Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Patient Care Issues
VA Medical Center
Lexington, Kentucky

Redacted

Report No. 05-03287-169 **July 17, 2006**

VA Office of Inspector General
Washington, DC 20420

Executive Summary

This review was done in response to multiple allegations received from the wife of a patient who died while an inpatient at the VA Medical Center Lexington, KY. The allegations included: a fall which resulted in an intracranial bleed, poor documentation, poor communication with the patient/family, unavailability of drinking water, loss of dentures, and other issues.

It is likely, but not certain, that this patient's intracranial bleed resulted from a fall in the presence of unsafe levels of an anticoagulant he was prescribed. Regardless of the cause of the fall, we concluded that the medical center's clinical staff did not appropriately monitor the level of the anticoagulant during his stay on the psychiatry unit. The absence of a medicine inpatient consultative service together with the facility's own internal review documenting system and process deficiencies suggest the need for a re-evaluation of the consultative services available to Mental Health Service patients.

We substantiated that nursing documentation of hypoglycemic episodes and post-fall reassessments was inadequate. We did not substantiate the allegations of poor communications with the family, unavailability of drinking water, mishandling of dentures, or premature discharge on May 26, 2005. We could not confirm or refute the allegations of abuse or improper disclosure of confidential information.

We made recommendations that the facility should:

- Make General Internal Medicine consults available to the Mental Health Service on a 24-hour basis.
- Complete a Root Cause Analysis to identify system failures contributing to the outcome in this case.
- Ensure nursing staff conducts and documents post-fall reassessments.
- Ensure accurate documentation of hypoglycemic episodes including medical and dietary interventions and results.

The facility concurred with the findings and recommendations and provided acceptable improvement plans.

Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid-South Healthcare Network (10N9)

SUBJECT: Healthcare Inspection – Patient Care Issues, VA Medical Center, Lexington, Kentucky.

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations of poor patient care and inadequate documentation at the Lexington, KY, VA Medical Center (the medical center).

Background

The medical center is a tertiary care hospital that is part of Veterans Integrated Service Network (VISN) 9. The medical center has 99 hospital beds including a locked 19-bed inpatient psychiatry unit, 2 medical/surgical units, and an intensive care unit (ICU).

Medical center policy states that the medical problems of patients on the inpatient Mental Health ward are the responsibility of the Mental Health Service.[1] However, Mental Health Service psychiatrists do not provide in-house coverage outside regular business hours and resident psychiatrists only come to the medical center outside regular hours to address psychiatric issues. Further, the medical center does not have a general medicine consult service.

Currently, when a medical issue arises on a Mental Health Service patient after hours, the attending psychiatrist contacts the cardiology or pulmonary fellow if the problem involves the heart or lungs, and the upper level in-house Medicine Service resident for all other urgent medical problems.

[1] Memorandum from Chief of Medical Service and Chief of Mental Health Service, "Inpatient Mental Health Service Interactions with Medical Service Outside of Regular Business Hours," dated November 30, 2004.

The wife of a patient who died while an inpatient at the medical center contacted VA's OIG with multiple allegations concerning her husband's May 24 and May 28, 2005, hospital admissions.

She complained that her husband's medical problems were poorly managed during the May 28 hospitalization after her husband was transferred to the inpatient psychiatric unit. Specifically, she alleged that:

- The patient suffered a brain hemorrhage that nursing staff told her may have occurred after a fall.
- Significant hypoglycemic episodes (patient incoherent with blood sugar of 31mg/dl[2] and an episode where patient seemed to "blank out") were not documented in the patient's medical record.
- Clinical staff failed to update the family regarding the patient's medical condition.
- Visitation hours were inappropriately restricted.
- A nurse reported that the patient had a "little temperature" when, in fact, his temperature was 103 degrees Fahrenheit (º F).
- The patient did not have drinking water in his room.
- The staff misplaced the patient's dentures and did not adequately address this issue with the family.
- The patient complained of a "big nurse" who hurt him.

She also alleged that during the May 24 hospitalization on an acute medical floor:

- The patient was discharged in his pajamas.
- He was given no medical instructions or release papers.
- His legs were still infected.
- He was discharged because he tape-recorded another patient who was being restrained.

The complainant further alleged that a medical center employee acted unprofessionally and conveyed confidential information about the patient while he was in the emergency room (ER) waiting area.

[2] The abbreviated form of milligrams per deciliter, a term used to describe how much glucose is present in a specific amount of blood. A deciliter is one-tenth of a liter or about one-tenth of a quart.

Scope and Methodology

We visited the medical center October 31–November 4, 2005. We reviewed the patient's medical records, medical center policies, staffing schedules, fall assessment reports, incident reports, and peer reviews. We interviewed the Chief of Staff, Chief of Medicine Service, Chief of Psychiatry Service, the Associate Medical Center Director for Patient Care Services, the Psychiatry Unit Nurse Manager, the Quality Management Coordinator, the Patient Safety Officer, and the Regional Counsel. Prior to our visit, we interviewed the complainant and her two daughters by telephone.

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

Case Summary

May 24, 2005, Hospitalization

The patient was a 76-year-old male with a medical history of chronic atrial fibrillation,[3] coronary artery disease, coronary artery bypass graft surgery (1990), congestive heart failure, Type II diabetes, hypertension, and depression. He underwent gallbladder surgery at the medical center on May 6, 2005, and was discharged May 18 with a Foley® urinary catheter in place. On May 24, the patient was seen in the medical center's ER with complaints of drainage around the Foley® catheter insertion site. Physicians admitted him to Medicine Service with diagnoses of cellulitis (an infection of skin and tissue), urinary tract infection (UTI), and chronic atrial fibrillation, and started him on intravenous (IV) antibiotics and 5 milligrams (mg) of warfarin (anticoagulant) daily. His admission International Normalized Ratio (INR)[4] was 1.5.[5]

On May 25, the patient's attending physician wrote a progress note stating, "Pt [patient] will need to be on abx [antibiotics] for 7 days for UTI, on warfarin for afib [atrial fibrillation] so will need to be closely monitored. Anticipate d/c [discharge] later today." The patient's INR was 1.7. That evening, medical center police confiscated a tape recorder from the patient because he recorded another patient being placed in restraints. The physician discharged the patient on May 26 and scheduled a May 31 follow-up appointment for him in the anticoagulation clinic.

[3] Atrial fibrillation is an arrhythmia of the heart that can increase the risk of blood clots.

[4] The INR is a measurement of blood coagulation time, and therefore it is utilized in monitoring the efficacy of anticoagulation with warfarin.

[5] Desired value for patients in chronic atrial fibrillation = 2.0 – 3.0.

May 28, 2005, Hospitalization

On May 27, the patient's wife brought him to the medical center ER and told clinicians that he had been experiencing chills, increased leg redness, and worsening confusion. The physician admitted the patient to Medicine Service on May 28 with a diagnosis of possible cellulitis and started him on IV antibiotics. The physician consulted Psychiatry Service regarding the patient's confusion.

Psychiatry Service evaluated the patient on May 28 and ordered a computerized tomography (CT) of the head, which revealed generalized atrophy of the brain. The psychiatrist diagnosed the patient as suffering from acute mania with underlying bipolar disorder. The next day (May 29), the patient voluntarily transferred from the medical unit to the psychiatry unit. He required psychotropic medications on a regularly scheduled basis as well as on an "as needed" basis in order to control his manic symptoms. The patient also required injectable tranquilizers multiple times over several days to treat continued agitation. On June 1, the patient's INR was 2.5. Daily psychiatry resident notes state, "Afib [atrial fibrillation]: Continues warfarin."

The patient experienced multiple episodes of hypoglycemia (low blood sugar with symptoms such as profuse sweating, confusion, and irritability). The lowest documented blood sugar level was 37 mg/dl on June 3 (normal blood sugar is 65–110 mg/dl). The medical center's Diabetes Research Team saw the patient on three occasions and recommended medication and/or blood sugar testing adjustments. The team nurse and physician researcher recommended that the patient receive his insulin injection at bedtime. However, the patient continued to receive his insulin with his morning medications. We found two Nutrition Service consults in which the dietitian noted that the patient did not have his dentures and was not eating his prescribed diet. The patient lost approximately 21 pounds during this hospitalization.

This patient's diabetes presented a significant management challenge. His behavior did not permit diet discipline and the frequent adjustment in psychotropic medications made glucose control more difficult.

On June 11, the patient developed a fever and the psychiatrist consulted Medicine Service. A chest x-ray revealed pneumonia. The consulting physician prescribed a 7-day regimen of azithromycin. The physician also ordered INR studies, but there is no evidence that the studies were performed.

On June 16, a resident physician spoke to the complainant about her concerns that the patient was getting worse. The physician discussed the patient's medication changes and explained that the medications require time to work. He told the complainant that the patient was making progress.

Patient Falls During May 28 Hospitalization

Nurses recorded three falls (June 12, 15, and 22) during the patient's stay on the psychiatry unit. Nurses did not notify the patient's family of the June 12 or 15 falls "as there were no injuries noted" and because one occurred "late at night."

On June 22, nurses documented that they found the patient on the floor in his room at 6:45 a.m. The nursing fall assessment stated that the patient did not sustain any injuries, his vital signs were within normal limits, and that the patient's family was notified. After rounds on June 22, the psychiatry resident documented that "The patient denied the fall, was speaking slower, and was irritable."

On June 23 at 12:15 a.m., a nurse documented that during the 3:30 p.m. to midnight tour on June 22, "The patient was sleeping when staff came on duty…At supper vet was helped into his chair with a lot of asst. [assistance]…not able to eat. Sleeping in the chair. After supper, vet continued to sleep. Staff began to worry when he never woke up or did much moving...A finger stick was done and a pulse ox [oxygen]. Everything was ok in those departments. Dr. [the attending psychiatrist] was notified. He called Dr. [the on-call Psychiatry Service resident] who came to the floor and ordered labs and a CT scan of the head…asap [as soon as possible]." According to the note by the on-call psychiatry resident, nurses did not give the patient his evening's lorazepam[6] dose.

The CT scan conducted on June 22 at 9:05 p.m. showed bilateral subdural hemorrhages. A neurosurgical resident examined the patient and noted "a left frontal contusion" but concluded that no immediate surgical options existed. A Pulmonary Service fellow examined the patient and accepted him for admission to the ICU. The patient's INR was 8.2. The Pulmonary Service fellow documented, "Contusion s/p [after] fall" and wrote orders "to reverse coagulopathy with FFP [fresh frozen plasma] and vitamin K."[7] He concluded that the patient's highly elevated INR was probably a result of warfarin interactions with the psychotropic medications the patient had been prescribed. He discontinued psychotropic medications, and the ICU staff administered vitamin K and FFP. Labs drawn at 4:38 a.m. June 23 showed the patient's INR had decreased to 2.5.

A June 23 follow-up head CT showed that the "large left frontal hamartoma [hematoma] has increased in size with increasing edema and mass effect . . . ." Neurosurgery attending staff indicated that "his lesion and comorbidities make him extremely unlikely to improve with surgery. I have talked with the family and they do not want surgery. They would also not want him to be intubated. They agree with comfort measures only." The ICU team discussed the patient's condition with the family, and they declined intubation or resuscitation. The patient expired at 10:10 a.m. on June 23. The autopsy

[6] Anti-anxiety medication often used for sedation.
[7] A treatment to reverse supra-therapeutic levels of warfarin.

report lists the cause of death as intracranial bleed, hypothesizing that this was a hypertensive bleed. The report states there was "no scalp or cutaneous contusions or lacerations; skin of the head shows no evidence of trauma."

Inspection Results

Issue 1: Fall Allegedly Resulting in Intracranial Bleed

It is likely that this patient developed subdural hematomas after a fall with head trauma on June 22 when his INR was supratherapeutic. Both the neurosurgery and pulmonary residents documented a contusion to the patient's head. However, the autopsy report states, "there was no evidence of external head trauma, deep scalp hemorrhage, or skull fracture." The autopsy report also hypothesizes a possible hypertensive event, but there is no documentation in the medical record that the patient had high blood pressure during this admission; his blood pressures ranged from 82/59[8] to 138/70. The complainant made no mention of any marks or bruises on her husband's head.

During the course of our review, we did determine that the patient's INR was not properly monitored. Neither the patient's attending psychiatrist nor the psychiatry resident ordered an INR test after June 1. Bristol Meyers Squibb, in their prescribing information for warfarin writes,

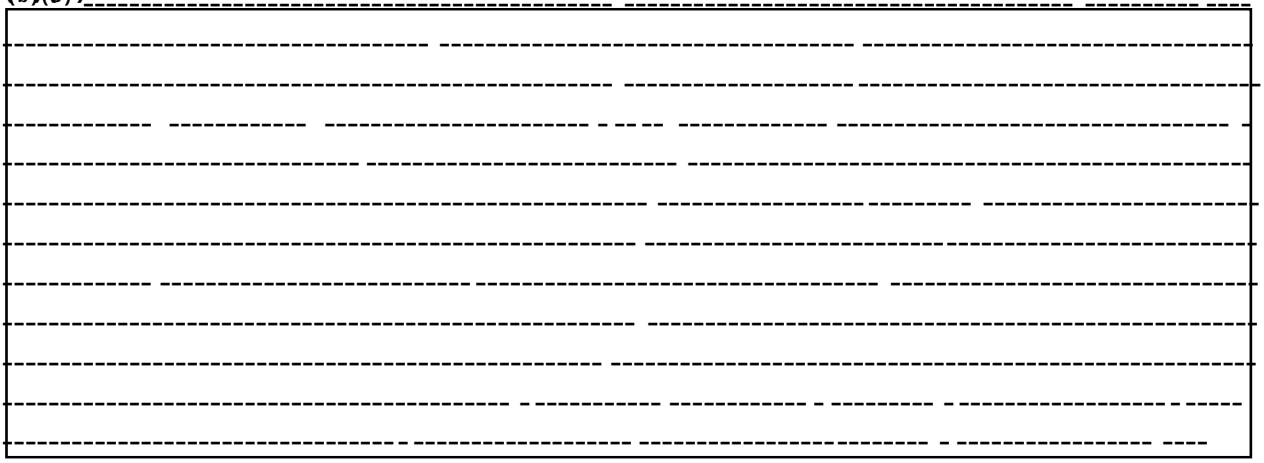
> Periodic determination of PT (prothrombin time)/INR or other suitable coagulation test is essential. Numerous factors including travel, changes in diet, environment, general health, and medication may affect the patient's response to warfarin.

The patient received three different antibiotics (piperacillin, amoxicillin, and azithromycin), varied dosages of psychotropic medications (risperidone, valproate, haloperidol, and quetiapine), and other medications (levothyroxine, ranitidine, simvastatin) that can all affect the INR of a patient on warfarin. On June 12, a Medicine Service physician ordered an INR during a consult for the treatment of the patient's pneumonia; however, we found no evidence that the INR studies were completed. During our interview with the Chief of Psychiatry, he reported not knowing that the patient's INR needed to be monitored. He confirmed that psychiatrists monitor inpatients for chronic medical conditions, but told us that there was no system for psychiatry to directly consult general internal medicine, and that the present method of obtaining consults was ineffective. However, we found no evidence that Psychiatry Service attempted to consult Medicine Service regarding the patient's warfarin management.

[8] All blood pressure measurements are in millimeters of mercury.

When patients are on an anticoagulant such as warfarin, monitoring is critical. When the INR is too low, chances increase that a patient will have a blood clot; when too high, massive bleeding can occur. Lack of INR monitoring contributed to the dangerous elevation in the patient's INR, thereby making him more vulnerable to bleeding, including an intracranial hemorrhage. However, inconsistency of the data between the residents' notes and the autopsy report, and the lack of post-fall reassessment documentation make it impossible to determine with certainty what caused the patient's intracranial bleed and subsequent death.

(b)(3)



Issue 2: Alleged Poor Documentation

We substantiated the complainant's allegation that clinical staff did not adequately document elements of the patient's condition and treatment in the medical record. Nursing staff completed a fall assessment June 22 at 7:20 a.m. We found no evidence of nursing reassessments for more than 12 hours, until staff became worried and called the attending physician. Nursing staff did not document again on the status of the patient until June 23 at 12:15 a.m.

Although nursing checked blood sugar levels 179 times with widely varying results, there was scant documentation about hypoglycemic episodes, treatments, or the results of treatment. For example, on 26 documented occasions, the patient's blood sugar was 65 mg/dl or less. These hypoglycemic episodes required food, juice, or concentrated glucose to increase his blood sugar to an appropriate level; however, nursing progress notes reflect only two such interventions.

The overall lack of documentation in the medical record also prevented us from confirming or refuting that the family witnessed one such hypoglycemic episode and informed staff that the patient's eyes rolled back into his head, and he was "blanking out." We did not substantiate that the patient's blood sugar was 31 mg/dl. The lowest recorded blood sugar was 37 mg/dl.

Issue 3: Alleged Poor Communication with Patient/Family

We did not substantiate the allegation that clinicians failed to provide medical status updates to the family and restricted family visits. Nursing staff told us that they only give general patient condition information in response to telephone inquiries due to patients' privacy rights. Nursing and psychiatry staff met with the patient's family members twice to discuss the patient's condition and treatment needs and documented their discussions in the patient's medical record. Because of the patient's mania and need for supervision, he was restricted to the psychiatry unit. However, his attending psychiatrist modified the unit visiting hours to allow maximum family visits, except for the afternoon of June 21, when visitation was denied due to the patient's behavior.

We did not substantiate the allegation that a nurse told the complainant that the patient had a "little temperature," but it was actually 103.0º F. The patient's highest recorded temperature was 102.0º F on June 11. All other temperatures recorded were within normal limits. A chest x-ray and laboratory studies taken that day confirmed a mild pneumonia that physicians treated promptly and appropriately. A follow-up x-ray on June 12 showed that the patient's lungs were clear.

Issue 4: Alleged Unavailability of Drinking Water

We substantiated the allegation that the patient did not have a pitcher of water in his room. However, we did not substantiate the implication that the patient did not get the drinking water he needed. Nursing staff told us, and we found evidence in the medical record, that the patient had a habit of carrying around his water pitcher and frequently spilling it. Nurses kept his water pitcher at the nurses' station where he could get as many glasses of water as he wanted, while decreasing both his and other patients' fall risk due to spilled liquid.

Issue 5: Alleged Loss of Dentures

While the allegation that the patient's dentures were lost was technically accurate, we did not substantiate the implication that staff did not properly care for his dentures. A physician's note indicated that the patient's first set of dentures fit poorly, and caused abnormal mouth movements. Nursing staff documented finding the patient's dentures in the garbage or with the linen, as the patient would not keep them in his mouth. These dentures were eventually lost. The patient's wife brought in a second set of dentures that had been broken and glued back together. A nursing assistant put them away fearing they would come apart and the patient would aspirate pieces of the dentures during one of his frequent hypoglycemic episodes. However, the nursing assistant did not communicate where he put the broken dentures to his colleagues before going on annual leave. The broken dentures were given to the family with the patient's personal effects after his death.

We did not substantiate the allegation that the psychiatry unit Nurse Manager and Patient Safety Officer did not respond to the complainant's request about who withheld the dentures from the patient. The Nurse Manager and Patient Safety Officer met twice with the family prior to our site visit and discussed their concerns regarding the patient's dentures and other issues.

Issue 6: Alleged Patient Abuse by a Medical Center Nurse

We were unable to substantiate or refute the complainant's allegation that her husband was afraid to go to sleep because of a "big nurse" who was mean and hurt him a lot. The patient's wife alleged this in a letter to the congressional representative and the OIG. While nursing staff completed incident reports for three falls, there were no incident reports containing allegations of patient abuse during the patient's May 28 hospitalization. The nurse manager did not know of any instance in which the patient or a family member complained of abuse during his hospitalization. Finally, the medical record and autopsy contained no documentation of unexplained injuries or physical findings consistent with abuse.

Issue 7: Alleged Premature Discharge

We did not substantiate the allegation that the patient was discharged on May 26 without any medical instructions or release papers. Medical record documentation shows that clinicians gave the patient discharge instructions and medications at the time of his discharge. While we could not say with certainty whether the patient was discharged in his pajamas, it is typically the family's responsibility to provide the patient's personal clothing.

We did not substantiate the allegation that the patient's legs were infected when he was discharged on May 26. On admission, the patient's wife told the physician that the redness of the patient's legs was worse than usual. Although during the hospitalization physicians noted the possibility of cellulitis, Doppler studies and cultures demonstrated the patient suffered from venous stasis related to his diabetes. The attending physician noted that the patient had a "long history [of] chronic venous stasis with changes [to] bilateral lower extremities, lower extremity edema. Lower extremity edema resolving with Lasix [a diuretic medication], leg elevation."

We did not substantiate the allegation that the patient was discharged prematurely because he tape-recorded an incident involving another patient. The attending physician wrote in the patient's medical record "Anticipate d/c [discharge] later today" at noon on May 25, 14 hours before the tape recorder incident occurred.

Issue 8: Alleged Disclosure of Patient Information

We could neither substantiate nor refute that an employee, working at the ER triage desk on May 27, acted unprofessionally and conveyed confidential information to co-workers concerning the patient. The alleged event occurred 5 months prior to our visit, and the complainant did not provide the employee's name for us to follow up. We did not find evidence that a complaint was lodged at the time.

Conclusion

It is likely, but not certain, that this patient's subdural hemorrhage resulted from a fall in the presence of a supratherapeutic INR. Regardless of etiology, we concluded that the medical center's clinical staff did not appropriately monitor the patient's INR during his stay on the psychiatry unit. The absence of a medicine inpatient consultative service together with the facility's own internal review documenting system and process deficiencies suggest the need for a re-evaluation of the consultative services available to Mental Health Service patients.

We substantiated that nursing documentation of hypoglycemic episodes and post-fall reassessments was inadequate. We did not substantiate the allegations of poor communications with the family, unavailability of drinking water, mishandling of dentures, or premature discharge on May 26, 2005. We could not confirm or refute the allegations of abuse or improper disclosure of confidential information.

Recommendations

Recommendation 1. The VISN Director should ensure that the Medical Center Director:

a) Makes General Internal Medicine consults available to the Mental Health Service on a 24-hour basis.

b) Completes a Root Cause Analysis (RCA) to identify system failures contributing to the outcome in this case.

c) Ensures nursing staff conducts and documents post-fall reassessments.

d) Ensures accurate documentation of hypoglycemic episodes including medical and dietary interventions and results.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with our findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plans. A new General Internal Medicine consultation arrangement for the mental health unit began in December 2005. An RCA was completed with recommended actions implemented. Nursing managers are conducting a concurrent review of all fall incident reports and reassessments to improve fall assessment/reassessment documentation. Blood glucometers' programming is being modified to allow nurses to directly input medical and dietary interventions, which will automatically download into the computerized patient record system (CPRS).

Assistant Inspector General Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

(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: May 26, 2006

From: Director, Mid-South Healthcare Network (10N9)

Subject: **Patient Care Issues, VA Medical Center Lexington, Kentucky: Project Number 2005-03287-HI-0331**

To: Assistant Inspector General for Healthcare Inspections thru: Director, Management Review Service (10B5)

1. I concur with the findings and recommendations of the Office of Inspector General relative to this individual case at the Lexington VA Medical Center. The facility Director had already initiated improvements and will be adding to those as indicated in the attached action plan.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Donna Savoy, Staff Assistant to the Network Director at (615) 695-2205 or me at (615) 695-2206.

(original signed by:)
John Dandridge, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 15, 2006

From: Director, VA Medical Center, Lexington, Kentucky (596/00)

Subject: **Patient Care Issues, VA Medical Center Lexington, Kentucky: Project Number 2005-03287-HI-0331**

To: Assistant Inspector General for Healthcare Inspections thru: Director, Management Review Service (10B5)

1. On behalf of the Lexington VA Medical Center I would like to acknowledge the comprehensive review of this case performed by the Office of Inspector General. Their efforts complemented our facility efforts to thoroughly examine this difficult and complex case so that we might learn from it and take advantage of any opportunities to improve patient care. Policy, procedural and/or process changes have already been put into place based on lessons learned from our reviews.

2. We concur with additional actions recommended by OIG including improving key nursing documentation and are submitting our action plans with this report.

(original signed by:)

Sandy J. Nielsen

Medical Center Director

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)

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director:

a. Makes General Internal Medicine consults available to the Mental Health Service on a 24-hour basis.

Concur **Target Completion Date:** Complete

The Director approved a new General Internal Medicine consultation arrangement for the mental health unit in December of 2005. Since late December, there have been 22 General Internal Medicine consults to the mental health unit under this arrangement. The Chief of Mental Health has attested that this arrangement has been effective.

b. Completes an RCA to identify system failures contributing to the outcome in this case.

Concur **Target Completion Date:** Complete

Following the identification of a systems issue during the peer review process, Lexington had initiated an improvement team to address the systems issue related to anticoagulation management on the mental health unit. That review was underway at the time of the OIG review of this case. When the OIG reviewers were on site in November 2005 they recommended that an RCA be initiated in addition to/in lieu of the team already in progress. The review was converted to RCA format on 11/4/05, completed and entered into SPOT (VA national patient safety reporting software) on 12/09/05. Actions resulting from the RCA were approved by management and implemented.

c. Ensures nursing staff conducts and documents post-fall reassessments.

Concur **Target Completion Date:** 6/30/06

Medical Center record review reveals that the patient received a post fall assessment by an RN on the date of his three falls which occurred 6/12/05, 6/15/05, and 6/22/05. On 6-22-05, the post fall document was completed at 0724. The patient was reassessed on 6-23-05 at 0015 in accordance with medical center policy which requires daily nursing reassessment on inpatient acute psychiatry. Although not documented, there was another nursing assessment prior to 2051 as that is when the CT was ordered by the medical staff. Documentation of this was lacking and should have been done. Actions being taken to improve fall assessment/reassessment documentation include:

1. Associate Director for Patient Care Services has instituted concurrent review of all fall incident reports to ensure that a post fall assessment has been completed for every reported fall.

2. The Nurse Manager on the Mental Health Unit (4S) will review the Patient Care Services documentation policy with all staff on the unit to ensure compliance with current policy, including the requirement to document re-assessment on change in condition.

d. Ensures accurate documentation of hypoglycemic episodes including medical or dietary interventions and results.

Concur **Target Completion Date:** 6/30/06

Medical Center policy defines glucometer critical values to be <60 or >400 mg/dl. Review of medical records revealed eleven glucose values for this patient that were of critical value. However, there was inconsistent documentation of intervention of these critical values. The Ancillary Testing Coordinator currently monitors all critical blood sugar levels to ensure that they are repeated and appropriate comments are entered by the nursing staff. Actions to improve documentation include:

1. The programming of the blood glucometer is being modified by the Ancillary Testing Coordinator to enhance the comment section so nursing staff can more easily document medical and dietary interventions. These notations will be directly entered into the glucometer which in turn downloads into CPRS. The Ancillary Testing Coordinator will include these parameters in the daily monitoring and reporting.

2. Capillary Blood Glucose Monitoring policy is being revised by the Clinical Nurse Specialist to include more specific clinical management guidelines and documentation requirements for patients with critical low blood sugar values. Revisions will include requirements for documenting medical and dietary interventions as well as nursing evaluation post intervention in low blood sugar levels.

3. Patient Care Services will in-service staff on these requirements and will initiate monitoring of nursing compliance with the policy.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5962
Acknowledgments	Andrea Buck, M.D. Bertie Clarke, RN George Wesley, M.D. Susan Zarter, RN

Appendix D

Report Distribution

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