Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care and Communication Issues Northport VA Medical Center Northport, NY

Report No. 12-01077-188

May 24, 2012

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant concerning a patient's quality of care and communication between facility staff and the patient's family at Northport VA Medical Center (facility). The complainant alleged that:

- The one-to-one nursing staff member assigned to monitor the patient was not present when the patient fell and sustained a laceration on his head.
- Facility staff did not perform adequate tests after the patient fell to ascertain whether the patient had suffered life-threatening head injuries.
- A facility surgeon stapled the patient's head laceration in an inappropriate setting, at the patient's bedside.
- A facility surgeon and staff on the psychiatric unit did not provide timely or effective pain management for the patient after his fall.
- Facility staff did not disclose specific clinical information about the patient's fall or treatment to the family in a timely manner and, even after repeated requests, did not respond to family complaints about care.

Due to insufficient documentation and conflicting accounts by facility staff, we could neither confirm nor refute the allegation that the one-to-one monitor assigned to the patient was not present when the patient fell and sustained a gash on his head. Nor could we assess whether the one-to-one monitor was properly observing the patient throughout his shift, as required. We did not substantiate the allegation that facility staff did not perform adequate tests after the patient's fall to ascertain whether the patient had suffered life-threatening head injuries. We also did not substantiate the allegation that a surgeon performed a surgical stapling intervention at the patient's bedside.

We substantiated the allegation that the patient did not receive effective and timely pain management from the facility surgeon or staff on the psychiatric unit after the fall. We also substantiated that the facility did not appropriately follow Veterans Health Administration (VHA) and local clinical disclosure policies and did not adequately respond to the family's complaints.

We recommended that the Medical Center Director strengthen processes to ensure that documentation for one-to-one monitoring of patients is accurate, the facility reassess the incident reporting process for effectiveness, the facility implement procedures to ensure that facility staff comply with VHA pain management policies and VHA and local clinical disclosure policies, and that facility responses to patient and family complaints are timely and facilitate resolution.

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

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

TO: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

SUBJECT: Healthcare Inspection – Alleged Quality of Care and Communication Issues, Northport VA Medical Center, Northport, NY

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant concerning a patient's quality of care and communication between the facility and the patient's family at the Northport VA Medical Center.

Background

The Northport VA Medical Center (facility) is part of Veterans Integrated Services Network (VISN) 3 and serves veterans from the Nassau and Suffolk counties of Long Island and the surrounding five boroughs of New York City. The facility provides medical and surgical care, primary care, extended care, and inpatient and outpatient mental health services. In 2011, the facility had 506 operating beds, with 306 hospital beds, 170 Community Living Center beds, and 30 domiciliary beds.

Allegations

A complainant contacted the OIG's Hotline Division and made allegations regarding the quality of care the veteran received and asserted a lack of communication with the family.

The complainant alleged that:

- The one-to-one nursing staff member assigned to monitor the patient was not present when the patient fell and sustained a laceration on his head.
- Facility staff did not perform adequate tests after the patient fell to ascertain whether the patient had suffered life-threatening head injuries.
- A facility surgeon stapled the patient's head laceration in an inappropriate setting, the patient's bedside.

- A facility surgeon and staff on the psychiatric unit did not provide timely or effective pain management for the patient after his fall.
- Facility staff did not disclose specific clinical information about the patient's fall or treatment to the family in a timely manner and, even after repeated requests, did not respond to family complaints about care.

Scope and Methodology

We reviewed the quality of care provided to the patient before, during, and after his fall in mid-July 2011, and the communication from that date to late December 2011, between the family and the facility regarding the fall and the patient's care.

We conducted a site visit on January 11–12, 2012, which included an inspection of the unit where the patient fell and received treatment. We reviewed the patient's medical record, local and Veterans Health Administration (VHA) policies, fall and incident reports for the patient, clinical and institutional disclosures related to the fall, one-to-one monitor flow sheets, and documented discussions and meetings between family members and facility representatives. We also examined internal reviews conducted by the facility as related to the patient's fall and head injury. We interviewed the complainant, members of the patient's family, facility employees, and managers.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient was a man in his eighties with dementia, behavioral dyscontrol,[1] hypertension, hypothyroidism, bladder cancer with urostomy,[2] hyperlipidemia,[3] a history of chronic renal insufficiency, and recurring urinary tract infections (UTIs).

The facility hospitalized the patient for 18 days in April 2011, for increased agitation and aggressive behavior. The provider discharged him to his home with medication to help control his behavior.

Approximately 2 months later, the patient's son brought the patient to the facility's emergency department reporting that his father had nightly changes in mood and behavior that was argumentative and combative. A psychiatric nurse practitioner documented a primary diagnosis of dementia with behavioral dyscontrol. The patient was involuntarily admitted to the acute psychiatric unit with a one-to-one nursing staff

[1] Dyscontrol is defined as the inability to control one's behavior.
[2] A urostomy diverts urine away from the bladder through a surgically created opening in the skin.
[3] Hyperlipidemia is an elevated concentration of lipids or fats in a person's blood stream.

member (one-to-one monitor) for unpredictable behavior and dementia. According to facility policy, when a psychiatric patient is at risk for falls or injury, a one-to-one monitor is assigned exclusively to provide intensive and continuous observation.[4] The patient remained on the psychiatric unit until mid-July, when he transferred to a medical unit for treatment of his renal failure and a UTI.

Four days later, the patient transferred back to the psychiatric unit, as his medical conditions had improved. According to the medical unit provider, the patient was not back to baseline, but his intravenous fluids could be discontinued and his UTI treated with oral antibiotics. Later that night, after the transfer, the unit psychiatrist responded to a concerned family member who felt that "only three weeks ago" the patient was "walking and talking on the unit, and now appears to be in a semi-comatose state." The psychiatrist examined the patient and reviewed his medications and laboratory tests. In a discussion with the family, the psychiatrist stated there were several factors causing the patient's lethargy including a UTI, renal failure, low blood calcium, and recent medication adjustments.

Two days later, between midnight and approximately 2:00 a.m., the patient received two medications to treat his restlessness and agitation. Though the patient was quiet for a short time after he received the first medication, lorazepam, he became agitated again and received a different medication, haloperidol, to treat his escalating symptoms. Those symptoms included trying to get out of bed and hitting the staff. During this time, the patient was in a semi-private room with his one-to-one monitor. The patient's roommate also had a one-to-one monitor.

The patient's nurse documented that at 2:40 a.m. the patient was trying to get out of bed and was swinging his hands at the one-to-one monitor who was trying to prevent the patient from falling. The patient hit his head on the headboard while falling backwards and simultaneously twisting his body in the bed. A staff member cleaned the laceration caused by the fall and applied ice while the nurse contacted the attending psychiatrist. At approximately 3:00 a.m., the attending psychiatrist examined the patient, ordered a surgical consultation and computerized tomography (CT)[5] of the head, and adjusted the patient's medications for agitation and delusions.

A surgical resident evaluated the patient at 4:05 a.m. and identified a 4-centimeter laceration located on the right frontal-parietal region of the head. The surgical resident determined that the laceration could be surgically stapled.

At 4:12 a.m., in a post-fall assessment note, the nurse documented that the patient was unable to communicate but listed "hallucinating" as a non-verbal indicator for new pain.

[4] Medical Center Memorandum 116A-14, *Intensive Psychiatric Observation of Patients Judged Dangerous to Self or Others*, July 28, 2010.
[5] Computerized tomography is computer generated radiograph images that can show three-dimensional images of a structure or tissue.

A fall risk assessment was completed, and the nurse notified other clinical staff that the patient was at risk to fall again. The nurse also performed two neurological examinations, the Glasgow Coma Scale[6] and pupillary dilation examination. Results correlated with a moderate brain injury. The CT scan of the patient's head at 4:26 a.m. showed no acute post-trauma injury.

At 6:07 a.m., the surgical resident, along with an attending surgeon, cleansed the wound by irrigating it with a saline solution, then placed 10 staples to close the laceration. The surgeon applied antibacterial ointment to the stapled area to prevent infection.

The attending psychiatrist documented contact with the patient's wife about the incident at 7:43 a.m. and ordered around-the-clock medication to control the patient's agitation and psychosis.

At 3:55 p.m., the nurse completed a shift note that described the patient as restless and combative early in the morning but after 10:00 a.m., sleeping through most of the shift. The nurse documented that the patient's family was very upset about the patient's fall and injury. The nursing note also depicted the patient's oral intake as poor and that he was unable to ambulate. The nurse reported at 2:36 p.m. that the patient pain scale rating was 0, indicating no pain.

At 5:22 p.m., the patient was transferred to the medical unit for acute renal failure secondary to his 3rd stage kidney disease[7] and hyperkalemia.[8] The medical unit physician started the patient on intravenous fluid therapy for the renal failure and pain medication for his head trauma. The physician noted that the patient was extremely agitated, confused, and disoriented. The patient continued to have these mental status issues throughout his admission at the facility and, though he was visited by a psychiatrist, he never returned to the psychiatric unit.

Though the patient's renal failure and hyperkalemia stabilized[9] by the beginning of August, he began to have difficulty swallowing and, as a result, was at risk for aspiration pneumonia.[10] Tests showed that enlarged glands in his neck and pressure on his esophagus from an inoperable subclavian artery aneurysm[11] caused the swallowing difficulty. Because the patient was unable to swallow correctly, he received intravenous

[6] A scale for measuring level of consciousness, especially after a head injury, in which scoring is determined by three factors: amount of eye opening, verbal responsiveness, and motor responsiveness.
[7] 3rd stage kidney disease occurs when there is a reduced capacity for the kidney to act as a filter for body waste products and the patient is showing symptoms fatigue, shortness of breath, low urine output and edema.
[8] An above normal potassium blood level which can cause abnormal heart rhythms or slower than normal heart rates; it is often caused by kidney disease.
[9] Stabilized in this context means the patient's renal failure had no life threatening symptoms and the potassium blood level was normal.
[10] Inflammation of lungs and airways to the lungs when a foreign object such as oral or stomach contents is inhaled into the respiratory system.
[11] Abnormal dilation of an artery which is located below the collarbone.

medications and fluids. He eventually underwent a surgical procedure to place a feeding tube through his stomach wall. After this procedure, he received medications, food and fluids through the feeding tube. The patient was diagnosed with probable aspiration pneumonia in mid-August and treated with intravenous antibiotics until the pneumonia resolved at the end of August. During this same time, the patient's renal failure became worse and his potassium blood levels began to drop below normal.[12] He received intravenous electrolyte[13] fluids until the end of August when his renal failure and potassium blood level stabilized.

At the beginning of September, the physician diagnosed the patient with bilateral pneumonia and started the patient on a different intravenous antibiotic regimen. The physician also diagnosed the patient with worsening renal failure and pleural effusion.[14] The physician treated the patient with diuretic[15] medications and oxygen therapy. Despite the ongoing medical interventions, laboratory and imaging results indicated that the patient's renal failure, pneumonia, and pleural effusion continued to worsen. The physician advised the family that the patient's prognosis was poor. At the end of September, a family member, acting as the patient's surrogate, decided that the patient would forgo any life extending measures such as intubation[16] and cardiopulmonary resuscitation. The patient continued to receive treatment for his multiple health issues but his medical condition continued to deteriorate. The patient died of cardiopulmonary complications in late September.

Inspection Results

Issue 1: Quality of Care

Alleged Absence of One-to-One Monitor

Due to insufficient documentation and conflicting accounts by facility staff, we could neither confirm nor refute the allegation that the one-to-one monitor assigned to the patient was not present when the patient fell and sustained a laceration on his head. Nor could we determine whether the one-to-one monitor was observing the patient throughout his shift, as required. While staff members we interviewed reported that the one-to-one monitor was with the patient at the time of the fall, we found that their recollections of the fall varied significantly and were inconsistent with medical record and incident report documentation. In addition, we found that the flow sheet the one-to-one monitor used to document patient observations lacked sufficient detail.

[12] Below normal potassium blood levels can cause an abnormal heart rate.
[13] A type of electrically charged body salt, such as sodium and potassium, that helps maintain the body's functions.
[14] Excess fluid that accumulates between the two layers of tissue that line the lungs.
[15] Medications that promote the formation of urine by the kidneys and decrease fluid overload in the body.
[16] The insertion of a tube into the patient's airways to keep the airway open and administer anesthetics or oxygen.

According to local policy, an incident report must be completed by the person who witnessed or discovered the event or the most senior clinical person to whom the incident was reported. Local policy stresses that incident reporting is an important factor in the facility's commitment to patient safety and quality of care, as the emphasis is on improving systems and processes. The accurate and timely reporting of incidents to Patient Safety and Quality Management is a collaborative effort that must be supported by all staff and supervisors.[17] However, there is no specific procedure or VHA requirement that establishes processes for how staff should ascertain accurate information when reporting incidents, such as interviewing or requesting statements from additional witnesses.

After the patient's fall, the floor nurse assessed the patient and notified the attending psychiatrist and nurse supervisor. Based on the report from the patient's one-to-one monitor, the floor nurse documented the circumstances of the patient's fall in the medical record and initiated an incident report. After the attending psychiatrist examined the patient, he completed the physician's section of the incident report. The incident report was forwarded to Patient Safety and Quality Management for review.

Although both one-to-one monitors reported during their interviews that they were in the room at the time of the patient's fall, we found that their recollections of the fall conflicted and, furthermore, were inconsistent with medical record and incident report documentation. The patient's one-to-one monitor told us that because the room was darkened, he did not see the patient fall and only heard the patient bang his head on the headboard. The roommate's one-to-one monitor told us that the room was "all lit up" and that the patient fell in the opposite direction of his one-to-one monitor, making it difficult for the patient's one-to-one monitor to help the patient before injury. According to the medical record and incident report completed by the floor nurse, the patient's one-to-one monitor was with the patient and "attempted to stop fall on headboard." However, the nurse did not include important information, such as the roommate's one-to-one monitor witnessing the patient's fall, witness statements, and the patient's response to the event.

We also reviewed the flow sheet that staff used to document the patient's behavior and found each 15-minute interval completed and initialed by the one-to-one monitor, as required by local policy.[18] However, the flow sheet lacked significant details. For example, according to the flow sheet, the patient's behavior was unchanged from 12:15 a.m. until 7:45 a.m., yet according to the medical record, it was during this period of time that the patient was swinging at staff and then fell, requiring a CT scan and surgical procedure to staple a laceration on his head. The omission of these key details for this time period on the flow sheet calls into question the reliability of the entire flow sheet. Therefore, we could not determine if the patient was properly observed by the one-to-one monitor prior to, during, or after the fall.

[17] Center Memorandum 00-134, *Patient Safety Improvement Program*, May 18, 2010.
[18] Center Memorandum 116A-14.

Alleged Inadequate Post-Fall Patient Evaluation

We did not substantiate the allegation that the facility did not perform adequate tests after the patient fell to ascertain whether the patient had suffered life-threatening head injuries. The nurse evaluated the patient after the fall using neurological testing tools that determined the patient had a moderate head trauma. After the facility provider's examination, he ordered a CT scan of the patient's head. These forms of evaluation follow industry standard protocols,[19] and although the patient did have a moderate head trauma, none of the tests, including the CT scan, revealed a life threatening head injury.

Alleged Inappropriate Setting for Surgical Procedure

We did not substantiate that the surgeon performed the surgical stapling intervention at the patient's bedside. According to the staff present during the time of the fall and procedure, the provider stapled the patient's laceration in a treatment room on the psychiatric unit floor. During our site visit, we visited the treatment room and confirmed with facility staff that it is used for examinations and other clinical treatments.

Alleged Inadequate Post-Fall Pain Management

We substantiated the allegation that the patient did not receive effective and timely pain management from a facility surgeon or the psychiatric unit staff after his fall.

When a patient sustains an injury such as head trauma or scalp laceration, VHA requires a four-step process to manage the patient's pain effectively. Process steps include: (1) accurate timely assessments when tissue trauma or new pain occurs, (2) treatments such as pain medication, (3) reassessments within a reasonable time to determine whether the treatment is effective or pain is diminishing, and (4) continuation or changes in treatments according to reassessments. The process repeats as long as the patient has pain or receives treatment.[20] In addition, staff must consider that patients with dementia have cognitive impairments that compromise their ability to perform self-report tasks, such as accurately describing and reporting pain.[21] For this reason, VHA requires modification of pain assessments to include patient observations or family input. VHA also requires that staff document patient behavior and other measures when determining pain levels.[22]

Following the patient's fall and assessment of his more serious injuries, psychiatry staff and the facility surgeon should have initiated the four-step process. However, we found

[19] Medscape Reference, *Head Trauma Treatment & Management*, updated September 26, 2011, http://emedicine.medscape.com/article/433855-treatement@a1127, accessed December 20, 2011.
[20] VHA Directive 2009-053, *Pain Management*, October 28, 2009.
[21] Buffum, Martha, DNS; Hutt, Evelyn, MD; Chang, Victor, MD; Craine, Michael, PhD and Snow, A. Lynn, PhD, "Cognitive Impairment and Pain Management: Review of Issues and Challenges" *VA Journal of Rehabilitation Research and Development*, 44:315–330, 2007.
[22] VHA Directive 2009-053.

that psychiatry unit staff did not document an evaluation for pain until 4:12 a.m., approximately 1½ hours after the fall. During that assessment, a nurse documented that the patient was unable to communicate but demonstrated new pain with a nonverbal indicator of hallucinations. The assessment had no further description of pain and when interviewed, staff could not recall any pain symptoms until after the surgeon stapled the laceration. No further pain assessments were documented by nursing until almost 10 hours later (at 2:36 p.m.), at which time a nurse documented the patient's pain as "0-No Pain." This measurement indicated the patient was able to self report his pain; however, according to the medical record, though the patient was restless and combative early in the morning, he slept throughout the rest of the shift. The nurse should have documented that the patient was unable to communicate and what the behavioral basis was for a conclusion of no pain.

We found no documentation that the surgeon assessed the patient's laceration pain before, during or after the stapling procedure or ordered pain medication. A staff member stated that after the stapling procedure the patient verbalized that the stapled laceration "hurt." Despite evidence that the patient experienced pain as a result of his injury, we found he received no pain medication until he was transferred to a medical unit, nearly 15 hours after the fall.

Issue 2: Communication

We substantiated the allegation that facility staff did not disclose specific clinical information about the patient's fall or treatment to the family within a timely manner and, even after repeated requests, did not respond to family complaints about care.

Alleged Insufficient Disclosure of Adverse Event Clinical Information

Approximately 5 hours after the patient's fall, the attending psychiatrist documented a call to the patient's wife in the medical record. The psychiatrist's note did not state the exact time of the call or what information he relayed to the wife but only that the psychiatrist "informs" her of the incident. No other documented meeting concerning the fall or treatment occurred between the family and the attending psychiatrist or designee during the 24 hours after the fall; although, according to staff and family interviews, the family did request additional information when they came in to visit the patient later that day.

VHA policy states that facilities and providers have a legal and ethical obligation to disclose to patients any adverse events that occurred during their course of care in a VHA medical center or outpatient clinic. These events are defined as untoward incidents or other undesirable occurrences where injury may not be obvious or severe. If a patient is incapacitated, the disclosure process should involve the patient's personal representative. The clinical disclosure is considered part of the patient's routine care but needs to occur face-to-face and, in general, includes facts about the incident/adverse event; concern for

the patient's welfare; reassurance that steps are being taken to investigate the incident and prevent future incidents; and the remedy for any harm that may have occurred. The clinical disclosure should occur within 24 hours of the incident.[23]

Alleged Ineffective Complaint Response

On the day after the patient's fall, his son called a psychiatric unit social worker to express concern about his father's care and to ask why the family had not received detailed information about what happened when his father fell, whether the one-to-one monitor was present during the fall, whether pain medications were given during treatments, and whether appropriate tests were ordered following the fall. The son also expressed concerns about conflicting accounts he and other family members had received from staff members regarding his father's fall and subsequent care, such as, whether the surgeon stapled the laceration at the patient's bedside or in a treatment room. According to facility records, the social worker informed the son that someone from the unit would call him to answer his questions. There was no documented call back to the son regarding his concerns.

The next day, two days after the fall, the patient's wife and grandson contacted the facility's patient advocate with a complaint about the same concerns the son had previously described. The patient advocate referred the family to the medical unit social worker and psychiatric staff who were meeting with them that day. The patient advocate also notified the medical unit social worker and psychiatry staff that he had spoken with the family members. The family met with the medical unit social worker and discussed their concerns. The medical unit social worker stated in her notes that she would request that someone from the psychiatric unit contact the son, but, because the incident occurred on the psychiatric unit, she was unable to assist in the discussion. A psychiatric nurse practitioner was also present during the meeting, but the family did not discuss the complaint with her as she was not working during the time of the fall. There were no documented calls back to the family from the psychiatric unit, medical social worker, or patient advocate and no documented discussions between the social worker and patient advocate.

A month later, the son called the medical unit social worker again to reiterate the family's complaints and that they had received no follow-up calls from the psychiatric unit. The social worker told the son that she would call the psychiatric unit again and ask that the nurse manager call him. During our interview with the son, he stated that the psychiatric unit nurse manager and psychiatrist did contact him after his call, but he was dissatisfied with the response. He felt, at this point, there was a cover-up concerning the fall and care.

[23] Center Memorandum No. 00-154, *Subject: Disclosure of Adverse Events,* February 23, 2009.

According to the patient advocate log, the family did not contact the patient advocate about their complaints again until early October, when the son called. During that call, the patient advocate informed the son that to start a complaint investigation he would need the names of the employees who had spoken with the family about the patient's care. The son stated he would get back to the advocate. In his interview with us, the son acknowledged that he did not know all the employee names and was afraid to get the employees who spoke to the family in trouble. The son and daughter called the patient advocate 4 days later and again in early November with the same complaints. The patient advocate told them each time that the facility needed them to provide the previously requested employee names to pursue these complaints. The patient advocate did offer family meetings; however, the son and daughter refused until December, when the patient advocate arranged a meeting with several psychiatric unit staff. There were no calls during this time from the patient advocate back to the family concerning the complaints, and the patient advocate documented no resolution for each family call and complaint. The patient advocate stated that, generally, he does not consider complaints to be serious until the complainant calls back a second time.

During the December meeting, facility staff members, including the patient advocate, advised the son and daughter that the facility still needed the employee names to proceed with an investigation of the family's complaints. Immediately after the meeting, the patient advocate assisted the family to obtain the patient's medical records.

The communication from facility staff to the patient's family, spanning a 4-month period, was not timely or responsive to the family complaints as required by VHA policy. Initially, the family's concerns were sent from the patient advocate to the medical unit social worker who then referred them to the psychiatric unit. The psychiatric unit took 1½ months to respond to the request for information, and the response was not satisfactory to the family. Once the patient advocate became involved again with the complaint in October, 2½ months after the patient's fall, and shortly after the patient's death, he informed the family that they needed to provide additional information or the complaints could not move forward. This additional information included the names of employees with whom the family had spoken following the patient's fall. Family members were uncertain of the names and/or concerned about getting the employees in trouble.

Facility staff should have responded immediately to the family's concerns when they were first expressed. When patients or families make complaints, whether written or not, VHA requires that a patient advocate become involved and a response to the complainant, whether from the front line staff, such as a social worker, or patient advocate, must be no later than 7 days after the complaint. If the complaint requires more than 7 days to resolve, the patient advocate is ultimately responsible for continuously updating the patient or family about the progress of the complaint. Patient advocates

manage the complaint process and assist front line staff in resolving issues that occur at the point of service, or address complaints that front line staff were unable to resolve.[24]

We found that in December, the facility's Ethics Committee, at the request of facility leadership, completed a fact-finding review of the family's complaints. They performed their review without any additional information from the family. Though the fact-finding did not address all of the family's complaints, it did include an assessment of the patient's fall and subsequent events. The Ethics Committee review identified several communication issues and concluded that clinical staff contacts from the psychiatric unit should have been more timely and that the family should have been informed earlier of the process to obtain patient medical records. The committee review made no communication recommendations but stated in the conclusion that a thorough investigation while "events were still fresh in everyone's mind and possibly a family meeting" could have helped "this concerned, involved family" understand what happened to the patient and "could have eliminated the mistrust that built up over time."

Conclusions

We could neither confirm nor refute the allegation that a one-to-one monitor assigned to the patient was not present when the patient fell and sustained a laceration on his head. Documentation concerning the fall, including the incident report, was vague and did not include information that would determine the validity of this allegation. Staff interviews conflicted with each other and, in some cases, with documentation.

We did not substantiate the allegations that the evaluation of the patient after the fall was inadequate to assess life threatening head injuries, or that the provider stapled the laceration at the patient's bedside.

We substantiated the allegation that on the night of the fall, the patient did not receive adequate pain management after his head injury, including timely assessments, reassessments, and treatment. Documentation in the patient's record indicated he had pain after the fall, and, according to staff interviews, he had pain after the procedure to staple his laceration. However, clinical staff only documented one pain assessment during the 10 hours after the fall, and pain medications were not ordered for the patient until he was transferred to the medical unit 15 hours after the fall.

We also substantiated that the clinical disclosure with the family after the adverse event was insufficient and that communication and follow-up concerning the family's complaints about the psychiatric unit did not meet the intent of the VHA Patient Advocacy policy.

[24] VHA Handbook 1003.4, *VHA Patient Advocacy Program,* September 2, 2005.

Recommendations

Recommendation 1. We recommended that the Medical Center Director strengthen processes to ensure that documentation for one-to-one nursing staff members is accurate.

Recommendation 2. We recommended that the Medical Center Director reassess the incident reporting process for effectiveness.

Recommendation 3. We recommended that the Medical Center Director implement procedures to ensure that facility staff comply with VHA and local policies regarding pain management and Clinical Disclosures.

Recommendation 4. We recommended that the Medical Center Director implement procedures to ensure that facility staff response to patient and/or family complaints is timely and facilitates resolution, as required by VHA policy.

Comments

The VISN and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. (See appendixes A and B, pages 13 through 18, for Directors' comments). We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 24, 2012

From: VISN Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Subject: **Healthcare Inspection – Alleged Quality of Care and Communication Issues, Northport VA Medical Center, Northport, NY**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Thru: Director, Management Review Service (10A4A4)

1. This is to acknowledge receipt and review of the draft Healthcare Inspection report of Alleged Quality of Care and Communication Issues, Northport VA Medical Center, Northport, NY.

2. We appreciate the opportunity to comment and concur with the draft document.

3. Should you have any questions, please contact Pam Wright, RN MSN, VISN 3 QMO at 718-741-4125.

Michael A. Sabo, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 4/24/12

From: Director, Northport VA Medical Center (632/00)

Subject: **Healthcare Inspection – Alleged Quality of Care and Communication Issues, Northport VA Medical Center, Northport, NY**

To: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Attached is the response as requested for the Alleged Quality of Care and Communication Issues, Northport VA Medical Center.

Please review and if approved forward to Director, Bedford Office of Healthcare Inspections (54BN) through Director, Management Review Service (10A4A4).

Philip C. Moschitta

Philip C. Moschitta

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 Medical Center Director strengthen processes to ensure that documentation for one-to-one nursing staff members is accurate.

Concur **Target Completion Date** 10/1/12

Facility Response:

Process/practice change for the RN [registered nurse] to review and sign the Observation Flow sheet every four hours and document the results in the RN Progress note in CPRS [Computerized Patient Record System]. Nursing Service Memorandum C-27 Policy – Patient Management Policy for Inpatient Psychiatric Units will be revised to reflect the above changes. All inpatient psychiatry nursing staff will be educated on this process.

Target date for education completion - July 1, 2012

Monitoring of the compliance with the updated observation flow sheet process will commence on July 1, 2012. This will continue until 90% compliance is sustained for three consecutive months and be reported at the Quality Management Council.

Target date for monitor completion - Oct 1, 2012

Status - Open

Recommendation 2. We recommended that the Medical Center Director reassess the incident reporting process for effectiveness.

Concur **Target Completion Date** 9/1/12

Facility Response:

Team (Associate Chief of Nursing Service /Psychiatry, Associate Director for Patient Care Services, Chief Performance Improvement, Nurse Manager Psychiatry, Associate Chief of Mental Health Services, Patient Safety

Manager) convened to review the current reporting of adverse events as framed by CM 00-134 The Patient Safety Improvement Program.

The team decided to implement a process that the Nurse Manager/Designee in the Inpatient Psychiatry Service will review all Incident Reports (2633) for Inpatient Psychiatry Units and cross reference with CPRS documentation and then sign the 2633 form. This update in process will be documented in CM 00-134 The Patient Safety Improvement Program.

Target date of completion of policy/CM update - May 15, 2012

Inpatient Psychiatric Nurse Managers will be trained on this change in process.

Target date of completion for education - June 1, 2012

Monthly monitoring of all Incident Reports (2633) on the Inpatient Psychiatry Units for accurate documentation that the Nurse Manager reviewed the incident and signed the incident report. Monitor the Inpatient Psychiatry unit's Nurse Manager or Designee's signature/ the number of Inpatient Psychiatry Incident Reports (2633). This will be reported monthly to the Quality Management Council. Monitoring will continue until 90% compliance is sustained for three consecutive months.

Target date of completion - Sept 1, 2012

Status - Open

Recommendation 3. We recommended that the Medical Center Director implement procedures to ensure that facility staff complies with VHA and local policies regarding pain management and Clinical Disclosures.

Concur **Target Completion Date** 10/1/12

Facility Response:

Updates to the Pain Management Program CM 11-193 were discussed at the Clinical Executive Board (CEB) on April 10, 2012. An endorsement of Step Care to manage pain effectively is included in the updated CM.

Target Completion Date: Currently undergoing final review with target completion of June 1, 2012

All Surgical Physicians, Inpatient Psychiatric Nurses will complete the mandatory Pain Module and will be trained on the revised Pain Management Program CM 11-193.

Target Completion Date – July 1, 2012

Pain Management Committee will report monthly committee minutes to Clinical Executive Board (CEB).

Target Date – May 2012

The Inpatient Psychiatry Observation Flow sheet will be revised to include Registered Nurse assessment and reassessment of pain and to document the Pain Scale used. This information will also be included in each RN progress note. This new process will be documented in Nursing Service Memorandum C-27 Policy. All Inpatient Psychiatric Nurses and Inpatient Psychiatric Nursing Assistants will be trained on this process.

Target for completion of the policy and training will commence - June 1, 2012

Target for completion of training - July 1, 2012

Nursing will monitor all Inpatient Psychiatric Observation Flow Sheets for Pain Assessment, Pain Scale used and Pain Reassessment completed after intervention. Monitoring of this process will commence on July 1, 2012. Monitoring will continue until 90% compliance is sustained for three consecutive months. Compliance will be reported at the Quality Management Council.

Target for completion of monitoring - Oct 1, 2012

A PowerPoint was presented on Clinical Disclosure of Adverse Events at the Clinical Executive Board (CEB) on April 10, 2012

Status - Open

Recommendation 4. We recommended that the Medical Center Director implement procedures to ensure that facility staff response to patient and/or family complaints is timely and facilitates resolution, as required by VHA policy.

Concur **Target Completion Date** 6/1/12

Facility Response:

The Patient Advocacy Program was re-aligned under Social Work & Chaplain Service. Social Work has assumed responsibility for program development, administration and management.

Target Date – Completed February 26, 2012

The medical center Patient Advocacy Program Center Memorandum is being revised/re-issued based upon the VHA Patient Advocacy Handbook. This revised CM will address the role and responsibility of medical center employees in resolving patient and family complaints, procedures to ensure service staff collaboration and communication with the Patient Advocacy Program, the interface between the Patient Advocacy Program and QM/Risk Management, and the timelines for complaint resolution. Service line advocates will be trained on this new policy.

Target Completion Date - Policy revised by June 1, 2012

Target Completion Date - In-service for all Service line advocates will be completed and the updated process in place by July 1, 2012

The Patient Advocacy tracking tool will be used by Social Work supervisory staff to track appropriate and timely closures of veteran complaints by Patient Advocates on a weekly basis. Complaint processing time will be monitored. Any complaints greater than 7 days will be reviewed and addressed. A Monthly report with the number of complaints, number complaints resolved, and the number of complaints pending, will be generated to the Services. Complaint closure/resolution will be reported quarterly at the Quality Management Council.

Target Start Date - June 1, 2012

Status – Open

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Claire McDonald, MPA, Project Leader Elaine Kahigian, RN, JD, Team Leader Clarissa Reynolds, CNHA, MBA George Wesley, MD

Appendix D

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