Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Quality of Care Issues in the Traumatic Brain Injury Unit, James A. Haley VA Medical Center, Tampa, Florida

Report No. 05-03053-77 **February 3, 2006**

VA Office of Inspector General
Washington, DC 20420

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

TO: Director, Veteran Integrated Service Network (10N08)

SUBJECT: Healthcare Inspection - Quality of Care Issues, James A. Haley Veterans Medical Center, Tampa, Florida

1. Purpose

The Department of Veterans Affairs Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), inspected the James A. Haley VA Medical Center (JAHVAMC) in response to allegations by a patient of the Traumatic Brain Injury (TBI) unit that clinicians and staff did not provide acceptable nursing care, committed patient safety/infection control violations, improperly denied or delayed treatment, permitted Environment of Care (EOC) lapses, and were rude and unprofessional in communications with the patient and his wife. The purpose of the inspection was to determine the validity of the allegations.

2. Background

The TBI unit serves specialized medical and rehabilitation care for both veterans and active duty military personnel with head injuries. Part of the Defense and Veterans Brain Injury Center, the TBI unit has 12 beds and is accredited by the Commission on Accreditation of Rehabilitation Facilities.

The complainant was an active-duty Navy male who suffered a blast injury in Iraq on May 3, 2004. He sustained head trauma resulting in left hemiplegia,[1] a craniotomy, a comminuted fracture of the right leg, and enucleation of his left eye. He also suffered from acute post-traumatic stress disorder (PTSD). Prior to this injury, the complainant had no significant past medical history. He was the first patient admitted to the TBI unit injured in Operation Iraqi Freedom.

During a National Review on TBI patient care conducted by the OIG, the patient made allegations to one of our inspectors. The patient alleged that he received unacceptable

[1] Left Hemiplegia is a condition of paralysis affecting the left upper and lower extremities.

care from June 4–July 1, 2004, on the TBI unit at the medical center. Specifically, the patient alleged that JAHVAMC:

- Provided substandard nursing care by not providing appropriate assistance with activities of daily living, responding to call lights, or changing bed linens.
- Permitted unsafe conditions by permitting him to fall and giving him scissors.
- Delayed and/or denied the patient care relating to transitional assistance, prosthetic equipment, and appointments with a Wound Care Specialist at JAHVAMC and a neurologist at the Brevard Community Based Outpatient Clinic (CBOC).
- Permitted unacceptable EOC lapses relating to pest control and cleanliness of the patient's room.
- Communicated poorly and inappropriately with the patient and his wife.

3. Scope and Methodology

We conducted a site visit at the JAHVAMC in September 2005. We interviewed clinical staff, administrators, managers, and other employees knowledgeable about the allegations. We reviewed the patient's medical records and administrative records, as well as pertinent facility and medical center policies, procedures, and standards. We also conducted an interview with the patient and his wife at their home.

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

4. Inspection Results

Issue 1: Nursing Quality of Care

We could neither substantiate nor refute that the patient received substandard nursing care at the time referred to by the complainant. The patient alleged that during his admission for the period June 4–July 1, 2004, the TBI unit provided inadequate assistance with activities of daily living, did not respond promptly to patient call lights, and did not change his bed linens regularly. We reviewed medical records and available internal reports used to document nursing care, including logs of activities of daily living. We found no evidence to support the patient's specific allegations. During our site visit, we observed TBI practices for providing assistance with daily living, responding to patient call lights, and changing bed linens and found it acceptable.

Issues 2: Patient Safety/Infection Control

We partially substantiated the patient's allegations regarding patient safety and infection control. The patient alleged that TBI staff left him unattended and permitted him to fall, gave him scissors, administered medications that had fallen on the floor to other patients after they had fallen on the floor, and staff did not wash their hands.

Patient Fall

We did substantiate that the patient was left unattended in the bathroom on July 1, 2004, and fell as a result. Although no further brain injury was noted on the Computerized Tomography [CT] scan after the fall, the patient experienced significant pain. We reviewed the incident report, nursing post-fall note, and medical records related to the fall. We found that the TBI unit had assessed the patient's fall risk as moderate risk, although he should have been assessed as a high risk due to his severe cognitive and functional deficits. Nurses did not take proper precautions to prevent the patent from falling and left him unattended in the bathroom, resulting in his fall.

We reviewed a JAHVAMC patient fall study for fiscal year (FY) 2004 and noted that the patient fall rate at JAHVAMC exceeded national fall rate for three of the four quarters of FY 2004. Consequently, JAHVAMC has initiated fall prevention training efforts and initiatives to reduce the number of falls.

Scissors

We could not substantiate or refute that the patient was given scissors with which he could harm himself. We reviewed incident reports and other internal records relating to the time of the patient's TBI stay and found no documentation of such an incident. We interviewed TBI staff on duty at the time of the alleged incident. The staff stated that they did not remember an incident in which a staff person permitted the patient to hold scissors for any reason.

Contaminated Medications

We could not substantiate or refute that any medications that may have been contaminated by falling on the floor were given to other patients on the TBI unit. However, the patient resided in a private room and was not able to observe the administration of medications to others on the unit. We reviewed medication records and internal reports for the period of the patient's TBI stay and found no documentation of medication errors or contamination. We observed the administration of medications by TBI staff and concluded that appropriate procedures were being followed at the time of our inspection.

Hand Washing

We could not substantiate or refute that the TBI staff did not routinely wash their hands. We found that the TBI staff did not have sinks to wash their hands outside patients' rooms and were required to use patients' bathroom sinks to wash their hands. This arrangement discouraged mandatory hand washing[2] before and after patient care. Since the time of the alleged incident, alcohol gel dispensers have been installed in patient rooms and in the central hallways to promote compliance with hygiene policy. We reviewed JAHVAMC hand washing compliance records for FY 2005 and found a compliance rate of 70 percent of observed care encounters.

Issue 3: Denied or Delayed Treatment

We did not substantiate the patient's allegations that JAHVAMC denied transitional financial assistance to the patient, did not properly equip his house for handicapped accessibility, or delayed his clinical appointments.

Transitional Financial Assistance

At the time of his admission to JAHVAMC's TBI unit, the patient was a military member receiving treatment for TBI through a joint agreement between the VA and the Department of Defense (DoD). Financial transitional assistance was the responsibility of DoD. There was not effective coordination between VA and DoD. Effective the summer of 2005, DoD appointed an officer to act as liaison between DoD and VA during the transition of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) soldiers from DoD treatment facilities to designated polytrauma treatment facilities. The liaison has effectively integrated into the VA environment and appears to provide the necessary transition services to OIF/OEF soldiers and their dependents.

Handicapped Accessibility

We found that adaptive equipment necessary for handicapped accessibility and requested through Prosthetics and Sensory Aids Service (P&SAS) was purchased and installed in the patient's previous home, which he had been renting. However, we found that the patient purchased and moved to a new home which was not modified for handicapped accessibility. Adaptive equipment purchased and installed at the former house was not functional for the patient at his current house due to architectural interferences between the equipment and the structure. The patient's motor deficits were well-documented, as were requirements for continual hands-on assistance from his wife to ensure his safety during transfer when toileting and/or showering (see picture below).

[2] Centers for Disease Control and Prevention's *Guidelines for Hand Hygiene in Health-Care Settings,* 2000 http://www.cdc.gov/handhygiene/

Master Bathroom Shower

Shower/Tub Chair offers no stability for patient to shower alone. Wife must manually transfer husband to shower chair and remain with him, assisting him in bathing and stabilizing him in the chair to maintain safety.

Because the patient now owns his current home, he is eligible to apply for VA grants for adaptive equipment and structural alterations to this house to ensure handicapped accessibility.

Treatment Delays

We did not substantiate that JAHVAMC denied or delayed the patient's appointments with a wound care specialist and a neurologist. We reviewed patient records and other documentation showing dates and times of the patient's clinical appointments. We found that JAHVAMC clinicians ordered a consult with the wound care specialist on June 4, 2004, and the patient was seen on June 7, 2004. We found that JAHVAMC clinicians ordered a neurology consult at the Brevard Community Based Outpatient Clinic (CBOC) on November 16, 2004, but the patient did not keep the December 7, 2004, appointment. The patient kept a primary care appointment at Brevard CBOC on December 14, 2004, at which time the primary care physician recommended he see a neurologist. The patient was seen by a neurologist in West Palm Beach VAMC on December 27, 2004. Since then, the patient has been followed by the neurology clinic at the Brevard CBOC.

Issue 4: Environment of Care

We partially substantiated the patient's allegations regarding the TBI environment of care. We could not substantiate nor refute that the patient was bitten by ants or that TBI patients' rooms were not clean, but we found that improvements were needed in the TBI's pest control procedures.

Ants and Other Pests

We could not substantiate or refute that the patient was bitten by ants or that there were ants in his room. We reviewed medical records, environmental reports, and pest control

logs. We also interviewed TBI staff as well as the wound care specialist. We found no record of ants biting the patient, and the TBI staff did not remember any such incidents. Although we found no evidence of ants or other pests in patients' room, statements by clinical staff confirmed observation of pest control treatments applied to the patient's room. Staff reported the family stored food in the patient's room and felt this was a major contributing factor to the potential pest control issue. Clinicians expressed knowledge of JAHVAMC policy prohibiting food being brought into and stored in patients' rooms. However, we found that patient information and education documents distributed to patients and family members did not include this information.

We found that JAHVAMC was not using the VA electronic work order system to receive, record, dispatch, and close-out requests for pest control treatment and interventions. Instead, JAHVAMC used a less reliable hand-written log that inconsistently recorded pesticide dispensing information. The federal Environmental Protection Agency (EPA) and the Florida State Pest Control and Pesticide Commission require accurate records of pesticide dispensing. The JAHVAMC Environmental Officer was aware of the EPA and Florida State documentation regulations and was attempting to meet their documentation requirements.

Room Cleanliness

We could not substantiate or refute the patient's allegations that TBI patient rooms were littered with trash and used urinals. We reviewed environmental reports and other internal documents and found no report of trash or urinals in patients' rooms. During our inspection of the TBI unit, we found the patients' rooms were relatively free of litter.

Issue 5: Poor Communication/Patient Relations

We did not substantiate the patient's allegations that TBI unit staff were rude, yelled at his wife or family members, or threatened the patient or family members in any way. We found that the staff attempted to address the complaints made by the patient and his wife. However, the TBI unit environment was clearly very stressful for patients, staff, and families, and communications were often tense. The care required for a combat veteran with serious head injuries and PTSD was demanding, and the emotional factors affecting the patient and his wife strained communications. The TBI staff acknowledged that, at the time of the patient's stay, they were often overwhelmed and ill-equipped to deal with the psychological factors involved in the patient's care. Additional staff, including a psychologist, have been added to the TBI since the patient's hospital stay.

We reviewed TBI patient satisfaction surveys, patient records, and patient complaints. We also interviewed TBI staff, as well as the JAHVAMC patient advocate and social worker, regarding communications with patients and family members. We found that TBI staff did not sufficiently document patient complaints and did not adequately involve the JAHVAMC patient advocate in handling the patient's complaints. VHA policy

required prompt response to all patient complaints[3] and documentation of resolution efforts within 7 days of the complaint. Documentation of complaints is necessary to ensure that complaints are satisfactorily addressed and issues are trended for quality improvement purposes.

6. Conclusion

We concluded that the quality of care provided to TBI patients met acceptable standards. However, JAHVAMC needs to make improvements in fall prevention, environment of care, and patient advocacy. Staff did not comply with fall prevention measures at the time of the patient's stay and, as a result, the patient suffered a painful and potentially very dangerous fall. JAHVAMC needs to continue fall prevention precautions and training initiated since the patient's fall. Staff needs to provide patient/family written information of the prohibition of food in patient rooms. Pest control procedures lacked documentation required to comply with Federal and state regulations. The patient advocacy function was insufficiently involved in TBI patient relations issues, and staff did not adequately document patient complaints.

Our conclusions were qualified by the one-year time lapse between the time of the patient's TBI stay in June 2004 and our inspection in September 2005. This time lapse made determinations regarding the patient's specific allegations difficult. Additionally, JAHVAMC made considerable improvements since the time of the alleged incidents.

7. Recommendations

The VISN Director needs to ensure the JAHVAMC Director takes action to:

1. Review TBI fall prevention measures to ensure appropriate patient fall risk assessments, adequacy of staff training in fall prevention, and compliance with fall prevention precautions.

2. Provide written information to patients and family regarding prohibition of food in patients' rooms.

3. Develop pest control documentation that is in compliance with Federal and state regulations.

4. Strengthen patient advocacy and documentation of patient complaints on the TBI unit.

[3] VHA Directive 1050.2, June 12, 2000

8. VISN and VAMC Director Comments

We have reviewed the Healthcare Inspection report and appreciate the difficulties in conducting the review following such a long time lapse. Many improvements have been made in the TBI program since this complaint in 2004. We concur with the recommendations that were identified and have implemented actions to improve the care we deliver to our veterans.

9. Assistant Inspector General for Healthcare Inspections Comments

We agree with the improvement plans and actions taken by the VISN and Medical Center Director to the issues raised in this report. We will follow up until all actions are completed.

(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: January 9, 2006

From: Director, Veteran Integrated Service Network (10N8)

Subject: **Alleged Substandard Nursing Care, Patient Safety/Infection Control, Denial/Delay of Treatment, Environment of Care Issues, and Communication Issues in the Traumatic Brain Injury Unit, James A. Haley Veterans Medical Center, Tampa, Florida**

To:

Thank you for the opportunity to review the Draft Report regarding the allegations in the Traumatic Brain Injury (TBI) Unit.

We appreciate the difficulty in trying to substantiate or refute a complaint following a long time lapse. The facility has made many improvements to the care they provide to these patients presenting with complex issues over this past year.

We concur with the recommendations that have been identified and have taken corrective actions to improve in those areas.

Please contact Karen Maudlin (727) 319-1063 if you have any questions.

Thank you,

(original signed by:)
George H. Gray, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 9, 2006

From: Medical Center Director

Subject: **Alleged Substandard Nursing Care, patient Safety/Infection Control, Denial/Delay of Treatment, Environment of Care Issues, and Communication Issues in the Traumatic Brain Injury Unit, James A. Haley Veterans Medical Center, Tampa, Florida**

To:

We appreciate the opportunity to have reviewed the Healthcare Inspection report and thoroughness that was involved in conducting the review following such an extended period of time.

Our facility and staff have made a variety of improvements in the Traumatic Brain Injury (TBI) program since this complaint was originally submitted in 2004.

We concur with the recommendations that were identified and have implemented actions along with targeted completion dates to improve the care we deliver to our veterans.

Please contact Dr. Steven Scott, Chief, Physical Medicine & Rehabilitation Service at (813)972-7506, if there are any questions.

Appendix C

Medical Center Director Comments

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

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN 8 Director needs to ensure that the JAHVAMC Director takes action to review TBI fall prevention measures to ensure appropriate patient fall risk assessments, adequacy of staff training in fall prevention, and compliance with fall prevention precautions.

Concur **Target Completion Date:**

Target Completion Date: February 1, 2006

All inpatients on admission, discharge or change in medical condition have an appropriate patient fall risk assessment. Further staff training on fall prevention and transferring of patients will be done by the rehabilitation clinical nurse specialist and physical therapy. Falls rates are regularly reviewed by the Hospital Performance Improvement Committee. There has been a decline in fall rates for FY05 at JAHVAMC .

Recommended Improvement Action(s) 2. The VISN 8 Director needs to ensure that the JAHVAMC Director takes action to provide written information to patients and family regarding prohibition of food in patients' rooms.

Concur **Target Completion Date:**

Appendix C

Medical Center Director Comments

Target Completion Date: February 1, 2006

The Physical Medicine and Rehabilitation Orientation Handbook for inpatients will be revised to include the Hospital Policy Memorandum No., 120-3 on the "Receipt, Storage and Distribution of Food Items Obtained from Sources other than Nutrition and Food Service." The Policy governs food item restrictions in patient rooms.

Recommended Improvement Action(s) 3. The VISN 8 Director needs to ensure that the JAHVAMC Director takes action to develop pest control documentation that is in compliance with Federal and state regulations.

Concur **Target Completion Date:**

Target Completion Date: Completed

All requests for pest control have an associated electronic work order. The work order, when completed, is entered electronically and meets documentation that is in compliance with Federal and State Regulations.

Recommended Improvement Action(s) 4. The VISN 8 Director needs to ensure that the JAHVAMC Director takes action to strengthen patient advocacy and documentation of patient complaints on the TBI unit.

Concur **Target Completion Date:**

Target Completion Date: February 1, 2006

There has been an additional FTE added to the patient advocacy program at JAHVAMC, bringing the total staffing to 3 FTE. In addition, a care partner training program will be initiated this month to enhance patient advocacy on the 2CN Rehabilitation

Appendix C

Medical Center Director Comments

Unit. Two Case managers were hired in May to document regularly and be available 24 hours per day on family concerns or complaints. In addition, Multi-Disciplinary Rounds are done two times per week.

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Marisa Casado, Director, Bay Pines Regional Office of Healthcare Inspections, (727) 395-2416
Acknowledgments	Raymond Tuenge, Associate Regional Director, Bay Pines Regional Office of Healthcare Inspections Annette Robinson, Healthcare Team Leader Charles Cook David Griffith Triscia Weakley

Appendix E

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