**Administrative Closure**
**Patient Safety Issues, Hampton VA Medical Center**
**Hampton, Virginia**

7/7/08

## Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding patient elopement, inadequate staffing levels, and insufficient social services on the Extended Care Rehabilitation Care Units (ECRC) at the Hampton VA Medical Center (the medical center) in Hampton, VA.

## Background

The medical center is a 516-bed facility that serves a veteran population of more than 160,000 in a 15-county area in eastern Virginia and a 10-county area in northeastern North Carolina. Comprehensive health care is provided through primary care, acute inpatient care, psychiatric care, chronic spinal cord care, long-term care, hospice and palliative care, and domiciliary rehabilitative residential care.

On March 1, 2007, a VA employee at the medical center contacted the OIG expressing concerns about compromised patient safety on the ECRC Unit and alleging the following:

- The electronic system that monitored the location of patients and notified staff of patient elopement did not work consistently. As a result, increasing numbers of ECRC patients identified as high risk for elopement wandered away from the medical center.
- ECRC Unit nurse staffing levels were inadequate to meet patient needs.
- A social worker was mismanaging a patient's funds and failing to provide the patient with clothing and toiletries (neglect).

The ECRC has two units—A and B. Unit A had 52 beds (was staffed for 32 beds) with a patient run census between 27 and 32. Patients on Unit A receive rehabilitation care, short stay care (waiting to be placed in a nursing home), wound care, and intravenous therapy. Unit B had 60 beds (was staffed for 48 beds) with an average patient census between 45 and 48. Patients on Unit B receive long-term care, ventilator care (four ventilator beds), wound care, intravenous therapy, and dementia care.

## Scope and Methodology

Prior to our site visit on April 16, 2007, we reviewed the electronic VA medical records of the patients on the ECRC Unit that were identified as high risk for elopement by the complainant and ECRC Unit staff. We interviewed the Associate Chief of Staff for Geriatrics, Rehabilitation, and Extended Care; the Chief Nurse Executive; nurse

managers for ECRC; clinical and administrative staff; the ECRC social worker; the Chief of Fiscal Services; and the complainant. We reviewed biomedical work orders, police logs, policies and procedures, quality management documents, patient fiscal data, and other pertinent documentation. We made unannounced visits to the ECRC Unit during different shifts and talked with patients (including the alleged neglected patient) and families.

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

## Inspection Results

*Issue 1: Patient Elopement*

We substantiated that the safety of the patients identified as high risk for elopement was compromised by an electronic patient monitoring system that functioned inconsistently. However, at the time of our visit, the medical center had already taken actions to replace the troublesome system with a new, more reliable system and to open a Geriatric Special Care Unit for high-risk patients.

The complainant alleged that the system did not work consistently and that patients left the facility without authorization. The system was comprised of a bracelet with a radio transmitter, which was attached to a patient's ankle. The bracelet transmitted a signal to a wall-mounted receiver that tracked patients and alarmed when patients left a specific area. The system was used to prevent cognitively impaired patients from wandering or leaving without an escort.

The complainant also alleged that ECRC supervisors and executive nursing leadership had been aware of the problems with the system for more than 3 years and did nothing to remediate the problems, except to tell staff to keep a closer eye on the patients.

ECRC patients are generally elderly and either in various stages of confusion or suffer from dementia. One patient eloped three times in 1 day. Another patient, who repeatedly cut off his bracelet, eloped and was found by local police heading for the nearby interstate. He was returned to the ECRC Unit by the police and was then admitted to the locked psychiatric unit. Further, when two patients wearing their bracelets walked through an alarmed exit door, only one patient was identified by the system as having eloped. Staff was unaware of the second patient's elopement until the absence was discovered by staff making rounds.

Engineering staff reported that the system had multiple failures starting in 2006. However, nursing staff cited problems as far back as 2004 and recalled that management informed them that replacement parts for the system were difficult to find and that staff would need to be more vigilant in monitoring patients. From April 2006 to April 2007, 21 work orders to repair the system were submitted to Engineering by ECRC staff.

On March 13, 2007, the medical center completed (b)(3):38 U.S.C. 5705 review of 15 patient elopements from July 1, 2006, to December 31, 2006, and found the following:

(b)(3):38 U.S.C. 5705

The medical center took steps to decrease patient elopements from the ECRC Unit by photographing patients identified as high risk for elopement, placing the photographs in the medical records and on a staff bulletin board, and providing the photographs to medical center police. A patient identification transmitter worksheet and transmitter log was used to ensure that patient transmitter bracelets were in place and alarming properly.

In January 2007, the medical center requested Veterans Integrated Service Network approval for the use of local funds to replace the system. In April 2007, a contract was approved. Work on a new system began on April 17, and was completed on June 18.

The medical center recognized the need for a locked Geriatric Special Care Unit. The only locked unit available was the psychiatric unit. Placing wandering patients in with psychiatric patients who might be territorial or violent, was not an optimal solution. On October 10, 2007, the medical center opened a locked Geriatric Special Care Unit.

*Issue 2: Inadequate Staffing*

We substantiated that staff shortages and recruitment and retention issues have been a problem on the ECRC Units; however, corrective actions were taken to address the problems.

The complainant alleged that ECRC staff was asked to increase monitoring of patients from every hour to every 30 minutes due to patient elopements. This increased monitoring was somewhat effective, but it was difficult to comply with because of inadequate staffing levels and the increase in numbers of patients with more complex medical needs. Nursing management and staff from the ECRC Unit agreed that staffing, recruitment and retention of nurses, and the increased acuity of the patient population created patient safety issues.

Despite the increased acuity level of patients on the ECRC units and the staffing issues, the expectation was for staff to pursue eloping patients, leaving other patients and responsibilities until they returned. Nurses complained that they were "verbally

reprimanded" if their patients wandered off the unit. Nurses were afraid of losing their licenses if eloping patients died or were injured.

At the time of our visit, the following staffing, retention, and recruitment challenges were identified by the medical center:

- The acuity level of patients on ECRC units had increased.
- No clinical nurse specialist was assigned to the ECRC units.
- Medical center policy required orientation of new nurses by experienced staff/preceptors, but only one preceptor class was offered in 2006.
- Nursing assistants wanted registered nurses and licensed practical nurses to have the same number of patients for clinical care.
- Processing new hires through Human Resources took too long.
- Staff shortages were covered by overtime, which limited in-house staffing resources that could have been assigned duties in ECRC.
- Weekend staffing was described by staff as a "challenge, bare minimum, very bad, and dangerous."
- ECRC had a 9 percent turnover rate (6 out of 68) for October, November, and December of 2006 and was unable to consistently meet the nursing hours per patient day staffing goal.

We found that the medical center initiated an ongoing process to improve staffing, recruitment, and retention. The medical center took the following actions:

- Hired a nurse recruiter.
- Initiated an instant interview process.
- Increased the full-time employee equivalents for ECRC.
- Implemented the nursing hours per patient day staffing model.
- Established an interdisciplinary working group to initiate the Cultural Change Program on the ECRC units.
- Initiated the Simple Ideas Program where staff can contribute an idea, which if used, entitles the staff member to a time off award.

*Issue 3: Patient Neglect*

We did not substantiate the allegations that a social worker assigned to a patient residing in the ECRC was neglecting the patient's needs.

The complainant alleged that a social worker assigned to an elderly, blind petient who resided on the ECRC unit was not purchasing clothing or toiletries for the patient even though the patient had funds available in his account. The complainant also alleged that the social worker failed to help the patient properly manage his finances. The complainant understood that the patient had a balance of over $40,000 in his account and received a $90 monthly check. The complainant further alleged that because of the social worker's neglect, the patient was forced to wear clothes donated to the unit.

The patient, who is elderly and blind, has been a resident in the medical center's long-term care units for more than 40 years. He was placed on ECRC in 1993. He was in an assisted living environment for many years, and in 1993, when his health declined, he was moved to ECRC for supportive care. A sister acted as his guardian and managed his funds until she died in 2005.

We interviewed the Chief of Health Administration, who is responsible for overseeing patient funds. Patients can receive a variety of funding—treasury checks, pensions, social security checks, and other checks—which are deposited into personal accounts. This particular veteran had two personal accounts. One was an account that had been controlled by his sister, and the other was a local account. According to the social worker, since the patient's sister died, the patient has not been able to gain access to the account that was controlled by the sister. The issue was being handled by the attorney that administered the sister's estate.

Before the social worker can make purchases (such as clothing and toiletries) on behalf of the patient, the patient must approve the withdrawal of funds from his account. The patient can make such purchases from the canteen or elsewhere, but according to the social workers and the nurse manager of ECRC Unit B who knew the patient for many years, he does not like to spend his money. The patient prefers wearing pajama bottoms and clothing donated to the unit. A veteran's service organization volunteer visits the patient twice a month and brings him snacks and occasionally home cooked food. Interviews with staff confirmed that the patient has snacks at his bedside and wears clothes donated to the unit. They described the patient as alert but with a tendency to isolate himself and not leave the unit. The patient cannot be forced to spend his money. From January 2004 through April 2007, the patient only authorized the withdrawal of a total of $70 from his account.

We interviewed the patient and found him to be alert and orientated. He was pleased with the care he received on the unit and spoke fondly of the staff that has cared for him. He told us that he is happy with wearing pajama bottoms and clothes that come from the donation closet on the unit. The patient stated that he does not like to leave the unit and does not need a lot of things. He confirmed that a volunteer comes to see him twice a month and brings snacks that he likes and home cooked food on occasion.

He enjoys these visits and likes being on the unit where he knows the other patients and their families. The patient is pleased with the services provided by his social worker and confirmed that the social worker is trying to help him gain access to the account once controlled by his sister. The patient told us that after he dies, he would like some, but not all, of his money to be donated to the church he attended as a young man.

The patient is competent and directs how his money is spent. His social worker is providing services to support those decisions. The patient is well supported by staff, volunteers, and others; therefore, we did not substantiate the allegation that his care was substandard.

**Conclusions**

We found that the safety of patients identified as high risk for elopement was compromised by an electronic patient monitoring system that functioned inconsistently. We also found that staff shortages and recruitment and retention issues were a problem on the ECRC units. However, at the time of our visit, the medical center had taken appropriate actions to remedy these problems by replacing the outdated monitoring system, opening a Geriatric Special Care Unit for high-risk patients, and taking corrective actions to remedy nurse staffing shortages.

We did not find evidence that an elderly, blind patient was neglected. The patient was competent, directed his own affairs, and was properly supported by staff.

We made no recommendations.

**Comments**

The VISN and Medical Center Directors concurred with our findings. (See attachments, page 7 and 8, for the full text comments) We consider this case closed.

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

## VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: June 6, 2008

From: VISN Director

Subject: Healthcare Inspection – Patient Safety Issues, Hampton VA Medical Center, Hampton, Virginia

To: VA Office of Inspector General (54DC)

Thru: Director, Management Review Service (10B5)

1. Thank you for the opportunity to respond. VISN 6 concurs with the report.

2. If further information is required, please contact Wanda Mims, Director, Hampton VA Medical Center, (757) 728-3100.

DANIEL F. HOFFMANN, FACHE

## Medical Center Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 6, 2008

**From:** Medical Center Director

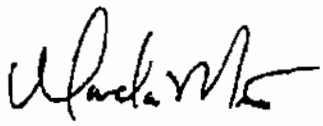
**Subject:** **Healthcare Inspection – Patient Safety Issues, Hampton VA Medical Center, Hampton, Virginia**

**To:** VA Office of Inspector General (54DC)

**Thru:** Director, Management Review Service (10B5)

1. Thank you for the opportunity to respond. I have carefully reviewed the draft report and concur with the report.

2. If further information is required, please contact me at (757) 728-3100.



WANDA MIMS, MBA