Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02903-211

Healthcare Inspection

Reporting of Suspected Patient Neglect Central Alabama Veterans Health Care System Tuskegee, Alabama

July 16, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to evaluate allegations related to the reporting of suspected patient neglect at the Central Alabama Veterans Health Care System in Tuskegee, AL.

We did not substantiate that a registered nurse (RN) failed to report a case of suspected neglect to Adult Protective Services or that the RN failed to triage the patient to determine the need for intervention. The RN's actions on April 4 were clinically appropriate. Documentation reflected that the RN attended to the caregiver's concerns and initiated processes to secure respite care and in-home nursing services to support both the patient and caregiver.

We did not substantiate that a social work supervisor improperly restricted a social worker's ability to report cases of abuse and neglect. Facility practice is for social workers to discuss, when possible, cases of suspected abuse and neglect with their supervisors before reporting.

We made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes A and B, pages 6–7 for the Directors' comments.)

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to evaluate allegations related to the reporting of suspected patient neglect at the Central Alabama Veterans Health Care System (CAVHCS) in Tuskegee, AL. The purpose of the review was to determine whether the allegations had merit.

Background

CAVHCS is a two-division health care system located in Montgomery and Tuskegee, AL, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community-based outpatient clinics located in Dothan and Fort Rucker, AL, and in Columbus, GA. CAVHCS is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 134,000 in central and southeastern Alabama and western Georgia.

Veterans Health Administration (VHA) Directive 2012-022, *Reporting Cases of Abuse and Neglect* (September 4, 2012), requires VHA medical facilities to follow relevant state statutes for the identification, evaluation, treatment, referral and/or mandated reporting of possible victims of physical assault, rape or sexual molestation, and abuse and/or neglect of elders, spouses, partners, and children.[1]

The State of Alabama defines neglect as the "failure of a caregiver to provide food, shelter, clothing, medical services, or health care for the person unable to care for himself or herself . . . ."[2]

Allegations

On April 6, 2014, the OIG Hotline Division received an e-mail alleging that:

1. A registered nurse (RN) failed to report a self-described case of caregiver (sibling) neglect of a patient to Adult Protective Services (APS).

2. The RN did not perform health-related triage to determine the veteran's status after an April 4 telephone call with the caregiver in which the neglect was described.

3. A social work supervisor improperly restricted a social worker's ability to report patient abuse and neglect.

[1] VHA Directive 2012-022, *Reporting Cases of Abuse and Neglect*, September 4, 2012.
[2] Alabama Code - Section 38-9-2.

Scope and Methodology

We reviewed VHA, VISN, and facility policies related to reporting of suspected abuse and neglect; Alabama law regarding reporting of suspected elder abuse and neglect; facility reporting agreements with law enforcement; RN and social work scopes of practice; selected social worker and nurse competency and training records; reports of contact; and the patient's medical record for the period January 1, 2013, through April 25, 2014.

We interviewed the complainant, facility director, Deputy Chief of Staff, Chief of Social Work, social work supervisor, social worker, patient's primary care provider, weekend cross-covering physician, subject nurse, and others with knowledge about this issue.

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.

Event Summary

The patient is an elderly male with a primary medical history significant for poorly controlled diabetes mellitus, hypertension, and dementia. His medications include insulin and metformin for diabetes, and carvedilol, lisinopril, and Lasix® for high blood pressure. He has resided at home with a sibling caregiver for the past 3 years and has received periodic home health aide support. The patient has a history of refusing medications and not attending medical appointments and has been described by his caregiver as "uncooperative." The patient's primary medical care is provided through the geriatric clinic patient-aligned care team (PACT), and although the patient sometimes misses scheduled appointments, the caregiver and PACT team communicate regularly over the telephone.

The PACT RN spoke with the patient's caregiver in the late afternoon on a Friday in April 2014. The RN documented the caregiver's report that "she is not giving the veteran life sustaining medications; she feels he is too uncooperative and he refuses to take his medications." The RN documented that the caregiver requested a skilled nurse to assist with administering medications and a change from "standard insulin methods" to a "pen" to help the patient with insulin compliance." The RN encouraged the caregiver to seek social work and mental health assistance regarding the patient's care, and she addressed future appointments and documented that several medications had been refilled. The RN wrote, "Writer will forward to provider for further instructions regarding this situation" and copied the patient's PACT primary care provider (PCP), the weekend cross-covering physician, and the PACT social worker.

The PACT social worker completed an addendum to the RN's note indicating that she would follow up with the PCP about a homemaker home health aide application. The social worker signed the addendum after 5 pm of the same afternoon and copied the PACT team RN, the PCP, and the covering physician.

The following Monday, the covering physician spoke with the patient and caregiver via telephone. The covering physician documented, "[caregiver] stated that the veteran is non-compliant with his medications, and she got angry at him and stopped giving his medications about 1½ months ago, she stated that the veteran has been giving insulin by himself, but she is not giving him any of his PO [oral] medications." The covering physician and the caregiver discussed service options, and while the caregiver declined nursing home placement for her brother, she agreed to respite care and homemaker home health aide services. The covering physician counseled the patient and caregiver about the importance of taking prescribed medications and to attend a follow-up appointment later in April (which he missed). Both agreed.

As of early May, applications for respite and home care services for the patient and caregiver were in process.

Inspection Results

Issue 1: Nurse's Actions

APS Reporting

We did not substantiate that the PACT RN failed to report a case of caregiver neglect of a veteran to APS. While the caregiver's report was concerning, medical record documentation did not reflect a "failure of the caregiver to provide food, shelter, clothing, medical services, or health care for the person unable to care for himself or herself…" Rather, the medical record reflected the patient's refusal to take medications.

A basic principle in bioethics is the patient's right to self-determination, including the right to accept or refuse treatment.[3] The RN's progress note described the caregiver's frustration at the patient's ongoing resistance to taking medications. Because the caregiver could not *force* the patient to take medication, she sought other options to promote the patient's compliance with treatment and requested a visiting nurse to assist with medication administration and to change from an insulin syringe to an insulin pen. Ultimately, the patient may still decline medications or other treatment, even if doing so would be life-limiting.

The RN told us that while she did not suspect neglect in this case, she was concerned about the patient not taking his medications as prescribed. She took appropriate action by documenting the situation, notifying the physician and social worker, and initiating support services. These actions also conform to local policy when nurses suspect abuse or neglect.[4]

Triage

We did not substantiate the allegation that the RN did not perform health-related triage of the patient's status.

Triage is a clinical process where the provider assesses the patient's current status and determines the priority level for intervention, if any is needed. The patient's refusal to take medications and participate in medical care and appointments was a well-documented problem in the previous year, and this behavior did not reflect a change from the patient's baseline.

The caregiver did not express concerns, and although the RN could have assessed the patient's medical status, there was no indication that the patient was emergently symptomatic or at imminent risk because he had not taken medications recently. That the RN addressed the caregiver's expressed concerns and properly notified the physician of the situation was a reasonable course of action. The physician followed up with the caregiver the following Monday, counseled both the caregiver and patient about

[3] VA Patient Bill of Rights, www.va.gov/vhapublications. Retrieved May 20, 2014.
[4] CAVHCS Memorandum 11-10-36, Assessment, Treatment and Reporting of Abuse, September 3, 2010.

the importance of taking medications as prescribed, and scheduled an appointment approximately 2 weeks later (which the patient later refused to attend).

Issue 2: Social Work Supervisor's Actions

We did not substantiate that a social work supervisor improperly restricted a social worker's ability to report patient abuse and neglect. The social worker was instructed to discuss cases of suspected abuse or neglect with the supervisor before reporting. This is a clinically sound practice to ensure accurate reporting of appropriate cases.

Conclusions

We did not substantiate that an RN failed to report a case of suspected neglect to APS or that the RN failed to triage the patient to determine the need for intervention. The RN's actions were clinically appropriate. Documentation reflected that the RN attended to the caregiver's concerns and initiated processes to secure respite care and in-home nursing services to support both the patient and caregiver.

We did not substantiate that a social work supervisor improperly restricted a social worker's ability to report cases of abuse and neglect. Facility practice is for social workers to discuss cases of suspected abuse and neglect with their supervisors before reporting whenever possible.

We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 13, 2014

From: Director, VA Southeast Network (10N7)

Subject: **Draft Report**—Healthcare Inspection—Reporting of Suspected Patient Neglect, Central Alabama Veterans Health Care System, Tuskegee, AL

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the subject Draft Report which indicates that there are no findings. VISN 7 appreciates the OIG's efforts and partnership as we strive to provide Veterans the highest quality care.

2. If there are any questions, please contact Robin Hindsman, QMO at 678-924-5700.

(original signed by:)

Charles E. Sepich, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 9, 2014

From: CAVHCS Director (619/00)

Subject: **Draft Report**—Healthcare Inspection—Reporting of Suspected Patient Neglect, Central Alabama Veterans Health care System, Tuskegee, AL

To: Director, VA Southeast Network (10N7)

1. I have reviewed the Tuskegee, AL OIG Draft Report and concur with the report, which indicates that there were no findings. We appreciate the OIG's efforts to support CAVHCS' delivery of the highest quality of care to our Veterans.

2. If there are any questions, please contact Ms. Brenda Winston, Chief, Quality Management, at 334-272-4670, extension 6397.

(original signed by:)

James R. Talton, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Sheyla Desir, RN, MSN Victoria Coates, LICSW, MBA Alan Mallinger, MD

Appendix D

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