Department of Veterans Affairs
Office of Inspector General

Healthcare Inspections

Alleged Patient Abuse
Central Texas
Veterans Health Care System
Temple, Texas

Report No. 05-01027-116 **March 25, 2005**

VA Office of Inspector General
Washington, DC 20420

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

TO: Veterans Integrated Service Network Director (10N17)

SUBJECT: **Final Report** – Healthcare Inspection – Alleged Patient Abuse, Central Texas Veterans Health Care System, Temple, Texas – Project numbers: 2005-01027-HI-0141/2005-01027-HL-0266

1. Purpose

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) reviewed allegations of patient abuse at the Central Texas Veterans Health Care System (CTVHCS), Temple, Texas. The purpose of the inspection was to determine the validity of the allegation.

2. Background

During the Combined Assessment Program (CAP) review the week of January 10-14, inspectors received an anonymous letter that alleged that nursing staff on a palliative care unit (5J) had abused patients through medication mismanagement and stealing patient nourishments. Specifically, the complainant alleged:

- Evening nurses were chemically restraining patients by combining 6pm and 9pm medications and administering them all at 6pm.
- Medications were taken from one patient and given to another without a physician's order.
- Nursing assistants were stealing patient nourishments.

It was alleged that the practices had been ongoing for several years prior to the complaint.

3. Scope and Methodology

We made an unannounced evening shift visit to 5J on February 1, 2005. We interviewed nurses, pharmacists, quality managers, and administrative employees. We reviewed relevant medical records, quality management documents, policies and procedures, nutrition records, bar code administration records (BCMA), and official personnel

records. We inventoried two BCMA carts, one narcotic cart (Pyxis)[1], and inspected selected 5J patient care areas.

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

4. Inspection Results

Issue 1: Medication Administration

We did not substantiate the allegation that evening nurses were chemically restraining patients by combining the 6pm and 9pm medications and administering them together at 6pm.

During the unannounced inspection, medications were inventoried on the BCMA carts and in Pyxis. All medications were properly accounted for and were documented on the medication administration sheets as ordered. Fifteen nurses were interviewed, and all indicated that medications were given in accordance with CTVHCS policies.

Issue 2: Physician Orders

We did not substantiate the allegation that medications were taken from one patient and given to another without a physician order.

A review of the BCMA records indicated that nurses had physician orders for all medications. On the evening and night tours, the emergency room (ER) physician is available for hospital emergencies and medication orders. During our inspection, we observed a nurse requesting medication from an ER physician. The process from obtaining the order to getting the medication from pharmacy took less than 15 minutes to complete. Nurses interviewed indicated there would be no reason to take medication ordered for one patient and administer it to another, since obtaining needed medication was simple and quick.

Issue 3: Patient Nourishments

We did not substantiate the allegation that nursing assistants were stealing patient nourishments.

During our inspection we observed nursing assistants providing nourishments to patients, labeling leftover snacks, and placing them in the patient refrigerator. Nurses interviewed stated they had never observed nursing assistants stealing patient nourishments. We inspected the employee refrigerator and did not find patient nourishments.

[1] Automated medication and narcotic system

5. Conclusion

We found that patients received appropriate prescribed medications and nourishments as ordered by physicians. We did not substantiate any of the allegations. The allegations were not by supported by review of medical records, quality management documents, policies and procedures, nutrition records, BCMA records, and interviews.

We recognize that this unannounced inspection was one day only. However, by virtue of interviewing 15 nursing staff and reviewing multiple medical and other records covering approximately 60 days, we consider that the data reviewed were sufficient to address the allegations.

6. Recommendations

We offer no recommendations as a result of this inspection.

7. VISN and Medical Center Director Comments

The VISN Director and Medical Center Director concurred with the results of this inspection.

8. Assistant Inspector General for Healthcare Inspections Comments

The Assistant Inspector General for Healthcare Inspections agrees with the response of the VISN Director and Medical Center Director of the Central Texas VA Health Care System to the issues raised in this inspection report.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 11, 2005

From: VISN Director

Subject: **Alleged Patient Abuse, Central Texas Veterans Health Care System, Temple, Texas**

To: Director, Dallas Regional Office (51Q)

1. Network 17 appreciates the Office of Inspector General's (OIG) review of the Central Texas Veterans Health Care System. We will continue to monitor and collaborate with Central Texas to ensure excellent care is continuously provided to our nation's veterans.

(original signed by:)

Thomas J. Stranova

Network Director

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 11, 2005

From: Medical Center Director

Subject: **Alleged Patient Abuse, Central Texas Veterans Health Care System, Temple, Texas**

To: Director, Dallas Regional Office (51Q)

1. On behalf of Central Texas Veterans Health Care System, we wish to express our appreciation for the sensitive and professional manner in which this inspection was conducted. The OIG staff provided pertinent and timely information to the CTVHCS Director and staff on the purpose of their visit and findings.

2. If you need additional information, please contact me at 254-743-2306.

(original signed by:)

Bruce A. Gordon

Director, Central Texas Veterans Health Care System

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Linda Delong, Director, Dallas Regional Office, (214) 253-3331
Acknowledgments	Virginia Solana, Associate Director, Dallas Regional Office Shirley Carlile Marnette Dhooghe Dorothy Duncan Peter Moore Roxanna Osegueda Marilyn Walls

Appendix D

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