THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

August 24, 2009

The Honorable William E. Reukauf
Acting Special Counsel
U.S. Office of Special Counsel
1730 M. Street, NW
Washington, DC 20036-4505

RE: OSC File No. DI-08-23-79

Dear Mr. Reukauf:

This is in response to your December 23, 2008, letter regarding allegations that employees at the Department of Veterans Affairs Medical Center, Geriatric Extended Care Unit, Prescott, Arizona, engaged in a violation of law, rule, or regulation, gross mismanagement, an abuse of authority and a substantial and specific danger to public health and safety. The specific allegations were made by Ms. Jerri Bedell, a former Registered Nurse at the Community Living Center, who alleged there had been a number of care-related and administrative issues on the unit where she worked. I asked the Under Secretary for Health to review this matter and take any actions deemed necessary under 5 U.S.C. Section 1213(d)(5). He, in turn, directed the Office of the Medical Inspector (OMI) to investigate the disclosures and report on their findings. Details of the OMI review are contained in the enclosed report. I have reviewed the report, and now submit it to the Office of Special Counsel for your review as the Final Report of the Department of Veterans Affairs.

Sincerely,

Eric K. Shinseki

Enclosure

OFFICE OF THE MEDICAL INSPECTOR

Final Report to the Office of Special Counsel
OSC File Number DI-08-2379

Quality of Care
Department of Veterans Affairs
Bob Stump Medical Center
Prescott, Arizona

Veterans Health Administration
Washington, DC

Report Date: June 11, 2009

OMI TRIM # 2009-D-297

Executive Summary

At the request of the Under Secretary for Health, the Office of the Medical Inspector (OMI) investigated the complaint lodged with the Office of Special Counsel (OSC) by a registered nurse (RN) (OSC File Number DI-08-2379), formerly employed at the Bob Stump VA Medical Center in Prescott, Arizona (hereafter, the Medical Center). The complainant, a former staff nurse in the Community Living Center (CLC), was employed by the Medical Center for 3 years from April 3, 2005, until her termination on April 22, 2008. She alleged there had been a number of care-related and administrative issues on the unit where she worked.

The OMI team made a site visit to the Medical Center January 13-15, 2009. The OMI spoke to the complainant before the site visit and met with her in Arizona. On both occasions, the complainant provided additional information to assist the OMI in identifying some of the specific patients involved in the incidents she described. In addition to the concerns detailed in the OSC complaint, (the index cases in this report), the complainant described several other incidents which are addressed in this report as supplemental cases where the individuals could be identified. The complainant described some events which could not be evaluated because they lacked sufficient information on dates and names. Based on index case reviews, OMI identified several additional cases for evaluation which are also identified in this report as supplemental cases.

After review of the electronic medical records and administrative documents and following interviews with staff, the OMI team addressed each complaint individually. For each allegation, the full report contains a narrative of findings, relevant medical considerations and OMI's conclusions for each case. The OMI ***could not substantiate*** allegations when there was no conclusive evidence to either sustain or refute the allegations. The OMI ***did substantiate*** allegations when the facts and findings supported that the alleged events or actions did take place. The OMI ***did not substantiate*** allegations when the findings showed that the allegations were unfounded. The conclusions also include OMI commentary on other aspects of the case relevant to the initial complaint. Summary conclusions and recommendations are provided for each theme (A to G). Actions taken by the Medical Center are included where appropriate.

Summary of conclusions regarding complaint A.1.

Over-medication of patients with narcotics (pain medication)

The OMI did substantiate that, in three of 14 cases reviewed, the patients' dose of narcotic was increased too rapidly. Based on review of records and extensive interviews with nursing and physician staff of the CLC, OMI concluded that, in the problematic cases evaluated narcotics were used with the clear intent to relive suffering. The hospice practitioners and nursing staff were well-intentioned and cared deeply for their patients. However, in some cases the parameters of their use of narcotics were outside the bounds of usual practice.

Narcotics intended for management of pain and other distressing symptoms in the weeks or days before death were prescribed with unclear indications and limited safeguards. In some cases, the dose of narcotics was increased more rapidly than appeared warranted. The OMI concludes that narcotic orders did not contain specific indications for as-needed use or a maximum dose per time period, that a 15 minute dosing interval was too short for an oral narcotic, and that documentation of the indication for which as-needed pain medication was administered was inadequate.

Recommendations regarding complaint A.1.

1. The Medical Center should obtain ongoing consultative support from the Phoenix VA to review cases and local pain management practices in the CLC and hospice.
2. The Medical Center should institute use of a comprehensive admission evaluation instrument to document pain requirements and indicate expected length of survival at admission and document hospice criteria.
3. The Medical Center should ensure that all as-needed (prn) orders for narcotics should include indications for use, maximum dose per period, and conditions for which the physician should be notified.
4. The Medical Center should ensure that all orders for periodically administered narcotics state conditions for which the medication should be held.
5. The Medical Center should establish a policy (and ensure compliance) that physicians, and other hospice practitioners, write a note whenever narcotic dosage is changed.
6. The Medical Center should arrange for the CLC Medical Director to receive additional professional development and establish a mentor relationship with an experienced VA hospice physician.
7. The Medical Center should ensure that nurses use the CPRS "pain medication administration" templated note (or a similar template) to document all as-needed narcotic administrations.
8. The Medical Center should ensure that the CLC nursing staff receive ongoing training on the evaluation of pain (both verbal and non-verbal), indications and options for treating terminal pain, and charting of narcotic use in the hospice setting.

A.2 Over-medication of patients with laxatives

Summary of conclusions regarding complaint A.2.

The OMI did substantiate that laxative use was excessive in the four cases reviewed. The OMI concludes that orders did not provide clarification as to when laxatives should be held in the event of diarrhea or bowel incontinence. The OMI concludes that nurses should have questioned the advisability of continuing to administer laxatives in the presence of incontinent diarrhea.

Recommendations regarding complaint A.2.

9. The Medical Center should ensure that all as-needed (prn) orders for laxatives should include indications for use, maximum dose per period, and conditions for which the physician should be notified.

10. The Medical Center should ensure that all orders for periodically administered laxatives state that medications should be held/evaluated in the presence of significant diarrhea or abdominal pain.
11. The Medical Center should ensure that the CLC nursing staff receives ongoing training on the evaluation and treatment of impaction, constipation and diarrhea in the hospice setting.

Medical Center Actions Taken

The area of greatest concern for the OMI team was the pattern of narcotic use in the hospice. This concern was identified while the team was on-site. At roughly the mid-point of the site visit, the team met with the Medical Center leadership to review preliminary findings. The team's observations were communicated to Medical Center leadership and a plan for corrective action was implemented immediately. The following day, a review of the medical records of patients then residing in the hospice revealed that the Medical Center had taken appropriate actions to ensure that as-needed orders for narcotics had already been modified in accordance with the OMI's recommendations.

The day after the OMI team left the Medical Center a specialist in geriatrics and palliative care from the Phoenix VA Medical Center, a major academic and teaching center, was engaged to review current care and to serve as a local clinical resource. This consultant physician conducted a site visit the next week. Physicians from the OMI team held a follow-up telephone conference with this consultant to review the priorities as outlined above. This senior physician will be available for additional site visits and case reviews at the request of the Medical Center Chief of Staff.

In order to provide additional support for the CLC Medical Director, the Medical Center Chief of Staff made arrangements for her to participate in a professional mentoring program with the VA Palliative Care Program at Palo Alto, CA. The latter is a nationally recognized center for hospice education and research. This relationship will provide the CLC Medical Director with an exceptional resource for personal development and will enhance the level of care in the CLC and hospice.

Nursing leadership re-instituted the use of the Hospice PRN Pain Medication Administration Template in January 2009, and trained nursing staff on its use. Staff members are required to complete this template on every shift for every hospice patient who received as-needed pain medication. Nurse Managers are required to validate this documentation daily.

An interdisciplinary team assesses each patient on admission and completes a comprehensive pain evaluation. Staff nurses reassess the patient daily documenting in CPRS notes either as a separate note or a progress note. Nurses use the FLACC pain tool if the patient is unable to respond.[1] The nurse manager reviews a "PRN Pain Effectiveness" report from BCMA at the end of each shift. These effectiveness

[1] The FLACC (Face, Legs, Activity, Cry, and Consolability) pain assessment tool is used for preverbal children and hospice patients in pain from surgery, trauma, cancer, or other disease processes. The results support nurses' clinical judgment to determine analgesic choice rather than providing distinct FLACC scores to guide analgesic selection.

reports are aggregated monthly and reviewed by the CLC Service Line Manager. Since the provider order now indicates the use of as-needed medications, the weekly BCMA report matches the CPRS and provides a crosscheck for their monitoring efforts.

On April 5, 2009, the OMI conducted a medical record review of 5 out of 10 current hospice patients at the Medical Center. All of the medical records had comprehensive admission evaluation completed which included indications for pain medication, pharmacy review of orders, a nursing template note with the total dose of PRN pain medications administered throughout the shift and multiple re-assessments of effectiveness of the medication administered. The provider's admission notes included a prognostic statement estimating survival and incorporating the Karnofsky Scale which is designed specifically for measuring physical status in palliative care.[2]

B. Patient abuse

Summary conclusion regarding complaint B.

The OMI could not substantiate patient abuse in the two cases reviewed.

The OMI made no recommendations regarding complaint B.

Medical Center Actions Taken

The Medical Center had taken appropriate action by counseling and providing education to the involved CNA prior to the OMI visit.

C. Overuse of urinary catheters in the hospice unit

Summary conclusions regarding complaint C.

The OMI did not substantiate that urinary catheter use in the CLC and hospice was excessive or outside the standards of medical practice. The OMI concludes that urinary catheter use in the four cases provided by the complainant was appropriate.

The OMI made no recommendations regarding complaint C.

No Medical Center actions were necessary.

D.1. Staff shortages resulted in patient neglect

Summary conclusions on complaint D.1.

The OMI did substantiate that there were difficulties in maintaining desired staffing levels in the CLC during FY 2007-2008. The OMI concludes that the Medical Center leadership took appropriate steps to address the issues by reducing the patient census,

[2] Karnofsky Performance Scale (KPS), is designed specifically for measurement of physical status in Palliative Care. Using the Palliative Performance Scale, only about 10% of patients with a score of 50% or less would be expected to survive more than 6 months.

providing additional staff from other units, and use of contract nurses. The OMI could not substantiate that patients were neglected as a result of staff shortages.

The OMI made no recommendations regarding complaint D. 1.

D.2. Staff shortages resulted in medical errors by nursing personnel

Summary conclusions regarding complaint D.2.

The OMI did substantiate that errors were made in two of the six cases reviewed. The OMI concludes that there were no lasting consequences to the involved patients and that the Medical Center took appropriate actions in each incident. The OMI did not substantiate that the errors occurred as a result of staff shortages. The OMI could not substantiate that all of the described events actually occurred as alleged.

The OMI made no recommendations regarding complaint D.2.

Medical Center Actions Taken

The Medical Center had taken appropriate action to address staffing by reducing the patient census, providing additional staff from other units, and use of contract nurses prior to the OMI site visit.

E. Unsanitary and unsafe conditions

Summary conclusions regarding complaint E.

The OMI did not substantiate that there was a statistically significant increase in MRSA infections in the CLC or that patient alarm systems in the CLC were limited to responses monitored at the nurses' station. The OMI could not substantiate that CLC employees failed to follow proper hand washing protocol, that inhalers were handled in a manner that carried a risk of cross contamination, or that specific events occurred as alleged. The OMI did substantiate that housekeeping services were only available to the day shift 5 days a week in 2007. The OMI concludes that Medical Center leadership has taken appropriate action regarding potential contamination of inhalers, CLC hours of coverage by housekeeping, and alarm systems on the CLC.

Recommendation regarding complaint E.

12. The Medical Center should continue the practice of periodic direct observation of hand washing, medication handling practices and environmental cleanliness. Leadership should communicate unit-specific results to staff members to encourage compliance and recognize exceptional performance.

Medical Center Actions Taken

The Medical Center had taken appropriate actions regarding potential contamination of inhalers, CLC hours of coverage by housekeeping, alarm systems on the CLC, and

conducting routine direct observation of hand washing, medication handling practice, and environmental cleanliness prior to the OMI site visit.

F. Falsification of records

Summary conclusions regarding complaint F.

The OMI could not substantiate falsification of documentation by CNAs of activities of daily living (ADL). The OMI concludes that Medical Center leadership has taken appropriate steps to increase the accuracy and efficiency of ADL documentation. The OMI substantiates that some staff members were using improper work processes when documenting medication administration with BCMA. The OMI could find no evidence that there was harm to any patient. The CLC leadership took appropriate actions to educate personnel and obtain new equipment to lessen the risk of error.

Recommendation regarding complaint F.

13. The Medical Center should review BCMA error reports and conduct periodic direct observations to ensure that the work practices and new BCMA equipment have minimized the opportunity for consequential error.

Medical Center Actions Taken

Medical Center had taken appropriate steps to increase the accuracy and efficiency of ADL documentation prior to the OMI site visit.

G. The complainant's reports to management were not acted upon.

Summary conclusion regarding complaint G.

The OMI did not substantiate that management failed to respond to the complainant's concerns.

The OMI made no recommendations regarding complaint G.

Medical Center Actions Taken

Contrary to the complainant's claim, the Medical Center had taken many actions in response to her complaints prior to the OMI site visit.

H. OMI conclusion regarding violation/apparent violation of regulations, directives, or policies.

Although there were opportunities to improve care, the OMI found no violation/apparent violation of VHA or Medical Center regulations, directives, or policies.

Table of Contents

Report of Investigation to the U.S. Office of Special Counsel
OSC File Number DI-08-2379

I. Introduction

At the request of the Under Secretary for Health, the Office of the Medical Inspector (OMI) investigated a complaint lodged with the Office of Special Counsel (OSC) by a registered nurse (RN), formerly employed at the Bob Stump VA Medical Center, Prescott, Arizona (hereafter, the Medical Center), part of the Northern Arizona Veterans Affairs Health Care System (NAVAHCS). The complainant, a former staff nurse in the Community Living Center (CLC), was employed by the Medical Center for 3 years from April 3, 2005, until her termination on April 22, 2008. She alleged there had been a number of care-related and administrative issues on the unit where she worked. She raised concerns in the following areas:

A. Over-medication of patients with
   1. pain medication (narcotics)
   2. laxatives

B. Patient abuse in which
   1. a care provider hit a patient
   2. a care provider jammed a patient's injured foot against a wall causing further injury.

C. Overuse of indwelling urinary catheters on the hospice unit

D. Staff shortages resulting in
   1. patient neglect
   2. medical errors

E. Unsanitary and unsafe conditions in patient care areas

F. Falsification of records

G. The complainant's reports to management were not acted upon.

II. Facility Profile

The NAVAHCS, part of Veterans Integrated Service Network (VISN) 18, includes the main medical facility, the Bob Stump VA Medical Center, Prescott, Arizona and five Community Based Outpatient Clinics (CBOCs) in Anthem, Kingman, Lake Havasu City, Bellemont, and Cottonwood, Arizona. The Medical Center provides a continuum of primary and secondary level medical, rehabilitative, and long term care services to Veterans residing in north central Arizona. Acute medical care consists of inpatient medicine (19 acute medicine and 6 Intensive Care Unit (ICU)/telemetry beds) and ambulatory care, which includes general medicine, ambulatory surgery, mental hygiene, and selected specialized medical clinics. Rehabilitative care consists of a four-bed inpatient physical medicine rehabilitation unit with a rehabilitation

therapy department, an outpatient substance abuse treatment program and a vocational rehabilitation/job training program. The Medical Center has a 120-bed domiciliary. Long-term care is provided in an 85-bed community living center (CLC), which is configured into two units designated CLC-1 and CLC-2. CLC-1 is located on the first floor of the building and CLC-2 on the second. The hospice is a subunit of CLC-2. The CLC includes a locked dementia unit on CLC-1, physical medicine and rehabilitation services, a geriatric evaluation and management (GEM) program, a care provider respite program and skilled nursing services.

III. Methods for Conducting the Investigation

The OMI team notified the Medical Center Director of the complaint and of the site visit planned for January 13-15, 2009. The Medical Center Director's Health Systems Specialist/facility planner served as the coordinator and point of contact and assisted with staff interview scheduling and information gathering. The team consisted of the Medical Inspector (a physician), a senior medical investigator (a physician), a geriatrics specialist from VISN 6 (a physician) and two OMI Clinical Program Managers (RNs). The team received full cooperation from the Medical Center staff as it conducted individual and group interviews, reviewed policies, procedures, reports, clinical notes, and patient care documents. The team held entrance and exit conferences with the Medical Center leadership. During the entrance conference, a brief overview of the CLC was provided by leadership and a tour of the CLC area followed.

The team spoke to the complainant before the site visit and met with her in Arizona. On both occasions, the complainant provided additional information to assist the OMI in identifying some of the specific patients involved in the incidents she described. In addition to the concerns detailed in the OSC complaint, (the index cases in this report), the complainant described several other incidents which are addressed in this report as supplemental cases where the individuals could be identified. The complainant described some events which could not be evaluated because they lacked sufficient information on dates and names. Based on index case reviews, OMI identified several additional cases for evaluation which are also identified in this report as supplemental cases. Attachment 1 matches the index and supplemental cases with patient identification.

During the site visit, the OMI team interviewed, either in person or via the telephone, the following individuals or groups from the Medical Center:

1. Director
2. Chief of Staff
3. Associate Director for Patient Care Services
4. Geriatric & Extended Care Service Line Manager
5. Non-Institutional Care Program Manager
6. Community Living Center Medical Director
7. Geriatric Extended Care Medical Officer
8. Evening Shift Supervisor
9. Infection Control Nurse
10. Director of Housekeeping

11. Chief Quality Manager
12. Patient Safety Manager
13. Risk Manager
14. Human Resource Manager
15. Two Nurse Practitioners
16. Two Licensed Practical Nurses(LPNs)
17. Seven RNs who work the day and evening shifts
18. Minimum Data Set (MDS) Coordinator
19. One Nursing Officer of the Day (works all tours)
20. Eight Certified Nursing Assistants (CNAs)
21. Geriatric Extended Care Educator.

Documents Reviewed:

1. *Hospice, Palliative Care and Bereavement Program and Team*: HCS Memorandum No. GEC-19, NAVAHCS, June 2006.
2. *Geriatric Evaluation and Management Program*: HCS Memorandum No. GEC-08, NAVAHCS, April 2006.
3. *Respite Care Program*: HCS Memorandum No. GEC-11, NAVAHCS, March 2005.
4. *Dementia Special Care Unit-Geriatrics and Extended Care Policy No. 1*: NAVAHCS, July 2008.
5. Resident Assessment Instrument/Minimum Data Set (RAI/MDS): HCS Memorandum 218-GEC-36, NAVAHCS, January 2008.
6. Kathleen Broglio, MN, ANP-BC, Russell K. Portenoy, MD: *Pain Management at the end of life*. 2009 UpToDate®, INC.
7. Jorge Cortina, MD, Presentation: *When to Shift Gears: Hospice Admission Guidelines and Prognostication*. January 9, 2009.
8. Stephen R. Connor, PhD, Bruce Pyenson, FSA, MAAA, Kathryn Fitch, RN, MA, Med, Carol Spence, RN, MS, and Kosuke Iwasaki, FIAJ, MAAA: *Comparing Hospice and Non-hospice Patient Survival Among Patients Who Die Within a Three-Year Window*. Journal of Pain and Symptom Management, Vol. 33 No. 3 March 2007.
9. Weissman DE: *Determining Prognosis in Advanced Cancer*. Fast Fact and Concept #13, 2nd Edition, July 2005. End-of-Life Palliative Education Resource Center http://www.eperc.mcw.edu/.
10. Von Gunten CF, Tsai S, Arnold RA: *Prognostication in Dementia*. Fast Fact and Concept #150, February 2006. End-of-Life Palliative Education Resource Center http://www.eperc.mcw.edu/.
11. Stegemann E, Kathleen Cantaben, Linda Mondoux: The Long Term Care Institute Report of the Community Living Center Survey, July 14, 2008.
12. The Community Living Center Survey Action Plan Update, January 6, 2009

IV. Report Structure and Conventions

After review of the electronic medical records and administrative documents and following interviews with staff, the OMI team addressed each case individually. For each allegation, the report contains a narrative of findings, relevant medical considerations and OMI's conclusions for each case. The OMI ***could not substantiate*** allegations when there was no conclusive evidence to either sustain or refute the allegations. The OMI ***did substantiate*** allegations when the facts and findings supported that the alleged events or actions did take place. The OMI ***did not substantiate*** allegations when the findings showed that the allegations were unfounded. The conclusions also include OMI commentary on other aspects of the case relevant to the initial complaint.

Because of the number of cases in the complaint, the individual allegations are listed together at the beginning of a section (A to G below) and, again, separately prior to the specific case findings and conclusion. Summary conclusions and recommendations are provided for each theme (A to G).

A. Over-medication of patients with narcotics and laxatives
B. Patient abuse in which a patient's foot was injured
C. Overuse of indwelling urinary catheters on the hospice unit
D. Staff shortages resulting in patient neglect and medical errors
E. Unsanitary and unsafe conditions in patient care areas
F. Falsification of records
G. The complainant's reports to management were not acted upon.

V. Findings, Conclusions, Summary Conclusions, and Recommendations Regarding Complaints

A. Over-medication of patients

1. Narcotics (pain medication)

a. The complainant alleged that Index Case #1 was given excessive doses of narcotic pain medication and that narcotic pain medication was given inappropriately for knee pain.
b. The complainant alleged that Index Case #2 was over medicated.
c. The complainant alleged that nurses were ordered to give pain medication to Index Case #3 without his consent.

2. Laxative overdose

The complainant alleged that Index Cases #1, #2, #3, and #4 received excessive doses of laxatives with the result that each had one or more episodes of diarrhea with soiling by stool.

Background on narcotic use in hospice

Concerns about over medication were evaluated by reviewing the records of individual patients for contemporaneous physician's orders; notes by physicians, nurses and other care givers; and by review of the Bar Code Medication Administration (BCMA) System.[3] In addition to reviewing medical records, staff nurses (RNs and LPNs) and CNAs were questioned about common practices and expectations regarding the use of medications in the hospice.

A variety of narcotic medications are commonly used to control pain. For narcotic medications administered on an as-needed[4] basis, documentation should include the clinical indication for additional medication and an evaluation of effectiveness. In evaluating total narcotic doses, the concept of "morphine equivalent" was employed. That is, all narcotics administered were converted to an equivalent dose in milligrams (mg) of intravenous (IV) morphine sulfate (MS) administered per 24 hour period (mg IV MS/24 hours) using the table below.

Narcotic medication	Dose	Equivalent mg MS IV/24 hours
morphine IV or SQ	10 mg	10
hydromorphone IV	1.5 mg	10
morphine oral	25 mg	10
oxycodone oral	20 mg	10
methadone oral	20 mg	10
fentanyl patch [5]	100 mcg/hour	96

A.1. Over-medication of patients with pain medication (narcotics)

a. The complainant alleged that Index Case #1 was given excessive doses of narcotic pain medication and that narcotic pain medication was given inappropriately for knee pain.

Findings regarding complaint A.1.a.

Index Case #1 was an 88 year-old male admitted to hospice on April 1, 2008, with a diagnosis of end-stage congestive heart failure. Prior to his admission, the Veteran's pain medications were minimal, consisting of 5 doses of propoxyphene/ acetaminophen from March 27-30, 2008, 3 doses of oxycodone 5 mg from

[3] The BCMA is a part of the VHA Computerized Patient Record System (CPRS) whereby a nurse documents the timing of every medication given to a patient.

[4] Orders are often written for a medication to be given "PRN" (pro re nata) or as-needed. The determination of when the medication is needed is at the discretion of the nurse authorized to administer the medication.

[5] Fentanyl is a potent narcotic which when used as a transdermal patch delivers drug by diffusion from a gel reservoir into the skin. The drug is delivered at a relatively constant rate described in micrograms (mcg) per hour. The drug from a new patch takes 12-15 hours to reach peak effect and residual drug in the skin continues to enter the circulation for a similar period after the patch is removed. Because of the long half life of the patches, another shorter acting narcotic is usually prescribed to treat breakthrough pain.

March 30-31, 2008, and one dose of hydromorphone 0.5 mg IV on March 31, 2008, for a total of less than 10 mg IV MS equivalent on March 31, 2008. The admission note stated "life expectancy < 90 days. Pain management...with Morphine SR and PRN Morphine liquid." The location, quality, and etiology of pain were not well characterized in the admitting documentation.

After admission to hospice, the Veteran received 3 doses of 15 mg of sustained release oral morphine from April 1-2, 2008. A 25 mcg/hour fentanyl patch was applied at 9:00 a.m. on April 2, 2008. The Veteran received an additional 13 doses of 20 mg morphine orally, including 3 doses in the 12 hours prior to his death on April 4. Nurses documented a variety of reasons for the supplemental narcotic including "anxiety," "restlessness," and "signs and symptoms of pain." For many of those administrations, a pain score was not entered into the record and on three occasions he was "unable to respond."

On April 2, 2008 (between 24 and 48 hours of death) he received the equivalent of 78 mg IV MS. In the 24 hours prior to his death, the Veteran received the equivalent of 56 mg IV MS. The rapid increase of narcotics between March 30 and April 2 was accompanied by excessive sedation. The evening shift nurses note from April 2, 2008, stated:

> "He kept crying out, help me eat, help me eat, I can't stay awake. He had a few bites of ice cream, did take his pills with difficulty. Kept nodding off. When awake asked him several times if he was in pain and he said No. When offered he refused pain medication. He just wanted to eat, stating, "I need to eat." Family in for last half of shift. Daughter upset that father was so sleepy and could not stay awake".

There are no rigid standards for how quickly narcotic doses can safely be increased in the care of terminally ill patients. Patients often become tolerant of the analgesic effect and may require very large doses with chronic use. General guidance is that narcotics can be increased between 50 and 100 percent each day. Particular caution is required when transitioning to oral methadone and fentanyl patches, as their sedating effect can be unpredictably great. In addition, caution is warranted when increasing narcotic doses in the elderly and in the presence of renal disease. Index Case #1 had moderate renal failure with a creatinine of 2.7 mg/dl (normal <1.2) and a blood urea nitrogen of 77 mg/dl (normal < 25).

Conclusions regarding complaint A.1.a.

Index Case #1 had an excessively rapid increase of narcotic pain medication after his transfer to hospice that did not take into account his prior usage, his age, and his impaired renal function. This was primarily from as-needed dosing of oral morphine the requirement for which was poorly documented. This resulted in over sedation and probably contributed to his incontinence of stool as detailed in a subsequent clinical summary.

A.1. Over-medication of patients with pain medication (narcotics)

b. The complainant alleged that Index Case #2 was over medicated.

Index Case #2, a 61-year-old male, was transferred at his request from the CLC to hospice on July 31, 2007, when it was discovered that his laryngeal carcinoma had progressed and was no longer treatable. He remained in hospice for 149 days until his death on December 27, 2007. At the time of his death, he was receiving large doses of regularly administered narcotics and an anxiety reducing drug—fentanyl 550 mcg/hour in multiple patches every 72 hours, methadone 60 mg orally every 8 hours, and lorazepam 4 mg orally every 4 hours. While those cumulative narcotic doses were very large (equivalent to 618 mg MS IV/24 hours), the doses were arrived at through gradual escalation over a period of many weeks. In addition to the regularly administered medications, an as-needed dose of MS 10 mg subcutaneous was available for pain.

For the 5 days from 9:58 a.m. on December 21 until 9:48 a.m. on December 26, he received 27 subcutaneous doses of MS—an additional 50 mg MS-IV equivalent/24 hours—which was less than 10 percent of his daily regular dose of narcotics. However, in reading the nurses' notes and notations in the BCMA, the indications for the additional pain medication were poorly documented. Notes indicate that in the days before his death, the patient was often unresponsive and his level of pain could not be assessed. Even so, additional pain medication was administered frequently for "signs and symptoms of pain" or at times, when the patient was unable to respond meaningfully. A note written by the complainant on December 26, 2007, at 11:08 p.m (just hours before his death) stated, "Obtunded all evening...MS subcutaneous given X 2 this evening with good results."

Interviews with nursing staff did not support the complainant's contention that it was neither common practice nor the stated intent of the CLC medical director that as-needed narcotics were to be given whether clinically required or not. The orders, as written, gave considerable latitude to nursing staff to administer medication as often as every hour if needed to control pain. This degree of professional judgment is common practice. However, the orders did not stipulate conditions for which the medication should be held or conditions for which the physician should be notified.

Administration of significant doses of narcotics, anxiety reducing drugs, or other medications is appropriate for the dying patient to relieve pain, dyspnea, or anxiety if consistent with the patient's wishes and done as part of a plan to deal with distressing symptoms and not to explicitly hasten death. However, assessment of a patient unable to communicate verbally requires significant clinical judgment in evaluating non-verbal signs of pain and distress. The Medical Center's Computerized Patient Record System (CPRS) has two types of nursing note templates that would have facilitated that evaluation—"Pain Medication Administration" and "Pain Screening Reassessment." The OMI found that neither note was used with any degree of regularity. And, in some of the cases reviewed, the majority of free text nurses' notes did not reflect an adequate evaluation of the need for additional pain medication.

Conclusions regarding complaint A.1.b.

The total dose of narcotic medication administered to Index Case #2 was within the standard of practice for treatment of terminal pain. The need for administration of "as

needed" narcotics was poorly documented but was not excessive in comparison to his regularly administered dose of narcotics.

A.1. Over-medication of patients with pain medication (narcotics)

c. The complainant alleged that nurses were ordered to give pain medication to Index Case #3 without his consent.

Findings regarding complaint A.1.c.

Index Case #3 was a 75-year-old male admitted to hospice on November 14, 2007, with metastatic bladder cancer. He did decline to take additional narcotic medications at various times, but took his regularly scheduled pain medications without concern. A nurse's note on November 19, 2007, stated, "He complained that he did not like to take pain medication due to it making him nauseated. I encouraged him to take the med and to try to eat crackers before. He did this and was pleased that it did not cause him nausea, with relief of all pain." On November 21, 2007, a nurse noted "pt requested tylenol. States liquid oxycontin sol makes him nauseated. Will notify provider via this note." On November 24, 2007, another note stated, "Refused pain med but did accept tylenol." The staff used Tylenol™, anti-nausea medication, topical analgesic cream, and switched his primary pain medication to a fentanyl patch in an attempt to manage his pain and nausea. On November 30, 2007, the CLC Medical Director wrote, "Patient educated on pain meds and need to keep taking pain meds when needed."

Conclusion regarding complaint A.1.c.

OMI did not substantiate that Index Case #3 was given medication against his will.

OMI supplemental investigations

In order to further assess the pattern of narcotic use at the CLC, the OMI team evaluated two other groups of patients. First, the CLC identified all hospice residents whose care had been the subject of a peer review in calendar year 2008. Seven individuals were identified, and problematic issues in pain management in four of those cases are summarized below. Second, the OMI team reviewed the medical records of the four Veterans residing in the hospice at the time of the site visit on January 14, 2009. In none of those four records was there evidence of excessive or inappropriate use of narcotic analgesics.

Findings regarding Supplemental Case #1

Supplemental Case #1 was an 80-year-old female admitted to hospice on May 4, 2008, from the CLC with a diagnosis of congestive heart failure, chronic lung disease, and osteoporosis with fractures. She was debilitated and intermittently confused. She was prescribed oxycodone 5 mg every 6 hours (10 mg MS IV/ 24 Hours equivalent) and oxycodone 5 mg every 3 hours as needed for pain. The Veteran's total dose of oxycodone was 15 mg on May 9, 2008, 20 mg on May 10, 2008, and 20 mg on

May 11, 2008. On the morning of May 12, 2008, the attending physician noted, "Patient seen to have labored breathing, pallor...fentanyl and pain medication was increased...patient was actively dying."[6] There was no documentation of level or character of pain. Orders were written for a fentanyl patch 25 mcg/hour (applied at 10:48 a.m.), for oxycodone solution 20 mg every 4 hours and oxycodone 20 mg every 2 hours as-needed for pain. The baseline narcotic dose was increased eight-fold in this one step, and there were no instructions for maximum dose in any period. The Veteran received 85 mg oxycodone during the morning of May 12, 2008, and expired at 2:15 p.m. that day.

Conclusions regarding Supplemental Case #1

The total narcotic dose for Supplemental Case #1 on May 12, 2008, was excessive. It is unlikely that the fentanyl patch contributed because it had not been in place long enough to have had a substantial effect.

Findings regarding Supplemental Case #2

Supplemental Case #2 evaluated for narcotic use is included in this report elsewhere for other concerns as Index Case #7. This Veteran was a 93-year-old male who was admitted to hospice on December 27, 2007, with a diagnosis of advanced dementia, blindness, and impacted femoral head fracture. He was started on a fentanyl patch at 25 mcg/hour on January 8, 2008. Additional oral medication for pain included an order written on January 3 for morphine 40 mg by mouth every hour as-needed. There was no specific indication given and no maximum dose for any time period. The Veteran was given 40 mg doses twice on January 8 and three times on January 9. On January 10-11 he received 40 mg of morphine at the times noted below for the reasons cited. Narcotics were given twice in the day before his death period, even though the patient was unresponsive. He expired at 9:42 a.m. on January 11.

Time	Reason
00:46 a.m.	Shortness of breath
5:42 a.m.	Signs and symptoms of pain
8:55 a.m.	Signs and symptoms of pain
2:11 p.m.	Unable to respond
4:38 a.m.	Signs and symptoms of pain
8:58 a.m.	Unable to respond

Conclusions regarding Supplemental Case #2

The daily increase of morphine dose was consistent with acceptable practice. However, the morphine orders did not contain indications for as-needed use or a maximum dose per time period. Documentation of the indication for as-needed pain medication was inadequate.

[6] An individual is considered to the actively dying when their death is imminent within hours or days. As the body begins to shut down, an individual may evidence pre-terminal signs such as restlessness, hallucinations, confusion, cold extremities, mottled skin, and other physiologic changes.

Findings regarding Supplemental Case #3

Supplemental Case #3 was an 81-year-old male admitted to CLC on November 5, 2007, with a diagnosis of dementia, congestive heart failure, and advanced bedsores. He was admitted to provide a respite for his daughter who cared for him at home. He was found to be filthy and with extensive bedsores soiled by pet hair. Adult Protective Services was notified and, because he was on the Hospice Crisis List, the Veteran was transferred to hospice. As an outpatient, the Veteran had been prescribed one tablet twice daily of 5 mg oxycodone and acetaminophen. When admitted to hospice, orders were written for oxycodone 20 mg every 6 hours and an additional 20 mg oxycodone every 3 hours as-needed. There was no specific indication given and no maximum dose for any time period. In the 18 hours prior to his death at 1:25 p.m. on November 6 the Veteran received 100 mg of oxycodone—more than a 10-fold increase in his prescribed baseline.

Conclusions regarding Supplemental Case #3

This patient had an excessively rapid increase of narcotic pain medication after his transfer to hospice that did not take into account his prior usage. The oxycodone orders did not contain either indications for as-needed use or a maximum dose per time period.

Findings regarding Supplemental Case #4

Supplemental Case #4 was a 72-year-old male Veteran admitted to hospice on March 4, 2008, with pancolitis secondary to *clostridium difficile*, gram negative sepsis, and severe peripheral arterial vascular insufficiency. Management of pain was an ongoing problem, and narcotic doses were rapidly escalated within an acceptable range. However, the pattern of use was unusual in that, despite a requirement for large daily doses of narcotics, most of the narcotics came in the form of as-needed medication rather than the preferred course of regularly administered doses. Nurses documented that morphine was given at various times for pain, restlessness, and anxiety. The pattern of pain medication from BCMA was:

Dates in 2008	"as needed" medication	scheduled medication
March 15	240 mg morphine	15 mg morphine x 3
March 16	300 mg morphine	15 mg morphine x 3
March 17	300 mg morphine	15 mg morphine x 3
March 18	300 mg morphine	30 mg morphine x 2
March 19	240 mg morphine	30 mg morphine x 2
March 20	340 mg morphine	30 mg morphine x 2 plus fentanyl 50 mcg/hour
March 21	320 mg morphine	30 mg morphine x 2 plus fentanyl 50 mcg/hour

The last order for as-needed narcotics was written as 80 mg by mouth every 15 minutes as-needed. There was no specific indication given and no maximum dose for

any time period. Oral morphine may not reach its full effect for an hour, so the possibility of dosing every 15 minutes is inappropriate and creates the possibility of overdose. Supplemental Case #4 was never given morphine doses that frequently.

Conclusions regarding Supplemental Case #4

The daily dose of morphine was consistent with acceptable practice; however, it relied excessively on as-needed dosing. The morphine orders did not contain indications for as-needed use or a maximum dose per time period. The prescribed parameter for as-needed frequency was too short for oral morphine.

Summary of conclusions regarding complaint A.1.

A.1. Over-medication of patients with pain medication (narcotics)

The OMI did substantiate that, in three of 14 cases reviewed, the patients' dose of narcotic was increased too rapidly. Based on review of records and extensive interviews with nursing and physician staff of the CLC, OMI concluded that, in the problematic cases evaluated narcotics were used with the clear intent to relive suffering. The hospice practitioners and nursing staff were well-intentioned and cared deeply for their patients. However, in some cases the parameters of their use of narcotics were outside the bounds of usual practice.

Narcotics intended for management of pain and other distressing symptoms in the weeks or days before death were prescribed with unclear indications and limited safeguards. In some cases, the dose of narcotics was increased more rapidly than appeared warranted. The OMI concludes that narcotic orders did not contain specific indications for as-needed use or a maximum dose per time period, that a 15 minute dosing interval was too short for an oral narcotic, and that documentation of the indication for which as-needed pain medication was administered was inadequate.

Recommendations regarding complaint A.1.

1. The Medical Center should obtain ongoing consultative support from the Phoenix VA to review cases and local pain management practices in the CLC and hospice.
2. The Medical Center should institute use of a comprehensive admission evaluation instrument to document pain requirements and indicate expected length of survival at admission and document hospice criteria.
3. The Medical Center should ensure that all as-needed (prn) orders for narcotics should include indications for use, maximum dose per period, and conditions for which the physician should be notified.
4. The Medical Center should ensure that all orders for periodically administered narcotics state conditions for which the medication should be held.
5. The Medical Center should establish a policy (and ensure compliance) that physicians and other hospice practitioners should write a note whenever narcotic dosage is changed.
6. The Medical Center should arrange for the CLC Medical Director to receive additional professional development and establish a mentor relationship with an experienced VA hospice physician.

7. The Medical Center should ensure that nurses use the CPRS "pain medication administration" templated note (or a similar template) to document all as-needed narcotic administrations.
8. The Medical Center should ensure that the CLC nursing staff receive ongoing training on the evaluation of pain (both verbal and non-verbal), indications and options for treating terminal pain, and charting of narcotic use in the hospice setting.

A.2. Over-medication of patients with laxatives

The complainant alleges that Index Cases #1, #2, #3, and #4 received excessive doses of laxatives with the result that each had one or more episodes of diarrhea with soiling by stool.

Background on laxative use in hospice

Constipation is a common problem in CLC and hospice care; so much so, that the presence of a fecal impaction is considered a serious complication. Constipation is made worse by the use of medications that decrease gastrointestinal motility, particularly narcotics to control pain, and by the inactivity of bed-ridden patients. It is expected practice that hospice patients are routinely placed on regular doses of medications to soften stools with directions to use stimulant medications "as needed" if bowel movements are not regular. Physician's orders, nurse's notes, and BCMA records for these four Veterans were reviewed.

Findings regarding A.2. for Index Case #1

Index Case #1 was an 88-year-old male admitted to hospice on April 1, 2008, with a diagnosis of end-stage congestive heart failure. Because he had limited mobility and was receiving a significant quantity of narcotics, his admission orders included a bowel regimen of both a regular dose of stool softener and stimulant (docusate and senna respectively) and an as-needed order for a rectal suppository stimulant (bisacodyl). In spite of having three large loose bowel movements on the evening of admission, the patient received both the docusate and senna at 9 a.m. the next morning and continued to receive those medications on a fixed schedule despite incontinence of bowel and bladder.

Conclusions regarding A.2. for Index Case #1

Laxative use was excessive. Nurses continued to administer laxatives despite ongoing incontinence of liquid stool. The bowel stimulants and softeners were ordered without a clarification that they should be held in the event of diarrhea or bowel incontinence. OMI expected that nurses caring for the patient should have questioned the advisability of continuing to administer laxatives to him.

Findings regarding A.2. for Index Case #2

Index Case #2 was admitted to hospice from the CLC on July 31, 2007, with metastatic laryngeal cancer. His initial orders included a regular dose of stool softener, a stimulant and an osmotic agent (docusate, senna, and lactulose respectively). On December 1, 2007, he was given a bisacodyl suppository to induce a bowel movement. He had two bowel movements that afternoon and was given his scheduled doses of docusate and lactulose. On the morning of December 2, a nurse wrote,

> Pt had another very lg liquid BM @ 0400. This movment was so large that is spilled from the bed onto the floor, with a brief for protection as well as 2 chux. liquid feces again covered him from the axilary to the knees.

Despite the copious diarrhea, the Veteran received all three of his regularly scheduled laxatives during the day of December 2, 2007. The evening shift nurse noted, "Three liquid stools this shift. Bowels meds held this evening." On the morning of December 3, his laxatives were again resumed.

Conclusions regarding A.2. for Index Case #2

The OMI substantiates that laxative use was excessive. OMI concludes that it was inappropriate for nurses to continue to administer laxatives despite ongoing incontinence of liquid stool.

Findings regarding A.2. for Index Case #3

Index Case #3 was a 75-year-old male admitted to hospice on November 14, 2007, with metastatic bladder cancer. His admission orders include twice daily doses of senna and an as-needed order for bisacodyl suppository. The Veteran had frequent complaints of abdominal discomfort which was attributed to constipation. Over the course of several days beginning November 22, the Veteran had only minimal bowel movements. The attending physician and nursing staff were concerned about his discomfort and limited bowel movements and employed a variety of agents to help him move his bowels including stimulants and osmotic agents (sorbitol, magnesium citrate, and phospha-soda). On several occasions the nurses manually removed stool from his rectum. On December 1, 2007, the Veteran had a large liquid stool with the nurse's note stating, "At 2200 hours found him lying in very large pool of liquid stool up to his armpits. He was cleaned, and warm blanket applied because he was shivering." A nurse's note written at 2:47 a.m. on December 2 stated:

> Pt has had 2 episodes of XL liquid BM that completely covered him from his waist to his knees and completely covered his groin/catheter area. ... He was very upset and embarrassed by the incontinent episodes, and was very uncomfortable during the cleaning process which upset him further.

Despite the multiple liquid stools, the Veteran was given his regularly scheduled dose of senna and bisacodyl at 9:45 a.m. on December 2. He had increased abdominal pain, possibly from the stimulant effects of the laxatives, and at 11:49 a.m. a doctor ordered an antispasmodic medication (belladonna-opium). The day shift nurse noted,

"Belladonna-opium supp given for spasms with good effect...Gave regular scheduled suppository with Dark brown Large Loose BM this shift." The evening shift nurse held his laxatives and wrote,

> Repositioned him, and he kept crying out no more, no more. Found he had another loose BM, med size, cleaned him. Scrotum is red and excoriated as is coccyx. Applied calmoseptine to both. About to give him B & O supp, and thats when he said no more, meaning no more things that make him have loose BMs. B & O supp not given.

Conclusions regarding A.2. Index Case #3

The OMI substantiates that laxative use was excessive. The OMI concludes that the aggressive treatment of constipation was within the standard of care, but once Index Case #3 had the large liquid stools on the morning and evening of December 2, he should not have received additional stimulant medications. OMI concludes that this led to additional incontinence of stool and possibly increased his abdominal pain.

Findings regarding A.2. for Index Case #4

Index Case #4 was an 80-year-old male admitted to hospice on November 28, 2007, with a diagnosis of advanced bladder cancer. His initial orders included a regular dose of stool softener and a stimulant (docusate and senna). On December 1, 2007, the evening shift nurse wrote:

> Patient complained of severe abdominal cramping and nausea for several hours... By 2000 hours he began to have continuous liquid stool draining from his rectum and leaving him sitting in a large pool of stool. This happened X3 this evening.

Despite the diarrhea, the nurse administered his oral stimulant laxative at 8:55 p.m.

The night nurse wrote at 1:55 a.m. on December 2,

> Pt had 5 episodes of diarrhea stools this evening by 0140. He has been very embarrassed by this, and dosn't understand why we would give him medication to make him go so often. He is very tired, is not getting any sleep and is upset that this is happening to him. The amount of stool each time has been a very large volume of liquid stool that completely covers him from knee to waist. The entire bed has had to be changed.

Despite the continued diarrhea, the Veteran was given his docusate and senna at 9:41 a.m. on December 2. The evening shift nurse on that day wrote, "Patient had two large loose incontinent bm's. Held bowel med." Although his senna was held that evening, he again received his scheduled doses of senna and docusate at 8:46 a.m. on December 3.

Conclusions regarding A.2. for Index Case #4

Laxative use was excessive. Nurses continued to administer laxatives despite ongoing incontinence of liquid stool. The bowel stimulants and softeners were ordered without a clarification that they should be held in the event of diarrhea or bowel incontinence. OMI expected that nurses caring for the patient should have questioned the advisability of continuing to administer laxatives to him.

Summary of conclusions regarding complaint A.2.

Over-medication of patients with laxatives

The OMI did substantiate that laxative use was excessive in the four cases reviewed. The OMI concludes that orders did not provide clarification as to when laxatives should be held in the event of diarrhea or bowel incontinence. The OMI concludes that nurses caring for the patients should have questioned the advisability of continuing to administer laxatives in the setting of incontinent diarrhea.

Recommendation regarding complaint A.2.

9. The Medical Center should ensure that all as-needed (prn) orders for laxatives should include indications for use, maximum dose per period, and conditions for which the physician should be notified.
10. The Medical Center should ensure that all orders for periodically administered laxatives state that medications should be held in the setting of significant diarrhea or abdominal pain.
11. The Medical Center should ensure that the CLC nursing staff receive ongoing training on the evaluation and treatment of impaction, constipation and diarrhea in the hospice setting.

Medical Center Actions Taken

The area of concern of the OMI team was the pattern of narcotic use in the hospice. This concern was identified while the team was on-site. At roughly the mid-point of the site visit, the team met with the Medical Center leadership to review preliminary findings. The following day a review of the medical records of the patients then residing in the hospice revealed that the Medical Center had taken appropriate actions to ensure that as-needed orders for narcotics had already been modified in accordance with the OMI's recommendations.

The day after the OMI team left the Medical Center a specialist in geriatrics and palliative care from the Phoenix VA Medical Center, a major academic and teaching center, was engaged to review current care and to serve as a local clinical resource. This consultant physician conducted a site visit the next week. Physicians from the OMI team held a follow-up telephone conference with this consultant to review the priorities as outlined above. This senior physician will be available for additional site visits and case reviews at the request of the Medical Center Chief of Staff.

In order to provide additional support for the CLC Medical Director, the Medical Center Chief of Staff made arrangements for her to participate in a professional mentoring program with the VA Palliative Care Program at Palo Alto, CA. The latter is a nationally recognized center for hospice education and research. This relationship will provide the CLC Medical Director with an exceptional resource for personal development and will enhance the level of care in the CLC and hospice.

Nursing leadership re-instituted the use of the Hospice PRN Pain Medication Administration Template in January 2009, and trained nursing staff on its use.

Staff members are required to complete this template on every shift for every hospice patient who received as-needed pain medication. Nurse Managers are required to validate this documentation daily.

An interdisciplinary team assesses each patient on admission and completes a comprehensive pain evaluation. Staff nurses reassess the patient daily documenting in CPRS notes either as a separate note or a progress note. Nurses use the FLACC pain tool if the patient is unable to respond.[7] The nurse manager reviews a "PRN Pain Effectiveness" report from BCMA at the end of each shift. These effectiveness reports are aggregated monthly and reviewed by the CLC Service Line Manager. Since the provider order now indicates the use of as-needed medications, the weekly BCMA report matches the CPRS and provides a crosscheck for their monitoring efforts.

On April 5, 2009, the OMI conducted a medical record review of 5 out of 10 current hospice patients at the Medical Center. All of the medical records had a comprehensive admission evaluation completed which included indications for pain medication, pharmacy review of orders, a nursing template note with the total dose of PRN pain medications administered throughout the shift and multiple re-assessments of effectiveness of the medication administered. The provider's admission notes included a prognostic statement estimating survival and incorporating the Karnofsky Scale which is designed specifically for measuring physical status in palliative care.[8]

Karnofsky Performance Scale	
%	Criteria
100	Normal; no complaints; no evidence of disease
90	Able to carry out normal activity; minor signs or symptoms of disease
80	Normal activity with effort; some signs of symptoms of disease
70	Cares for self; unable to carry on normal activity or do active work
60	Requires occasional assistance, but is able to care for most of his/her needs
50	Requires considerable assistance and frequent medical care
40	Disabled; requires special care and assistance
30	Severely disabled; hospitalization is indicated although death not imminent
20	Very sick; hospitalization necessary, active supportive treatment necessary
10	Moribund; fatal processes progressing rapidly
0	Dead

[7] The FLACC (Face, Legs, Activity, Cry, and Consolability) pain assessment tool is used for preverbal children and hospice patients in pain from surgery, trauma, cancer, or other disease processes. The results support nurses' clinical judgment to determine analgesic choice rather than providing distinct FLACC scores to guide analgesic selection.

[8] Karnofsky Performance Scale (KPS), is designed specifically for measurement of physical status in Palliative Care. Using the Palliative Performance Scale, only about 10% of patients with a score of 50% or less would be expected to survive more than 6 months.

B. Patient abuse

1. The complainant alleged in the summer of 2005, she observed a CNA "hitting" Index Case #5 on his arm while yelling "stop it, stop it" at the patient. The complainant further stated she requested the CNA to refrain from striking the patient and the CNA stopped.
2. Index Case #6 informed the complainant that a CNA became so angry that he spun the patient's wheelchair around, lost control and the patient's injured foot was "jammed into a wall" causing his foot pins to be moved which required them to be re-set.

Findings regarding complaint B.1.

Index Case #5 was a 69-year-old Veteran who suffered severe central nervous system damage from a brain hemorrhage in 1992 that left him with a right-sided hemiplegia, expressive aphasia, and a seizure disorder. He was admitted to the CLC in 1999 and required maximum assistance with all activities of daily living. He had speech impairment and could only follow simple instructions due to his dementia. Review of the patient's medical record dating from 1999-2007 reflects gradual deterioration of his condition. The medical record documents that he was able to follow only simple instructions and that he would grab onto staff tightly while they were providing care. His wife and sister visited the Veteran frequently but there is no record of their expressing concern about abuse. There was no documentation found from the complainant, other staff, or visitors reporting suspicious marks on the patient or suspicions of abuse. When interviewed by OMI, the implicated CNA denied ever hitting patients and was unable to recall the complainant calling her attention to any such acts. The GEC Service Line Manager and Nursing Supervisor could not recall any complaints of this CNA striking the Veteran or any other patient. The OMI reviewed all reports of contact submitted to the GEC Service Line Manager for the indicated period and found no evidence of the complainant reporting the incident. The patient expired May 6, 2007.

Conclusion regarding complaint B.1.

The OMI could not substantiate that Index Case #5 was abused.

B. Patient abuse

2. Index Case #6 informed the complainant that a CNA became so angry that he spun the patient's wheelchair around, lost control and the patient's injured foot was "jammed into a wall" causing his foot pins to be moved which required them to be re-set.

Findings regarding complaint B.2.

Index Case #6 was a 62-year-old male with diabetes, hypertension, right-sided weakness from a stroke, and morbid obesity all of which combined to make him wheelchair bound. On April 3, 2007, the Veteran fell at home injuring both legs. He was admitted to a community hospital for stabilization and surgical repair of

fractures. On April 10, the Veteran was transferred to the CLC with a stabilization device on his left leg and a cast on his right leg.

On June 8, 2007, the patient was being transferred from the bathroom to his bed by two employees using a sling lift. The Veteran's left leg was struck against both the bathroom door jam and the foot of the bed. The impact bent one of the fixation wires protruding from the skin. The Veteran wrote a report of contact documenting the event stating that one of the nursing employees was "angry and in a hurry" because he was staying late beyond the end of his scheduled shift. Although the Veteran denied discomfort immediately after the event, he expressed some concern two days later. An x-ray was performed on June 11 with the impression stating,

> External fixator is in place. All pin-sites are within normal limits. There does not appear to be significant change in the bony relationships at the ankle fracture site when compared with earlier studies.

The implicated CNA wrote a report of contact admitting he had inadvertently hit the patient's foot during a transfer, but stated he did not hurt the patient and was neither angry nor in a hurry. The CLC nursing leadership conducted an investigation and the CNA received a written counseling from his supervisor and was re-trained in the use of patient lifts. OMI interviewed the GEC Service Line Manager and Nursing Supervisor regarding the incident. They stated that the CNA did not have a history of reported incidents like this one. OMI interviewed the CNA and reviewed his personnel and competency folders. The latter contained appropriate documentation reflecting knowledge and skills in the care of the CLC patients.

Following the incident, the medical record does not reveal any concern about internal pin displacement or a need for revision. On June 25, the patient had his left leg external fixation device removed and a cast was applied at the community orthopedic clinic. This procedure had been planned during an orthopedic appointment on June 7. On July 18, his cast was removed and a protective boot was applied. At the time of this report, the Veteran remains in the CLC receiving care to improve functionality.

Conclusions regarding complaint B.2.

The OMI did substantiate that the foot of Index Case #6 was struck during a transfer. The OMI did not substantiate that any injury resulted or that the fracture had to be re-set as a result of that incident. Prior to the OMI visit, the Medical Center had taken appropriate action by counseling and providing education to the involved CNA. The OMI could not substantiate that Index Case #6 was abused.

Summary conclusion regarding complaint B.

The OMI could not substantiate patient abuse in the two cases reviewed.

The OMI made no recommendations regarding complaint B.

Medical Center Actions Taken

The Medical Center had taken appropriate action by counseling and providing education to the involved CNA prior to the OMI visit.

C. Overuse of urinary catheters in the hospice unit

1. The complainant alleged that the CLC adopted a hospice policy that is interfering with the health and welfare of patients. She alleged that the general rule is that every patient who is not fully capacitated must receive a urinary catheter regardless of whether it is medically necessary. The complainant stated she observed this policy in effect from November 2007 until April 2008.
2. The complainant alleged that she removed a urinary catheter from Index Case #7 because of excessive amounts of urine leaking out of the catheter. The patient's continuous pulling of the catheter caused bleeding. After its removal, the urine flow became normal and the bleeding stopped. Subsequently, a CNA was ordered to replace the catheter and the bleeding problems resumed.
3. The complainant alleged that Index Case #8 developed a urinary tract infection (UTI), because his indwelling urinary catheter was not removed, even though he was able to attend to the bathroom without assistance.
4. The complainant alleged that Index Case #9 did not require a urinary catheter and that a provider posted a message that the catheter was not to be removed without provider's orders.

Findings regarding complaint C.1.

In interviews with the OMI team, the CLC leadership and staff nurses denied that there was an official policy or expected practice that all patients not fully capacitated must receive a urinary catheter regardless of medical necessity. The hospice physician admission orders from CPRS do include, among other routine orders, the option to select "Foley/Straight cath PRN" and "Change Foley PRN." It is common and appropriate clinical practice to write individualized orders in a palliative care setting to allow nurses to exercise clinical judgment in when to initiate or change urinary catheters. The CLC's new nurse orientation and standard policy address circumstances under which a urinary catheter is appropriate. In the hospice setting, near the end of life, urinary catheters may be used as patients become less mobile, incontinent, retentive, and unable to care for themselves. In such cases, short-term catheterization may contribute to patient comfort and dignity.

OMI obtained a list of all 81 patients admitted to the CLC's hospice from October 2007 through April 2008. A convenience sample of eight cases was reviewed. In all eight cases, the admitting orders either acknowledged the presence of a urinary catheter at the time of admission or authorized catheterization as needed for comfort care. In all eight cases, the patient received an indwelling catheter prior to death.

The VHA regularly reports the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Quality Indicators (QI) developed by the Centers for Medicare and Medicaid Services (CMS). The prevalence of indwelling urinary catheters is documented in QI #10. From October 2007 through September 2008, the CLC

average prevalence of urinary catheters was 11.3 percent while the average of all 133 VHA CLCs was 14.9 percent. Hospice data is not broken out from overall CLC data.

OMI conducted a focused review of five CLC Veterans reported to have urinary catheters in April 2008. Each had medical diagnoses or conditions where the use of a urinary catheter may be appropriate.

Conclusions regarding complaint C.1.

The OMI did not substantiate that the CLC has an official policy or expected practice that all patients not fully capacitated must receive a urinary catheter regardless of medical necessity. The OMI reviewed a total of 13 cases and all had appropriate medical indications for the use of a urinary catheter. OMI concludes that urinary catheter use in the CLC is within standards of medical practice and is not excessive.

C. Overuse of urinary catheters in the hospice unit

2. The complainant alleged that she removed a urinary catheter from Index Case #7 because of excessive amounts of urine leaking out of the catheter. The patient's continuous pulling of the catheter caused bleeding. After its removal, the urine flow became normal and the bleeding stopped. Subsequently, a CNA was ordered to replace the catheter and the bleeding problems resumed.

Findings regarding complaint C.2.

Index Case #7 was a 93-year-old male admitted to hospice on December 27, 2007, from the Medical Center's acute medical unit with a diagnosis of non-displaced left femoral neck fracture for which the family did not want to pursue surgery due to poor quality of life. The patient was also legally blind and had increasingly severe dementia. He arrived to the hospice unit in a confused and combative state with a urinary catheter draining bloody urine. He was wearing soft mittens to prevent him from pulling the catheter out. On December 30, the complainant wrote a progress note stating she removed the patient's catheter because she observed urine leakage around it, and there was more urine on the bed than in the catheter bag. A nurse performed a bladder scan which showed a small quantity of urine remaining in the bladder (93 cc). The complainant's note further states "no need for re-catheterization at this time." There is documentation of frequent bed changes due to his urine incontinence and the concern for a potential skin breakdown. On January 1, 2008, a nurse's progress note documented bloody discharge with sediment from the patient's penis. The nurse notified the provider who evaluated the patient and wrote an order for re-insertion of the urinary catheter. The patient tolerated the procedure well and the urine return was 100 cc with an amber color. On January 9, 2008, the urinary catheter was removed because of the patient's frequent attempts to pull on it. The patient remained without a urinary catheter until his death on January 11, 2008.

Conclusion regarding complaint C.2.

The OMI did not substantiate that use of an indwelling urinary catheter was inappropriate for Index Case #7.

C. Overuse of urinary catheters in the hospice unit

3. The complainant alleged that Index Case #8 developed a urinary tract infection (UTI), because his indwelling urinary catheter was not removed, even though he was able to go to the bathroom without assistance.

Findings regarding complaint C.3.

Index Case #8 was an 83-year-old male, admitted directly into hospice from home on May 8, 2008, with a diagnosis of progressive pancreatic cancer and the residual of a previous stroke. The Veteran was very jaundiced and weak on admission. He reported difficulty passing urine and, after he attempted to void, a nurse performed a bladder scan which showed a large quantity of urine remaining in the bladder (502 cc). Such a high volume of retention poses a risk for infection, overflow incontinence, or other urologic injury, and the appropriate practice is to drain the bladder by placement of a urinary catheter. The nurse wrote a progress note stating, "Patient was given the choice of being straight cath or having a catheter inserted. He chose having the catheter inserted. Patient tolerated the procedure with very little discomfort."

The Veteran was evaluated as being at a very high risk for falls. There is no documentation that he was ever successful in urinating on his own, and his weakness and confusion hindered his ability to independently ambulate to the toilet or use a urinal. Consistent with the tenets of hospice care and his advance directive, the Veteran did not have routine laboratory testing such as a urinalysis or urine culture. However, on several occasions the nurses noted his urine to be foul smelling. His record did show that he had a multiple organism urinary tract infection during a hospitalization in January 2008. The Veteran died May 18, 2008, and no autopsy was performed.

Conclusions regarding complaint C.3.

The OMI did not substantiate that the use of an indwelling urinary catheter was inappropriate in Index Case #8 who had significant urinary retention and elevated risk of falls. The OMI did not substantiate that he was able to go to the bathroom without assistance. The OMI concludes that it likely that Index Case #8 did have a urinary tract infection prior to his death. The OMI is unable to establish whether the catheter caused the infection.

C. Overuse of urinary catheters in the hospice unit

4. The complainant alleged that Index Case #9 did not require a urinary catheter and that a provider posted a message that the catheter was not to be removed without provider's orders.

Findings regarding complaint C.4.

Index Case #9 was a 68-year-old male with advanced alcoholic liver disease and bleeding esophageal varices. He was transported to the Medical Center's Emergency

Room (ER) on January 24, 2008, after having fallen at home and being unable to get up for several days. The Veteran was initially resuscitated in the Medical Center's ICU, but, consistent with his advance directive and the late stage of his terminal condition, he was transferred to hospice on January 25, 2008. The Veteran received palliative care for several days and was frequently incontinent of urine. This was managed by adult diapers and the use of an external condom catheter. On January 30, 2008, at 1:38 p.m., a nurse wrote a progress note stating that the patient was restless after lunch and found sitting up at the side of his bed stating that he had to urinate. He was catheterized and 700 cc was removed from his bladder. The note further states that the patient was resting comfortably after the procedure.

At this point, the Veteran was judged to be actively dying with alternating confusion, agitation, and skin mottling. In interviews with the OMI team, nursing staff and providers acknowledged that, given the patient was hours to days away from death, there were differences of opinion about whether or not the indwelling catheter was necessary. Ordinarily, the nursing staff is allowed to exercise their independent judgment about whether to insert or remove a catheter. However, in this case, the responsible nurse practitioner wrote an order at 5:02 p.m. on January 30, 2008, stating, "Do NOT discontinue Foley catheter without this provider's order." The Veteran died less than 24 hours later at 3:00 p.m. on January 31, 2008.

Conclusions regarding complaint C.4.

The OMI did substantiate that an order was written instructing that a urinary catheter not be removed without a specific provider order. The OMI concludes that the use of the indwelling catheter was appropriate.

Summary conclusions regarding complaint C.

Overuse of urinary catheters in the hospice unit

The OMI did not substantiate that urinary catheter use in the CLC and hospice was excessive or outside the standards of medical practice. The OMI concludes that urinary catheter use in the four cases provided by the complainant was appropriate.

The OMI made no recommendations regarding complaint C.

No Medical Center actions were necessary.

D.1. Staffing shortages resulting in patient neglect

a. Staff to patient ratio was insufficient. Management informed staff the normal ratio for CLC was one licensed professional and one CNA for each wing (3 wings). Each shift a charge nurse is assigned to 3 wings on the same floor. In most situations, there are 19-35 patients spread out over three wings, which required at least 2 licensed professionals and 3 CNAs during each shift. Complainant alleged there were only 2 RNs and 3 CNAs for 21-28 patients throughout the 3 wings, which left one wing without a licensed professional (RN or LPN).

b. On one occasion there was 4 staff (2 RNs and 2 CNAs) for 19 patients, 5 of whom were total care. A fall with this coverage, would leave two staff for entire floor with one wing being unattended since two staff are required to operate the mechanical lift. The nursing supervisor requested that someone from the medical staff needed to pass out medications on the first floor. This occurred during dinner time at 5:00 p.m., when the CNAs were preparing patients in the hospice area for their meal. As a result, the complainant informed the supervisor that at least one staff member needed to remain in hospice. The supervisor insisted, and the complainant spent 1.5 hours passing meds on first floor. During that time, two patients fell (Index Case #10). Complainant completed an incident report and "cited" a shortage of staffing as the cause.
c. Index Case #11 had a painful wound in his chest. Complainant left a note for the day shift to examine the wound. The next day, she inquired about the patient to another RN who responded, "it had not been her priority, and did not matter since the patient was dying anyway." Subsequently, it was discovered that the wound had become infected with methicillin-resistant *Staphylococcus aureus*[9] (MRSA). Complainant believes the patient would have lived longer, if the wound had been treated in a timely manner.
d. Index Case #12 was being fed through a gastrostomy tube and had a tracheal tube, was observed by the complainant being fed without the head of his bed being elevated and not receiving proper care to his tracheal tube by the day shift nurses and respiratory therapist. According to complainant, failure to properly maintain his tracheal tube and/or elevate the bed could lead to aspiration pneumonia and possibly death. Complainant further alleges this was not done intentionally, but rather because of short staff. Ultimately, the patient developed aspiration pneumonia; the complainant believes this occurred due to inadequate care.
e. Index Case # 13 expressed to complainant that he was often ignored and left sitting in stool because many of the nurses did not like his personality. As a result he developed many infections and rashes.

D.2. Staffing shortages resulting in medical errors by nursing personnel

a. In one instance, Index Case #14 was placed back into bed while a sling that had not been cleaned, remained under the patient
b. During complainant's evening shift, she discovered urine bags were not being emptied by the day shift
c. In one instance, found a patient's pills still sitting in applesauce on desk
d. In January 2008, an LPN accidentally left the cap on a urinary catheter when she inserted it into a patient. As a result, no urine drained for several hours until staff from next shift discovered the problem
e. Two RNs erroneously placed forced air instead of oxygen on a patient who had returned from surgery

[9] Methicillin-resistant *Staphylococcus aureus* (MRSA). Staphylococci are bacteria that usually live on the skin and in the nose, usually without causing harm. MRSA is resistant to several types of antibiotics of the beta-lactam family, including methicillin and penicillin; because of its antibiotic resistance it may cause very serious infections.

f. A nurse practitioner ordered a patient's IV at a wide-open rate of 400 ml/hour. Complainant found this to be excessive and obtained a corrected order for 250 ml/hour.

D.1. Staffing shortages resulting in patient neglect

a. Staff to patient ratio was insufficient. Management informed staff the normal ratio for CLC was one licensed professional and one CNA for each wing (three wings). Each shift a charge nurse is assigned to three wings on the same floor. In most situations, there are 19-35 patients spread out over three wings, which required at least two licensed professionals and three CNAs during each shift. Complainant alleged there were only 2 RNs and 3 CNAs for 21-28 patients throughout the 3 wings, which left one wing without a licensed professional (RN or LPN).

Findings regarding complaint D.1.a.

During interviews with the staff nurses, the evening Nursing Officers of the Day (NODs), and the Associate Director for Patient Care Services (Executive Nurse), it was acknowledged that there were some staffing challenges during Fiscal Years (FY) 2007 and 2008 at the Medical Center and that both CLC units were no exception. The CNAs interviewed stated that they worked without the planned number of staff at times. However, during those under staffed periods, the patient census was reduced and the CLC was provided with help from other units, from staff working overtime, or from outside contract nurses.

The Associate Director Patient Care Services confirmed that in 2007 there were recruitment and retention issues throughout the Medical Center. In the CLC there were three losses of experienced staff, two retirements, and one relocation. There were also night shift vacancies that had been open for about 18 months on CLC-2. As part of her management efforts to address this issue, the Associate Director Patient Care Services sent out an e-mail outlining her plan to support the CLC. Staffing shortfalls on CLC-2 were addressed by pulling staff from CLC-1, using overtime and contract nurses, by limiting the number of admissions to the unit, and by utilizing flexible scheduling and compensatory time.

CLC night positions were the hardest to fill. Contract agency nurses were brought in for both RN and LPN positions on 13-week contracts. During March and April of 2008, some of the agency staff did not renew their contracts and the contractor had to recruit and train new staff. This resulted in a period of further decreased staffing during which the patient census was kept below bed capacity. A nurse recruiter was hired on March 8, 2008, and was given CLC as a priority. By the summer of 2008, the staffing issues had improved there was no longer a need for agency staff.

The Associate Director for Patient Care Services and the NODs reported that the complainant did bring to their attention occasions when only two RNs and three CNAs were available to cover all three wings of CLC-2. The matter was brought up to the Nurse Manager who remedied the situation immediately by cohorting patients

to just two of the three wings on the floor so there would be adequate coverage of licensed nursing staff.

The OMI conducted a review of the CLC-2 nurse staffing coverage sheets from October 2007 to April 2008. There were no separate staffing plans for CLC-2 and hospice. Appropriate assignment of staff between the two areas is at the discretion of the Charge Nurse, based on census distribution, patient acuity and workload intensity, and staff mix and skills. The average daily census in CLC-2 for this time period was 19-20 patients, including 4 patients in hospice. While there are no VHA-wide standards for staffing ratios, the Medical Center practice was to schedule a minimum of 4.45 staff on the evening shift for that average census. The actual staffing on CLC-2 averaged 6.3 on evenings, a ratio of 1 nurse for every 3-4 patients. The day shift had an average of 8 staff members and the night shift averaged 5.6.

Conclusions regarding complaint D.1.a.

The OMI substantiates that there were nurse staffing shortages in FY 2007 and 2008. The OMI concludes that Medical Center and CLC leadership took appropriate steps to address this shortfall. The OMI concludes that the actual nurse-patient ratio on CLC-2 during the evening was adequate and exceeded the Medical Center minimum.

D.1. Staffing shortages resulting in patient neglect

b. On one occasion there were 4 staff (2 RNs and 2 CNAs) for 19 patients, 5 of whom were total care. A fall with this coverage, would leave two staff for entire floor with one wing being unattended since two staff are required to operate the mechanical lift. The nursing supervisor requested that someone from the medical staff needed to pass out medications on the first floor. This occurred during dinner time at 5:00 p.m., when the CNAs were preparing patients in the hospice area for their meal. As a result, the complainant informed the supervisor that at least one staff member needed to remain in hospice. The supervisor insisted, and the complainant spent 1.5 hours passing meds on first floor. During that time, two patients fell. Complainant completed an incident report and "cited" a shortage of staffing as the cause.

Findings regarding complaint D.1.b.

The complainant provided information on what initially appeared to be two patients but a thorough review of medical records showed she had listed one patient twice by his name and again by his nickname. Index Case #10 was a 73-year-old male admitted to hospice on March 4, 2008, for end-stage chronic obstructive pulmonary disease, anxiety and confusion, general weakness of his lower extremities, and peripheral vascular disease. He was identified as a "high risk for falls" patient. According to documentation, he was provided with non-skid footwear, bed and chair alarms, and other safety precaution measures.

On March 15, 2008, day shift staff reported that the patient attempted to stand up from his reclining chair without assistance and fell to the floor. The patient census at

that time was 24 with 3 hospice patients. The staffing consisted of two RNs, three LPNs, and three CNAs. The patient was appropriately assessed, no injury was identified, and his recliner was replaced with a special Broda chair®. He was reminded to use the call light button when in need of assistance. A hospice volunteer was assigned to remain with the patient at all times during that shift. After the volunteer left, but before arrangements could be made for further volunteer coverage on the evening shift, the patient fell again at 5:30 p.m. The bed alarm in the patient's room was activated, and he was found lying on the padded floor mat. The CNA called the RN to assess the patient and no injuries were found. The nurse supervisor was notified, and she arranged for a sitter during the remainder of the evening shift and the upcoming night shift. The patient expired on March 22, 2008, from conditions unrelated to his falls.

The patient census during that evening shift was 26 patients and staffing was 3 RNs and 4 CNAs. The patient fell the second time when the complainant was away to pass medications on CLC-1, leaving two RNs and four CNAs remaining on the unit. The Medical Center minimum evening shift staffing plan for that census was 5.9.

Conclusions regarding complaint D.1.b.

The OMI did substantiate that Index Case #10 fell twice on March 15, 2008. The OMI concludes that the patient had been identified as being at high-risk for falls and that appropriate precautions had been implemented. The OMI concludes that nurse staffing was adequate even when the complainant was on another floor passing medications. The OMI could not substantiate patient neglect.

D.1. Staffing shortages resulting in patient neglect

c. Index Case #11 had a painful wound in his chest. Complainant left a note for the day shift to examine the wound. The next day, she inquired about the patient to another RN who responded, "it had not been her priority, and did not matter since the patient was dying anyway." Subsequently, it was discovered that the wound had become infected with MRSA. Complainant believes the patient would have lived longer, if the wound had been treated in a timely manner.

Findings regarding complaint D.1.c.

Index Case #11 was an 87-year-old male admitted to CLC-1 in December 30, 2005, with a diagnosis of chronic Alzheimer's disease. He remained in this unit until March 19, 2008, when he was transferred to hospice because of his deteriorating dementia. A review of the medical record indicates that the complainant wrote a progress note on April 5, 2008, at 11:30 p.m., stating the patient had a "large area on upper right side of chest that is red and blotchy with blisters, like herpes. Turned and repositioned for comfort when in bed." No further notes were written during the evening shift. A second note written at 4:27 a.m. on April 6 by a different RN states "will notify day shift RN of lesion to follow-up with MD." Later that day, a note written by the day shift nurse at 4:14 p.m. did not make any reference to the lesion. That evening at 7:00 p.m., the complainant wrote a progress note indicating that the

his chest rash was painful. She contacted the evening supervisor, and the patient was transferred to the ER where his skin rash was cultured. The wound was cleaned and the patient was begun on antibiotics for both virus (acyclovir) and bacteria (cephalexin). The culture grew a common skin contaminant, *Staphylococcus epidermidis*, and not MRSA.

On April 7, 2008, at 2:00 p.m., the patient's physician wrote a note indicating that the patient's wife and daughter were notified of the patient's rash. They stated that he had a history of developing numerous seborrhic keratosis which had to be removed in the past. [10] Subsequent progress notes reflect continuous skin care with improvement noted. The patient expired on April 16 of conditions unrelated to his skin rash or MRSA.

Conclusions regarding complaint D.1.c.

The OMI did substantiate that there was a delay in the evaluation of the chest rash on Index Case #11. The OMI did not substantiate that the rash was caused by MRSA. The OMI concludes that the evaluation and treatment of the rash was appropriate. The OMI could not substantiate patient neglect.

D.1. Staffing shortages resulting in patient neglect

d. Index Case #12 who was being fed through a gastrostomy tube and also had a tracheal tube, was observed by the complainant being fed without the head of his bed being elevated and not receiving proper care to his tracheal tube by the day shift nurses and respiratory therapist. According to the complainant, failure to properly maintain his tracheal tube and/or elevate the bed could lead to aspiration pneumonia and possibly death. Complainant further alleges this was not done intentionally, but rather because of short staff. Ultimately, the patient contracted aspiration pneumonia and the complainant believes this occurred due to inadequate care.

Findings regarding complaint D.1.d.

Index Case #12 was an 87-year-old male admitted to the CLC on March 13, 2008, following a prolonged hospitalization in a community hospital. He had been struck by a motor vehicle in January 2008, sustaining a major traumatic brain injury and required prolonged ventilator support. He was transferred to the CLC for skilled nursing care and rehabilitation. When admitted, he had a fenestrated tracheostomy[11] tube to facilitate clearance of secretions and a stomach tube for feeding and medications. He had very limited ability to care for himself and limited ability to communicate. He had an extensive family who visited frequently. During interviews

[10] Seborrheic keratosis usually appears as a brown, black, or pale growth on the face, chest, shoulders or back. The growth has a waxy, scaly, slightly elevated appearance. Occasionally, it appears singly, but multiple growths are more common. Typically, seborrheic keratoses do not become cancerous, but they can look like skin cancer.

[11] A fenestrated tracheostomy tube has one added feature from normal tracheostomy tubes; a hole in the outer cannula. This opening allows air to pass from the patient's lungs up through the vocal cords and out through the mouth and nose. It therefore, lets the patient breathe normally, as if one did not have tracheostomy. It also allows the patient to speak and cough out secretions through the mouth.

with OMI, the nursing staff indicated that the family was very involved in his care and would often lower the head of his bed and attempt to feed him solid food that he was incapable of swallowing. This increased his risk of aspiration and nursing staff worked with the family to modify their behavior.

Numerous progress notes from nurses and respiratory therapists reflect attention to pulmonary toilet and precautionary measures to minimize the risk of aspiration pneumonia. The Veteran was at a very high risk of aspiration because of his traumatic brain injury and the presence of the tracheostomy. Recognizing this, the attending provider consulted speech therapy to evaluate his swallowing and they completed a formal radiographic swallowing study. The staff and providers were very attentive to the risk of pneumonia and examined the patient regularly and ordered frequent chest radiographs. He was transferred to the acute care section of the hospital on five occasions when there was concern about the possibility of pneumonia or other infection. Over the course of his prolonged residence in the CLC, he received multiple courses of antibiotics. He remains in the CLC almost a year after admission.

Conclusions regarding complaint D.1.d.

The OMI could not substantiate patient neglect. The OMI concludes that Index Case #12 was at very high risk of aspiration due to his medical problems and that appropriate efforts were made to prevent, detect and treat aspiration pneumonia. .

D.1. Staffing shortages resulting in patient neglect

e. Index Case # 13 expressed to the complainant that he was often ignored and left sitting in stool because many of the nurses did not like his personality. As a result he developed many infections and rashes.

Findings regarding complaint D.1.e.

Index Case # 13 was an 85-year-old male with a history of stroke in 1985 and 2006 resulting in hemiplegia of the left upper extremity. He also had Parkinson's disease and dementia. He was admitted to the CLC on October 11, 2006, for physical medicine and rehabilitation treatment, with a focus on strengthening and gait training. Numerous progress notes written by physical therapy, nursing, and other members of the treatment team indicate that the patient voiced frustration with his deteriorating condition and at times became angry and argumentative during the care that was being provided.

On November 7, 2006, the patient reported to the nursing staff that "there were drug dealers attempting to give him drugs" and began refusing his medications. Psychiatry was consulted and neuro-cognitive testing was completed. The patient was found to be confused and paranoid, and antipsychotic medications were prescribed. Subsequent progress notes indicate that the patient's behavior escalated in that he became irritable upon approach, agitated, and combative during care. Various medication changes were made in an effort to reach therapeutic levels with only temporary improvements in behavior. He received frequent visits from his daughter

in which he told her that "the staff are withholding my baths because they are running for a political party." On November 13, 2006, his daughter decided to pursue power of attorney over his care. On November 19, 2006, the complainant wrote a progress note indicating the patient tends to be "rude" in his communication and became angry with his sister over the phone. Further notes from the complainant and other staff members reflect the patient's continued mental deterioration.

OMI review of the medical record and interviews with staff did not reveal any incidence when the Veteran was left sitting in stool for a prolonged period. The record does reflect appropriate and timely evaluation of several significant concerns. On March 29, 2007, the nursing staff requested a wound care team evaluation of a bilateral red macular rash on the Veteran's feet. The diagnosis was *tinea pedis* (athlete's foot) with associated cellulitis on his right foot. Appropriate antibiotics and topical cream medications were ordered. By April 2, the interdisciplinary care team noted that the rash was nearly resolved and that the foot clinic had provided the patient with special tennis shoes. During the evening of April 22, 2007, the patient complained of tenderness of his right calf and was taken to the ER. An ultrasound revealed a deep vein thrombosis (DVT) of his right leg. The patient was started on anticoagulation therapy and the symptoms of DVT resolved by April 30. Further recordings in the medical record indicate frequent patient care interventions by the nursing staff and other members of the interdisciplinary care team. The patient expired on June 22, 2007.

Conclusions regarding complaint D.1.e.

The OMI did substantiate that Index Case #13 did have a skin rash but concludes that it was appropriately evaluated and treated. The OMI could not substantiate that the Veteran was left sitting in stool. The OMI concludes that despite the Veteran's behavior problems that important medical concerns were appropriately addressed. The OMI could not substantiate patient neglect.

In discussions with the OMI, the complainant provided three additional Supplemental Cases alleging neglect

The complainant alleged that on April 6, 2008, Supplemental Case #5 failed to receive a spray medication on an area that was in danger of becoming a bedsore, and that milk of magnesia (MOM) was not given as requested by the patient.

The complainant alleged that on April 5, 2008, Supplemental Case #6 who was 2 days after surgery did not receive ice treatments as prescribed and that nurses did not properly assess the operative site.

The complainant alleged that Supplemental Case #7 received medication in his orange juice against his desires and that one of his children might have ingested some orange juice with his father's medication in it.

Findings regarding Supplemental Case #5

Supplemental Case #5 was a 76-year-old male admitted to hospice on April 2, 2008, with a diagnosis of advanced lung cancer. An area of concern at admission was a reddened area on his coccyx felt to be at risk for developing a bed sore. In addition to regular repositioning of the Veteran, the attending provider ordered that a preventive spray (castor oil/Peruvian balsam/trypsin) be applied every 8 hours. The medical record documents that, during the first week of admission, the spray was applied three times daily except on April 7, 2008, when the morning dose was not administered. Nurse's notes from that period only make one mention of the reddened area and do not address a reason for the missing treatment. Skin care remained a priority for the staff and the Veteran died on May 20, 2008, without a bed sore.

Supplemental Case #5 also had concerns about constipation. Because of his limited mobility, requirement for narcotic pain medications, and history of bowel impaction, the Veteran was placed on a routine regimen of stool softeners and stimulant laxatives. His admission orders also included an as-needed order for MOM. The BCMA record indicates that he was given MOM on April 4, 5, 6, and twice on April 7. The nurse's notes from that period reflect the Veteran's worries about becoming constipated and show appropriate responses—encouraging hydration, offering prune juice, providing MOM as requested, and documenting bowel movements.

Conclusions regarding Supplemental Case #5

The OMI did substantiate that a spray-on treatment to a reddened area was missed on April 7, 2008. The OMI concludes that there was no adverse effect on the Veteran as a result of the missed treatment. OMI could not substantiate that a dose of MOM was withheld from the Veteran. The OMI could not substantiate patient neglect.

Findings regarding Supplemental Case #6

Supplemental Case #6 was a 78-year-old male who presented to the Medical Center's emergency room (ER) on January 25, 2008, after having slipped on ice at home. He was diagnosed with a broken left upper arm and was transferred to a community hospital for orthopedic care. The community specialist advised that surgery was not appropriate and that the Veteran be treated conservatively with immobilization. He returned to the CLC on January 29, 2008, for rehabilitation. On January 30, 2008, the Veteran had a formal nursing falls risk assessment. He was judged to be at high risk for falls, and appropriate interventions were implemented. A note completed at 3:20 a.m. on February 2, 2008, documented:

> Bed in low position, Call light within reach, Low bed, Bed/chair alarm Safety Alarms (bed alert, Wander Alert, etc) are functioning and audible.

At 6:30 a.m. on February 2, 2008, the patient was found lying on the floor beside his bed. There is no documentation about whether the Veteran activated his call light or whether the bed alarm was activated. The Veteran was transported to the Medical Center's ER where the physician wrote, "Patient states he was getting out of bed and fell after standing up." The Veteran had a fracture of his right hip and was transferred

to a community hospital for definitive care. Both his right hip and his previously broken left upper arm were surgically repaired during that admission. He returned to the CLC on February 6, 2008, for rehabilitation.

Over the next 2 months, the Veteran remained in the CLC and was actively involved in physical therapy. He was followed by his community orthopedic surgeon for his fractures and for chronic instability of his right elbow. On April 3, 2008, he underwent surgical repair of his right elbow in a community hospital, returning the same day to the CLC. His postoperative orders written at 4:30 p.m. on April 3, 2008, included:

> If temperature is greater than 101 check operative site for signs of infection (increased pain, redness, swelling, foul odor or drainage)
> ICE to operative site 20 minutes at a time at every 4 hours for 72 hours—after this may use as needed for pain or swelling.
> Monitor for excessive bleeding. (Slow oozing that saturates dressing or frank bright red bleeding report to provider.
> RN to remove dressing on Saturday afternoon (4/5/08) document assessment in progress note (wound site color, swelling, drainage, sutures etc.)

Nurses' notes document appropriate attention to the surgical wound including removal of the dressing and observation on April 5, 2008, as ordered. The notes mention the frequent application of ice packs on April 3, 2008, but the evening note of April 4, 2008, states, "patient stated no ice packs were done during day shift today." There is no mention of ice packs on either April 5 or April 6, 2008. The BCMA log does not include documentation of non-medication orders such as ice packs.

The Veteran had a prolonged stay in the CLC with extensive rehabilitative services. He was discharged into an assisted living facility on December 4, 2008, and continues to receive physical therapy services at the Medical Center at the time of this report.

Conclusions regarding Supplemental Case #6

The OMI did substantiate that at least one postoperative application of ice packs were missed following the Veteran's surgery of April 3, 2008. The OMI does not substantiate that nursing staff failed to adequately evaluate the incision following the Veteran's surgery of April 3, 2008. The OMI could not substantiate patient neglect.

Findings regarding Supplemental Case #7

Supplemental Case #7 was a 39-year-old male admitted to hospice on February 22, 2006, with an aggressive brain tumor first diagnosed in 2000 and treated with surgery and radiation therapy at another facility. The Veteran was admitted after an MRI in January 2006 revealed tumor expansion and he had decreased mental alertness, frequent seizures, and difficulty ambulating. His medications were adjusted in the facility, and his alertness and communication gradually improved. During his CLC stay, he developed increasing combativeness with staff and family, erratic and aggressive behaviors, and hyper-religiousity. A psychiatric evaluation found him to lack the capacity for decision making and advised that his dose of anti-anxiety/anti-seizure medication (lorazepam) be increased. On March 30, 2006, an order was

written at 3:52 p.m. for lorazepam to be given in juice. At 5:21 p.m. the same day, the order was discontinued and the lorazepam was ordered as a tablet or by injection. The physician overseeing the patient's care recalled that the Veteran requested not to have the medication given in juice. There is no mention in the record of a child, or anyone else, ingesting lorazepam (or any other medication) in error. There were no incident reports filed at the CLC about any such occurrence and, almost 3 years after the alleged event, no one interviewed by OMI was aware of the incident. Despite the concerns of the staff and attending providers, the Veteran and his family decided to sign him out of the hospice against medical advice. He left on April 3, 2006. He has subsequently had additional neurosurgery and continues to receive care at the Medical Center.

Conclusions regarding Supplemental Case #7

The OMI could not substantiate that the child of Supplemental Case #7 ingested orange juice containing medication. The OMI could not substantiate patient neglect.

Summary conclusions on complaint D.1.

Staff shortages resulting in patient neglect

The OMI did substantiate that there were difficulties in maintaining desired staffing levels in the CLC during FY 2007-2008. The OMI concludes that the Medical Center leadership took appropriate steps to address the issues by reducing the patient census, providing additional staff from other units, and use of contract nurses. The OMI could not substantiate that patients were neglected as a result of staff shortages.

The OMI made no recommendations regarding complaint D.1.

D.2. Staffing shortages resulting in medical errors by nursing personnel

a. In one instance, Index Case #14 was placed back into bed while a sling that had not been cleaned, and remained under the patient.
b. During complainant's evening shift, she discovered urine bags were not being emptied by earlier shifts.
c. In one instance, complainant found a patient's pills in his bed and another's were still sitting in applesauce on the desk.
d. In January 2008, an LPN accidently left the cap on a urinary catheter when she inserted it into a patient. As a result, no urine drained for several hours until staff from next shift discovered the problem
e. Two RNs erroneously placed forced air instead of oxygen on a patient who had returned from surgery
f. A nurse practitioner ordered a patient's IV at a wide-open rate of 400 ml/hour. The complainant found this to be excessive and obtained a corrected order for 250 ml/hour.

D.2. Staffing shortages resulting in medical errors by nursing personnel

a. In one instance, Index Case #14 was placed back into bed while a sling that had not been cleaned, and remained under the patient

Findings regarding complaint D.2.a.

Index Case #14 was an 80-year-old male receiving long-term care since October 2005 for Lewy body dementia.[12] He was diagnosed recently with pancreatic cancer causing biliary obstruction and was admitted for hospice care at the family's request on October 18, 2007. OMI reviewed the medical record, which included the complainant's progress notes. There was no mention that the patient was found lying on a sling. OMI also reviewed all of the incident reports from the CLC. There were no incidents reported on this patient by the complainant or any other member of the interdisciplinary team. During the interviews with various nursing staff and supervisors, there was no recollection of a sling being reported left under this patient, or any other patients.

Conclusion regarding complaint D.2.a.

OMI could not substantiate that Index Case #14 was placed back into bed while a sling that had not been cleaned, remained under the patient.

D.2. Staffing shortages resulting in medical errors by nursing personnel

b. During complainant's evening shift, she discovered urine bags were not being emptied by earlier shifts.

Findings regarding complaint D.2.b.

During the OMI tour of the CLC, the urine drainage bags observed did not contain excessive volumes of urine. Privacy covers were in place as required by long-term care standards. In interviews conducted with nursing staff from the both the day and evening shifts, nurses denied that it was common for urine bags to be overfilled or not to be emptied regularly. OMI reviewed all of the incident reports from the CLC for the period of the complainant's employment and there were no reports of overfilled urine bags.

Conclusion regarding complaint D.2.b.

The OMI could not substantiate that urine bags were overfilled or not being emptied appropriately by staff.

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[12] Lewy body dementia shares characteristics with both Alzheimer's disease and Parkinson's disease. Like Alzheimer's, it causes confusion. Like Parkinson's, it can result in rigid muscles, slowed movement, and tremors. The most striking symptom of Lewy body dementia may be its visual hallucinations, which can be one of the first signs of the disorder. Hallucinations may range from abstract shapes or colors to conversations with deceased loved ones.

D.2. Staffing shortages resulting in medical errors by nursing personnel

c. In one instance, complainant found a patient's pills in his bed and another's were still sitting in applesauce on the desk.

Findings regarding complaint D.2.c.

No patients were identified as relating to this complaint. During the OMI tour of the CLC, the OMI team did not observe medications lying on the patients' desks or night stands. In interviews conducted with nursing staff from the both the day and evening shifts, nurses all stated that it was against policy to leave medications on the patients' desks or night stands during their rounds. OMI reviewed all of the incident reports from the CLC for the period of the complainant's employment and there were no reports addressing these allegations.

Conclusion regarding complaint D.2.c.

The OMI could not substantiate that patients' medications were left unattended at the bedside.

D.2. Staffing shortages resulting in medical errors by nursing personnel

d. In January 2008, an LPN accidently left the cap on a urinary catheter when she inserted it into a patient. As a result, no urine drained for several hours until staff from next shift discovered the problem

Findings regarding complaint D.2.d.

No patient could be identified as relating to this complaint. OMI interviewed the nurse identified in alleged incident. She worked the evening shift in the CLC from October 2005-February 2008. Currently, she works in the outpatient mental health program. The nurse stated that she remembered there were a number of different vendors for the urinary catheters used in January 2008. She could not recall inserting any urinary catheters. She had no recollection of anyone bringing the alleged incident to her attention. OMI reviewed the incident reports for the CLC and did not find this incident reported.

Urinary catheters do not have a cap on the end that goes into the urethra. The tubing from the urine drainage bag that connects to the external end of the catheter could have had a cap on it. Failure to remove such a cap could have caused the circumstance described in the complaint. However, there is no documentation or recollection of such an event. Such a circumstance would not cause harm to the patient if recognized and corrected within a few hours.

Conclusion regarding complaint D.2.d.

The OMI could not substantiate that this event occurred.

D.2. Staffing shortages resulting in medical errors by nursing personnel

e. Two RNs erroneously placed forced air instead of oxygen on Index Case #15 who had returned from surgery

Findings regarding complaint D.2.e.

Index Case #15 was an 82-year-old male resident of the CLC who was sent to a community surgical outpatient clinic for a right shoulder surgery on March 28, 2008. At 5:00 p.m., he returned to the CLC and his blood oxygen saturation (SO_2) was reported to be 77 percent (normal >90 percent) on 2 liters per minute of supplemental oxygen. At 6:30 p.m., an entry in the medical record indicated SO_2 of 83 percent. The next entry was at 11:00 p.m., documenting the patient complaining of difficulty breathing and SO_2 of 78 percent despite 3 liters per minute of oxygen. The physician was immediately notified and the patient was transferred to the ICU for evaluation. The patient was placed on 2 liters per minute of oxygen with an increase in his SO_2 to 98 percent. No cause was identified for the decreased SO_2. The Veteran remained stable overnight and was transferred back to the CLC the next day. He had no complications from the event.

When the ICU nurse returned the patient to his original room, she observed that an error had been made. On the wall of the patient's room there were standard outlets for both oxygen (with green markings) and for compressed air (with yellow markings) there was no oxygen flow meter in the patient's room. The compressed air outlet had a flow meter attached with a humidifier set-up. A humidifier would normally only be used when administering oxygen. It was obvious that the patient had been receiving air rather than oxygen and that led to his decreased SO_2. The staff wrote an incident report and the Medical Center conducted a root cause analysis. The resulting action plan included training all CLC staff on the difference between air and oxygen meters, on proper post-operative assessments, on the protocol for communications between nursing and respiratory therapy when low SO_2 occurs. OMI found the staffing level in effect at the time of the incident to be adequate. New air flow meters were purchased that could not be connected to a humidifier.

Conclusions regarding complaint D.2.e.

The OMI substantiates that Index Case #15 received air rather than oxygen in error. The OMI does not substantiate that the error was the result of staff shortage. The OMI concludes that the Medical Center took appropriate actions in response to the event.

D.2. Staffing shortages resulting in medical errors by nursing personnel

f. A nurse practitioner ordered a patient's IV at a wide-open rate of 400 ml/hour. Complainant found this to be excessive and obtained a corrected order for 250 ml/hour.

Findings regarding complaint D.2.f.

Index Case #16 was a 59-year-old male who sustained a broken neck with quadriplegia in June 2007. His initial surgical treatment and rehabilitation was in a community hospital and he was transferred to the CLC to continue rehabilitative therapy on October 10, 2007. He had a pressure ulcer on his coccyx at the time of transfer and this caused him severe pain throughout his stay. His pain was treated with gradually escalating doses of fentanyl via patch up to 150 mcg/hour ordered on November 23, 2007, and oral Vicodin™ tablets for breakthrough pain. The patient had significant problems dealing with his disability and evidenced depression, voluntarily reduced food intake and limited engagement in rehabilitative activities. He frequently expressed a desire to die rather than live with his quadriplegia, and he instituted an advance directive expressing his wishes. He was treated for his depression and received frequent mental health counseling. His desires were distressing to the staff, so much so that, on November 26, 2007, the nurse practitioner wrote a statement in his orders indicating that the patient had the right to determine his treatment, therapy time, food and medications. The staff members were instructed to honor his refusals and to document them in the chart.

On December 16, 2007, when a new fentanyl patch was placed on the patient, the old fentanyl patch was inadvertently left on. Fentanyl patches work by slowly releasing the contained drug through the skin into the bloodstream. They are routinely changed every 72 hours but, even after 3 days, the patches still contain a significant amount of the medication and must be removed to prevent an overdose.

At 11:00 a.m. on December 18, 2007, the patient was given a supplemental acetaminophen/oxycodone (5mg) tablet for pain and at 11:30 a.m. he was noted to be somnolent and difficult to arouse. His blood pressure decreased as did the oxygen levels in his blood. While the staff was trying to arouse him they noticed that the old fentanyl patch had not been removed. They removed the patch and contacted the physician and nurse practitioner who recognized that this was likely an accidental narcotic overdose. They were concerned that using a narcotic antagonist to reverse the sedation might precipitate a withdrawal crisis or a pain crisis. Given the patient's wishes to have limited interventions, they chose to use intravenous fluids to raise his blood pressure and not to transfer him to the hospital.

An order was written at 1:41 p.m. on December 18, 2007, for normal saline to be infused at 500 ml per hour. At 4:14 p.m., this was reduced to 250 ml per hour and, as the patient began to recover at 9:22 p.m. it was further reduced to 100 ml per hour. The patient recovered to his pre-overdose condition by the next morning and was informed about the medication error.

Discussion with staff and the nurse practitioner confirmed that the practice on the CLC is to limit intravenous infusions to 250 ml per hour.

Conclusions regarding complaint D.2.f.

The OMI substantiates that Index Case #16 received intravenous fluids in excess of usual practice in the CLC. However, the OMI concludes that the decision to use such

large volume resuscitation in the CLC was well considered and represented an appropriate response to the clinical circumstances and the patient's wishes. OMI concludes that a medication error occurred and that CLC staff members took appropriate clinical actions and provided an appropriate clinical disclosure. The OMI does not substantiate that the error was the result of staff shortage.

Summary conclusions regarding complaint D.2.

Staffing shortages resulting in medical errors by nursing personnel

The OMI substantiates that errors were made in two of the six cases reviewed. The OMI concludes that there were no lasting consequences to the involved patients and that the Medical Center took appropriate actions in each incident. The OMI did not substantiate that the errors occurred as a result of staff shortages. The OMI could not substantiate that all of the described events actually occurred as alleged.

The OMI made no recommendations regarding complaint D.2.

Medical Center Actions Taken

The Medical Center had taken appropriate action to address staffing by reducing the patient census, providing additional staff from other units, and use of contract nurses prior to the OMI site visit.

E. Unsanitary and unsafe conditions

1. The complainant noticed a "sharp increase" in the number of patients who contracted MRSA. She observed many of the medical personnel did not exercise hand washing before their next change of gloves.
2. The complainant said she observed a CNA cleaning a patient's foot that was infected with MRSA in a whirlpool tub, using another patient's water pitcher to pour water into the tub, thus contaminating the pitcher. The CNA returned the pitcher without sanitizing or disposing of pitcher. The patient (Index Case #17) complained to management and consequently was discharged 1 week after he made the complaint. The patient reported to the complainant he believed he was discharged because he reported the matter.
3. The complainant said she observed a nurse using an inhaler on a patient with lung MRSA and then placing the same inhaler in a cart or drawer used by multiple patients, and that this action was likely to cause cross contamination. She reported her concerns about the spread of MRSA to management officials.
4. The complainant said she reported housekeeping problems to management. She observed rooms insufficiently cleaned. Housekeeping would end operations by 3:00 p.m.; however, in 2008, they extended their shifts until 11:00 p.m. Sunday-Thursday. There is no coverage after 11:00 p.m. or housekeeping services from 3:00 p.m. to 6:00 a.m. on Fridays and Saturdays.
5. The complainant alleged that Medical Center policy required employees to rinse urinals with antiseptic spray. The medical staff had not received the spray when she left her employment in April 2008.

6. The complainant contended there were problems with the call lights on the first and second floors of the CLC. As a result, only employees who were in the nursing front desk area were able to be notified that a patient needed help. There were many times she observed there were no employees in the front desk area because of staff shortages. This remained a problem when she left her employment in April 2008.

E. Unsanitary and unsafe conditions

1. The complainant noticed a "sharp increase" in the number of patients who contracted MRSA. She observed many of the medical personnel did not exercise hand washing before their next change of gloves.

Findings regarding complaint E.1.

OMI conducted a review of the Medical Center's Infection Control surveillance report for Healthcare-Acquired MRSA Infections per 1,000 Bed Days of Care (BDC) from FY 2004 – 2008 (see table below). The total number of patients in the CLC identified with a MRSA infection was 40 in the 5 years. Statistical tests revealed no difference in infection rate over this 5 year period.

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
CLC Patients with MRSA	11	8	7	6	8
BDC	28, 085	28, 149	25,483	22,426	22,245
Occurrences per 1000 BDC	0.39	0.30	0.27	0.26	0.35

OMI also interviewed the Infection Control Nurse who indicated that there are two important initiatives to help reduce MRSA infections. One is a monthly newsletter titled *MRSA Reduction News.* The January 30, 2008, edition recognizes a Mobile Equipment Cleaning Technician for her contributions in reducing infection rates and each month an employee is acknowledged as an incentive for their efforts. The remainder of the newsletter provides information for continued education purposes concerning appropriate practices in the reduction of MRSA. She also stated that, as part of her efforts to increase compliance with the Centers for Disease Control and Joint Commission standards for infection prevention and control, she conducts an observation walk-through at least monthly on all units of the Medical Center. During this activity, and during other unscheduled unit visits, she has observed that the CLC staff members routinely follow the hand hygiene guidelines which are posted throughout the units. During OMI's tour of the CLC, members of the nursing staff were observed washing their hands between patient encounters and frequently using the alcohol-based hand washing dispensers as they entered and left patient rooms.

Conclusion regarding complaint E.1.

The OMI did not substantiate that there was a statistically significant increase in MRSA infections in the CLC. The OMI could not substantiate that CLC staff failed

to follow proper hand washing protocol but did observe appropriate practice during the site visit.

E. Unsanitary and unsafe conditions

2. The complainant said she observed a CNA cleaning a patient's foot that was infected with MRSA in a whirlpool tub, using another patient's water pitcher to pour water into the tub, thus contaminating the pitcher. The CNA returned the pitcher without sanitizing or disposing of pitcher. The patient (Index Case #17) complained to management and consequently was discharged 1 week after he made the complaint. The patient reported to the complainant he believed he was discharged because he reported the matter.

Findings regarding complaint E.2.

Patient Index Case #17 was a 55-year-old male with an extensive history of bipolar disorder and multiple chronic illnesses including diabetes mellitus, obstructive sleep apnea, hypertension, hyperlipidemia, obesity, and sinusitis. He was admitted to the CLC on December 3, 2007, after a prolonged admission in a community hospital for a fracture of his left leg after falling from a ladder at home. He was not able to bear weight on that leg and was unable to care for himself at home. During his stay in the CLC, he developed a re-occurrence of chronic sinusitis. After attempts to treat his sinusitis were unsuccessful, he was referred to otolaryngology (ENT) in the community. A nasal lavage was done and a culture of his nasal cavity grew MRSA. He was treated appropriately with two antibiotics. He improved clinically, but his nasal drainage never completely resolved. He was discharged home on April 16, 2008. He was able to bear weight, off of antibiotics, and in stable condition.

Throughout the review of the medical record, there was no indication that this patient had a foot infection with MRSA. OMI interviewed the CNA implicated in the allegation. He denied knowledge of the event and stated that, if he needed to cool the bath water, he would just open the cold water faucet directly into the whirlpool. He stated that he would not leave the shower area to obtain a pitcher. The OMI interviewed other nursing staff, and they confirmed that using a pitcher of water would not be necessary to cool bath water.

Conclusions regarding complaint E.2.

The OMI could not substantiate that the event described by the complainant occurred. The OMI did not substantiate that Index Case #17 had a MRSA infection of his foot. The OMI concludes that the Veteran's discharge was consistent with his improved medical condition.

E. Unsanitary and unsafe conditions

3. The complainant said she observed a nurse using an inhaler on a patient with lung MRSA and then placing the same inhaler in a cart or drawer used by multiple patients, and that this action was likely to cause cross contamination. She reported her concerns about the spread of MRSA to management officials.

Findings regarding complaint E.3.

The complainant did not provide sufficient information to identify the patient or staff member involved in the incident. As a result of the complainant's 2007 report of her concerns in pertaining to the likelihood of cross contamination when placing different patient inhalers in a cart drawer, the Medical Center's MRSA Reduction Committee announced in their January 30, 2008, *MRSA Reduction News,* a new policy that required all inhalers be placed in plastic bags and that the medication cart drawers need to be cleaned with bleach wipes between use. At that time, pharmacy staff members instituted a routine twice weekly cleaning of the medication cart drawers. During the OMI interview with the Infection Control Nurse, she stated that throughout her monthly unit walk-through, she has observed that the inhalers and other topical medications have been in plastic bags in accordance with the new policy.

Conclusions regarding complaint E.3.

The OMI could not substantiate that inhalers were handled in a manner that carried a risk of cross contamination. However, the OMI concludes it very possible that such practices did occur. The OMI concludes that Medical Center leadership has taken appropriate action in regard to the complainant's concerns regarding potential contamination of inhalers.

E. Unsanitary and unsafe conditions

4. The complainant said she reported housekeeping problems to management. She observed rooms insufficiently cleaned. Housekeeping would end operations by 3:00 p.m.; however, in 2008, they extended their shifts until 11:00 p.m. Sunday-Thursday. There is no coverage after 11:00 p.m. or housekeeping services from 3:00 p.m. to 6:00 a.m. on Fridays and Saturdays.

Findings regarding complaint E.4.

OMI conducted a telephone interview with the Chief of Environmental Management Services (EMS). He has been at the Medical Center for 2 years, but in the environmental cleaning field for 25 years. He stated that when he received the complainant's housekeeping issues via e-mail, he immediately investigated the issues and found that the housekeepers had been mixing cleaning materials incorrectly which made the floor sticky. Immediate action was taken and the problem was resolved. The other issue brought to his attention was the lack of cleanliness of the patients' over-bed and bed-side tables. He informed OMI that housekeepers are not to touch these tables, as they usually contain the patient's personal items. He has instituted a monthly "deep cleaning" process where the patient's personal items are stored in plastic bins and the patient's personal areas are cleaned. The tidiness of the patient's living area is usually up to them. Another change he instituted was expanded housekeeping coverage to the day shift 7 days a week and during the night shift for 5 days a week. At the time of the site visit, housekeeping covered the CLC night shift 7 days a week and additional personnel have been hired to cover the

evening shift. The Chief of EMS has also instituted training programs and chemical mixing stations to improve the services provided. Daily walk-a-rounds are conducted by housekeeping supervisors to monitor compliance with these services.

During OMI's tour in the CLC, the floors appeared clean and polished and the general appearance was hygienic. Most of the patients' rooms appeared orderly. Some Veterans expressed it was their preference to have the various personal items on their bedside tables.

Conclusions regarding complaint E.4.

The OMI did substantiate that housekeeping services were only available to the day shift 5 days a week in 2007. Medical Center leadership has responded appropriately to the concerns about cleaning by adding coverage 7 days a week for the day and night shifts with plans to add coverage for the evening shift.

E. Unsanitary and unsafe conditions

5. The complainant alleged that Medical Center policy required employees to rinse urinals with antiseptic spray. The staff had not received the spray when she left her employment in April 2008.

Findings regarding complaint E.5.

During the interviews with the Infection Control Nurse, nursing staff, and supervisors, the general practice stated was that the urinals purchased are disposable and changed weekly. Therefore, they are not required to clean the urinals during routine use. The Infection Control Nurse indicated she was not aware of any Medical Center policy that required cleaning urinals with an antiseptic spray.

Conclusion regarding complaint E.5.

The OMI could not substantiate that employees were not provided with a required antiseptic spray.

E. Unsanitary and unsafe conditions

6. The complainant contended there were problems with the call lights on the first and second floors of the CLC. As a result, only employees who were in the nursing front desk area were able to be notified that a patient needed help. There were many times she observed there were no employees in the front desk area because of staff shortages. This remained a problem when she left her employment in April 2008.

Findings regarding complaint E.6.

The CLC leadership and staff explained that the CLC has two separate alarm systems. The first incorporates an intercom system that rings both at the nurses' station on the CLC floor and in the patient's room. It allows the nurses to verbally respond to the

patient's signal via the intercom from the nurses' station. The auditory alarm also sounds in the patient room and there are flashing lights above the doors and in the hallways that alert nearby staff. The alarm differentiates between a bedside call and a call from the bathroom. If staff members are working in the hallway, they are expected to respond by promptly going to the room with the alarm. But, they do not have the ability to phone the patient's room as they would from the nurses' station. According to staff members and CLC leadership, the system functions as designed and has not been identified as a patient safety issue.

The second system is the "RN on Call System" that is used in the CLC for patients at high risk of falling. This system alerts the nursing staff that a patient has gotten out of bed unassisted and is thereby at risk for falling. The alarm is loud and rings in both the patient's room and at the nurses' station.

As a result of a patient safety root cause analysis (RCA) done in January 2008 to assess the risk of falls, one of the recommended actions was to implement a new alarm system. The desired system would provide better information on location and patient status to staff members who are away from the nurses' station when an alarm sounds. The CLC chartered an evaluation team including front line staff members and piloted a commercial alarm system in July 2008. The Medical Center leadership decided to purchase the system for the entire CLC and, at the time of the site visit, the system was on station and in the process of being installed.

Conclusions regarding complaint E.6.

The OMI did not substantiate that existing alarm systems only alerted employees at the CLC nurses' stations. The OMI concludes that Medical Center leadership have evaluated alarm vulnerabilities and are deploying a new system to alert staff to the needs of patients.

Summary conclusions regarding complaint E.

Unsanitary and unsafe conditions

The OMI did not substantiate that there was a statistically significant increase in MRSA infections in the CLC or that patient alarm systems in the CLC were limited to responses monitored at the nurses' station. The OMI could not substantiate that CLC employees failed to follow proper hand washing procedures, that inhalers were handled in a manner that carried a risk of cross contamination, or that specific events occurred as alleged. The OMI did substantiate that housekeeping services were only available to the day shift 5 days a week in 2007. The OMI concludes that Medical Center leadership has taken appropriate action in regard to concerns regarding potential contamination of inhalers, CLC hours of coverage by housekeeping, and alarm systems on the CLC.

Recommendation regarding complaint E.

12. The Medical Center should continue the practice of periodic direct observation of hand washing, medication handling practices and environmental cleanliness.

Leadership should communicate unit-specific results to staff members to encourage compliance and recognize exceptional performance.

Medical Center Action Taken

The Medical Center had taken appropriate actions regarding potential contamination of inhalers, CLC hours of coverage by housekeeping, alarm systems on the CLC, and conducting routine direct observation of hand washing, medication handling practice, and environmental cleanliness prior to the OMI site visit.

F. Falsification of records

1. CNAs were observed by complainant falsifying entries in their Activity of Daily Living (ADL) books.
2. CNAs were documenting in their treatment books that they had administered medications which were later found by the complainant at the patients' bedsides.
3. An LPN was entering false information in the computerized Patient Record System (CPRS) by pre-pouring medications, scanning them and then administering to the patient. She indicates this is called a "work around" and has caused this nurse to erroneously give medications that have been changed by a physician order
4. Late 2007, the ADL recordings were converted to electronic entries into CPRS. Complainant alleged that false entries were still occurring. On a patient who was unable to ambulate, it was recorded in one entry, that he walked a certain distance.

F. Falsification of records

1. CNAs were observed by complainant falsifying entries in their Activity of Daily Living (ADL) books

Findings regarding complaint F.1.

The OMI team interviewed a broad cross section of CNAs and staff nurses about documentation practices. Every day, CNAs are to document each Veteran's need for assistance with routine daily activities such as feeding, toileting, and ambulation. Paper logbooks were used during the first part of the complainant's employment. Since September 2007, CNAs have entered their observations and activities into a templated note in CPRS. As a matter of common practice and efficiency, staff members routinely waited until the end of a duty period and completed documentation of all of a shift's activities on multiple patients at one time. Staff nurses were required to review and sign-off on the CNA entries. This might be done contemporaneously or days later. While this process might result in errors of accuracy or completeness for a given patient, supervising nurses denied that there was a pattern of intentional falsification. The OMI team could find no incident reports about false entries in ADL books.

The Medical Center leadership has addressed the issue of inefficient and untimely documentation of ADLs by purchasing a documentation system that allows staff

members to enter formatted data through multiple access points located throughout the CLC. The system was scheduled for deployment by mid-2009.

Conclusions regarding complaint F.1.

The OMI could not substantiate falsification of ADL documentation. The OMI concludes that Medical Center leadership has taken appropriate steps to increase the accuracy and efficiency of ADL documentation.

F. Falsification of records

2. CNAs were documenting in their treatment books that they had administered medications which were later found by the complainant at the patients' bedsides.

Findings regarding complaint F.2.

No patients were identified as relating to this complaint. During the OMI tour of the CLC, the OMI team did not observe medications lying on the patients' desks or night stands. In interviews with nursing staff from both the day and evening shifts, nurses all stated that it was against policy to leave medications on the patients' desks or night stands. OMI reviewed all of the incident reports from the CLC for the period of the complainant's employment and there were no reports addressing these allegations.

Conclusion regarding complaint F.2.

The OMI could not substantiate the allegation.

F. Falsification of records

3. An LPN was entering false information in BCMA by pre-pouring medications, scanning them and then administering to the patient. She indicates this is called a "work around" and has caused this nurse to erroneously give medications that have been changed by a physician order

Findings regarding complaint F.3.

No patients were identified as relating to this complaint. However, the Associate Director for Patient Care Services (ADPCS) indicated that she became aware of similar BCMA "work arounds" in the fall of 2007. It is unclear whether this was a result of communication from the complainant. The ADPCS convened a meeting with the nurse managers to review the medication administration error reports and to identify where a "work around" could have contributed to an error. As these unsanctioned work practices were identified, staff members were counseled and re-trained on the proper practices. Staff members were informed that if the improper practices continued, then progressive disciplinary action would be taken. The CLC recognized that the layout of the BCMA medication administration carts could have contributed to the issue and new carts were purchased in September 2007. OMI reviewed all of the incident reports from the CLC for the period of the complainant's

employment and there were no reports indicating patient harm as a result of these improper practices.

Conclusions regarding complaint F.3.

The OMI substantiates that some staff members were using improper work processes when documenting medication administration with BCMA. The OMI could find no evidence that there was harm to any patient. The CLC leadership took appropriate actions to educate personnel and obtain new equipment to lessen the risk of error.

F. Falsification of records

4. Late 2007, the ADL recordings were converted to electronic entries into CPRS. Complainant alleged that false entries were still occurring. It was recorded on one occasion that Index Case #11, who was unable to ambulate, had walked a certain distance.

Findings regarding complaint F.4.

Index Case #11 was an 87-year-old male admitted directly from home to the CLC on December 30, 2005, with a diagnosis of Alzheimer's disease. He had been living with his wife who had recently suffered a heart attack and was unable to continue as his primary caregiver. He was a total care patient, unable to ambulate and incontinent of his bowel and bladder. The complainant did not provide a specific date of the alleged false entry. The Veteran has extensive documentation concerning his ADLs in which the nurses entered for his locomotion status, "activity did not occur."

The OMI team interviewed a broad cross section of CNAs and staff nurses about documentation practices. Everyday, CNAs were required to document each Veteran's need for assistance with routine daily activities such as feeding, toileting, and ambulation. Since September 2007, CNAs have entered their observations and activities into a templated note in CPRS. As a matter of common practice and efficiency, staff members routinely waited until the end of a duty period and completed documentation of all of a shift's activities on multiple patients at one time. Staff nurses were required to review and sign-off on the CNA entries. This might be done contemporaneously or days later. While this process might result in errors of accuracy or completeness for a given patient, supervising nurses denied that there was a pattern of intentional falsification. OMI reviewed all of the incident reports from the CLC for the period of the complainant's employment and there were no reports about false entries in ADL books.

The Medical Center leadership has addressed the issue of inefficient and untimely documentation of ADLs by purchasing a documentation system that allows staff members to enter formatted data through multiple access points located throughout the CLC. The system was scheduled for deployment by mid-2009.

Conclusions regarding complaint F.4.

The OMI could not substantiate that a false entry was made in the medical record of Index Case #11. The OMI concludes that Medical Center leadership has taken appropriate steps to increase the accuracy and efficiency of ADL documentation.

Summary conclusion regarding complaint F.

Falsification of records

The OMI could not substantiate falsification of documentation by CNAs of activities of daily living. The OMI concludes that Medical Center leadership has taken appropriate steps to increase the accuracy and efficiency of ADL documentation. The OMI substantiates that some staff members were using improper work processes when documenting medication administration with BCMA. The OMI could find no evidence that there was harm to any patient. The CLC leadership took appropriate actions to educate personnel and obtain new equipment to lessen the risk of error.

Recommendation regarding complaint F.

13. The Medical Center should review BCMA error reports and conduct periodic direct observations to ensure that the work practices and new BCMA equipment have minimized the opportunity for error.

Medical Center Actions Taken

The Medical Center leadership had taken appropriate steps to increase the accuracy and efficiency of ADL documentation prior to the OMI site visit.

G. The complainant's reports to management were not acted upon.

Findings regarding complaint G.

The OMI team reviewed the extensive documentation provided by the complainant including e-mail dialogue with Medical Center leadership. The OMI team conducted interviews with individuals currently in leadership positions in the CLC and the Medical Center. The OMI team interviewed the complainant on multiple occasions.

As detailed in the preceding findings (notably D.1.a., E.1., E.3., E.4., E.6., F.1., and F.3.), many of the complainant's concerns had been acknowledged and many have been addressed by management actions. The Medical Center leaders emphasized that their recognition of issues requiring remediation did not result solely from concerns raised by the complainant. Management stated that issues were brought to their attention by a variety of sources including incident reports from other staff members, routine review of quality data, and direct observation by supervisors. Management did not agree with all of the concerns raised by the complainant. Many of the complainant's allegations to management lacked specificity and did not attempt to differentiate between acceptable variations in practice or minor errors in work processes and intentional acts of neglect or falsification.

Summary conclusion regarding complaint G.

The OMI did not substantiate that management failed to respond to the complainant's concerns.

The OMI made no recommendation regarding complaint G.

Medical Center Actions Taken

Contrary to the complainant's claim, the Medical Center had taken many actions in response to her complaints prior to the OMI site visit.

H. OMI conclusion regarding violation/apparent violation of regulations, directives, or policies.

Although there were opportunities to improve care, the OMI found no violation/apparent violation of VHA or Medical Center regulations, directives, or policies.

Attachment 1

Case	Identified as	Concern
Index Case # 1		narcotics/laxatives
Index Case # 2		narcotics/laxatives
Index Case # 3		narcotics/laxatives
Supplemental Case # 1		narcotics
Supplemental Case # 2		narcotics
Supplemental Case # 3		narcotics
Supplemental Case # 4		narcotics
Index Case # 4		laxatives
Index Case # 5		abuse
Index Case # 6		abuse
Index Case # 7		catheter use
Index Case # 8		catheter use
Index Case # 9		catheter use
Index Case # 10		fall
Index Case # 11		infected wound
Index Case # 12		feeding tube
Index Case # 13		ignored by nurses
Supplemental Case # 5		decubitus ulcer
Supplemental Case # 6		fall
Supplemental Case # 7		medication in juice
Index Case # 14		placed in bed on soiled sling
Index Case # 15		did not hook up O_2 correctly
Index Case # 16		excess fluids
Index Case # 17		infected foot