Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care, Personnel, and Other Community Living Center Issues
Hampton VA Medical Center
Hampton, Virginia

Report No. 10-03275-04 **October 12, 2010**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

At the request of the Honorable Jim Webb, United States Senator from Virginia, the VA Office of Inspector General Office of Healthcare Inspections reviewed the validity of allegations regarding quality of care, personnel, and other issues in the community living center (CLC) at the Hampton VA Medical Center (medical center), Hampton, VA. We reviewed allegations from an anonymous complainant that:

- Residents did not receive weekly showers as scheduled.
- Nursing staff did not assist residents with meals in a timely manner.
- Staff did not receive disciplinary action after borrowing money from a resident.
- Nursing staff's work environment was hostile and unprofessional.
- Staff were not disciplined for tardiness.
- Residents did not have access to Resident Council meeting minutes and follow-up.

We substantiated that weekly showers do not occur for all residents; however, culture transformation and veteran-centered care allows for liberalized bathing types and schedules. We also substantiated the allegation that some staff members were habitually tardy without disciplinary action; however, CLC managers addressed this issue prior to our review.

We did not substantiate that nursing staff did not assist residents with meals in a timely manner, that a staff member borrowed money from a resident and no disciplinary action occurred, that the work environment for nursing staff was hostile and unprofessional, or that Resident Council meeting minutes and follow-up were not available to residents.

During our review, we identified an aspect of care warranting improvement. Nursing staff did not consistently document showers, tub baths, and bed baths accurately. We recommended that **t**he medical center Director require that CLC Nurse Managers monitor accurate documentation of resident bathing. Because the medical center addressed the issue identified in the recommendation, we consider this recommendation closed.

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

TO: Director, VA Mid-Atlantic Health Care Network (10N6)

SUBJECT: Healthcare Inspection – Alleged Quality of Care, Personnel, and Other Community Living Center Issues, Hampton VA Medical Center, Hampton, Virginia

Purpose

At the request of the Honorable Jim Webb, United States Senator from Virginia, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations by an anonymous complainant regarding quality of care, personnel, and other issues in the community living center (CLC) at the Hampton VA Medical Center (the medical center), Hampton, VA.

Background

The medical center provides primary, specialty, and long-term care services. It has 157 hospital beds and 112 CLC beds. The medical center serves a veteran population of about 220,000 throughout a 15-county region in eastern Virginia and northeastern North Carolina and is under the jurisdiction of Veterans Integrated Service Network (VISN) 6.

A significant change in philosophy has occurred in the delivery of nursing home care. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers*, issued August 13, 2008, authorized the official name change from VA Nursing Home Care Units to CLCs. In addition, it outlined procedures for the implementation of culture transformation[1] in CLCs.

In support of VA's culture transformation, the medical center began an extensive renovation project to update portions of the existing CLC units in 2008. The project is currently 60 percent complete. Renovations include refurbishment and updating common areas, nurses' stations, resident rooms, bathrooms, dining rooms, furniture, and décor.

[1] Culture transformation focuses on veteran-centered care, where personal preferences with regard to care and environment are honored.

In July 2010, the complainant sent a letter to Senator Webb alleging that:

- Residents did not receive weekly showers as scheduled.
- Nursing staff did not assist residents with meals in a timely manner.
- Staff did not receive disciplinary action after borrowing money from a resident.
- Nursing staff's work environment was hostile and unprofessional.
- Staff were not disciplined for tardiness.
- Residents did not have access to Resident Council meeting minutes and follow-up.

Scope and Methodology

We received the complaint on July 20, 2010, and conducted a site visit July 21–23. We interviewed the Medical Center Director, the Associate Director for Patient Care Services, the CLC Medical Director, CLC managers and nursing staff, CLC social workers, and others with knowledge related to the allegations.

We reviewed nursing care records, CLC performance scores, Resident Council meeting minutes, employee satisfaction scores, and VA police reports related to monetary issues. We also reviewed CLC policies, procedures, and documentation.

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: Weekly Showers

We substantiated the allegation that weekly showers do not occur for all residents; however, residents who do not receive weekly showers receive alternate types of weekly bathing such as tub baths or bed baths.

VHA Handbook 1140.01 allows for the liberalization of bathing and grooming schedules as part of veteran-centered care. The goal is to provide care in an environment where the resident is respected, treated with dignity, and is an active participant in his or her own care. Residents of the CLC can choose a shower, tub bath, or bed bath, and how frequently they receive them. CLC staff is aware of resident bathing preferences. If a resident refuses to bathe at their scheduled time, following shifts will continue to offer bathing options.

Residents were clean and well groomed during our observations. We reviewed the previous 4 weeks of nursing care records for nine residents. We found that each received a shower, tub bath, or bed bath at least weekly.

Issue 2: Meal Assistance

We did not substantiate the allegation that nursing staff do not assist residents with meals in a timely manner.

CLC residents have the choice to dine where they choose. Generally, CLC residents choose to eat their meals in the dining room. Some residents cannot leave their room to eat or choose to eat their meals in their room or another location.

We observed a breakfast, a lunch, and a dinner service in the CLC dining room and in selected resident rooms. Adequate nursing and dietary staff were available. Staff interacted socially with residents during meal times and provided all meal service, set up, and feeding assistance in a timely manner.

Issue 3: Money Borrowing

We did not substantiate the allegation that "staff borrowed money from a resident 2 paydays ago and no disciplinary action occurred." However, we did have one finding of staff borrowing money.

The Code of Federal Regulations, Title 5, Part 2635, Standards of Ethical Conduct for Employees of the Executive Branch prohibit monetary transactions between staff and residents. A medical center memorandum[2] also directs that staff may not borrow money from residents because it may cause conflicting relationships.

We reviewed CLC reports of contact and VA police reports related to monetary issues for the prior 12 months. We found one instance of a staff member who borrowed money from residents. CLC managers appropriately disciplined the staff member. We found no other instances of staff borrowing money from residents.

Because the medical center took appropriate action and disciplined the staff member who borrowed money from residents, we made no recommendation.

Issue 4: Work Environment

We did not substantiate the allegation that the work climate for nursing staff is hostile and unprofessional.

We observed and interacted with day, evening, and night shift nursing staff. We did not observe instances of hostility or unprofessionalism between nursing staff, or between nursing staff and CLC nurse managers.

We interviewed the medical center executive leadership, CLC nurse managers, and CLC nursing staff. Most staff interviewed expressed job satisfaction and stated they did not

[2] Hampton VA Medical Center, *Memorandum 11*, issued on January 5, 2010.

believe their work environment was hostile or unprofessional. Some staff reported recent CLC leadership changes, recent operational changes, and CLC managers' efforts to enforce staff accountability that may have caused some staff unhappiness.

We reviewed the 2010 CLC employee satisfaction survey scores and *Tell the Director* comment cards. CLC employee satisfaction scores indicated overall employee satisfaction with their work environment. Comment cards did not indicate staff unhappiness with their work environment.

Issue 5: Unexcused Tardiness

We substantiated the allegation that some CLC staff members were habitually tardy without disciplinary action.

In May 2010, CLC managers began to track, monitor, and discipline tardy staff. We reviewed the disciplinary process and found it was appropriate. Administrative reprimands for unexcused tardiness were either issued or pending prior to our onsite review. Because CLC managers now track, monitor, and discipline tardy staff, we made no recommendation.

Issue 6: Resident Council

We did not substantiate the allegation that Resident Council meeting minutes and facility follow-up actions are not available to residents.

The Resident Council consists of CLC residents who meet on a monthly basis. Nearly 50 percent of the CLC residents attend Council meetings. Council members elect official roles such as President and Secretary. The Council members vote on issues that affect CLC residents. A designated facility representative is responsible for recording the meeting minutes, which include facility follow-up actions related to Council concerns. Residents who want to review meeting minutes may request them from the facility representative or from the Council President.

The facility representative told us residents could request and review Resident Council meeting minutes. The Council President did not voice concerns related to meeting minute availability to residents.

Issue 7: Other Issues Identified

We identified one aspect of care needing improvement.

Bathing Documentation

We found that nursing staff did not consistently document showers, tub baths, and bed baths accurately.

CLC nursing staff is required to document the type of resident bathing provided in the electronic medical record (EMR). Seven (78 percent) of nine resident EMRs showed residents received a bed bath, when a shower or tub bath was actually provided. Three residents, whose EMR indicated that they received bed baths regularly, told us they actually received showers or tub baths.

CLC nurse managers reviewed bathing documentation and found that some nursing staff did not accurately document the type of bathing provided to residents. Some staff always selected the bed bath option, regardless of the type of bathing provided. While we were on-site, nurse managers began reviewing nursing documentation daily to provide immediate feedback to individual staff for accurate documentation.

Conclusions

We substantiated the allegation that weekly showers do not occur for all residents; however, residents who do not receive weekly showers receive alternate types of bathing such as tub baths or bed baths at least weekly. Culture transformation and veteran-centered care promotes resident choice, which includes liberalized bathing types and schedules. All residents observed were clean and well groomed. We did not substantiate the allegation that nursing staff do not assist residents with meals in a timely manner.

We substantiated the allegation that some staff members were habitually tardy without disciplinary action. CLC managers began tracking, monitoring, and disciplining tardy staff prior to our review. We did not substantiate the allegations that a staff member borrowed money from a resident "2 paydays ago and no disciplinary action occurred," that the work environment for nursing staff is hostile and unprofessional, or that Resident Council meeting minutes and follow-up are not available to residents.

We identified one aspect of care that needed improvement. Nursing staff did not consistently document showers, tub baths, and bed baths accurately.

Recommendation

We recommended that **t**he Medical Center Director require that CLC Nurse Managers monitor accurate documentation of resident bathing.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations (see Appendixes A and B, pages 7–9, for the Director's comments). Because the medical center addressed the issue identified in the recommendation, we consider this recommendation closed.

(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 27, 2010

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Healthcare Inspection – Alleged Quality of Care, Personnel, and Other Community Living Center Issues, Hampton VA Medical Center, Hampton, Virginia**

To: Director, Denver Office of Healthcare Inspections (54DV)

Thru: Director, Management Review Service (10B5)

I concur with the response by the Medical Center Director and with the recommendation for improvement identified in the report.

(*original signed by*:)
Daniel F. Hoffmann, FACHE
Network Director, VISN 6

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 27, 2010

From: Director, Hampton VA Medical Center (590/00)

Subject: **Healthcare Inspection – Alleged Quality of Care, Personnel, and Other Community Living Center Issues, Hampton VA Medical Center, Hampton, Virginia**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Healthcare Inspection – Alleged Quality of Care, Personnel, and Other Community Living Center Issues. I concur with the recommendation for improvement identified in the report.
2. The response and action plan for the recommendation is enclosed.
3. Should you have any questions regarding the comments or implementation plan, please contact me at (757) 722-9961, extension 3100.

(*original signed by*:)
Deanne M. Seekins, MBA
Medical Center Director

Medical Center 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

We recommended that **t**he Medical Center Director require that CLC Nurse Managers monitor accurate documentation of resident bathing.

Concur **Target Completion Date: July 30, 2010**

Facility's Response:

The bathing schedule for Hampton VA Medical Center residents is determined after staff discusses with residents and/or families (based on cognitive abilities) their preferences. As a part of routine CLC admission processes, staff inquires about residents' desired preference and frequency of bathing at home. Those residents that are not able to express desired preference and do not have family participation will be assigned a schedule for baths by staff based on the resident's activities. The information obtained from residents and/or families is incorporated with therapies and other activities. At a minimum, each resident is provided at least one shower/bath per week. A shower schedule is maintained and updated by CLC staff and checked weekly by nurse managers to ensure all residents are scheduled. The verification of the shower/bath is documented in the Care Tracker system. The charge nurses have been re-educated on verifying appropriate documentation of showers versus bed baths in the care tracker system.

Status: Completed on July 30, 2010.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana Director, Denver Office of Healthcare Inspections (303) 270-6500
Acknowledgments	Clarissa Reynolds, Team Leader Laura Dulcie Stephanie Hensel Ann Ver Linden

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