicians for the hospital's medical service. This new program, which began in July 1975, is in the initial phase. When fully implemented, it will virtually eliminate foreign graduates in residency at the hospital. As the following table shows, the new program has already decreased the percentage of foreign graduates.

FY	American graduates	Foreign graduates	Percentage of foreign graduates
1971	5	24	83
1972	3	26	90
1973	4	28	88
1974	4	27	87
1975	6	31	84
1976 (note a)	19	24	56

a/Statistics at September 17, 1975.

Delayed appointments to key medical positions

The chief of staff and the chief of medical service are key medical positions at the hospital, yet permanent appointments for the positions have not been made promptly.

The chief of staff assists the hospital director in directing and coordinating patient care, research, educational training and designated health services within the hospital. He also collaborates with the hospital's assistant director in formulating and supervising the administrative activities of his position.

Between 1962 and 1973, one physician served as chief of staff. Since July 1973 there have been three acting and two permanent chiefs. One permanent chief resigned after only 12 months. The present chief of staff became acting chief on July 1, 1975, and was permanently appointed effective January 4, 1976.

This chief believes that serving in an acting capacity limited his effectiveness. He cited the following problems caused by a temporary appointment:

--Recruiting quality personnel becomes more difficult.

--Staff physicians are reluctant to recognize the appointee's authority, and securing their cooperation is difficult.

--Medical schools do not cooperate fully in controlling residents.

--Hospital morale suffers.

The medical service is a major patient care function at the hospital. Its chief is responsible for the diagnosis, care, and treatment of inpatients and outpatients assigned to the service.

The acting chief of medical service was appointed January 1, 1974, and believes a permanent chief should be named as soon as possible. He believes the absence of a permanent chief of medical service is a major factor in an overall morale problem at the hospital. He also believes

that his acting capacity has impaired his effectiveness. He considers it inappropriate for him to make major changes needed in the operation of the medical service.

PATIENT MEDICAL RECORDS

Patient medical records at the New Orleans hospital are not maintained in accordance with VA regulations; they are incomplete and are not readily accessible. Maintaining complete, readily accessible medical records is particularly important in the VA system, because patients do not have personal physicians. Both inpatients and outpatients are treated by many different staff physicians and residents.

Incomplete

VA regulations and Joint Commission on Accreditation of Hospitals standards recognize that a patient's medical record is the official record documenting the diagnosis, treatment, and care of a patient and that without this record, quality medical care is impossible. VA regulations require hospitals to maintain complete, concise, and adequate medical records which conform to the highest professional standards. Prompt completion of medical records upon discharge is mandatory.

As early as July 1973, New Orleans hospital officials recognized that incomplete medical records were a problem, but they took no action. As noted previously, the Joint Commission in February 1975 cited incomplete medical records as a serious problem at the hospital. At that time, approximately 1,100 medical records were incomplete. According to the commission's report, some of the records had been incomplete for as long as 10 months after patients were discharged.

Since the commission's review, hospital officials have strongly emphasized prompt completion of medical records. They have threatened enforcement action against physicians and implemented techniques to monitor the time it takes to process medical records.

In October 1975, the hospital reported about 800 incomplete medical records. Our analysis showed that about 400 were delinquent beyond the 30 working days the hospital

allows for completion. Some of these records had been outstanding for as long as 7 months. While the hospital had made some progress since the commission survey in reducing the backlog of incomplete medical records, a large problem remains.

Unavailable

VA regulations and Commission on Accreditation standards state that patients' medical records must be readily available. Hospitals are required to establish the necessary systems and controls.

The New Orleans hospital is experiencing difficulty in locating outpatient medical records. A daily average of 25 to 30 medical records are unavailable when needed by clinic administrative personnel to prepare for clinic visits by patients. Although most of these records are found before the patient sees a physician, special searches are required.

Retrieval problems are further complicated by about 80 unscheduled patients a day who come to the clinics for treatment and whose medical records must be located immediately. Despite intensive efforts to locate records, clinic physicians must often treat patients whose medical records cannot be located. During a 3-week period, clinic physicians treated 28 patients who had previously been treated at the hospital but whose records could not be found.

Many factors contributed to the unavailability of patients' medical records:

--VA procedures for borrowing records were not followed.

--Adequate control over incomplete records was not maintained.

--Forms for requesting records were difficult to read and use.

Laboratory and radiology reports

VA regulations and Commission on Accreditation standards require procedures to assure prompt filing of laboratory and radiology reports in patients' medical records. New Orleans hospital procedures for outpatient treatment do not achieve this objective.

Hospital physicians said they lose time each day trying to locate delayed and missing outpatient laboratory reports. When reports cannot be found, retests must be ordered. Delays become so frustrating that physicians sometimes admit outpatients to the hospital to assure completion and prompt reporting of test results. The chief of staff believes these problems are due to the report distribution and medical record handling systems. He said they have persisted because hospital management has failed to identify their causes and correct them.

We also found that the radiology service does not have adequate control over X-ray films and film files. These records are often removed from the radiology service and radiologists can't prepare reports until they are retrieved.

In early 1975 the hospital did not have a centralized filing system for X-rays. Hospital officials believe this lack accounted for the inadequate control over X-ray films and files. During our review, the hospital was trying to establish a centralized system.

MEDICAL STAFF COMMITTEES

The New Orleans hospital medical staff committees have not met VA requirements for prompt identification and resolution of hospital problems. Committee members generally agree they have not effectively evaluated the hospital's performance during the past several years. They believe the recent appointment of a new hospital director and a permanent chief of staff and the attention focused on the hospital by the Joint Commission's review will strengthen the committees' efforts to assure quality patient care.

Medical staff committee activity

We reviewed the minutes of 20 key medical staff committees for the 2-year period ending June 30, 1975. The committees usually met as required and attendance averaged about 74 percent. However, the committees did not deal effectively with major problems. Our review of the minutes revealed that:

--Deficiencies discussed by the committees were not followed by recommendations and positive action.

--The committees had not identified some of the deficiencies cited by the Commission on Accreditation or discussed in this report.

The 1975 commission report cited a total of 31 deficiencies in the hospital's operation. Although the committees had identified some of these problems, their recommendations had been ineffective.

For example, the minutes of the medical record review committee revealed that it frequently discussed incomplete medical records, one of the major deficiencies cited by the commission. The VA Central Office review team agreed with the commission's finding. It also noted that medical record deficiencies had been reported in hospital committee minutes, but the committee made no positive recommendations to correct the deficiencies.

The commission also cited several deficiencies in the way other medical staff committees performed their tasks. For instance, the commission stated, "It must be documented that the medical staff executive committee receives and acts upon the reports of all other medical staff committees." (Underscoring supplied.)

Our review of committee minutes also disclosed that the committees had not identified certain deficiencies the commission cited in the dietetic, anesthesia, and nursing services. Also, the nurse staffing shortage (see pp. 4 and 5) was a major problem not discussed by any of the committees.

Reasons for ineffective medical staff committees

Hospital officials generally attributed the medical staff committees' ineffectiveness to complacency starting at the top of the hospital's management structure and extending to committee chairmen and members, chiefs of hospital services, and staff physicians. One official believed the complacent attitudes were best expressed by the phrase "don't rock the boat." He said physicians became so discouraged they were reluctant to bring their problems before the committees.

Hospital officials believe current medical staff committees will be more effective for two reasons:

--The loss and subsequent reinstatement of Joint Commission accreditation focused attention on the hospital's problems.

--The hospital management team is being restructured. Specifically, a new director was appointed in September 1975 and a permanent chief of staff in January 1976. Both officials play key roles in the committees' effectiveness.

These factors should improve the committees' performance, but insufficient time has elapsed to measure their impact.

- - - - -

As you requested, the Veterans Administration has not been asked to formally comment on this report; however, we have discussed it with VA Central Office and New Orleans hospital officials and recognized their comments where appropriate. We will be in touch with your office in the near future to arrange for release of the report to the Veterans Administration.

Sincererly yours,

Comptroller General
of the United States