Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Patient Safety Deficiencies in the Community Living Center Canandaigua VA Medical Center Canandaigua, New York

Report No. 12-03543-73

December 21, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of an allegation concerning an increased number of patient injuries due to "unnecessary roughness" by staff in the community living center (CLC) at the Canandaigua VA Medical Center (the facility), Canandaigua, NY.

We did not substantiate the allegation that the CLC experienced an increase in patient injuries due to unnecessary roughness by staff. We did find that since October 2011, the CLC experienced an upward trend in patient falls, with a spike in April and May 2012. While not all of the falls resulted in patient injuries, four of the falls that occurred in May resulted in major injuries, such as a fractured hip or fractured femur.

Facility leaders were aware of the increase in patient falls and the April and May spike and had taken steps to identify contributing factors and implement preventive strategies prior to our review. These interventions generally focused on patient falls resulting in major injuries, which represent a small portion of total falls.

The facility has an established Falls Committee; although, it reportedly "floundered" following the retirement of the Committee Chair in spring 2012. According to the Geriatrics and Extended Care Line Chief, who is now the chair, the Committee has been "rejuvenated" and has held several meetings since July 2012. While the specific role of the Committee had not been clearly defined previously, the expectation is that the Committee will provide a big picture review of all falls (not just falls resulting in major injuries) and will research and educate staff about best practices in fall prevention.

We found that the facility's Falls Reduction Program could be strengthened by more consistently addressing all falls and ensuring CLC unit-level reviews of falls are tailored to patient-specific needs and circumstances surrounding each fall and ensuring that fall prevention interventions are accurately reflected in patient care plans. We recommended that the facility Director implement procedures to ensure that CLC unit-level reviews of patient falls are patient-specific and address the specific circumstances surrounding the fall and that fall prevention interventions are documented in patient care plans.

The Veterans Integrated Service Network and Facility Directors concurred with the 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 Health Care Network Upstate New York (10N2)

SUBJECT: Healthcare Inspection—Alleged Patient Safety Deficiencies in the Community Living Center, Canandaigua VA Medical Center, Canandaigua, New York

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of an allegation made by a complainant concerning an increased number of patient injuries due to "unnecessary roughness" by staff in the community living center (CLC) at the Canandaigua VA Medical Center (the facility), Canandaigua, NY.

Background

Canandaigua VA Medical Center

The facility provides inpatient and outpatient care to Veterans residing in upstate New York. It provides primary care, mental health care, specialty care, alcohol and drug abuse rehabilitation, and CLC (or long-term) care. The facility is part of the Upstate New York Veterans Integrated Service Network (VISN) 2.

The facility's CLC has 138 operating beds in four units, including two units that provide general long-term care and hospice, a dementia care unit, and a geriatric-psychiatry unit. The CLC also provides brief stay or respite care.

Allegations

In July 2012, OIG's Hotline Division received two allegations concerning the facility's CLC. The complainant alleged that the CLC had experienced an increase in the number of patient injuries, including hip fractures, that required patients to be transferred to a local community hospital. The complainant expressed concern that the increased injuries were possibly due to "unnecessary roughness" in staff handling of patients. The complainant also identified a specific patient who suffered a fractured hip and further alleged that a staff member was verbally abusive towards the patient when he was being transported to the community hospital.

Scope and Methodology

We visited the facility the week of September 24, 2012, and interviewed the Chief of Staff (COS), Associate Director for Patient and Nursing Services (ADPNS), Patient Safety Officer and Lead Physician for Patient Safety, Quality Manager, Risk Manager, Pharmacy Manager, the Geriatrics and Extended Care (GEC) Line Chief and Manager, Nurse Managers for two CLC units, the Patient Advocate, and members of the facility's interdisciplinary treatment teams.

We reviewed the electronic health records (EHRs) of 16 patients who were transported to other medical facilities due to falls during the period October 1, 2011–July 30, 2012. We also reviewed patient safety and falls data; incident reports; root cause analyses; staffing records; and meeting minutes from the Environment of Care Committee, Executive Committee of Medical Staff, and Executive Committee of Nursing Staff.

During our initial review, we found that facility leadership was already aware of the allegation concerning the patient who suffered a broken hip and was allegedly verbally abused. Prior to our review, facility leadership had conducted a thorough review of this matter and took appropriate actions in response to their findings. Therefore, we did not review this allegation. Our review focused on the broader allegation of increased injuries in the CLC.

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.

Inspection Results

Issue 1: Increase in Patient Injuries

We did not substantiate the allegation that the CLC experienced an increase in patient injuries due to unnecessary roughness by staff. However, we did find that since October 2011, the CLC experienced an upward trend in patient falls, with a spike in April and May 2012. While not all of the falls resulted in patient injuries, four of the falls that occurred in May resulted in major injuries, such as a fractured hip or fractured femur, and patients had to be transferred to a community hospital for treatment.

Facility leaders were aware of the increase in patient falls and the April/May spike and had taken steps to identify contributing factors and implement preventive strategies prior to our review. For example, Root Cause Analysis (RCA) Teams were convened to determine the root causes and contributing factors for the four falls resulting in major

injuries.[1] The facility also conducted an aggregate review of other falls that occurred in fiscal year (FY) 2012. Facility leadership reported that they also "rejuvenated" the facility's Falls Prevention Committee, which had not been meeting regularly, to identify trends and explore best practices in falls prevention.

While we agree that the facility took important and appropriate steps in response to the FY 2012 overall increase and April/May spike in patient falls, our review found several opportunities for improvement in the facility's Fall Reduction Program.

As recommended by the Veterans Health Administration (VHA) National Center for Patient Safety (NCPS), the facility's Fall Reduction Program policy[2] defines a fall as, "A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions." The facility uses three approaches to address patient falls.

RCAs—For falls resulting in major injuries, the facility director convenes RCA Teams, which are interdisciplinary teams responsible for identifying contributing causal factors for an incident and making recommendations to facility leadership based on their analyses. Recommendations generally are targeted to broader system and process interventions, as opposed to patient-specific interventions.

The facility's RCA process is led by the Patient Safety Officer and the Lead Physician for Patient Safety. Because RCAs are convened only for major injuries, most falls that occur in the CLC are not reviewed through this process. In recent years, the facility has strengthened its RCA process to ensure consistency in RCAs, to include clinical staff at all levels in the facility on the RCA Teams, and to follow-through on RCA recommendations.

Falls Committee—The facility has an established Falls Committee; although, it reportedly "floundered" following the retirement of the Committee Chair in spring 2012. According to the GEC Line Chief, who is now the chair, the Committee has been "rejuvenated" and has held several meetings since July 2012.

However, the specific role of the Committee has not been clearly defined in facility policy or a charter, and in our interviews, we heard different descriptions as to the purpose of the Committee. According to the COS, the Committee Chair has been requested to provide a charter to the Executive Committee of the Medical Staff by November 2012. Based on our interviews with the COS and ADPNS, the expectation is that the Committee will provide a big picture review of all falls at the facility (not just

[1] VHA Handbook1050.01, "VHA National Patient Safety Improvement Handbook," March 4, 2011, defines RCA as "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."
[2] Local Policy 400-001-02-11, "Fall Reduction Program," September 7, 2011.

falls resulting in major injuries) and will research and educate staff about best practices in fall prevention.

CLC Unit Reviews—Primary responsibility for investigating patient falls and implementing fall prevention interventions rests with the CLC unit Nurse Managers and interdisciplinary treatment teams. Unit staff are responsible for reviewing all falls, completing a post-fall investigation form, and reviewing and updating patient care plans to address fall risks and interventions. Members of the interdisciplinary treatment teams agreed, and facility policy supports, that reviews of falls should not only be patient-specific and performed within the context of patient care plans, but they should address the specific circumstances surrounding the fall. Likewise, fall prevention interventions should be tailored to the risks and needs of individual patients, be documented in care plans, and communicated to all patient-care staff.

Based on our interviews with unit staff and review of the EHRs for 16 patients who were transferred to other medical facilities due to falls, we found that unit-level post-fall interventions were not always tailored to specific patient needs and did not address the specific circumstances surrounding a fall. Following a patient fall, nursing staff on a unit are required to complete the Patient Safety Note template in the EHR. The template includes details about the fall, the patient's condition, and interventions to minimize the risk of further falls. The drawback of the template is that it provides a list of general interventions, and nursing staff frequently select all that apply, even if an intervention is not appropriate to the specific circumstances surrounding a fall.

The following examples illustrate what we found in the EHR review:

- **Patient A** was found on the floor near an elevator in the basement of the building by VA Police. The patient reported that he was having difficulty breathing and was short-of-breath. The interventions listed in the Patient Safety Note included instructing the patient to use his call bell for assistance when getting out of bed and placing a mat next to his bed. This patient had prior falls, and according to the Patient Safety Note, the prior intervention was a floor mat (by his bed). The patient also had a fall the following day in a common area while trying to get into his wheelchair.

- **Patient B**, who had Type II diabetes mellitus, was being assisted by CLC staff with his hygiene when his knees reportedly buckled, and he fell. His blood glucose level was 40 mg/dl, which is critically low. The interventions listed in the Patient Safety Note included instructing him to use his call bell for assistance before getting out of bed. This patient had prior falls, and according to the Patient Safety Note, the prior intervention was a wheelchair alarm.

- **Patient C** was being assisted by one CLC staff member to transfer from his wheelchair to the toilet when his knees reportedly buckled, and the staff

member helped lower him to the floor. The interventions listed in the Patient Safety Note included orienting the patient to his surroundings and assigned staff, ensuring adequate lighting for safe ambulation, providing non-slip footwear, and attaching a bed alarm.

For all three patients, the EHR contained generic interventions that did not address the specific circumstances of the falls, such as a fall outside the patient's room, or the underlying causes of the falls, such as a critically low blood glucose level.

During our rounds of two CLC units and spot-checking of unit documentation, we also found that patient care plans used by the unit nurses and nursing assistants were not consistently updated to reflect fall prevention interventions.

Conclusion

We did not substantiate the allegation that the CLC experienced an increase in patient injuries due to unnecessary roughness by staff. However, we did find that since October 2011, the CLC experienced an upward trend in patient falls, with a spike in April and May 2012. The facility was appropriately addressing falls resulting in major injuries through its RCA process; however, these falls accounted for only a small portion of falls in the CLC. While the specific role of the Falls Committee had not been clearly defined previously, the expectation is that the Committee will provide a big picture review of all falls (not just falls resulting in major injuries) and will research and educate staff about best practices in fall prevention.

The facility's Falls Reduction Program could be strengthened by more consistently addressing all falls and ensuring CLC unit-level reviews of falls are tailored to patient-specific needs and circumstances surrounding each fall, and ensuring that fall prevention interventions are accurately reflected in patient care plans.

Recommendation

Recommendation 1. We recommended that the facility Director implement procedures to ensure that unit-level reviews of patient falls are patient-specific and address the specific circumstances surrounding the falls.

Recommendation 2. We recommended that the facility Director implement procedures to ensure that fall prevention interventions are documented in patient care plans.

Comments

The VISN and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 7–9 for the 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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 3, 2012

From: Director, VA Health Care Network Upstate New York (10N2)

Subject: **Healthcare Inspection—Alleged Patient Safety Deficiencies in the Community Living Center, Canandaigua VA Medical Center, Canandaigua, New York**

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

Thru: Director, Management Review Service (VHA 10AR MRS)

1. Attached is the response from VA Medical Center Canandaigua, New York to the draft report from the Healthcare Inspection conducted the week of September 24, 2012.
2. The Medical Center carefully reviewed all items identified as opportunities for improvement and has concurred in all the recommendations that were made. The Network concurs with the recommendations contained in the report.
3. If you have any questions or need additional information, please contact the Canandaigua VA Medical Center Performance Manager, Paula LeGrett, at (585) 393-7573.

(original signed by:)

David J. West, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 30, 2012

From: Director, Canandaigua VA Medical Center (528A5)

Subject: **Healthcare Inspection—Alleged Patient Safety Deficiencies in the Community Living Center, Canandaigua VA Medical Center, Canandaigua, New York**

To: Director, VA Health Care Network Upstate New York (10N2)

1. The Department of Veterans Affairs Medical Center at Canandaigua, New York was inspected by the Office of Inspector General's Review Team the week of September 24, 2012. The inspection was conducted in a thorough and professional manner.

2. After reviewing the draft report, VAMC Canandaigua concurs with the review Team's findings. The corrective actions and their target dates for completion are set forth in the action plans.

3. If you have any questions or need additional information, please contact Paula LeGrett, Performance Manager, at (585) 393-7573.

(original signed by:)

Craig S. Howard

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 facility Director implement procedures to ensure that unit-level reviews of patient falls are patient-specific and address the specific circumstances surrounding the falls.

Concur **Target Completion Date:** 12/1/2012

Facility Response:

Geriatrics and Extended Care Line Leadership implemented a unit-level review process which includes a post fall huddle, treatment team review and care plan update after each patient fall. This will ensure that patient specific and circumstances surrounding the fall are thoroughly evaluated. The data collected by Nurse Managers will be submitted monthly to the Falls Committee who will review and report quarterly to Executive Committee of the Nursing Staff and Executive Committee of the Medical Staff.

Status/Completion Date: Closure Requested: 12/1/2012

Recommendation 2. We recommended that the facility Director implement procedures to ensure that fall prevention interventions are documented in patient care plans.

Concur **Target Completion Date:** 12/1/2012

Facility Response:

Geriatrics and Extended Care Line Leadership implemented a monitor to ensure patient specific care plans are updated after each fall to ensure fall prevention interventions are documented in the medical record. The data collected by Nurse Managers will be submitted monthly to the Falls Committee who will review and report quarterly to Executive Committee of the Nursing Staff and Executive Committee of the Medical Staff.

Status/Completion Date: Closure Requested: 12/1/2012

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 Marlene Demers, RN Monika Gottlieb, MD

Appendix D

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