



# **Department of Veterans Affairs Office of Inspector General**

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## **Healthcare Inspection**

### **Delay in Treatment and Quality of Care Issues**

**James A. Haley VA Medical Center  
Tampa, Florida**

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## **Executive Summary**

The purpose of the review was to determine the validity of allegations made by the wife of a veteran on the spinal cord injury unit (SCIU) at the James A. Haley VA Medical Center. The complainant alleged that her husband's muscle flap surgery for a sacral pressure ulcer was delayed. She further alleged that the nursing care was inadequate, medical and nursing staff was insufficient, and staff did not communicate the treatment plan to the family.

We substantiated the complainant's allegation that her husband's sacral decubitus ulcer muscle flap surgery was delayed, but found that the delay was because he required improved nutrition prior to surgery. We did not substantiate that he was not assessed for 4 hours, that his ear drops were not administered as ordered, or that there was insufficient medical and nursing staff on the SCIU. We could not confirm or refute the allegation that a nurse hurt the patient's ears cleaning them with a cotton swab, that a nurse did not know how to do an assisted cough procedure, that a nurse lowered the thermostat and placed the patient in a cold room after his shower, or that the staff did not communicate the patient's treatment plan to his family.

We substantiated the complainant's allegation that her husband developed a pressure ulcer on his heel from lying in bed. We found that medical center staff did not follow policy for documenting skin reassessments and implementing preventive measures to reduce the risk for pressure ulcers. We also found that the documentation of staff competencies was lacking and nursing staff were not always assigned patients based on their competencies and clinical skills.

We recommended that: (1) staff adhere to local policies as they relate to skin integrity and skin care management, (2) supervisory staff evaluate initial and recurring competencies for nursing staff and document this validation, and (3) staff are assigned patients based on their competencies and clinical expertise. The VISN and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans.



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

**TO:** Director, Veterans Integrated Service Network (10N8)

**SUBJECT:** Healthcare Inspection – Delay in Treatment and Quality of Care Issues,  
James A. Haley VA Medical Center, Tampa, Florida

## **Purpose**

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections received allegations of delay in treatment, substandard nursing care, insufficient staffing, and poor communication on the Spinal Cord Injury (SCI) Service at the James A. Haley VA Medical Center (the medical center) in Tampa, Florida. The purpose of our review was to determine whether the allegations had merit.

## **Background**

The medical center is a tertiary care hospital that is part of Veterans Integrated Service Network (VISN) 8. The SCI Service provides rehabilitative care to both veterans and active duty military personnel. The SCI Service consists of two 30-bed spinal cord injury units (SCIUs) and a 10-bed ventilator dependent unit.

On November 15, 2006, the complainant (the patient's wife) contacted the OIG Hotline and alleged that debridement surgery of the patient's sacral (lower back above the tailbone) pressure ulcer was delayed. She further alleged that his condition was deteriorating while he was waiting to have surgery. The OIG Hotline referred the complainant's concerns to the medical center's Director for evaluation and action, as needed. The medical center acknowledged the delay but noted that there was no urgent requirement for surgery. The patient had surgery on November 22.

On February 26, 2007, the complainant contacted the OIG again and alleged that the patient had been waiting to have muscle flap<sup>1</sup> surgery for his sacral pressure ulcer since

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<sup>1</sup> Muscle flap is a surgical procedure whereby skin from another part of the body is used to close the wound, providing a new tissue surface over the bone.

November 2006 because no plastic surgeon was available. She reported that, had her husband stayed at the private hospital (where he was admitted in October 2006), both the debridement and muscle flap would have been completed at the same time. The complainant also alleged substandard nursing care, in that:

- Nurses did not provide appropriate skin care, and her husband developed a pressure ulcer on his heel from lying in bed.
- Nurses did not assess her husband for 4 hours.
- A nurse did not know how to “quad cough.”<sup>2</sup>
- Nurses did not administer her husband’s ear drops as ordered.
- A nurse hurt her husband’s ears cleaning them with a cotton swab.
- A nurse lowered the thermostat, and placed her husband in his cold bedroom after a shower.

Further, the complainant alleged that ward D of the SCI Service had insufficient medical and nursing staff, and that staff did not communicate the patient’s treatment plan to the family.

## Scope and Methodology

We conducted a site visit on April 17–18, 2007. During our visit, we interviewed the patient and his roommate, clinical staff, administrators, managers, the patient advocate, and the Paralyzed Veterans of America (PVA) representative. Prior to our visit, we interviewed the complainant. We reviewed the patient’s medical records and pertinent medical center and Veterans Health Administration (VHA) policies and procedures. We performed the inspection in accordance with the Quality Standards for Inspections published by the President’s Council on Integrity and Efficiency.

## Case Summary

The patient is a 56-year-old quadriplegic<sup>3</sup> male with a history of cervical (C) 3-4 discectomy<sup>4</sup> spasticity, urinary tract infection, blood clot, and pneumonia. He was injured in August 2004 as a result of a fall; he had been followed by clinicians at the medical center’s community based outpatient clinic in Viera, FL, for wound care (left hip pressure ulcer) and depression.

On October 8, 2006, the patient was admitted to a private hospital with abdominal complaints and was found to have *Enterobacter* bacteremia (bacteria in the blood). The

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<sup>2</sup> Assisted cough is also called “quad coughing.” With the patient upright or lying on his/her back, the nurse pushes inward and upward with the heel of the hand against the diaphragm with a quick thrust. This procedure is repeated until secretions are cleared.

<sup>3</sup> A quadriplegic is a person who has sustained an injury to the brain or spinal cord and loses partial or total use of the arms and legs.

<sup>4</sup> Discectomy is the removal of a disk in the spine.

patient had been on intravenous (IV) antibiotics (vancomycin and ciprofloxacin) for a chronic sacral pressure ulcer since September 2006. A magnetic resonance imaging (MRI) exam of his pelvis showed a complex abscess (infection) of his hip with osteomyelitis (bone infection) and possible septic arthritis.<sup>5</sup> On October 20, he was transferred to the medical center for further management.

The patient was evaluated by infectious disease physicians (ID) who recommended plastic surgery debridement as primary therapy for the infected wound. The patient was first seen by plastic surgeons on October 21, who determined that the patient had a widely undermined<sup>6</sup> left sacral pressure ulcer with a fistula.<sup>7</sup> Plastic surgeons recommended fistula debridement and wound vacuum assisted closure (VAC)<sup>8</sup> for management. No date was set for the surgical procedure.

On October 22, the patient had a temperature of 101.6 and was started on antibiotics as recommended by ID. The patient's computed tomography scan showed chronic inflammation, but blood cultures were negative.<sup>9</sup> ID discouraged further delay of the patient's wound debridement as he was at risk for developing complications from his infection. General Surgery was consulted November 6 for urgent incision and debridement of the hip abscess. Surgeons evaluated the patient that day and again on November 15. On both occasions, they assessed that the patient was stable with no signs of blood stream infection, and that there was no urgent need for abscess drainage. Their physical examination revealed a small sinus tract<sup>10</sup> located on his buttocks, with minimal drainage and no evidence of inflammation or hardness of the tissue. They recommended debridement; on November 22 the patient had an incision and drainage of the left sacral wound with VAC placement performed by plastic surgeons.

From November 2006 to the time of the complaint (February 2007), the patient received wound VAC therapy and was followed by Plastic Surgery for progression of wound closure. On December 9 and again on January 8, 2007, plastic surgeons assessed that the wound was without signs of infection or bleeding and that the cavity was closing. They recommended continued VAC treatment. On February 23, they determined that the wound was almost ready for closure with a flap; however, they were still concerned that the hip was also infected. Plastic Surgery staff informed the patient and family that surgery could require a Girdlestone procedure (removal of the femoral head) in addition to the muscle flap procedure. Surgery was scheduled for March 26 but was postponed

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<sup>5</sup> Septic arthritis is the invasion of the joint space by an infectious agent.

<sup>6</sup> Undermined is when the wound edges are worn away or damaged so that new skin cells cannot attach properly.

<sup>7</sup> A fistula is an abnormal connection or passageway between organs or vessels that normally do not connect.

<sup>8</sup> Wound Vacuum Assisted Closure is a Negative Pressure Wound Therapy that removes fluids and infectious materials, and helps protect the wound environment, promote perfusion and a moist healing environment, and draw together wound edges.

<sup>9</sup> Negative blood cultures generally indicate no blood stream infection.

<sup>10</sup> Sinus tract is a narrow space leading to a cavity which may be filled with pus.

because the patient's serum prealbumin level ( 11 mg/dl, normal range 18–45)<sup>11</sup> indicated that the patient's nutritional status was poor. On April 6, the patient was informed that his surgery could not be scheduled until his prealbumin level was 18 or higher.

## **Results**

### **Issue 1: Delay in Treatment**

We substantiated the allegation that the muscle flap surgery was delayed, but found that the delay was warranted due to the patient's nutritional status. The attending physician reported that the treatment of a pressure ulcer typically requires debridement, antibiotics, VAC therapy for 4–6 weeks, and closure of the wound with a flap. However, in this case, the patient had a serious wound infection, possibly involving the hip bone, which complicated the treatment process. Providers treated the patient with IV antibiotics, opened and drained the wound, and initiated VAC therapy. While the patient was scheduled for a Girdlestone procedure on March 26, his prealbumin level was inadequate, and the procedure was cancelled.

Although the treatment and healing process had been slow, the patient's wound continued to heal with the VAC therapy. At the time of our visit, he no longer needed the more complex surgical procedure (Girdlestone), which is often considered as a last resort to control infection and would involve an extensive recovery period. The plastic surgeon told us that they will close the wound with a muscle flap when the patient's prealbumin reaches an acceptable level.

While we did not substantiate an inappropriate delay in surgery for this patient, staff acknowledged that operating room time for plastic surgeries was limited, and that some patients were waiting for non-emergent procedures. During the period May 1 – August 5, 2006, there was no plastic surgeon available at all. Clinical staff denied that any patients experienced negative outcomes from delayed surgeries. Medical center staff told us that emergent cases were addressed immediately and that non-emergent cases were maintained on a list and scheduled based on clinical priority. The medical center now has one full-time and one part-time plastic surgeon, and patients can be referred to community providers for plastic surgery procedures when necessary.

### **Issue 2: Substandard Nursing Care**

We substantiated two of the allegations related to the quality of care. We verified the complainant's allegation that the patient developed a pressure ulcer on his heel while lying in bed. We found that the medical center staff did not follow policy for documenting skin reassessments and implementing preventive measures to reduce the

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<sup>11</sup> Prealbumin is a protein that reflects nutritional status. Studies have shown that good nutrition prior to surgery helps to promote wound healing and avoid complications such as pneumonia and infection after surgery.

risk for pressure ulcers. In addition, we determined that the assigned nursing employee did not know the “quad cough” maneuver.

We did not substantiate the allegations that the patient was not assessed by a nurse for 4 hours, or that the patient’s ear drops were not administered as ordered. We did find, however, that managers improperly assigned a student nurse to care for the patient on a day when the patient was experiencing respiratory problems.

We could not confirm or refute the complainant’s allegation that a nurse hurt the patient’s ears cleaning them with a cotton swab, or that a nurse turned down his bedroom thermostat and returned him to his cold room after a shower.

During the course of our review, we also found that the documentation of staff competencies was inadequate.

### Heel Pressure Ulcer

We substantiated the complainant’s allegation that the patient developed a pressure ulcer on his heel while lying in bed. According to protocol, the patient should have been turned and repositioned every 2 hours. We found, however, that the medical record did not reflect that this task was accomplished about 50 percent of the time.

On October 24, 2006, the patient was assessed to be at moderate risk for skin breakdown using the Braden Scale.<sup>12</sup> Although moderate risk patients require the use of heel protectors and form wedges to support the lateral position, we found no documentation that these devices were used until December 16. We also found that while the initial skin integrity assessment was completed, reassessments were not completed, at a minimum, every 48 hours as required by VHA policy.<sup>13</sup> Medical center managers presented us with a draft policy, Skin Assessment and Pressure Ulcer Program, which outlined skin assessment, reassessment, and treatment requirements. Managers planned to implement the policy in May 2007.

### Nursing Assessment and Quad Cough

Although we did not substantiate that the patient was not assessed by a nurse for 4 hours, we determined that he may not have been assessed by a nurse for more than 90 minutes. We substantiated that the nurse did not know how to “quad cough.”

The nurse on the day shift reported that the patient required frequent suctioning, and that she assessed him every 30–60 minutes. She told us that the last time she suctioned the patient was at 3:45 p.m., just prior to the day/evening change of shift report. She also

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<sup>12</sup> The Braden Scale is a clinically reliable and valid instrument utilized by healthcare personnel to score or predict an individual’s level of risk for developing pressure ulcers.

<sup>13</sup> VHA Handbook 1180.2, *Assessment and Prevention of Pressure Ulcers*, June 29, 2006.



told us that she reported to the evening shift that the patient needed close observation. The evening shift nurse said that he became aware of the patient's condition when the roommate came to the nurse's station to report that the patient was in trouble. The nurse stated he immediately went to the patient's room (between 5:00 and 5:30 p.m.), where he found him "blue in the face" and in respiratory distress. The nurse advised us that he was not the patient's primary nurse that evening and only responded to the emergency.

The patient's primary caregiver that evening was a student nurse technician (SNT)<sup>14</sup> who told us that he was making rounds on his three other assigned patients at the time of the incident. The SNT said that when he got to the patient's room, the nurse was performing the "quad cough" maneuver and suctioning the patient. He could not remember if the day shift nurse reported any significant changes in the patient's status. He acknowledged that he was not proficient in some skills, including the "quad cough" maneuver, but said that he would call the charge nurse if he needed assistance.

We reviewed the SNT competency checklist and found that his competencies for oral and nasal suctioning had not been validated, and that the "quad cough" maneuver was not listed as a competency at all. We determined that the SNT did not possess the skills and competencies to assure the patient received the appropriate level of care that day. Staff should be assigned to patients based on their competencies, level of clinical expertise, and patient acuity.

According to local policy, the SNT works under the direct supervision of a registered nurse (RN) and may perform duties consistent with the courses completed in nursing school. We determined that the SNT was not adequately supervised by an RN. Additionally, when asked, the nurse manager seemed unsure of whether the SNT was a 2nd, 3rd, or 4th year student. This designation defines, in part, the level of duties that the SNT is able to perform.

### Ear Drop Administration

We did not substantiate the allegation that the patient's ear drops were not given as ordered. We reviewed the patient's medication record and found documentation that his ear drops were administered 9 out of 10 times that they were ordered.

### Ear Care

We could not confirm or refute the complainant's allegation that a nurse hurt the patient's ears while cleaning them with a cotton swab. The nurse manager was aware of the incident and reported that she spoke to the nurse involved. She stated that the nurse told her that she cleaned the patient's outer ear with a cotton swab. The nurse manager, who

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<sup>14</sup> The SNT is a 2nd, 3rd, or 4th year student in good standing at an accredited school of nursing. This student has knowledge and skills sufficient to provide basic and advanced nursing care of patients in a variety of hospital settings but requires appropriate supervision from a registered nurse.

is also a nurse practitioner, told us that she examined the patient's ears and found them to be impacted with cerumen (earwax), but she did not find any eardrum damage. The nurse manager also reported that it was not standard practice to clean the inside of patients' ears with cotton swabs. The nurse involved denied using a cotton swab and told us that she used a washcloth to clean the outer surface of the ears only.

### Thermostat Issue

We could not confirm or refute the allegation that an agency (contract) nurse turned down the thermostat in the patient's bedroom, and then returned him to his cold room after a shower. The nurse manager was aware of the alleged incident and told us that she met with the agency nurse; however, the agency nurse did not confirm or deny the allegation. We could not say with certainty what happened on the day in question. The nurse manager assured us that the comfort and safety of the patient were priorities.

### Nurse Training and Competency

We could not determine if SCI nurses' competencies were adequately assessed. The nurse manager reported that new employees attend a week of hospital orientation, a week of SCI orientation, and 4 weeks on the unit with a preceptor. In addition, the nurse manager stated that she observed the staff daily on the unit, and was sure they were competent. However, we did not find adequate or consistent documentation in the employees' competency files to support the nurse manager's assertion. Medical center memorandum 05-01, Competency Assessment, dated May 2005, states that the supervisor, team leader, or designated preceptor will conduct and document an assessment of the employee's capability to perform assigned tasks, duties, and responsibilities.

We reviewed 10 employee records and found 6 initial competency assessments and 5 annual (recurring) competency checklists were incomplete as they were missing initials, dates, and/or signatures to validate the nurses' competencies. In addition, we could not locate two nurses' competency checklists in the files.

The Joint Commission requires that the medical center assess and document an employee's ability to carry out assigned responsibilities safely, competently, and in a timely manner at the completion of orientation. Ongoing assessments of staff competency should be completed annually according to the medical center's competency assessment process. Initial and ongoing reviews of staff competencies are necessary to ensure the safe delivery of patient care.

### **Issue 3: Insufficient Staffing**

We did not substantiate the allegation of insufficient medical and nursing staff in SCIU. VHA policy<sup>15</sup> defines the minimum number of physician and nursing staff for SCI programs. We found that the medical center exceeded this requirement, and that due to increased patient acuity, the medical center had approved and was recruiting for additional nursing staff.

The SCI nurse administrator and nurse managers reported that staffing was reviewed daily and overtime was used to maintain acceptable staffing levels. Medication errors and fall rates, which can often be inversely correlated with nurse staffing levels, were at acceptable levels and fairly consistent for the period July 2006–March 2007 (during which time the patient was admitted to the SCIU). This is one indication that nurse staffing was adequate to assure patient care and safety.

### **Issue 4: Poor Communication**

We could not confirm or refute the allegation that medical center staff did not adequately communicate with the family. The complainant alleged that in December 2006, she complained to the patient advocate that she was not receiving information about her husband's treatment plan. The complainant stated that she was referred to a social worker on the SCIU who had an uncaring attitude about the situation. The complainant said that she informed the social worker she could only visit on the weekends (when many of her husband's primary treatment team providers were not on duty), so she wanted to be called every other week for updates on her husband's condition, or at least monthly, if there was nothing new to report. She said that she was told a nurse would call her, but she was not contacted by any clinical staff until March 2007 when she received a call from the attending physician.

The patient advocate did not have a record of, nor could he remember a contact with, the complainant in December 2006. However, he provided documentation of a contact he had with the complainant in November about another matter. The clinical staff told us that they informed the complainant of the patient's treatment plan, and that their communication was professional and courteous. However, we found minimal documentation of team members' communications with the complainant. The complainant clearly perceived that communications were lacking, yet due to the subjective nature of this perception, it was difficult to validate.

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<sup>15</sup> VHA Handbook 1176.1, *Spinal Cord Injury and Disorders System of Care Procedures*, May 2, 2005.

## Conclusion

We substantiated that muscle flap surgery was delayed, but found that the delay was warranted due to the patient's nutritional status. While the patient was waiting for surgery, the additional time allowed the wound to heal on its own and improved the chances that the flap would be successful. We substantiated that the patient developed a pressure ulcer on his heel while lying in bed. Medical center staff did not follow policy for documenting skin reassessments and implementing preventive measures to reduce the risk of pressure ulcers. We also substantiated that an SNT did not know how to perform the "quad cough" maneuver and was improperly assigned to care for this patient with complex needs.

We did not substantiate other allegations related to substandard nursing care, insufficient staffing, or poor communication. We did, however, determine that documentation of nurse competencies was inadequate.

## Recommendations

**Recommendation 1.** We recommended that the VISN Director ensure that the Medical Center Director requires that staff adhere to medical center policies as they relate to skin integrity and skin care management.

**Recommendation 2.** We recommended that the VISN Director ensure that the Medical Center Director requires supervisory staff to evaluate initial and recurring competencies for nursing staff and document this validation.

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Center Director requires that staff assignments are based on staff competencies, level of clinical skills, and patient acuity.

## 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 actions. A risk management program, educational initiatives, and a process for skin assessment of patients will be implemented. The medical center has dedicated more than five additional wound care nurse specialists to assure patients are assessed and appropriate actions taken to prevent pressure ulcers. Supervisory staff will review all nursing competency folders and ensure patient care assignments are commensurate with the qualifications of staff.

## **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

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 10, 2007

**From:** Director, VA Sunshine Healthcare Network (10N8)

**Subject:** **Healthcare Inspection – Delay in Treatment and Quality of Care Issues, James A. Haley VA Medical Center, Tampa, Florida**

**To:** Assistant Inspector General for Healthcare Inspections (54)

**THRU:** Director, Management Review (10B5)

1. I reviewed the response from the VAMC Tampa and concur with their comments to the recommendations.
2. If you have any questions, please contact Mary Huddleston, VISN 8 QMO at (727) 319-1143.

*(original signed by:)*

George H. Gray, Jr.

## Medical Center Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 9, 2007

**From:** Director, James A. Haley VA Medical Center, Tampa, FL  
(673/00)

**Subject:** **Healthcare Inspection Delay in Treatment and Quality of  
Care Issues James A. Haley VA Medical Center, Tampa,  
Florida**

**To:** Director, VA Sunshine Healthcare Network (10N8)

Attached are my comments in response to the recommendations in the Office of the Inspector General's Report. As indicated, vigorous strategies are in progress to address the issues cited in the report regarding adherence to hospital policies related to skin care management, evaluation and documentation of nursing staff competencies, and staff assignments.

*(original signed by:)*

Stephen M. Lucas

Director

## 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)**

**Recommendation 1.** We recommend that the VISN Director ensure that the Medical Center Director requires that staff adhere to medical center policies as they relate to skin integrity and skin care management.

Concur      **Target Completion Date:** 9/30/07

The facility is in the process of vigorously implementing VHA Handbook 1180.2, "Assessment and Prevention of Pressure Ulcers," including an innovative risk management program, educational initiatives, and a process for skin assessment of inpatients and outpatients. The facility has dedicated 5.5 additional wound care nurse specialists to assure that standards are met for assessment and prevention of pressure ulcers.

**Recommendation 2.** We recommend that the VISN Director ensure that the Medical Center Director requires supervisory staff to evaluate initial and recurring competencies for nursing staff and document this validation.

Concur      **Target Completion Date:** 7/30/07

As indicated in hospital policy, supervisory staff are



## Medical Center Director Comments

accountable for providing initial and on-going assessment and verification of employee competence based upon the employee's position description or functional statement. By 7/30/07, supervisory staff will review all nursing competency folders to ensure documentation of initial and ongoing staff competencies. Ongoing nursing staff competence assessments for FY'07 will be completed by end of fiscal year.

**Recommendation 3.** We recommend that the VISN Director ensure that the Medical Center Director requires that staff assignments are based on staff competencies and level of clinical skills.

Concur

**Target Completion Date:** 7/30/07

Principles for nurse staffing from the American Nurses Association (ANA, 1999) guide Nursing Service budgeting and planning processes, allocation of resources, and unit-level staffing decision making. Multiple factors are considered when nursing staff are assigned to care for patients. These include the acuity of the patient, the clinical skills and competencies of the nursing staff, and infection control precautions.

Supervisory staff will review with all nursing staff general provisions in the Hospital Plan for the Provision of Nursing Care related to patient care assignments:

- Registered nurses will be responsible for all nursing care. This will include the direct supervision of all categories of nursing personnel and nursing students.
- Patient care assignments will be specific and individualized according to the needs of patients and the qualifications of nursing personnel, and will provide continuity in care.

## Medical Center Director Comments

- Registered nurses will exchange essential patient care information at the change of each tour of duty and at other times when appropriate.

Supervisory staff will ensure that Student Nurse Technicians (SNTs) are not assigned as primary caregivers for patients.

Supervisors will review with staff the following key points in the Nursing Service Memorandum, "Staffing Policy:"

- To the extent possible, a registered nurse makes a patient assessment before delegating appropriate aspects of nursing care to ancillary nursing personnel.
- The patient care assignment minimizes the risk of the transfer of infection and accidental contamination.
- The patient care assignment is commensurate with the qualifications of each nursing staff member, the identified needs of the patient population, and the prescribed medical regimen.

## **OIG Contact and Staff Acknowledgments**

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OIG Contact	Victoria Coates, Acting Regional Director St. Petersburg Office of Healthcare Inspections (404) 929-5962
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Acknowledgments	Deborah Howard Jerome Herbers, M.D.
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