Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues at the Dayton VA Medical Center Dayton, Ohio

Report No. 07-00562-209 **September 25, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of the review was to determine the validity of a complaint alleging abuse of Alzheimer's and dementia patients and alleging substandard living conditions on Nursing Home Care Unit 4 (NHCU4) at the Dayton VA Medical Center. We made three visits to NHCU4, two of which were unannounced.

We did not substantiate allegations of patient abuse on NHCU4. Staff and family members whom we interviewed denied that any abuse occurred on the unit. We did not observe inappropriate care during our visits.

We substantiated that violations of individual patients' rights occurred and that the environment of care needed improvement.

We identified problems in staff training in the care of dementia patients. We identified that there was a lack of communication between the executive staff, the NHCU4 Nurse Manager, and unit staff.

We also identified problems with the cultural transformation initiative and a lack of management oversight of and appropriate committee membership on the Cultural Transformation Committee.

We recommended that management ensure respect for patients' rights by leaving bedroom doors unlocked, using sedatives within approved protocols, and providing adequate supplies of bulk snacks.

We also recommended that management improve communication between staff on NHCU4 and the executive staff, provide continuous dementia training and education to NHCU4 staff and medical readiness technicians, and adhere to VISN guidelines for implementation of the cultural transformation initiative.

Introduction

Purpose

The VA Office of Inspector General's (OIG's), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the care and treatment of Alzheimer's and other dementia residents on Nursing Home Care Unit (NHCU) 4 (referred to as NHCU4) at the Dayton VA Medical Center (the medical center).

Background

The medical center is a tertiary care facility that provides a full continuum of care that encompasses a broad range of inpatient and outpatient health care, including nursing home services, domiciliary services, and home and community health care programs. The medical center is part of Veterans Integrated Service Network (VISN) 10 and serves a veteran population of about 159,000 in a primary service area that includes 16 counties in Ohio and Indiana. NHCU services include extended care, rehabilitation, palliative care, and skilled nursing care.

On November 21, 2006, the OIG received a complaint that the nursing staff on NHCU4 had abused patients and that the patients resided on a unit with many environment of care issues. Specifically, the complainant alleged:

Patient Abuse

- During the night shift, a nursing assistant repeatedly punched a veteran and told him that his wife had slept with another man.
- A nursing assistant forcefully pushed an elderly patient down the hall.
- A patient was beaten with a coat hanger.
- A patient with a bleeding foot was allowed outside to smoke.
- Medical center employees played war movies to elicit post-traumatic stress disorder (PTSD) symptoms.

Individual Rights

- Patients were locked out of their rooms during meal times.
- Patients were dressed in clothes that did not fit.
- Patients were either not given their evening snacks or given the wrong kinds of snacks.

Environment of Care

- Patient rooms did not have blankets on the beds or curtains.
- The dining room was not cleaned after meals on the evening shift due to the lack of a housekeeper.
- Dirty laundry was piled up in the patients' closets.

Other Issues

- Unit-specific and staff-level ongoing training in the care of dementia patients was not available.
- The Cultural Transformation Committee lacked management oversight and appropriate membership.
- NHCU4 staff lacked training on the cultural transformation initiative.
- NHCU4 staff were not included in the planning and design of the new unit.
- NHCU4 and executive staff communication needed improvement.

The medical center recently completed three Administrative Boards of Investigation (Board) concerning patient abuse on NHCU 1 (referred to as NHCU1) and NHCU4. The first Board found that a medical center staff member had abused a patient on NHCU1, and the Board recommended referral of the case for further review. The second and third Boards did not substantiate allegations of patient abuse on NHCU4.

Scope and Methodology

We conducted a site visit December 5–7, 2006. We interviewed the Medical Readiness Team (MRT) nursing assistant who brought the complaints to the Director, who in turn notified the OIG. In addition, we interviewed the Director, the Chief of Police, the Medical Quality Managers, administrative staff, and the NHCU4 Nurse Manager. We reviewed relevant medical records, official personnel records, time and attendance logs, policies and procedures, quality management documents, the two Board records concerning NHCU4, and other relevant documentation. We inspected NHCU4 on the evening shift and at other times during our visit. We also re-visited the unit when we conducted a Combined Assessment Program (CAP) review at the medical center February 26–March 2, 2007, and during an unannounced visit April 10–12, 2007.

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

Results

Issue 1: Patient Abuse

We did not substantiate the allegations that: (a) a patient was repeatedly punched and told his wife had slept with another man, (b) a patient was forcefully pushed down the hall to his room, (c) a patient was beaten with a coat hanger, and (d) a patient with a bleeding foot was allowed outside to smoke. Further, we did not substantiate that staff played war movies for the patients to elicit PTSD symptoms. During our three site visits, we observed NHCU4 staff treating the patients with respect, saw no evidence of patient abuse, and noted that patients were appropriately dressed.

We interviewed 13 NHCU4 staff who denied ever witnessing any form of abuse occurring on the unit. In addition, we spoke with one family member who came to the unit daily to visit her husband. She told us that staff treated the patients with respect and that she was very satisfied with the care her husband received. She said that she had never witnessed any staff member hitting, yelling at, or pushing a patient.

Issue 2: Individual Rights

We substantiated that patients' rights had been violated. Joint Commission[1] standards provide that patients in nursing homes have the right to freedom from physical and chemical restraints.[2] Further, Joint Commission and Veterans Health Administration (VHA) Cultural Transformation Committee standards state that patients in nursing homes have the right to a home-like setting with access to food 24 hours a day.[3] During our December 2006 visit, we substantiated that NHCU4 did not meet these criteria.

Patients on NHCU4 eat meals in two shifts due to the limited space of the dining room. During meal times, all patient rooms are locked. When patients are not in the dining room eating, they wander the halls. Keeping patients out of their rooms and in the hallways allowed staff to monitor those patients while simultaneously feeding patients unable to feed themselves. Staff deemed this necessary in order to keep patients from wandering into other patient rooms and taking items and to keep one patient in particular from going room to room and placing objects into the toilets and flushing them, which created flooding and fall hazards.

A patient's wife told us that there were instances when staff insisted on a patient receiving care after the patient had refused. NHCU4 registered nurses (RNs) told us that Alzheimer's patients frequently refused bathing and dressing. When this occurred, staff insisted that patients bathe and dress, which consequently agitated the patients. When a

[1] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.
[2] Joint Commission *Comprehensive Accreditation Manual for Long Term Care 2007*, Standard RI.2.230.
[3] Joint Commission *Comprehensive Accreditation Manual for Long Term Care 2007*, Standard RI.2.230.

patient became agitated, staff sometimes used Ativan (a sedative) to reduce the patient's agitation and improve compliance with bathing and dressing. Use of sedation to force patients to comply with activities of daily living can be construed as a chemical restraint and should therefore be used cautiously and in accordance with physician orders.

During our December 2006 site visit, evening and night shift staff told us that the snacks supplied to the unit are delivered at 10:00 a.m. By the evening and night shifts, the snacks are either gone or of very limited selection (usually only fruit cups). Staff we interviewed stated that patients have difficulty with this type of snack because it comes in a cup that is difficult to hold. Consequently, patients often spill it on themselves and the floor. When we returned for our CAP review in February 2007 and our unannounced review in April 2007, we were told that fruit cups were still usually the only snack available on the evening and night shifts. The Cultural Transformation Committee reviewed this issue; however, we did not find any indication that committee members followed up to ensure that the issue was resolved. We discussed this issue with the NHCU4 Nurse Manager who told us that he thought the situation had been resolved because staff had not told him differently.

Issue 3: Environment of Care

In December 2006, we found the following conditions in NHCU4:

- Broken and missing floor and shower tiles patched with duct tape.
- Broken base boards and exposed mold.
- Sticky, dirty floors.
- Holes in walls.
- A dirty diaper in a patient's closet.
- Dirty unit refrigerator.
- Dirty dining room bathroom.
- The unit needed painting.
- Bare rooms.
- Beds without bedspreads.
- Torn and bent window blinds.

During this visit to the unit, we were told by staff that they did not submit work orders for repairs to the walls and the flooring because they were told by members of the Environmental Rounds Committee not to submit them. Staff were told that these work orders would not be completed due to the impending move to the newly remodeled unit. Staff stated that not having housekeeping resources on the evening shift contributed to the overall lack of cleanliness of the unit. On our subsequent visits, we noted many improvements on the unit. Many of the walls had been repaired, the unit had been cleaned, the mold problem was being addressed in accordance with local and state guidelines, work orders were submitted and addressed in a timely manner, and an evening housekeeper had been hired to help keep the unit clean.

Issue 4: Staff Training

According to training records, most of the staff had received initial dementia education when they were assigned to the unit. However, the training was not unit specific, and classes were not designed to address the various levels of staff education. The training information was written for the RN and licensed practical nurse (LPN) level of education. The nursing assistants had trouble understanding the materials and needed help from the RNs to pass the required tests. In addition, the MRT nursing assistants, who were used to supplement the LPN staff, did not have training in the care of dementia patients.

Issue 5: Communication

The medical center is involved in a VHA nursing home cultural transformation initiative aimed at transforming patient care from medical-centered care to patient-centered care in a home-like atmosphere. Six medical center staff attended a VHA nursing home summit on the cultural transformation initiative in April 2005. When they returned, they formed the Cultural Transformation Committee. The committee reports to the VISN but does not report to any executive committee at the medical center. However, efforts to transform the culture of care were delayed because four of the original six committee members left the medical center and were not replaced. Also, the lack of executive-level management support, as evidenced by failure to include key NHCU4 staff in the process and by not filling the four empty positions on the Cultural Transformation Committee, contributed to the delay in implementation of this initiative.

The NHCU4 Nurse Manager, who is directly responsible for the care of the patients on the dementia unit, was not involved in planning for the new unit and had not received any formal training on the cultural transformation initiative. In addition, NHCU4 nursing staff we spoke with indicated that they had not received any education concerning changes that will occur when the patients move to the new unit. The NHCU4 Nurse Manager and staff indicated that they expect the unit to continue to operate in the same manner as it currently operates.

Conclusions

We did not substantiate the allegations of patient abuse on NHCU4. We substantiated that violations of individual patients' rights occurred and that the environment of care needed improvement. We identified problems with NHCU4 and MRT staff training in the care of dementia patients and on the cultural transformation initiative. We identified a lack of communication between the executive staff, the NHCU4 Nurse Manager, and unit staff. In addition, we identified a lack of management oversight of and appropriate committee membership on the Cultural Transformation Committee.

Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that patients' bedroom doors remain unlocked.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that administration of sedatives is done with caution and in accordance with physician orders and that all NHCU4 staff receive education regarding the proper use sedatives.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that an adequate supply and variety of bulk snacks are available on all shifts on NHCU4.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that communication between the executive staff, the NHCU4 Nurse Manager, and unit staff is improved and enhanced.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that all NHCU4 and MRT staff receive ongoing dementia patient treatment education and training.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the cultural transformation initiative continues per VISN guidelines and that the Cultural Transformation Committee has medical center executive support and oversight.

Comments

The VISN and Medical Center Directors concurred with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 7–13, for the full text of the Directors' comments.) We will follow up on the planned actions until they 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: July 30, 2007

From: Director, VA Healthcare System of Ohio

Subject: **Quality of Care Issues at the Dayton VA Medical Center, Dayton, Ohio**

To: Assistant Inspector General for Healthcare, Office of Inspector General

Please find the attached comments from the Medical Center Director, VA Medical Center Dayton, Ohio on pages 8–13.

Based on information that was shared with us during this survey, I took the following actions:

•An unannounced Environment of Care VISN Team visited Dayton to review all Long Term Care Units on April 20, 2007. Quarterly follow-up reports are due to the VISN Director.

•A VISN team visited Dayton on April 23, 2007, to review and assess the issues raised in various inspections, to review the facility response to those inspections, and make recommendations to the VISN Director regarding what actions were required to assure a safe environment of care for our patients.

•VISN 10 point of contact for Cultural Transformation made a consultative visit to Dayton the week of May 14–18, 2007.

•VISN 10 selected Dayton facility to place a Psychologist FTE, which was funded by OMHS.

(original signed by:)

JACK G. HETRICK, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 30, 2007

From: Director, VA Medical Center Dayton

Subject: **Alleged Quality of Care Issues at the Dayton VA Medical Center, Dayton, Ohio**

To: Assistant Inspector General for Healthcare, Office of Inspector General

Please find attached our comments regarding the Allegations related to Quality of Care Issues at the Dayton VA Medical Center.

In response to information shared with us from this survey, the following actions were taken:

•Immediate corrective action was taken to address the Environment of Care Issues identified by the team.

•A second shift Housekeeping Aide was hired for NHCU4.

•Additional weekend Environmental Management Service support was added to Building 320.

•Chief, Quality Management Service, was detailed on a full-time basis to act as the NHCU Program Manager on April 18, 2007, until key requirements could be completed.

•Recruitment was initiated for a full-time Medical Director with an expected filling date of August 2007.

•A proposal was initiated and accepted for an Assistant Director position. Responsibilities will include administrative oversight of the NHCU.

•The position of Associate Chief Nurse Community Living Center (NHCU) was posted and interviews have been completed.

•Acting NHCU Program Manager, NHCU Coordinator, and NHCU4 Nurse Manager attended the Veterans Health Administration NHCU National Conference April 24–26, 2007.

•Cultural Transformation Steering Committee was reinvigorated with executive-level leadership and new members. This committee meets weekly with minutes to reflect action items and follow-up.

•Eight interdisciplinary teams were formed to address specific opportunities incorporating the principles of cultural transformation. The teams are representative of all stakeholders—patients, families, all disciplines/shifts of staff. These teams report to the Culture Club. Leadership staff is briefed weekly on Cultural Transformation progress.

•Arrangements were made for staff from various disciplines to tour a long term care facility in our community that embraces the "Eden Alternative," which supports deinstitutionalizing the culture and environment of today's nursing homes.

•VISN 10 point of contact for Cultural Transformation made a consultative visit to Dayton the week of May 14–18, 2007.

(original signed by:)

GUY B. RICHARDSON, MHSA, FACHE

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

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director ensures that patient bedroom doors remain unlocked.

Concur Target Completion Date: Completed

•Patient bedroom doors remain unlocked on NHCU4. The locks have been removed from the resident rooms on the existing and the newly renovated unit.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director ensures that administration of sedatives is done with caution and in accordance with physician orders and that all NHCU4 staff receive education regarding the proper use of sedatives.

Concur Target Completion Date: 8-10-07

•All medications administered to patients on NHCU4 have a physicians order, and administration is in accordance with orders.

•External peer review was conducted for the specific reference cases.

•All RNs and LPNs have completed the required review of psychotropic medications. A plan is in place to have all NAs review position related information on psychotropic medications.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director ensures that

an adequate supply and variety of bulk snacks are available on all shifts on NHCU4.

Concur Target Completion Date: Completed

•After review and consultation with the NHCU4 Nurse Manager, additional snacks, as well as an expanded variety of snacks, have been added to the bulk nourishment rotation. Feedback has been positive, and no further issues have been brought forward by the nursing staff or dietitian.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director ensures that communication between the executive staff, the NHCU4 Nurse Manager, and unit staff is improved and enhanced.

Concur Target Completion Date: Ongoing

•Communication has been enhanced through involvement of the Nurse Manager and NHCU4 staff in the Culture Transformation Steering Committee and subcommittees to promote participation in the cultural transformation mission. The NHCU4 staff are actively involved in planning the open house and move to the newly constructed unit.

•Chief, Quality Management Service, was detailed on a full-time basis to act as the NHCU Program Manager on April 18, 2007, until key recruitments could be completed.

•Recruitment was initiated for a full-time Medical Director with an expected filling date of August 2007.

•A proposal was initiated and accepted for an Assistant Director position. Primary responsibilities will include administrative oversight of the NHCU.

•The position of Associate Chief Nurse Community Living Center (NHCU) was posted and interviews have been completed.

•All executive leadership make rounds on NHCU4 to speak to staff, residents, and families and assure that effective communication is maintained.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director ensures all NHCU4 and MRT Staff receive ongoing dementia patient treatment education and training.

Concur Target Completion Date: Completed

•All NHCU4 staff have completed dementia training.

•Dementia orientation is included for all new staff assigned to the NHCU.

•Dementia orientation is included in the MRT NA class.

•The Nurse Manager of NHCU4 attended a community offering of person-centered dementia care, called "Connections," supported by the Alzheimer's Association.

•The Nurse Manager of NHCU4 attended the Veterans Health Administration NHCU National Leadership Conference April 24–26, 2007.

•A community offering of person-centered dementia care workshop, called "Connections," supported by the Alzheimer's Association was presented at the Dayton VA on July 17, 2007, with 33 interdisciplinary staff attending.

•Staff have been touring a local long term care facility in our community that embraces the "Eden Alternative," which supports deinstitutionalizing the culture and environment of today's nursing homes.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director ensures the cultural transformation initiative continues per VISN guidelines and that the Cultural Transformation Steering Committee has medical center executive support and oversight.

Concur Targeted Completion Date: Ongoing

•Cultural Transformation Steering Committee was reinvigorated with executive level leadership and new

members. This committee meets weekly, with minutes to reflect action items and follow-up.

•Eight interdisciplinary teams were formed to address specific opportunities, incorporating the principles of cultural transformation. The teams are representative of all stake holders—patients, families, all disciplines/shifts of staff. These teams report to the Culture Club.

•Medical center staff participated in the follow-up teleconference with Dr. Hojlo, Director, Veterans Administration State Homes and Nursing Home Care. She was pleased with the progress that had been made with identified environment of care issues and our implementation of cultural transformation.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Nelson Miranda, Director Office of Healthcare Inspections, Washington, D.C.
Acknowledgments	Randall Snow, JD Donna Giroux, RN Gail Bozzelli, RN Richard Horansky Gavin McClaren

Appendix D

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