Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Nursing Quality of Care Issues
Edward Hines Jr. VA Hospital
Hines, Illinois

Report No. 09-02449-01

October 2, 2009

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The purpose of this inspection was to determine the merit of allegations made by an anonymous complainant alleging that the following incidents occurred on one nursing unit in a 3–4 week period prior to April 27, 2009, at the Edward Hines Jr. VA Hospital.

- On two occasions, nurses attempted to administer a medication to a patient who was allergic to the medication.
- A nurse failed to remove a tourniquet from a patient who was diagnosed with dementia.
- A patient with large wounds on the buttocks was left lying in feces because the nurse called to the bedside said the next shift should clean the patient.

We substantiated that two nurses attempted to administer a medication for which the patient had a documented allergy. However, we found that nursing and the supervising physician took appropriate corrective actions. The nursing staff never administered the medication, which was discontinued prior to the next scheduled administration.

We substantiated that a nurse failed to remove a tourniquet from the arm of a patient with dementia. However, we found that nurse managers took appropriate actions and adequately addressed the issue.

We did not substantiate that a patient with large wounds on his buttocks was left lying in feces or that the nurse told the patient that the next shift should clean and dress the wounds.

Although we substantiated two of the three allegations, we concluded that clinical managers took appropriate administrative actions prior to our review. We made no recommendations.

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

TO: Director, VA Great Lakes Health Care System (10N12)

SUBJECT: Healthcare Inspection – Alleged Nursing Quality of Care Issues
Edward Hines Jr. VA Hospital, Hines, Illinois

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed allegations regarding the quality of nursing care on a unit the Edward Hines Jr. VA Hospital (the hospital). The purpose of this inspection was to determine whether the allegations had merit.

Background

The hospital is a tertiary care facility located 12 miles west of downtown Chicago, IL. The hospital offers acute medicine, surgery, primary care, extended care, and acute and outpatient psychiatry services. Specialized clinical programs include blind rehabilitation, spinal cord injury, neurosurgery, radiation therapy, and cardiovascular care. The hospital affiliates with Loyola University's Stritch School of Medicine and the University of Illinois College of Medicine at Chicago. It is part of Veterans Integrated Service Network (VISN) 12.

An anonymous complainant contacted OIG's Hotline Division on May 5, 2009, alleging that the following incidents occurred on one nursing unit in a 3–4 week period prior to April 27, 2009:

- On two occasions, nurses attempted to administer a medication to a patient who was allergic to the medication.
- A nurse failed to remove a tourniquet[1] from the arm of a patient diagnosed with dementia.
- A patient with large wounds on the buttocks was left lying in feces because the nurse called to the bedside said that the next shift should clean the patient.

The complaint was forwarded to OHI on June 17, 2009.

[1] A device, typically a tightly encircling bandage used to dilate veins before blood is drawn.

Scope and Methodology

We conducted a site visit on August 10–14, 2009. During the visit, we interviewed the Associate Director for Patient Care Services (ADPCS), the Associate Chief Nurse (ACNS) Inpatient Care, clinicians, the nurse manager, and unit nursing staff. In addition, we interviewed patients currently on the unit as well as two of the patients named by the anonymous complainant. We were unable to reach one patient or the patient's family.

We also conducted reviews of medical records, patient incident reports, and complaints for the unit. We reviewed staffing schedules and daily staffing reports for the unit from October 2008–July 2009.

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

Inspection Results

Issue 1: Safe Medication Administration

We substantiated that two nurses attempted to administer a medication for which the patient had a documented allergy. However, we found that nursing and the supervising physician took appropriate corrective actions.

We interviewed the ADPCS, the ACNS, the nurse manager, the nurse involved with the initial administration attempt, and the patient. We also interviewed the service chief who supervised the resident physician who ordered the medication for the patient. We reviewed the patient's medical record and Bar Code Medication Administration (BCMA) records during the time of the patient's admission. We found appropriate documentation of the medication allergy in the Computerized Patient Record System (CPRS).

The nurse involved in the initial attempt to administer the medication told us that medication administration procedures require verification of medication allergies in the Crisis Notes, Warning Notes, Allergies, and Directives (CWAD) section of CPRS during medication administration. However, verification of patient allergies in the CWAD did not occur for this patient during the administration procedure in question. The nurse became aware of the allergy when the patient asked the nurse to identify the medications prior to accepting them. The patient informed the nurse of an allergy to one of the medications, and refused the dose.

The nurse notified the physician caring for the patient and documented the information in a nursing progress note. The nurse told us that the information was conveyed to the oncoming shift. Despite this communication, a nurse on the next shift attempted to administer the same medication to the patient. However, when the patient relayed being allergic to the medication, the nurse did not administer the dose.

The supervising physician told us that the order for the medication had triggered an alert to the resident who ordered the medication regarding a medication allergy; however, the resident chose to override the alert without comment and continued with the order. The pharmacist also received an alert, placed a notation in the record that the resident was notified of an allergy, and processed the order. Of note, nursing staff do not receive allergy alerts when verifying orders in CPRS or when scanning medications or patient armbands in BCMA. The patient did not receive the medication, and the nurse caring for the patient took the appropriate action of notifying the resident that the patient had an allergy to the ordered medication.

The resident and the supervising physician both spoke with the patient regarding the incident, and the resident discontinued the medication prior to the next scheduled administration. In addition, supervising physician took appropriate administrative action.

The patient related to us that, outside of the medication incident, there were no complaints regarding the nursing or medical care received while an inpatient during the April 2009 admission or during previous admissions.

Issue 2: Phlebotomy Protocol

We substantiated that a nurse failed to remove a tourniquet from the arm of a patient with dementia. However, we found that nurse managers took appropriate actions and adequately addressed the issue.

We interviewed senior managers, the nurse manager, the charge nurse at the time of the incident, and the nurse who found the tourniquet on the patient's arm. The nurse caring for the patient stated that while doing rounds on assigned patients shortly after midnight, it was noted that the left arm of the patient was very swollen. After further investigation, the nurse found a tourniquet on the patient's arm. The nurse notified the charge nurse, the nursing supervisor, and the physician on duty. The nurse also reported that the patient was confused but did not complain of pain when questioned. The physician saw the patient at the bedside and ordered the nurse to elevate the limb on a pillow.

The nurse caring for the patient on the previous shift drew blood from the patient for testing at approximately 7:00 p.m. and mistakenly left the tourniquet in place when the procedure was complete. The nurse manager took appropriate administrative action. We were unable to contact the patient or the patient's family, but the medical record did not indicate any permanent injury to the patient because of the incident.

Issue 3: Wound Care

We did not substantiate that a patient with large wounds on the buttocks was left lying in feces or that the nurse told the patient that the next shift should clean and dress the wounds.

We interviewed senior managers, the nurse manager, wound care specialists, and the nurse thought to be involved in this complaint. The nurse recalled only one incident involving the named patient. The nurse related that on one occasion the patient became verbally belligerent when the nurse attempted to change the patient's dressing 15 minutes prior to the scheduled time. The nurse left without changing the patient's dressing and notified the supervisor and the unit charge nurse of the incident.

The wound care specialists and the nurse told us that the patient was continent while on the unit. In addition, there was no evidence in the patient's medical record that the patient was incontinent of urine or feces or that the dressing required frequent changing due to soiling while on the unit. The wound care specialists told us that the patient's wound healed well with no complications, and the wound care for the patient was within the standard of care. During our interview, the patient expressed satisfaction with the nursing care and the medical care provided while on the unit. The patient did not recall this incident or any other incident with nursing staff.

Additional Review Areas

We found that reported nurse staffing on all shifts met established standards on the unit for the period covered by the allegations, and patient incident reports for May 1, 2008, through June 30, 2009, revealed no trends related to poor nursing care. The patient advocate reports for the unit from October 2008 through April 2009 did not reflect a high complaint rate related to poor nursing care and included many compliments from patients of the nursing care received.

Conclusions

Although we substantiated two of the three allegations, we concluded that clinical managers took appropriate administrative and corrective actions with the staff involved prior to our investigation. We also concluded that staffing during the time period met unit standards, and patient complaint data revealed no negative trends related to nursing care. We made no recommendations.

Comments

The VISN Director and Hospital Director agreed with the findings and conclusions. (See Appendixes A and B for the Directors' comments.)

(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**

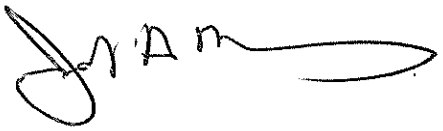
Date: September 18, 2009

From: Network Director, VA Great Lakes Healthcare System (10N12)

Subject: Healthcare Inspection – Alleged Nursing Quality of Care Issues, Edward Hines Jr. VA Hospital, Hines, Illinois

To: Assistant Inspector General for Healthcare Inspections

I have reviewed your report regarding the above investigation at the Edward Hines, Jr. VA Hospital and I concur with your findings.



Jeffrey A. Murawsky, MD

Appendix B

Acting Hospital Director Comments

Department of Veterans Affairs **Memorandum**

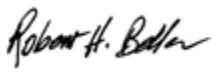
Date: September 18, 2009

From: Acting Director, Edward Hines Jr. VA Hospital (578/00)

Subject: Healthcare Inspection – Alleged Nursing Quality of Care Issues, Edward Hines Jr. VA Hospital, Hines, Illinois

To: Assistant Inspector General for Healthcare Inspections

We, at Edward Hines, Jr. VA Hospital, have reviewed the findings from the report of the above subject investigation; and we concur with your findings.



Robert H. Beller, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Jeanne Martin, PharmD, Associate Director Bedford Office of Healthcare Inspections (603) 222-5872
Acknowledgments	Glen L. Pickens, Sr., BSN

Appendix D

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