



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Patient Neglect and Abuse VA Central California Health Care System Fresno, California

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of an allegation regarding patient neglect and abuse at the VA Central California Health Care System (the system), Fresno, CA. A complainant alleged that a patient developed bed sores (pressure ulcers) due to neglect and abuse while an inpatient on the system's medical units and as a resident in the system's community living center.

We found that the patient did develop pressure ulcers while being treated by the system as well as subsequent pressure ulcers that developed when not an inpatient. However, we concluded that these were not the result of neglect or abuse. More likely, they resulted from his debilitated, catabolic state, and the insertion of a Foley catheter used in the treatment of life-threatening urosepsis. The patient's skin breakdown was identified and attended to in a timely manner. This report makes no recommendations.



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

TO: Director, VA Sierra Pacific Network (10N21)

SUBJECT: Healthcare Inspection – Patient Neglect and Abuse, VA Central California Health Care System, Fresno, California

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of an allegation regarding patient neglect and abuse at the VA Central California Health Care System (the system) in Fresno, CA. The complainant alleged that the patient developed bedsores¹ (pressure ulcers) while an inpatient on the system's medical units, and as a resident in the system's community living center (CLC). The purpose of the review was to determine whether the allegation had merit.

Background

The system is a 56 bed acute care, general medical and surgical center with primary, secondary, and tertiary care in major diagnostic and treatment specializations. Five primary care teams and numerous specialty care clinics, including mental health and women's health, provide extensive outpatient services in a managed care environment. A 60 bed CLC provides skilled nursing and rehabilitation care. The system serves a veteran population of approximately 103,000 throughout six counties in central California and is part of Veterans Integrated Service Network (VISN) 21.

On January 10, 2011, a complainant contacted the OIG hotline with an allegation that a patient developed bedsores due to neglect and physical elder abuse while both an inpatient of the system and a CLC resident.

¹ Bedsores are painful skin ulcers that form when constant pressure on parts of the body shut down blood vessels supplying that area of the skin.

Scope and Methodology

We conducted a site visit on March 21–23, 2011. During our visit, we interviewed the Chief of Medical Service, physicians, nurse managers, nurses, social workers, dietitians, wound care specialists, the palliative care coordinator, and the discharge planner. We reviewed VHA and local policies and procedures, the patient's medical record, Activity of Daily Living flow sheets from the medical units and CLC, quality management documents, and published journals.

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.

Case Summary

The patient was a man in his seventies with a medical history of chronic kidney disease, diabetes mellitus, hypertension, and noncompliance with his medication regimen. In mid-October, 2010, the patient was seen in the system's Renal Clinic for a routine follow-up appointment and was sent to the Emergency Department (ED) due to severely elevated blood pressure. While in the ED, he became confused and disoriented with slurred speech, drooling, and left-sided weakness. The patient had an emergent endotracheal intubation² due to a respiratory arrest.

The patient was admitted to the Special Care Unit (intensive care and telemetry unit) with a diagnosis of a hypertensive emergency episode and possible stroke. As part of the nursing assessment of the patient, no skin breakdown was identified. The patient's initial skin assessment using the Braden Scale³ was 13 (moderate risk). The system's pressure ulcer protocol was initiated, which included the following:

- Turn and reposition patient every two hours while in bed.
- Use pillows to separate pressure points.
- Place cushion while in a wheelchair.
- Elevate the heels using pillows or foam blocks.
- Apply heel/elbow pads.
- Avoid turning/positioning patient on side at greater than a 30-degree angle.

² Endotracheal intubation is a medical procedure in which a flexible plastic tube is placed into the windpipe to maintain an open airway.

³ The Braden Scale is a tool used for predicting the risk of developing pressure ulcers; this assessment is performed by a staff nurse. The scale runs from 6-23, with lower numbers indicating higher risk.

The patient's nutritional risk assessment revealed a moderately compromised albumin (serum protein) level of 2.9 (normal range 3.4–5.4) grams per deciliter.⁴

The next day, the patient's endotracheal tube was removed. The nurses noted periods of confusion and urinary incontinence (loss of bladder control). A physician wrote that the patient attempted to get out of bed without assistance and was at risk for injury, warranting the use of restraints.

The patient was transferred to the medical/surgical unit on hospital day (HD) 7. At that time, his skin assessment score was 17 (mild risk). The nurse noted no pressure ulcers or other skin problems. The physical therapist saw the patient for muscle strengthening and noted increased confusion, lethargy, and decline in function.

On HD 8 a bladder scan⁵ was done, which revealed greater than 600 milliliters of retained urine in the bladder. A Foley catheter was inserted to ensure adequate drainage of the bladder. A physician noted the continued use of restraints as the patient attempted to remove medical devices/tubes and lacked decision-making capacity.

On HD 9 the patient was admitted to the CLC for rehabilitation care. The nurse noted no pressure ulcers and a skin assessment score was again 17. The patient's Foley catheter was in place. The nurse wrote that the patient would need much assistance with his activity of daily living and transfers. The restraint order was not renewed.

On HD 13, a physical therapist noted that the patient demonstrated increased difficulty with walking. The patient was seen in physical therapy the following day. Because of further decline in his mental and functional status, he was unable to participate in rehabilitation. The physical therapist wrote that the patient was not able to follow simple directions and appeared to have been hallucinating.

On HD 18, the nurse noted an open area at the tip of the patient's penis. The area was cleansed with normal saline and aloe vesta cream⁶ was applied. On November 13, a nurse documented two abrasions/lacerations on the scrotum and erosion at the tip of the penis, "most likely from the Foley catheter." The nurse wrote that both areas were cleansed with normal saline and Xeroform™ (a sterile gauze wound dressing) applied twice a day. The patient had been refusing care (shower, medications, meals, and getting out of bed).

On HD 26, the nurse found the patient unresponsive with an elevated temperature of 102.6°Fahrenheit and transferred him to the ED for further evaluation. The ED physician documented, "penis with Foley and bloody" and diagnosed him with a urinary

⁴ A low albumin level is an indication of malnutrition.

⁵ A bladder scan is a noninvasive method of assessing the volume of urine in the bladder.

⁶ Aloe vesta cream is used as a barrier to help protect sensitive skin from pressure ulcers and other skin injuries.

tract infection and septic shock.⁷ The ED nurse noted a skin assessment score of 11 (high risk) and implemented the system's pressure ulcer protocol. The patient was transferred to the Special Care Unit.

On HD 27, the Wound/Ostomy Nurse documented necrotic (dead) tissue on the edges of the penis consistent with a pressure ulcer. A stage II pressure ulcer⁸ was noted on the coccyx (tailbone) measuring 1.5 x 1.5 centimeters (cm) and was treated with aloe vera cream. The nursing staff placed the patient on an air mattress overlay⁹ to minimize the risk of further skin breakdown.

On HD 28, the patient had a nasogastric tube (NGT) inserted for administration of tube feedings. However, the following day the patient pulled out the NGT and was started on a pureed liquid diet. A dietitian assessed the patient and wrote, "albumin declining (2.1 grams per deciliter), which suggest severe visceral protein [amount of protein in the internal organs] depletion." A physician documented that the Foley catheter was removed to promote healing of the penile ulcer. The nurse placed the patient in adult diapers due to incontinence. Nurses later applied a condom catheter¹⁰ to keep his skin dry.

On HD 30, the patient was transferred to the medical/surgical unit. The Wound/Ostomy Nurse noted a stage II pressure ulcer located on the coccyx area and a fissure (cut or tear) on the buttocks measuring 4 x 5 cm. The nursing skin assessment score was 11 (high risk).

The physical therapist noted that the patient demonstrated a steady decline in functional mobility. The patient was not able to lift his lower extremities off the bed or initiate standing, and he required maximum assistance for bed mobility.

On HD 31, a physician noted that the family was planning for the patient's return home. A staff physician wrote that the patient was able to eat with assistance from his wife and agreed with the plan to discharge the patient from inpatient care with close clinic follow-up. The physical therapist evaluated the patient and documented that he required maximum assistance for transfers and bed mobility tasks. Discharge plans were made for a hospital bed, air mattress overlay, shower chair, and wheelchair in the home. Home Based Physical Therapy was to provide equipment training to the patient's family and training on transfer techniques. A home health consultation was initiated for home physical therapy.

⁷ Septic shock is life-threatening low blood pressure due to overwhelming infection.

⁸ A stage II pressure ulcer is a partial thickness skin loss involving the epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

⁹ An air mattress overlay is a mattress specifically designed to allow for efficient air flow throughout the mattress for use in the treatment and prevention of pressure ulcers. Continually changing air pressure keeps body fluids moving, improving circulation. The pad feature uniform air tubes that alternately inflate every 4 minutes.

¹⁰ A condom catheter is an external device that encircles the penis and connected to a urinary collection bag by a tube.

On HD 34, the patient was discharged to his home. The nurse noted a pressure ulcer on the coccyx area and excoriation (skin tear) on his scrotum and penis at the time of discharge. The following discharge instructions were provided to the family:

- Management and treatment of the pressure ulcer.
- Turning and repositioning the patient.
- Application of aloe vera cream to the ulcer.
- Heel protection.

In early December, the patient presented to the ED with complaints of abdominal pain and constipation. The ED physician noted large blisters on both heels despite wearing heel supports and a pressure ulcer on the coccyx area. The ED physician treated the constipation and discharged the patient to his home. A consult was sent for the patient to follow up with the Wound/Ostomy Nurse at the system.

Two days later, the Wound/Ostomy Nurse responded to the consult and recommended a complete assessment of the patient's wounds and a nutritional assessment at the patient's next primary care visit.

Four days later, the patient was seen by his primary care physician in the clinic for a follow-up appointment. The family reported the patient had no food intake or bowel movement since the ED visit. The clinic nurse noted concern for the family's ability to care for the patient at home. The patient was transferred to the ED and seen by a physician. The physician admitted the patient to the medical/surgical unit with a diagnosis of urosepsis¹¹ and wrote "multiple developing pressure ulcers on his lower extremities."

On HD 2, the patient was placed on an air mattress overlay. A nurse documented, "patient is resting in bed currently refusing to be rolled or moved."

On HD 3, a physician documented that the patient's albumin level was 1.9 grams per deciliter. The dietitian wrote to add Glucerna® (liquid nutrition) oral supplements to the patient's diet for extra calories and that tube feedings may be required. The nurse documented a stage II pressure ulcer on the left heel and a stage III pressure ulcer¹² on the coccyx area and right heel. Pictures were taken and dressings applied to the wounds. The system's pressure ulcer protocol was initiated.

¹¹ Urosepsis is a bloodstream infection from a urinary tract infection.

¹² A stage III pressure ulcer is a full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

On HD 4, the Wound/Ostomy Nurse saw the patient and documented multiple pressure ulcers on the lower half of his body, overgrown toenails, and steady decline in albumin level.

The Wound/Ostomy Nurse wrote in the treatment plan:

Continue to use the overlay mattress [air mattress overlay]; the patient's potential to heal is poor and has potential for further skin breakdown due to nutritional status; keep foot wounds dry and wrap with gauze to protect; a podiatry consult for nail care; use a pillow between knees; apply Santyl[®] [an enzyme therapy used to removes necrotic tissue] to unstageable wounds twice daily and use cover dressing; and place a foley catheter securing the device at all times to prevent further damage to meatus.

On HD 6 the physician recommended placement of an NGT and when stable a general surgery consult for percutaneous endoscopic gastrostomy tube¹³ placement; however, the patient and family declined this intervention.

On HD 7, the family made a decision to place the patient in a nursing home where he would be on comfort care.¹⁴ The physician documented that the family understood the consequences and potential outcome of refusing the NGT and other aggressive medical treatment.

On HD 10, the patient's family decided to take the patient home instead of community nursing home placement. The physician discharged the patient to his home and noted, "as patient is comfort care, do not need to continue any meds [medications]."

The patient died the next day at a community regional medical center.

Inspection Results

Issue 1: Quality of Care

A. Patient Neglect and Physical Elder Abuse

We did not substantiate the allegation that the patient developed pressure ulcers due to neglect or physical elder abuse.

According to medical record documentation, the patient did not have pressure sores when he was admitted to the system in early December. However, when the patient was a resident in the CLC, he developed a pressure ulcer on the tip of his penis from a Foley

¹³ Percutaneous endoscopic gastrostomy tube is a feeding tube that provides a safe and effective way to provide food, liquids, and medications directly into the stomach through a tube placed in the abdomen.

¹⁴ Comfort care is supportive treatment for patients who are suffering from a terminal illness or who refuse life-sustaining treatment.

catheter and a stage II pressure ulcer in his coccyx region most likely due to friction and shearing forces when moving the patient. Nursing staff initiated the system's pressure ulcer protocol and placed the patient on a special bed to minimize the risk of further skin breakdown.

In November 2010, when the patient was discharged to his home, he had two pressure ulcers, one on his penis and one in his coccyx area. Four weeks later, the patient was readmitted to the system with multiple pressure ulcers on his lower extremities.

Conclusions

Although the patient developed pressure ulcers while in the CLC, we did not substantiate that the pressure ulcers were the result of nursing neglect or physical abuse. We determined that the patient was assessed for skin breakdown and pressure ulcer interventions were initiated. The patient refused nursing care, medical treatment, food and fluids resulting in a steady decline in his medical condition and functional mobility.

We made no recommendations.

Comments

We made no recommendations. The VISN and Medical Center Directors agreed with our findings.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 26, 2011
From: Director, Sierra Pacific Network (10N21)
Subject: **Healthcare Inspection – Patient Neglect and Abuse, VA Central California Health Care System, Fresno, California**
To: Director, San Diego Office of Healthcare Inspections (54SD)
Thru: Director, Management Review Service (10B5)

1. Thank you for the opportunity to review the draft report of a review that took place in March 2011 regarding an allegation of patient neglect and abuse at VA Central California Health Care System, Fresno, CA. I am pleased your review did not substantiate this allegation.
2. I know the facility appreciated the professional manner with which the team conducted the review.
3. Should you have any further questions please feel free to contact Terry Sanders, Associate Quality Manager for VISN 21.

(original signed by:)
Sheila M. Cullen
Director, VA Sierra Pacific Network (10N21)

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 24, 2011

From: Director, VA Central California Health Care System (570/00)

Subject: **Healthcare Inspection – Patient Neglect and Abuse, VA Central California Health Care System, Fresno, California**

To: Director, VA Sierra Pacific Network (10N21)

1. We appreciate the opportunity to provide our input on the VA OIG Healthcare Inspection which took place March 21-23, 2011.
2. We would also like to express our thanks to the OIG review team which visited our facility. We found the team members very helpful and fair throughout our preparatory activities as well as during the inspection itself.
3. In the patient's case which was reviewed, we concur with the findings that there was no evidence to substantiate claims of nursing neglect or physical abuse.



Alan S. Perry, FACHE
Director, VA Central California Health Care System (570/00)

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	Deborah Howard, RN, Project Leader Judy Montano, MS, Team Leader Stephanie Hills, RN Robert Yang, MD Derrick Hudson, Program Support Assistant

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