



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Inappropriate Care in the Community Living Center Tomah VA Medical Center Tomah, Wisconsin

Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection at the Tomah Veterans Affairs Medical Center (the medical center) in Tomah, Wisconsin, after receiving a complaint regarding an incident in the Community Living Center (CLC). The purpose of the inspection was to determine the validity of the allegation.

An anonymous complainant contacted the OIG regarding concerns reported by staff who witnessed an incident in the medical center's CLC the evening before a patient died. While the complainant was not a direct witness to the event, the complainant felt a duty to report. The complainant alleged that the events may have led to the patient's death based on staff's concern that a Registered Nurse (RN) on duty delivered inappropriate care and caused a patient distress.

We did not substantiate that an intentional unsafe act occurred or that the patient died as a result of the incident. Documentation shows that the patient's health was progressively deteriorating, and the patient had respiratory difficulties prior to this incident. We interviewed all of the nursing personnel who cared for the patient the evening before the patient died. We found that each had a different recollection of the events that transpired; however, there was consensus that the patient was extremely anxious that evening and complained of stomach pain. Additionally, all of the nursing personnel demonstrated the manner in which the patient was positioned in order to facilitate postural drainage with percussions. The positioning was unorthodox when compared to the nursing clinical reference source endorsed by the medical center; however, there was no intent to harm the patient.

We determined that managers did not follow Veterans Health Administration (VHA) or medical center policy related to allegations of patient abuse. A nursing supervisor informed us that they received a written complaint related to the events that transpired the evening before the patient died; however, they could not recall who made the complaint. The supervisor directed a review of the incident, although only the RN alleged as providing inappropriate care was interviewed. No other staff who witnessed the incident or who were on duty that evening were interviewed. VHA and medical center policies that pertain to suspected patient abuse and require specific notifications, actions, and investigation were not followed.

We recommended that the Veterans Integrated Service Network (VISN) Director ensure that the Medical Center Director takes action to ensure staff immediately report suspected incidents of patient abuse and that further actions are taken, in accordance with VHA and medical center policy.



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

TO: Director, VA Great Lakes Health Care System (10N12)

SUBJECT: Healthcare Inspection – Alleged Inappropriate Care in the Community Living Center, Tomah VA Medical Center, Tomah, Wisconsin

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations that a registered nurse (RN) at the Tomah VA Medical Center (the medical center) provided inappropriate care during an incident involving a terminally ill patient, who was more than 85 years old, in the Community Living Center (CLC).

Background

Located in Tomah, Wisconsin, the medical center is a 271-bed facility that provides primary care, mental health, and CLC (long-term care) services. Outpatient care services are also provided at community based outpatient clinics located in LaCrosse, Loyal, Wausau, and Wisconsin Rapids, WI. The medical center is part of Veterans Integrated Service Network (VISN) 12.

The OIG received allegations from a complainant regarding an incident that occurred in the CLC the night before a patient died. While the complainant was not a direct witness to the event, the complainant felt a duty to report based on information gained from employees who were on duty that evening. These employees were concerned that the RN delivered inappropriate care, causing the patient distress. The complainant alleged that an RN approached an end-of-life patient and began aggressively administering oral suctioning, which caused the patient to vomit. The complainant alleged that the suctioning was initiated because the patient may have been choking on medication. Two certified nursing assistants (CNAs) were reportedly instructed by the RN to hold the patient's ankles on the bed while hanging the patient's upper body off the bed facedown. Further, the complainant alleged that the patient was alert and calling "someone please help me" as the RN continued to deliver "severe pounding" on the patient's upper back. The complainant alleged that the events transpiring during the incident resulted in the patient's death the following morning.

Scope and Methodology

We conducted a site visit January 6–9, 2009, and interviewed the complainant, nursing personnel, physicians, and managers who were knowledgeable about the incident. We reviewed reports of contact, mortality and morbidity reports, VHA and medical center policies and procedures, and the patient’s medical record.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President’s Council on Integrity and Efficiency.

Case Summary

The patient was more than 85 years old, with an extensive medical history that included depression, prolonged post-traumatic stress disorder, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and liver cancer. The medical center’s long-term care staff was familiar with this patient as a result of multiple admissions over the years.

In the summer of 2007, the patient was placed on Palliative Care status in the CLC. Palliative Care is a broad term that includes Hospice Care. The primary goal of Palliative Care treatment is comfort rather than cure in a person with an advanced disease.¹

Almost a year later, in the early summer of 2008, the provider documented that the patient had symptoms of bronchitis, which included difficulty breathing, cough, and pain. A pulmonary assessment revealed respiratory congestion, difficulty expectorating sputum due to weakness, and gurgling sounds heard on exhalation. According to documentation, the patient remained in bed 40 percent of the time and was unable to independently perform self-care activities. It was at this point, in the early summer of 2008, that the provider documented that the patient’s status was changed from Palliative Care to Hospice Care. Hospice Care generally requires the acknowledgement of the patient, the family, and the physician that the illness is terminal, that the primary focus of treatment is on comfort rather than cure, and that aggressive attempts at curative treatment are relinquished.²

Eleven days after the patient’s status changed to Hospice Care, staff documented on Activities of Daily Living flowsheets that the patient was progressively sleeping throughout waking hours of the day. On the 12th day after being on Hospice Care, the patient’s provider consulted the Respiratory Therapy department for evaluation and recommended treatment to address the patient’s breathing difficulties related to COPD

¹ VHA Directive 2003-008, *Palliative Care Consult Teams (PCCT)*, February 4, 2003; VHA Directive 2002-038, *Hospice and Palliative Care Workload Capture*, July 5, 2002.

² VA Office of Geriatrics and Extended Care, “Hospice and Palliative Care.”

and CHF. The first of several nebulizer medicated breathing treatments was administered.

The 13th day after going on Hospice Care, medical record documentation indicates that the patient was feeling weak and had no appetite. The provider documented hearing an audible rattling noise, mostly from the patient's throat area, during respirations. The provider also documented that the patient had physically deteriorated and had lost weight. The provider discussed the patient's declining status with the spouse.

Documentation from the 14th day after beginning Hospice Care shows that after lunch the patient was dressed and taken outdoors to a picnic for 1 hour. The patient reportedly tolerated the activity but, according to documentation, "was tired" and required two staff to transfer the patient back to bed upon return to the unit. At 8:54 p.m., documentation shows that the patient had increased congestion, and postural drainage³ with percussions⁴ was implemented. In response, the patient expectorated drainage, and the patient's oxygen saturation improved from 84 to 94 percent. The note also reflects that the patient continued to vomit and complain of stomach pain. The provider was notified, and additional medications were ordered. At 10:10 p.m., the spouse was updated regarding the patient's condition. A progress note signed at 11:07 p.m. indicates that the patient was resting comfortably, denied pain, and had no further vomiting. Continuing rattling, "noisy" respirations were noted.

Fifteen days after transfer to Hospice Care, at 8:15 a.m., a progress note documents that the patient was lethargic, not alert or oriented, and not responding to commands. The Chaplain was notified of the patient's condition. The Chaplain came to the patient's bedside to be with the patient and spouse. At 9:30 a.m., the Chaplain informed the RN that the patient had "passed." The RN confirmed that the patient had no pulse or respirations. An autopsy was offered, but the family declined.

Inspection Results

Issue 1: Patient Care Delivery

We did not substantiate that an intentional unsafe act occurred or that the patient died as a result of the incident.

We interviewed the complainant and the nursing staff who cared for the patient at the time of the incident the evening before the patient died. Each staff member interviewed had a different recollection of the events that transpired; however, all of the staff reported that the patient was extremely anxious and complained of stomach pain. Staff described

³ Drainage of the lungs by placing the patient in an inverted position so that fluids are drawn by gravity toward the trachea.

⁴ Massage consisting of the striking of a body part with light rapid blows.

that the patient was more congested than usual and required assistance with clearing the airway. The RN who was responsible for the patient's care that evening initiated postural drainage with percussions to help clear the patient's airway.

We reviewed the medical center's endorsed clinical reference source⁵ for patient care related to postural drainage with percussions. The patient positioning described and demonstrated to us, by use of a mannequin, was unorthodox when compared to illustrations in the clinical reference source for facilitating postural drainage. The RN demonstrated a position that supported the patient's trunk during prone positioning (for effective postural drainage). The certified nursing assistants (CNAs) reported holding the patient's feet for safety so the patient would not fall off the bed while percussions were administered. The theory and implementation related to postural drainage and percussions were not familiar to all of the nursing personnel involved, as this is a skill generally taught to licensed nurses. It was apparent during our interviews that CNAs were unfamiliar with the procedure, which attributed to their anxiety. According to medical center policy,⁶ Respiratory Therapy is responsible for performing bronchial hygiene therapies which include chest percussion, postural drainage, and medication delivery associated with mucus clearance and suctioning. Respiratory Therapy staff provided coverage Monday through Friday, from 8:00 a.m. to 4:30 p.m., and on-call during the off tours with a 1.5-hour response time. Additionally, medical center policy states that, in the absence of Respiratory Therapy staff, nursing staff are responsible for respiratory services related to patient care needs.

Medical records show that the on-call physician ordered medications to relieve the patient's nausea, vomiting, and pain. The patient had vomited after receiving postural drainage. A test was ordered to evaluate the patient's blood count. The on-call physician assessed the patient that evening and documented that the patient was pale, weak, and cold to the touch. Additionally, the patient was having difficulty clearing respiratory secretions due to weakness. The on-call physician received status updates from the RN during the night.

Issue 2: Management Response to Alleged Inappropriate Care

We found that managers did not follow VHA or medical center policy related to allegations of patient abuse.

According to VHA policy,⁷ intentionally unsafe acts, as they pertain to patients, are any events that result from:

⁵ Lippincott Williams & Wilkins, *Nursing Procedures*, Fourth Edition, 2004, p. 485.

⁶ Medical Center Memorandum SS-RES-02, *Respiratory Therapy Services*, December 30, 2008.

⁷ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

- A criminal act,
- A purposefully unsafe act,
- An act related to alcohol or substance abuse by an impaired provider and/or staff, or
- Events involving alleged or suspected patient abuse of any kind.

Because there was staff concern that the events during the incident caused the patient undue distress, and as the complainant alleged, potentially the patient's death, the matter should have been approached as a suspected incident of abuse. Consequently, the medical center's Director and Chief of Staff should have been immediately notified so that decisions could be made about the need for an administrative investigation or other review.

Two or 3 days after the patient's death,⁸ the nursing supervisor received a written complaint from a CNA; however, the supervisor could not recall the specific individual who generated the complaint. The nursing supervisor requested that the acting nurse manager interview the RN who was involved in the incident. Four days after the patient's death, the acting nurse manager interviewed the RN, reviewed the patient's medical record, and read reports of contact from unit staff. However, there were no additional interviews of employees who witnessed the incident or were on duty the evening the patient died. The acting nurse manager documented findings in a report of contact and discussed the incident with the nursing supervisor. It was determined there was no indication of improper care or need for further follow up. The nursing supervisor shared this assessment with nursing leadership.

According to VA policy,⁹ while informal information-gathering processes are often sufficient to meet the medical center's needs, many situations demand a more systematic, thorough, and objective analysis of evidence, documented in a manner that clearly conveys not only the facts found, but also the evidence from which those facts are ascertained and the investigator's conclusions about matters that may be disputed.

Medical center policy¹⁰ requires that all incidents of alleged beneficiary abuse be reported in the following manner:

- A completed VA Form 10-2633, Report of Special Incident Involving a Beneficiary, in accordance with Medical Center Memorandum No PI-03.

⁸ The nursing supervisor during interview could not recall the exact date the incident was reported. The supervisor was unable to produce the written document describing the incident.

⁹ VA Directive 0700, *Administrative Investigations*, March 25, 2002.

¹⁰ Medical Center Memorandum PI-09, *Prevention of Patient Abuse*, March 8, 2007.

- Patient Representative enters incident into the Patient Advocate Tracking Package.
- Patient Representative reports all allegations of abuse to the Chief of Staff or Administrative Assistant to the Chief of Staff directly and immediately.

We did not find that these actions, as detailed in medical center policy, were met.

Conclusions

We did not substantiate that an intentional unsafe act occurred or that the patient died as a result of the incident. The patient's prognosis was documented by providers as poor, declining, and Hospice Care was being provided, as the patient's death was anticipated. While the positioning of the patient for postural drainage and percussion was unorthodox when compared to the medical center's endorsed clinical reference source, there was no intent to cause the patient harm. The CNAs involved during the incident appropriately maintained the patient's safety during positioning. We did identify that managers did not follow VHA or medical center policy in response to an incident that was suspected to be patient abuse. Consequently, a full and proper administrative investigation, or other review, was not conducted.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure staff immediately report suspected incidents of patient abuse and that further actions are taken in accordance with VHA and medical center policy.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. (See Appendixes A and B, pages 7–10 for the full text of their comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 8, 2009

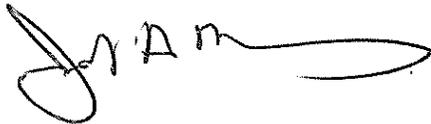
From: Director, VA Great Lakes Health Care System (10N12)

Subj: **Healthcare Inspection – Alleged Inappropriate Care in the
Community Living Center, Tomah VA Medical Center, Tomah,
Wisconsin**

To: Director, Management Review Service (10B5)

Thru: Director, Chicago and Kansas City Offices of Healthcare Inspections
(54CH)

I have reviewed and concur with the recommendation of the Office of Inspector General. The Tomah VA Medical Center is moving forward with completion of the following attached action plan.



Jeffrey A. Murawsky, M.D.

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 30, 2009

From: Director, Tomah VA Medical Center (676/00)

Subj: **Healthcare Inspection – Alleged Inappropriate Care in the
Community Living Center, Tomah VA Medical Center, Tomah,
Wisconsin**

To: Director, VA Great Lakes Health Care System (10N12)

I have reviewed and concur with the recommendation of the Office of Inspector General. The Tomah VA Medical Center is moving forward with completion of the following action plan. If additional information is needed, please contact my office at (608) 372-1777.

Thank you,

*(original signed by:
David Houlihan, M.D. for:)*
Jerald D. Molnar

The success of our interventions will be determined through monthly tracking of all incidents of allegations of patient abuse by the Risk Manager starting July 1, 2009, through September, 2009. Tracking will include timeliness for reporting completion of fact finding and thorough determination of further action to closure.

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, MN, RN Director, Chicago and Kansas City Offices of Healthcare Inspections (708) 202-2672
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Acknowledgments	Lisa Barnes, MSW, Team Leader Judy Brown Paula Chapman, CTRS Jennifer Reed, RN
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