Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Provided by a Nurse John Cochran Division,

St. Louis VA Medical Center
St. Louis, Missouri

Report No. 12-00835-271

September 12, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of care provided by a nurse at the John Cochran Division, St. Louis VA Medical Center, St. Louis, MO. A complainant alleged that a registered nurse (RN) was involved in serious medication errors, and that management did not respond when complaints were brought to their attention.

We determined that the facility took appropriate actions in response to the allegations by removing the subject RN from patient care and initiating an Administrative Investigation Board to review the alleged medication errors. We concurred with the findings and recommendations of the Administrative Investigation Board. We did not substantiate the allegation that management did not respond to complaints, but did find that a prior proposed administrative action in the face of serious errors by the subject RN was overridden by a senior medical center official without a clear explanation.

We also reviewed the facility's RN competencies, medication administration system, and quality and safety programs and made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Quality of Care Provided by a Nurse, John Cochran Division, St. Louis VA Medical Center, St. Louis, Missouri

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) performed an inspection to determine the validity of allegations regarding the care delivery and conduct of a registered nurse (subject RN) employed at the John Cochran Division, St. Louis VA Medical Center, St. Louis, MO.

Background

The St. Louis VA Medical Center provides tertiary care and has two campuses. The John Cochran Division (facility), located in downtown St. Louis, provides a wide range of specialty care and has 136 acute medical and surgical beds. The Jefferson Barracks Division, located in south St. Louis County, provides primary care and has 102 acute, 50 domiciliary, and 71 community living center beds. The facility serves veterans and their families in east central Missouri and southwestern Illinois and is part of Veterans Integrated Service Network 15.

The facility has two Level 1[1] medical intensive care units (MICU) that serve critically ill patients. Hemodynamic monitoring,[2] ventilation management,[3] and other critical care services are provided at bedside in the MICUs. A nurse manager trained in critical care oversees MICU nursing care.

[1] Level 1- Patients at risk of their condition deteriorating, or higher levels of care whose needs can be met on advice and support from the critical care team.
[2] Hemodynamic monitoring is the assessment of blood movement and pressure exertion in the veins, arteries, and chambers of the heart.
[3] Ventilation management refers to the care and machine assistance that helps or replaces patient breathing.

Allegations

The OIG received an anonymous complaint alleging that an MICU nurse, the subject RN:

- Committed several egregious acts resulting in death or near death of patients.
- Unthinkingly misprogrammed an intravenous (IV) pump and infused fentanyl[4] at a dangerously high rate. When alerted to the issue by a coworker, "refused to attend to the patient who was actively dying."
- Crossed professional lines by [overriding] a doctor's order for oral hydoxyzine and administering it intravenously instead.
- Exhibited a professionally lax and careless attitude.
- Used union intervention to influence upper management to reverse a proposed administrative action.

The complainant further alleged that upper management condoned this pattern of behavior and "turned a blind eye" to complaints about the subject RN because of a complaint.

Scope and Methodology

During November 2011–February 2012, OHI held regular conference calls with the facility leadership regarding the case and progress of a facility Administrative Investigation Board (AIB) that had been convened to address these same allegations. After the AIB was completed, we conducted a site visit from February 26 to 29. We interviewed MICU nursing staff, facility leadership; pharmacy, Human Resources (HR), and quality management staff; and others familiar with the case. We reviewed the documents and reports related to the AIB. We also reviewed facility policies, patients' electronic health records (EHRs), RN competency folders, pharmacy reports, HR records, and other documents that addressed these allegations.

We noted from a recent OIG report that the facility received several recommendations to strengthen its RN competency program.[5] Competency programs demonstrate staff's updated skills and ability to perform functions within their scopes of practice.

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.

[4] Fentanyl is a potent synthetic narcotic analgesic with a rapid onset and short duration of action, and is much more potent that morphine.
[5] *Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri*, Report No. 11-01606-277, September 13, 2011.

Case Summary

For many years the subject RN performed acceptably while employed at the facility. However twice in 2010, the subject RN was involved in serious medication administration incidents, and a supervisor initiated administrative actions against the nurse. Eventually, a senior facility leader decided not to sustain some of the administrative actions and the nurse continued in the MICU position.

In November 2011, facility leadership received a copy of the same allegation letter sent to the OIG. In response to the letter, facility leaders promptly reassigned the subject RN to a non-patient care role, placed the nurse on a training plan, and on December 9, chartered an AIB to review the allegations.[6] The AIB interviewed individuals and reviewed policies, procedures, and the EHRs of patients who were allegedly impacted by the subject RN. In a report dated February 9, 2012, the AIB documented findings and noted that the subject RN demonstrated irregularities in medical record documentation by not following the requirements of the unit. For example, the subject RN did not sign flow sheets, record hourly IV dose/rates, and had fewer EHR notes than other MICU RNs. The subject RN also failed to follow proper policy and procedure when withdrawing medication from the Pyxis MedStation® System,[7] and administered medication by a different method than was ordered.

The AIB did not address the complaint related to management actions.

Inspection Results

Issue 1: Quality of Care Provided by the Subject RN

The AIB substantiated the allegation of substandard care by the subject RN and recommended that the facility take appropriate administrative HR action. The AIB further recommended a review and revision of MICU documentation standards to ensure proper documentation of clinical care and a review of the facility's medication delivery methods.

OHI concurred with the findings and recommendations of the AIB. Therefore, we made no additional recommendations.

Issue 2: Leadership Response to Complaint

We did not substantiate the allegation that facility leaders took no action following notification of staff concerns.

[6] VA Handbook 0700, *Administrative Investigations*, July 31, 2002, and VA Directive 0700, *Administrative Investigations*, March 25, 2002.
[7] The Pyxis MedStation® System is an electronically secure medication dispensing cabinet.

Facility leaders became aware of concerns regarding the subject RN in January 2010 and took actions in accordance with VA's Title 38 administrative action guidelines.[8] For example, following an inquiry into the IV fentanyl incident, the Associate Director for Nursing Service issued a proposed action on April 5. In March, before the proposed action was issued, the subject RN had another lapse in patient care resulting in a more severe proposed action in May. However, upon review of the case, the facility Associate Director (AD), who was the Acting Medical Center Director(MCD) at the time, reversed the proposed action. Unrelated to and shortly after the reversal, the AD retired.

In an effort to gain a better understanding of the AD's rationale for the reversal of the proposed action, we reviewed available electronic correspondence and interviewed the AD by telephone. The AD reported that he could not recall the details of the incidents. However, we found correspondence from the AD that reflected his decision to not sustain the proposed action. The RN's complaint was not reflected in the decision.

The MCD reportedly was unaware of the AD's action and decision until the most recent allegations surfaced. Other facility leaders, who were knowledgeable about the employee's proposed action, informed us that the AD independently made the decision to reverse the action. The union representative also reported having no recollection of the incident.

We reviewed the annual performance ratings for the subject RN during the period of time when these lapses occurred. The subject RN's 2009–2011 performance ratings indicated that supervisory actions were in place. During our interviews, staff reported that the subject RN's substandard performance was not observed before 2009. We concluded that management appropriately conducted an AIB and took action based on the AIB recommendations when the latest issues related to patient care were identified and brought to their attention. Therefore, we made no recommendations.

Issue 3: RN Competencies

Staff competency is essential to deliver high quality care, reduce errors, and improve patient safety. The Joint Commission requires that hospitals define competencies of staff who provide patient care and that they use assessment methods to determine individual competence initially and on a regular basis thereafter.[9] The facility is required to take action when staff member competence does not meet expectations.

We reviewed 27 MICU RN competency folders and found that 15 contained appropriate documentation. Of the remaining 12 competency folders, 8 had incomplete or missing information, and 4 had delayed verification.

[8] VA Handbook 5021, *Employee/Management Relations*, April 15, 2002.
[9] Joint Commission, HR.01.06.01: Hospital Standards Human Resources

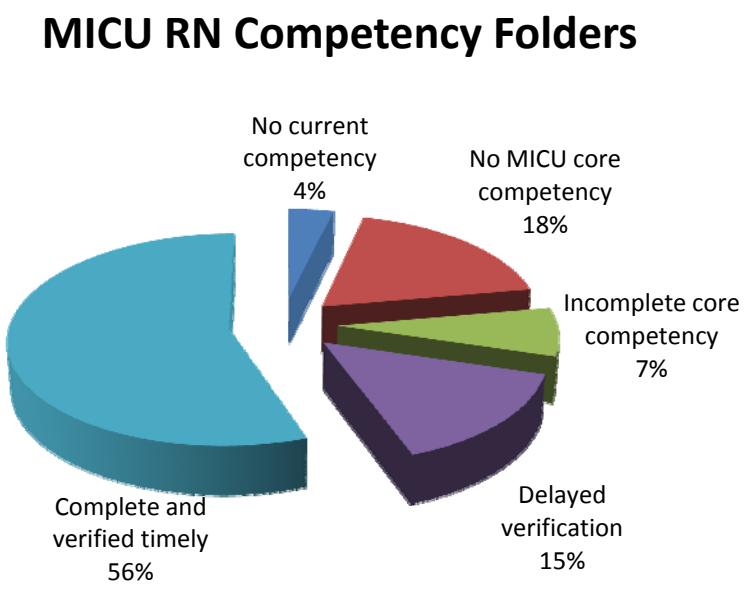

Figure 1

After discussing the issue with the Nursing Service staff and leadership, and reviewing the recently implemented processes, we determined that the facility was taking steps to improve the process of assessing competencies in nursing service. We found that employee competency folders incorporated elements of critical care nursing. We also found evidence that efforts were underway to improve the incorporation of competency requirements in the folders. Therefore, we made no recommendations.

Issue 4: Pyxis MedStation® System Access

The AIB confirmed that the subject RN ignored an order for oral hydroxyzine and, instead, of the nurse's own accord, administered intravenously a potentially harmful intramuscular form of the drug by overriding the medication administration safeguards of the Pyxis MedStation® System.

Pyxis Medstation 3500 is a computerized pharmacy managed inpatient medication transaction control, monitoring, and database archiving system. It can also help monitor compliance with facility policy on dispensing medications without a patient order (order overrides).[10]

There are exceptions for quick access that bypass safety features, including first dose emergency medication orders and the inventory function used to conduct inventory or perform maintenance on the Pyxis MedStation® System. During January 24–February 7, 2012, there were 450 instances of inventory function access throughout the

[10] CareFusion Knowledge Portal for the Pyxis MedStation® System, http://www.carefusion.com/pdf/Medication_Management/Pyxismed_KnowledgePortal.pdf {accessed July 27, 2012}.

facility. Of these instances, 397 were for scheduled inventory updates (i.e. restocking), and 32 were for maintenance access and other related issues. However, there were 21 instances when nurses used the inventory function for unscheduled reasons. The subject RN used the inventory function to obtain and administer hydroxyzine via a delivery route other than that which the physician ordered.

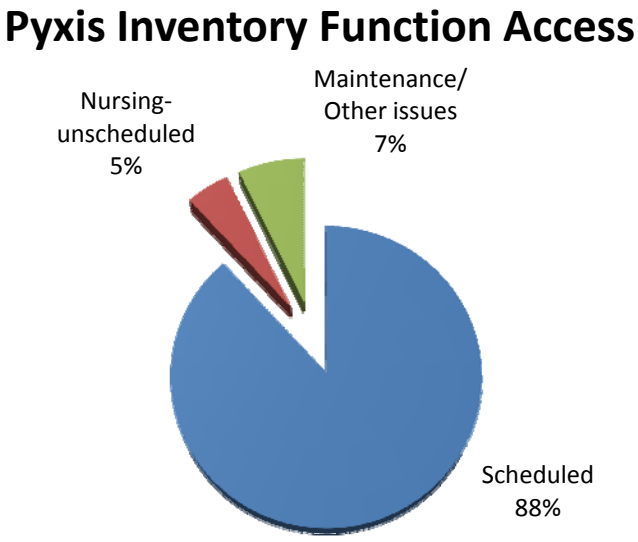

Figure 2

We discussed these results with pharmacy staff and leadership, and determined that the facility had implemented processes to ensure adequate monitoring and oversight of its medication dispensing processes, including overrides. Therefore, we made no recommendations.

Conclusions

We concurred with the facility's AIB findings that the subject RN provided substandard patient care, and its recommendations to take administrative action. We did not substantiate the allegation that management did not take necessary action when informed of patient care concerns, or that facility leaders took no action following notification of staff concerns or the subject RN's complaint. We made no recommendations.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the report. No further action is required.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 9, 2012

From: Director, VA Heartland Network (10N15)

Subject: **Healthcare Inspection – Quality of Care Provided by a Nurse, John Cochran Division, St. Louis VAMC, St. Louis, Missouri**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Thru: Director, VHA Management Review Service (10A4A4)

1. I have reviewd and concur with the findings and statements of the OIG Healthcare Inspection Report 2012-00835-HI-0320. Thank you for this opportunity of review to ensure that we continue to provide exceptional care to our Veterans.

2. Please contact Jimmie Bates, VISN QMO for any questions or concerns.

Jimmie Bates, QMO

for WILLIAM P. PATTERSON, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 8, 2012

From: Director, St. Louis VA Medical Center, John Cochran Division (657/00)

Subject: **Healthcare Inspection – Quality of Care Provided by a Nurse, John Cochran Division, St. Louis VAMC, St. Louis, Missouri**

To: Director, VA Heartland Network (10N15)

1. I have reviewed and concur with the findings and statements of the OIG Healthcare Inspection team. Thank you for your complete and through review of the allegations.

2. Please contact Ms. Patricia Hendrickson RN MSN CPHQ who is the point of contact for questions regarding this report. She may be reached at 314-289-7020.

RimaAnn O. Nelson RN MPH/HSA
Director, VA St Louis Health Care System (657/00)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Melanie Cool, RD, LDN, (Project Leader) Sonia Whig, RD, LDN, (Team Leader) Frank Miller, Ph.D. Robert Yang, M.D.

Appendix D

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