Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Inappropriate Treatment
Portland VA Medical Center
Portland, Oregon

Report No. 10-01528-258 **September 28, 2010**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections reviewed allegations that a woman veteran received inappropriate treatment at the Portland VA Medical Center (the facility) in Portland, Oregon. The purpose of this inspection was to determine whether the allegations had merit.

We confirmed that the patient was placed on unit 5C (a locked, mixed gender mental health inpatient unit) in a room with a shared bathroom. However, we could neither confirm nor refute the allegation that the patient was told that she had to share the bathroom with male patients. We did not substantiate the allegation that the unit was not equipped for patients with physical disabilities. The unit met the Americans with Disabilities Act and Veterans Health Administration requirements.

Although we could neither confirm nor refute the allegation that unit employees were insensitive to the patient's disability, facility managers, in conjunction with the Women Veterans Program Manager, agreed to conduct sensitivity awareness training. In addition, facility managers clarified the role of the patient advocate office in responding to patients' complaints or concerns.

The Veterans Integrated Service Network and Facility Directors agreed with the findings. We made no recommendations.

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

TO: Veterans Integrated Service Network 20 Director

SUBJECT: Healthcare Inspection – Alleged Inappropriate Treatment, Portland VA Medical Center, Portland, Oregon

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed allegations that a woman veteran received inappropriate treatment at the Portland VA Medical Center (the facility) in Portland, OR. The purpose of this inspection was to determine whether the allegations had merit.

Background

The facility is a tertiary medical center with 160 acute care beds and approximately 2,800 employees. Its operating budget is close to $500 million. The facility is part of Veterans Integrated Service Network (VISN) 20.

The wife of a veteran (the complainant) sent the OIG a copy of a letter she had written to the facility's Acting Director alleging that three women veterans were not afforded the same treatment as their male counterparts at two Veterans Health Administration (VHA) facilities. The complainant learned of the incidents through various veteran forums. She was upset because her husband has consistently received excellent care at the facility, and she felt that two women veterans were not afforded the same treatment as her husband. The correspondence also referenced a third woman veteran who received care at another VA facility.

In the letter, the complainant referred to the women veterans as Mary 1, Mary 2, and Mary 3. The OIG hotline staff contacted the complainant to obtain the identities of the veterans. However, only one veteran (referred to as the patient in the remainder of this report) authorized the OIG to review the allegations surrounding her admission to unit 5C (a locked, mixed gender mental health inpatient unit) at the facility in January 2010.

The complainant alleged that:

- The patient was placed in a room with a shared bathroom and that 5C staff told her that she would be sharing the bathroom with male patients.
- Unit 5C was not equipped for patients with physical disabilities.
- Unit 5C staff were not sensitive to the patient's disabilities as evidenced by staff failing to assist with her breakfast tray.

The VA system's ability to meet the physical and mental health care needs of women veterans was the subject of a recent report by the Government Accountability Office (GAO). While the report concluded that VA has taken steps to address the needs of women veterans, the review identified some gaps in services available to women and recommended revision of key policies and improved oversight processes.[1]

Prior to our review, the facility hosted a forum for women veterans, providing them the opportunity to discuss with facility leaders issues related to women veterans. The facility is in the process of addressing concerns raised at this forum by improving communication and adding a one-stop clinic for women. To ensure ongoing dialogue of women's issues, a monthly meeting between the facility's Chief of Staff and the Women Veterans Program Manager (WVPM) has been initiated. The WVPM considered this a significant step towards improving services to women veterans. On May 11, 2010, the facility had a groundbreaking ceremony for its women's health clinic (WHC). The WHC is expected to offer comprehensive, gender-specific primary care services to women veterans in a single location.

Scope and Methodology

We conducted this inspection in May 2010 in conjunction with the OIG Combined Assessment Program review at the facility. We interviewed program and facility managers and reviewed medical records, policies, and reports. We interviewed the patient by phone. The scope of our review was limited to the issues described by the complainant and subsequently verified by the patient. The patient's primary concern was related to her perception of unit 5C staff insensitivity.

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

[1] GAO, *VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Policies and Improve Oversight Processes*, GAO-10-287, March 31, 2010.

Inspection Results

Case History

The patient's medical history is significant for psychiatric and physical impairment. She requires a wheelchair for mobility. Since 2007, the patient has been receiving mental health, medication management, and women's counseling services at the community based outpatient clinic (CBOC) in Eugene, OR. Organizationally, VA Roseburg Healthcare System (the system) is the parent facility for the CBOC. From October through December 2009, the patient made several visits to the CBOC for medication management and women's counseling.

In early January 2010, the patient called the suicide hotline number and complained of sleeping difficulties and suicidal ideations. The patient reported that she had not been able to sleep since her primary care provider (PCP) changed her medications. At that time, the patient was given the option of an inpatient admission, which she declined.

Later in January 2010, the patient was seen at the CBOC and reported suicidal ideation with plan to overdose on morphine because of recent stressors that included the loss of a friend, an illness in another close friend, and worsening insomnia. Because the system did not have an inpatient unit designed to meet the needs of the patient, her PCP recommended admission at the facility. The patient agreed to go to the facility for admission but refused a secure transport. Early that evening, the patient presented to the facility's emergency department and was evaluated by a psychiatrist. Four hours later, the patient was admitted to unit 5C.

The following morning, the patient requested to be discharged. Her request was granted because she was compliant with her clinic visits, and there was no basis for involuntary admission. The patient was discharged that afternoon.

The patient's stay on unit 5C was less than 24 hours.

Issue 1: Shared Bathroom

We confirmed that the patient was placed with another woman patient in a room that had a shared bathroom. However, we could neither confirm nor refute the allegation that unit 5C staff told the patient that she would be sharing the bathroom with male patients.

The patient told us that the possibility of intrusion by male patients made her feel unsafe the entire evening. As a result, she did not use the bathroom during her entire stay on the unit.

The unit managers we interviewed told us that standard procedure on 5C is to place female patients in private rooms or in a room with a bathroom shared with other female

patients. However, there were no rooms with private bathrooms available when the patient was admitted at. Unit managers reiterated that while the patient's room had a shared bathroom, the adjacent room was empty. We reviewed the hourly patient safety check sheet and verified this information. We also confirmed that the patient and her roommate were transferred to a room with a private bathroom the following morning.

Issue 2: Unit Not Equipped for Disabled Veterans

We did not substantiate the allegation that the unit was not equipped for patients with physical disabilities. The patient expressed difficulties in maneuvering her wheelchair around the unit and in getting in and out of bed because the bed was not adjustable.

We inspected unit 5C and we found handrails in hallways and bathrooms and adequate space for patients to operate their wheelchairs. Facility managers confirmed that the beds on locked mental health units are not adjustable in order to limit potential physical hazards in the environment and thus reduce the risk of patient self-harm. The unit's configuration met Americans with Disabilities Act (ADA) requirements, and the unit is also furnished in accordance with those requirements. Additionally, the WVPM told us that she has not received complaints from other women patients related to this issue.

Managers told us that many patients with physical disabilities are admitted to unit 5C, including patients in wheelchairs, and that staff are accustomed to providing assistance as needed.

Issue 3: Staff Insensitivity

We could neither confirm nor refute the allegation that unit 5C staff were insensitive to the patient's disability, which was evidenced by their failure to assist her with her breakfast. The patient told us that a male veteran had to help her in opening up items on her breakfast tray. The patient acknowledged that she did not ask unit 5C staff for help. She stated that staff should have been more observant since it was evident that she was having difficulties in maneuvering with her hands. The patient felt strongly that unit 5C staff could benefit from sensitivity training.

Although we did not substantiate this allegation, unit managers told us that the facility has a strong commitment to customer service and that patients' perceptions are important indicators of their service recovery program. Unit managers, in conjunction with the WVPM, agreed to conduct sensitivity awareness training for unit 5C staff.

Issue 4: Other – Response to Patient's Complaints

During the course of our review, we learned that the patient contacted the facility's patient advocate office several days following her discharge from the facility and verbalized her concerns about her hospitalization on unit 5C. The patient requested a return call to address her concerns. The patient advocate referred the patient's complaints

to the appropriate unit managers. A unit manager reviewed the case and responded back to the patient advocate. However, no one contacted the patient.

While we were onsite, a patient advocate representative called the patient to let her know that her concerns had either already been addressed or were in the process of being addressed. This contact was documented in the patient's medical record. The patient confirmed that she received a call from a patient advocate, and she appeared to be satisfied that someone contacted her. However, she told us that she would hesitate to use the facility again in the future. Because it was unclear as to who is responsible for contacting patients regarding their concerns or complaints, facility managers agreed to clarify the process and have assigned this responsibility to the patient advocate office. In addition, facility managers agreed to involve the WVPM on all issues related to women veterans. Therefore, we did not make any recommendations related to this finding.

Conclusions

We confirmed that the patient was placed in a room with a shared bathroom. However, we could neither confirm nor refute the allegation that the patient was told that she had to share the bathroom with male patients. We did not substantiate the allegation that the unit was not equipped for patients with physical disabilities. The unit met ADA and VHA requirements.

Although we could neither confirm nor refute the allegation that unit 5C employees were insensitive to the patient's disability, facility managers, in conjunction with the WVPM, agreed to conduct sensitivity awareness training. In addition, facility managers clarified the role of the patient advocate office in responding to patients' complaints or concerns. The VISN and facility Directors agreed with the findings. We made no recommendations.

(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 17, 2010

From: Network Director, VISN 20 (10N20)

Subject: **Healthcare Inspection – Alleged Inappropriate Treatment, Portland VA Medical Center, Portland, Oregon**

To: Director, Los Angeles Healthcare Inspections Division (54LA)

Thru: Director, Management Review Service (VHA CO 10B5 Staff)

I concur with the attached OIG report.

(*original signed by:)*
Susan Pendergrass, DrPH

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 16, 2010

From: Facility Director (00/648)

Subject: **Healthcare Inspection – Alleged Inappropriate Treatment, Portland VA Medical Center, Portland, Oregon**

To: VISN 20 Director

I concur with the attached OIG report.

(*original signed by:)*
John E. Patrick
Medical Center Director, Portland VA Medical Center

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Daisy Arugay, Director Los Angeles Office of Healthcare Inspections (213) 253-5134
Acknowledgments	Douglas Henao Kathleen Shimoda Mary Toy

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Northwest Network (10N20)
Acting Director, Portland VA Medical Center (648/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Maria Cantwell, Jeff Merkley, Patty Murray, Ron Wyden
U.S. House of Representatives: Brian Baird, Earl Blumenauer, Peter DeFazio, Doc Hastings, Cathy McMorris Rodgers, Kurt Schrader, Greg Walden, David Wu

This report is available at http://www.va.gov/oig/publications/reports-list.asp.