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HEALTH CARE

The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate

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SUMMARY

At the request of the Chairman, Senate Committee on Veterans' Affairs, GAO (1) examined various medical and psychiatric quality assurance activities performed in 4 of 26 VA psychiatric facilities to determine how data obtained are used to identify and resolve potential quality-of-care problems and (2) compared quality-of-care problems encountered by VA and private sector hospitals and the programs each has implemented to monitor and correct those problems. We issued our report on these matters on April 22, 1992.

We found that

-- none of the four VA psychiatric hospitals we visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems in the psychiatric and medical care they are providing. As a result, psychiatric practices that are counterproductive or ineffective may not be identified, and medical procedures or practices that are known to have contributed to death or medical complications may continue to exist.

-- VA and non-VA hospital systems we visited, both psychiatric and acute medical/surgical, differ little in their approach to identifying quality-of-care problems. The quality assurance mechanisms each uses to make certain that quality-of-care standards are met are similar because most use the Joint Commission on Accreditation of Healthcare Organizations as their primary external review organization. Further, many of the problems found in VA hospitals have also been identified in non-VA hospitals.

While the results of our work at the four hospitals cannot be projected to all VA psychiatric hospitals, they are consistent with our findings at other VA hospitals.

Mr. Chairman and Members of the Committee:

In response to your request, we (1) examined various medical and psychiatric quality assurance activities performed in 4 of 26 VA psychiatric facilities to determine how data obtained are used to identify and resolve potential quality-of-care problems and (2) compared quality-of-care problems encountered by VA and private sector hospitals and the programs each has implemented to monitor and correct those problems. We issued our report to you on these matters in April.[1]

In summary, none of the four VA psychiatric hospitals we visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems in the psychiatric and medical care they are providing. As a result, psychiatric practices that are counterproductive or ineffective may not be identified, and medical procedures or practices that are known to have contributed to death or medical complications may continue to exist. While the results of our work at the four hospitals cannot be projected to all psychiatric hospitals, they are consistent with our findings at other VA hospitals.

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INSUFFICIENT QUALITY ASSURANCE DATA ARE COLLECTED ON PSYCHIATRIC PROGRAMS

None of the four VA psychiatric hospitals we visited are collecting the kind of quality assurance data needed to demonstrate that their psychiatric programs fully meet the psychiatric needs of patients. This situation is occurring for two basic reasons: VA has not defined its requirement for evaluating psychiatric programs to ensure that each program is providing high quality care, and nurses and physicians in two hospitals are not documenting the reasons they are placing patients under restraints and seclusion.[2]

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[1]VA Health Care: The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (GAO/HRD-92-17, Apr. 22, 1992).

[2]Restraints are usually leather arm straps, leather leg straps, and/or a waist belt. Seclusion is when a patient is set apart from all others and/or the ward environment.

Under the Code of Federal Regulations, 38 C.F.R. 17.507, every VA psychiatric hospital is expected to establish treatment goals for its psychiatric programs and monitor these goals to ensure that high quality patient care is provided. The accomplishment of these tasks is reviewed by hospital staff under the psychiatric program review continuous monitor.[3] But, the term "treatment goal" has not been defined by VA's central office, and three of the hospitals we visited have interpreted the term to relate to the processes used to deliver psychiatric care. As a result, hospital psychiatric staff and quality assurance staff in these facilities are monitoring the way care is provided; they are not collecting and evaluating information needed to ensure that the care obtains the desired results. Thus, VA does not know if the psychiatric programs in these hospitals are effective and whether high quality care is being provided to patients.

VA policies also require hospital staff to write in the patient's medical record the reason the patient is being restrained or secluded, interventions attempted to avoid restricting the patient before the action is taken, and other pertinent information. However, in two of the four hospitals we visited, nurses and physicians were not documenting their rationale for using restraints and seclusion. As a result, pertinent quality assurance data were not available, and hospital officials could not determine if the use of restraints and seclusion was clinically justified.

UNNECESSARY DEATHS OCCUR BECAUSE VA IS NOT USING AVAILABLE QUALITY ASSURANCE DATA TO CORRECT IDENTIFIED PROBLEMS

Quality assurance systems in VA hospitals are generally identifying real and potential problems in the quality of the medical care provided to psychiatric patients. But VA medical staff are not consistently using the data that are available to resolve these problems. As a result, medical procedures or practices that contribute to death or medical complications may continue to be used after they have been identified as being real or potential problem areas.

For example, in three of the hospitals we visited, several cases were identified in which potential quality-of-care problems were related to a patient's death. Each case was presented to the committees responsible for reviewing mortality and morbidity cases. However, one committee did not review all the facts associated with each case to determine if the deaths were caused by inappropriate medical procedures and practices, the second committee's

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[3]The continuous monitoring function is a process by which hospital staff review and assess clinical activities that are key indicators of the quality of care being provided.

recommendations were not implemented by hospital staff, and the third committee did not adhere to VA regulations that require certain mortality cases to be examined every time they occur.

Additionally, VA regulations require that a comparison be made between a patient's original diagnoses and postmortem autopsy diagnoses to determine, among other items, the thoroughness of the care provided to the patient. Actions must be taken to correct any identified problems. But none of the four hospitals are meeting these requirements. One hospital does not perform premortem and postmortem comparisons at all; the second performs a comparison but not for the purposes stipulated by VA regulations; the third does not identify the causes of differences found during the comparison; and the fourth does not identify the underlying reasons for specific missed diagnoses.

Finally, hospital staff in two of the four hospitals are not correcting problems identified through patient incident reports in a timely manner. These reports summarize such occurrences as suicides, suicide attempts, and patient injuries. Further, only two hospitals are performing the required trending or analysis of these identified problems to determine if they have applicability to the general patient population.

VA AND NON-VA QUALITY ASSURANCE INITIATIVES ARE SIMILAR-- AS ARE THE PROBLEMS IDENTIFIED

Quality assurance programs in VA and non-VA hospitals we visited are similar regardless of whether they primarily serve the medical-surgical or psychiatric needs of patients. Each VA and most non-VA hospitals are accredited by the Joint Commission and use its review to demonstrate that they have the necessary systems in place to ensure that quality care can be provided. Hospitals that seek Joint Commission accreditation must meet the same standards and are assessed using the same rating criteria. Thus, the quality assurance data for all hospitals are essentially the same, as are the techniques to obtain data.

Quality-of-care problems resulting in complications and/or death occur in both VA and non-VA psychiatric hospitals. Officials in non-VA hospitals were reluctant to share specific examples of quality-of-care problems and their frequency; therefore, we were unable to compare the incidence of quality problems within VA to those in non-VA hospitals. However, our review of recent reports issued on the quality of care delivered in certain non-VA psychiatric hospitals in New York and Florida identified problems similar to those found in some of the VA facilities we visited. For example, between July 1988 and June 1989, the New York State

Commission on Quality of Care for the Mentally Disabled[4] either gave special attention to or conducted a detailed investigation of 863 of 2,488 deaths that occurred in state and privately owned psychiatric centers, developmental centers, or other facilities within the state. Of the cases reviewed, 150 were found to have resulted in death because the quality of care was poor.

RECOMMENDATIONS

As a result of our review, we recommended that the Secretary of Veterans Affairs require the Chief Medical Director to

-- define the meaning of the term "treatment goal," provide guidance to hospital directors on how such goals should be evaluated, and ensure that program reviews are conducted in each hospital to evaluate the attainment of these goals, and

-- hold each hospital director responsible for making certain that identified medical and psychiatric quality-of-care problems are thoroughly examined and corrective actions are taken to prevent their recurrence.

In a letter dated February 18, 1992, which we included in our report, the Secretary concurred with our recommendations. He also agreed that our findings may indicate a need to examine practices in the remaining psychiatric facilities to ensure that there is no systemwide problem.

The Secretary did, however, express some concerns with the report and its findings. Specifically, he said that the findings at the four facilities we visited should not be extrapolated to the system as a whole. Further, he said that the report does not adequately acknowledge that other program monitors, such as mortality reviews and autopsy reviews, can be as effective or better than an analysis of treatment goals, restraints and seclusion, and commitments in evaluating whether the needs of psychiatric patients are met.

We agree that our findings are not necessarily applicable to every VA psychiatric hospital. But previous reports by both us and VA's Office of the Inspector General have consistently identified problems in VA's quality assurance programs in both medical and psychiatric hospitals. GAO believes this indicates that our current findings may not be limited to the facilities we visited.

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[4]The commission was statutorily established in 1977 in response to a large number of deaths and reports of poor quality of care in New York state psychiatric hospitals.

We also agree that program monitors--such as mortality and morbidity, autopsy review, and patient incident reporting--are important tools in evaluating whether the needs of psychiatric patients have been met. However, as we discussed earlier, we examined several of these monitors and found serious problems that VA must address before these monitors can be considered to be effective.

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Mr. Chairman, this concludes my statement. I will be happy to answer any questions.