October 2014

# VA HEALTH CARE

## Actions Needed to Ensure Adequate and Qualified Nurse Staffing

GAO Highlights

Highlights of GAO-15-61, a report to the Chairman, Subcommittee on Oversight & Investigations, Committee on Veterans' Affairs, House of Representatives

### Why GAO Did This Study

GAO and others have raised prior concerns about the adequacy and qualifications of VHA's nurse staffing. In part to address these concerns, VHA issued a directive in 2010 requiring all VAMCs to implement a standardized methodology for determining an adequate and qualified nurse workforce, which includes developing and executing nurse staffing plans. It also requires VAMCs to use the methodology on an ongoing basis to evaluate staffing plans.

GAO was asked to provide information on nurse staffing at VAMCs. This report reviews the extent to which (1) VAMCs have implemented VHA's nurse staffing methodology, and (2) VHA oversees VAMCs' implementation and ongoing administration of the methodology. GAO reviewed documents and interviewed officials from VHA, seven VAMCs selected to ensure variation in factors such as geographic location, and regional offices for these VAMCs. GAO used federal internal control standards to evaluate VHA's oversight. GAO also interviewed representatives of veterans service organizations, nursing organizations, and unions.

### What GAO Recommends

GAO recommends VA: (1) assess VAMCs' ability to implement the methodology, (2) monitor VAMCs' ongoing compliance with the methodology, (3) complete timely evaluations, (4) improve the timeliness of communication with VAMCs, and (5) define areas of responsibility and reporting within VA's management structure. VA concurred with the recommendations.

View GAO-15-61. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

### What GAO Found

The seven Department of Veterans Affairs medical centers (VAMC) in GAO's review implemented the Veterans Health Administration's (VHA) nurse staffing methodology, experienced problems developing and executing the related nurse staffing plans, and some reported improvements in nurse staffing. Specifically, GAO found that each of the seven VAMCs had developed a facility-wide staffing plan—which outlines initiatives needed to ensure appropriate unit-level nurse staffing and skill mix—and taken steps to execute it. However, VAMCs experienced problems—such as lack of data resources and difficulties with training—in both the development and execution of their staffing plans. Some VAMC staff reported improvements in the adequacy and qualifications of their units' nursing staff when nurse staffing plan initiatives were executed. For example, at two VAMCs where the number of nurses was increased or where support services for nurses were put in place, such as a designated group of staff to assist in transporting patients to and from appointments off the unit, unit staff said the adequacy of the nursing staff had improved. However, some VAMC unit staff reported that unit nurse staffing continued to be inadequate and that nurse unit assignments and job duties were not always appropriate for their qualifications.

VHA's oversight is limited for ensuring its nurse staffing methodology is implemented and administered appropriately. GAO found the following internal controls were limited in VHA's oversight process:

- **Environmental assessment.** VHA did not comprehensively assess each VAMC to ensure preparedness for implementing the methodology, including having the necessary technical support and resources, prior to the issuance of the directive requiring each VAMC to implement the methodology.
- **Monitoring compliance.** VHA does not have a plan for monitoring VAMCs to ensure compliance with the implementation and ongoing administration of the methodology.
- **Evaluation.** VHA has conducted limited evaluations of the methodology, and at least one of these evaluations has been significantly delayed.
- **Timeliness of communication.** VHA's protracted timeline for communicating methodology-related information may have hindered the ability of VAMCs to appropriately develop their staffing plans and to execute the initiatives contained in those plans.
- **Organizational accountability.** VHA did not define areas of responsibility or establish the appropriate line of reporting within VA's management structure for oversight of the implementation and ongoing administration of the methodology.

Without these internal controls in place, VHA cannot ensure its methodology meets department goals, such as establishing a standardized methodology for determining an adequate and qualified nurse workforce at VAMCs, and ultimately, having nurse staffing that is adequate to meet veterans' growing and increasingly complex health care needs.