



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Management of Patient Abuse Cases Charlie Norwood VA Medical Center Augusta, Georgia

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Executive Summary

The Office of Inspector General Office of Healthcare Inspections conducted an inspection related to the management of patient abuse incidents at the Charlie Norwood VA Medical Center, Augusta, GA. The complainant alleged that patient abuse cases were not managed properly, and as a result, patients were placed at risk.

We substantiated that some staff members and managers did not comply with policies for reporting patient abuse, evaluating victims of the alleged abuse, or evaluating the events. We also substantiated that some managers did not take appropriate or timely administrative action relative to the events. While non-compliance with policy may potentially place patients at risk, we found no evidence that patients were actually harmed by these procedural breaches.

We substantiated that a senior executive acted improperly in relation to the administrative action in the case of substantiated patient abuse and that responsible managers did not report the nurse to the State Licensing Board as required.

We made four recommendations. We recommended that the Medical Center Director ensure that:

- Staff members and managers receive training regarding the appropriate reporting and evaluation of alleged patient abuse cases.
- Staff responsible for the Administrative Investigation Board process receive appropriate training.
- Administrative Investigation Boards are completed in a timely manner, and that actions are implemented and tracked to completion.
- The appropriate process is followed when State Licensing Board reporting is indicated.

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Management of Patient Abuse Cases, Charlie Norwood VA Medical Center, Augusta, Georgia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to a confidential complainant regarding alleged mismanagement of two patient abuse incidents. The purpose of our review was to determine whether the allegations had merit.

Background

The Charlie Norwood VA Medical Center is a two-division facility located in Augusta, GA. The facility provides medicine, surgery, mental health, rehabilitation, and spinal cord injury services. It has 278 hospital beds, 60 domiciliary beds, and 132 community living center beds. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves approximately 101,000 veterans throughout east central Georgia and west central South Carolina.

On February 18, 2011, a confidential complainant alleged that two patient abuse incidents, which occurred in 2010 under previous facility leadership,¹ were not managed properly, and as a result, patients were placed at risk. Specifically, the complainant reported that:

- Some facility staff members did not comply with local policy regarding the reporting of alleged patient abuse.
- Some facility managers did not comply with local policies regarding completion of administrative actions.

Local policy describes patient abuse as any acts against patients that involve physical, psychological, sexual, or verbal abuse. Employees are required to report cases of actual

¹ The previous facility leadership included the Medical Center Director, Associate Director for Patient Care Services, and the Quality Manager.

and suspected abuse, and managers are required to assure a timely and appropriate investigation of the facts and circumstances. Veterans Health Administration (VHA) Human Resource (HR) regulations provide a table of penalties for the administration of disciplinary actions in cases of substantiated patient abuse.²

The complainant also cited personnel-related issues, which were outside of the OIG's purview, and were not addressed in this report.

Scope and Methodology

We conducted a site visit April 19–20, 2011. We interviewed the acting Risk Manager, acting Quality Management (QM) Coordinator, QM staff, ANEs, Associate Director for Patient Care Services, patient safety office staff, patient advocates, and the Chief and Assistant Chief of HR. We reviewed VHA and local policies and facility documents related to the reports and investigations of incidents of alleged patient abuse occurring between July 16, 2009, and April 20, 2011.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1. Compliance with Patient Abuse-Related Policies

We substantiated that some staff members and managers did not comply with policies for reporting patient abuse, evaluating victims of the alleged abuse, or evaluating the events. We also substantiated that some managers did not take appropriate or timely administrative action relative to the events. While non-compliance with policy may potentially place patients at risk, we found no evidence that patients were actually harmed by these procedural breaches.

The Table (on the following page) shows several important action steps for reporting, evaluating, and managing cases of actual and suspected abuse as outlined in local and VHA policies. Elements denoted with an asterisk indicate that while the steps were completed, they were not completed in a timely manner.

² VA Handbook 5021, *Employee/Management Relations*, April 15, 2002.

Table. Policy Requirements for Reporting, Evaluating, and Managing Abuse Cases

Policy Requirement	Case 1	Case 2
Witnessing employee notifies immediate supervisor without delay	Yes	Yes
Supervisor notifies Medical Officer of the Day (MOD) without delay	No	No
Supervisory nurse and MOD examine patient immediately	No	No
Supervisor notifies Police and Security Service (P&SS) without delay; P&SS conducts a preliminary investigation	No	Yes
Witnessing employee completes an incident report of the event within 24 hours	No	No
The responsible ANE completes a fact-finding review (suggested completion within 7 days)	Yes*	Yes
The Service Line Executive relieves the alleged abusing employee of patient care duties pending completion of the fact-finding or administrative investigation board (AIB)	Yes*	Yes

Case 1. The elapsed days from the date of the event to initiation of the final administrative actions totaled 242 days. The facility-level fact-finding review, which took about 4 months to complete, did not substantiate patient abuse in Case 1. However, some staff members (witnessing employee, charge nurse, nurse manager, and ANE) had not followed procedures to report and evaluate the suspected abuse event as required by policy. We found that:

- The MOD was not notified immediately of the suspected abuse, and the nurse supervisor and MOD did not conduct a physical examination of the patient. When these examinations are not promptly completed, physical evidence may be lost.
- P&SS was not notified of the suspected abuse, and therefore, did not complete an investigation that may have been needed for legal purposes.
- The alleged abusing employee (referred to as Nurse A) was not removed from direct patient care for more than 2 weeks after the event. In this case, Nurse A was not found to have abused the patient. However, immediate removal of subject employees from patient care activities pending the completion of relevant fact-finding is an important step to ensure patient safety.

Due to delays in completing the fact-finding review and providing related conclusions and recommendations, Nurse A was not returned to clinical duties on the unit until 6 months after the incident occurred, and administrative actions related to procedural lapses did not occur until 7 months after the event. These delays potentially compromised the reliability of witness' accounts of the events and due process for the involved employees. Because Nurse A was assigned to non-clinical duties for

approximately 6 months, the delays also affected Nurse A's availability for direct patient care.

Case 2. The elapsed days from the date of the event to final closure totaled 280 days. The AIB substantiated patient abuse in Case 2. We found that:

- The AIB was not completed in the 45-day time frame, the administrative action was not initiated for more than 60 days after the AIB was completed, and the case was not closed until nearly 6 months after completion of the AIB. The abusing employee (Nurse B) was placed in an off-duty with pay status for more than 3 months after the AIB substantiated abuse. The delay may have caused an unnecessary expenditure of resources.
- Without making comments or recommendations, the acting facility Director closed the AIB about 4 months after abuse was substantiated. By policy, the acting Director should have certified completion within 30 days. Further, the acting Director's failure to make recommendations in a substantiated case of patient abuse reflects either a lack of understanding or a lack of involvement in the proceedings.

To determine whether the deficiencies found in the above cases were unique or part of a systemic problem, we expanded the scope of our inspection to evaluate the timeliness of incident reports, fact-findings, and AIBs for 10 other alleged patient abuse cases, which occurred in fiscal years (FYs) 2010 and 2011 through March 30, 2011. Four cases did not have an incident report completed, and only one of the remaining six cases had an incident report completed within the required 24-hour timeframe. Seven cases had fact-finding reviews only, and five of those reviews were not completed within the suggested 7-day timeframe. Only one of the three AIBs was completed within the 45-day timeframe.

The two cases of alleged patient abuse occurred in 2010, and since that time, many of the facility leaders have changed. The individual previously responsible for oversight of the AIB process retired. At the time of our visit, we found that only one individual had formal training on the AIB process, which limited the facility's ability to ensure the timely completion of thorough and credible AIBs.

The facility's new leadership changed the process for reporting alleged patient abuse. All incidents are now reported to the Chief of Staff, the Administrative Assistant to the Chief of Staff, and the respective nurse manager and ANE.

Issue 2. Completion of Administrative Actions

We substantiated that a Senior Executive acted improperly in relation to the administrative action against Nurse B and that responsible managers did not report Nurse B to the State Licensing Board (SLB) as required.

Improper Actions. A senior executive did not follow through on a proposed termination issued to Nurse B in mid-October; rather, the executive delayed the termination. Thus, Nurse B was able to pursue a position at another VA healthcare facility without having to disclose the substantiated patient abuse or proposed termination. This was done without consulting HR or the facility Director.

In an e-mail to the HR chief in early December, the senior executive wrote that Nurse B “is working to transfer to [unnamed] VA to be closer to nurse B’s father. I am okay with the transfer in lieu of termination” for humanitarian reasons. The e-mail went on to say that, the [unnamed] VA facility had not asked for a reference; therefore, it would “become their problem.”

At the senior executive’s request, HR prepared a letter reflecting that the proposed removal was being “administratively withdrawn” while Nurse B “pursues transfer.” Nurse B received the letter 3 days later.

Nurse B was not selected for transfer to the other VA, and in mid-January 2011, HR informed nurse B that the proposed removal would be reinstated and that nurse B was to return to work in late January.³

In mid February, a senior executive e-mail granted Nurse B another 3 weeks to “have a commitment for employment from another VA or your termination will be effective on March 2, 2011.” Nurse B resigned from Federal service in late February without resuming any direct patient care duties.

The senior executive should have promptly implemented and followed through on the proposal to remove because the executive had a responsibility to protect patients from the potential threat of an abusive employee. Because the executive signed the original removal letter in October and then reinstated it after learning that Nurse B did not get the transfer, it seems to reflect the executive’s agreement that removal was an appropriate penalty in this case. While Nurse B would have been free to pursue transfer to another VA facility at any time during the process, the actions indicated that the senior executive did not understand or fully acknowledge the gravity of the situation and the potential threat of harm to future patients.

Reporting to the SLB. Responsible managers did not follow the necessary steps to report Nurse B to the SLB. VHA is responsible for ensuring that its patients receive appropriate and safe health care and requires⁴ that its facilities report each licensed health care professional whose behavior or clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. Patient abuse is specifically listed as an example of a reportable event.

³ Reinstatement of the proposed termination “reset the clock” of due process. Nurse B was assigned to a non-clinical position in another division during this time.

⁴ VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

The facility should have reported the patient abuse findings relative to Nurse B to VACO officials who would then make the official report to the SLB, if indicated. The SLB then determines whether modification, suspension, or revocation of a professional's license to practice is warranted. Because facility managers did not report to VACO, no report was made to the SLB. Without appropriate reporting, health care providers with substantiated performance and/or conduct issues could transfer to other VA or private-sector facilities and potentially place patients at risk for harm.

Conclusions

We substantiated that some staff members and managers did not comply with policies for reporting patient abuse, evaluating victims of the alleged abuse, or evaluating the events. We also substantiated that some managers did not take appropriate or timely administrative action relative to the events. While non-compliance with policy may potentially place patients at risk, we found no evidence that patients were actually harmed by these procedural breaches. We substantiated that a senior executive acted improperly in relation to the administrative action in the case of substantiated patient abuse and that responsible managers did not report Nurse B to the SLB as required.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that staff members and managers receive training regarding the appropriate reporting and evaluation of alleged patient abuse cases.

Recommendation 2. We recommended that the Medical Center Director ensure that staff responsible for the AIB process receive appropriate training.

Recommendation 3: We recommended that the Medical Center Director ensure that AIBs are completed in a timely manner and that actions are implemented and tracked to completion.

Recommendation 4: We recommended that the Medical Director ensure that the appropriate process is followed when SLB reporting is indicated.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations (see Appendixes A and B, pages 8–11, for the full text of their comments). The implementation plans area acceptable, and we will follow up on the planned actions until they are completed.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 15, 2011

From: Acting Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection – Management of Patient Abuse Cases,
Charlie Norwood VA Medical Center, Augusta, Georgia**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Service (10A4A4)

1. The VA Southeast Network's Quality Management Officer has reviewed the proposed actions and status updates in this enclosed plan and concur with the actions as described.

2. If there are any questions please contact Robin Hindsman, Psy.D, Quality Management Officer.

(original signed by:)

James A. Clark

Acting Director, VA Southeast Network (10N7)

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 10, 2011

From: Acting Director, Charlie Norwood VA Medical Center
(509/00)

Subject: **Healthcare Inspection – Management of Patient Abuse Cases,
Charlie Norwood VA Medical Center, Augusta, Georgia**

To: Acting Director, VA Southeast Network (10N7)

Concur with all recommendations. Actions have been taken and are in progress as noted in the comments section.

(original signed by:)

Richard T. Rose

Acting Director, Charlie Norwood VA Medical Center
(509/00)

**Director's Comments
to Office of Inspector General's Report**

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that staff members and managers receive training regarding the appropriate reporting and evaluation of alleged patient abuse cases.

Concur **Target Completion Date:** October 7, 2011

Facility's Response:

By October 7, 2011, just in time training will be coordinated by Education and Nursing, as well as a full campaign to ensure that staff and managers understand reporting avenues and time frames.

Status: In process

Recommendation 2. We recommended that the Medical Center Director ensure that staff responsible for the AIB process receive appropriate training.

Concur **Target Completion Date:** October 7, 2011

Facility's Response:

Formal training for all members of the AIB process will occur by the target date led by Quality Management and Human Resource staff. Just in time and reinforcement training for all staff who serve on an AIB began in March 2011.

Status: In process

Recommendation 3. We recommended that the Medical Center Director ensure that AIBs are completed in a timely manner and that actions are implemented and tracked to completion.

Concur **Target Completion Date:** October 7, 2011

Facility's Response:

A process for timeliness and tracking was put in place on March 2, 2011 to reinforce requirements and ensure closure on conclusions forwarded by the Board. Every Administrative Investigative Board that is chartered is educated on expectations and requirements and Quality Management tracks accomplishments. There have been four AIBs, three have been completed and two out of three were completed on time, one with an approved extension. One is currently pending an extension.

Status: In process

Recommendation 4. We recommended that the Medical Center Director ensure that the appropriate process is followed when SLB reporting is indicated.

Concur

Target Completion Date: October 7, 2011

Facility's Response:

The Handbook clearly lays out the steps to be followed in any reporting to the State Licensing Board. The Chief of Human Resources and the acting Risk Manager in Quality Management have been assigned action to oversee the process. Quality Management and Human Resources will work together to ensure compliance with reporting to the State Licensing Board in accordance with VA regulations.

Status: In process

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Toni Woodard, Team Leader Thomas Jamieson, MD Michael Shepherd, MD Susan Zarter, RN

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