Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02527-23

Healthcare Inspection

Alleged Nursing Care Deficiencies Led to a Patient's Death Hampton VA Medical Center Hampton, Virginia

November 5, 2014

Washington, DC 20420

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

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the validity of allegations that improper nursing care resulted in a patient's death at the Hampton VA Medical Center, Hampton, VA. The complainant alleged that nursing staff did not conduct required rounds and failed to properly respond when staff received reports that the patient's condition was deteriorating. The complainant also alleged that the patient's health record was incomplete.

We substantiated that the nursing staff did not perform patient rounds in accordance with the Medical Center policy, which requires a patient to be checked every 30 minutes. In addition, we found no documentation of actions taken when non-nursing staff notified Spinal Cord Injury staff of a change in the patient's condition. We could not determine whether a failure to immediately assess the patient for possible problems led to this patient's death.

We recommended that the Hampton VA Medical Center Director initiate a review to evaluate patient rounds and medical record documentation policies, train and educate appropriate staff to ensure consistent adherence to patient assessment and documentation procedures, and consult with Regional Counsel regarding institutional disclosure.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–11 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

Purpose

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the validity of allegations that improper nursing care resulted in a patient's death at the Hampton VA Medical Center (facility), Hampton, VA. The complainant alleged that nursing staff did not conduct required rounds and failed to properly respond when staff received reports that the patient's condition was deteriorating. The complainant also alleged that the patient's health record was incomplete. The purpose of the review was to determine whether the allegations had merit.

Background

The facility provides comprehensive health care through primary, acute inpatient, psychiatric, chronic spinal cord injury, long term domiciliary rehabilitative residential, hospice, and palliative care. The facility has a veteran population of more than 240,000 throughout a 15 county region in eastern Virginia and northeastern North Carolina and is part of Veterans Integrated Services Network (VISN) 6.

The Spinal Cord Injury (SCI) center at the facility has 54 dedicated beds and is one of the largest SCI centers in the VA system. It provides a coordinated lifelong continuum of services for eligible veterans of all ages with SCI. It focuses on the prevention or early detection of complications of SCI, with multidisciplinary teams providing comprehensive evaluation and treatment.

The SCI center utilizes two systems for the electronic health record (EHR)—the Computerized Patient Record System (CPRS) and CareTracker. CPRS allows health care providers to review and update a patient's EHR. This includes the ability to place orders, including those for medications, special procedures, X-rays, nursing interventions, diets, and laboratory tests. Facility policy requires that "atypical findings" or "exceptions to care" be addressed in CPRS.[1] CareTracker is an automated system, separate from CPRS, that allows nursing staff to record patient activities of daily living, including bathing, eating, personal hygiene, and repositioning schedules.

Nursing staff at the facility are required to make patient rounds "…every thirty (30) minutes on all tours of duty" and observe patient location and condition, assess for any environmental hazards, ensure personal care items are within patient reach, and take corrective actions when necessary.[2]

The facility has a Medical Rapid Response Team (RRT) consisting of an Intensive Care Unit (ICU) nurse, a respiratory therapist, and a physician that is available 24 hours per day, 7 days per week. The team can be activated to come to the patient's location

[1] Nursing Service Memorandum 118-32, *Documentation of Patient Care,* December 2012.
[2] Nursing Service Memorandum 118-37, *Nursing Safety Program*, January 2013.

when the first signs of deterioration in a patient's condition are noted in order to help prevent progression to more serious consequences. The RRT policy directs staff to call for the RRT when they discover patients in respiratory distress or observe acute changes in blood pressure and/or a patient's conscious state.[3]

The complainant alleged that required nursing rounds were not conducted, that the nursing staff failed to take appropriate action when notified that the patient was unresponsive, and that the EHR lacked required critical information regarding nursing care provided and the cause of death.

Scope and Methodology

We conducted a site visit at the facility from November 12–14, 2013. We interviewed selected clinical and administrative staff. We reviewed the patient's EHR, relevant facility policies, clinical guidelines, quality management documents, and VHA guidelines.

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.

[3] Medical Center Memorandum 111-01, *Medical Rapid Response Team,* November 2012.

Case Summary

The patient who was quadriplegic (paralysis of both arms and legs) was a long time resident of the facility's SCI center. In addition to quadriplegia, his medical history included chronic neck pain, recurrent urinary tract infections related to suprapubic catheter placements, multi-drug resistant organism infections, pneumonia, kidney stones, chronic pressure ulcers, acute kidney failure, sleep apnea, and neurogenic bowel and bladder dysfunction.

The patient required assistance to be turned and repositioned while in bed or on his motorized gurney. When he was in bed, he would lie on his side and back. Oxygen was available with a continuous positive airway pressure (CPAP) machine to treat the patient's sleep apnea. CPAP machines use mild air pressure to keep airways open and are most commonly used for patients with sleep disorders. The patient was routinely evaluated by physical and respiratory therapy. He required assistance to eat.

The following chronology is taken from the EHR.

In Spring 2013, the patient developed a fever and was taken to the facility's emergency department (ED) for evaluation of a possible urinary tract infection. A chest x-ray, blood samples, and urine cultures were obtained; oral antibiotics were given, and the patient returned to the SCI center where he continued taking antibiotics for the next 11 days. He also continued to receive daily wound care for chronic pressure ulcers on his lower back and hips and was seen by physical and respiratory therapy.

A little more than 3 weeks after the patient's spring ED visit, the patient told staff that he was staying in bed because he had neck and shoulder pain. On that day, at the end of the night shift, the nurse recorded the patient's urine output in the EHR. Later that morning, the day shift nurse gave the patient his morning medications with the exception of his pain medication, which he refused. The nurse documented in the EHR that he was awake, alert, and oriented to person, place, and time.

Close to noon, a clinical pharmacist and the patient's physician visited and noted in the EHR that the patient was alert and oriented to person, place, and time. The physician reconciled the patient's medications, decided to discontinue the nightly dose of one of the patient's medications that had been ordered to improve his breathing, as the patient was not experiencing any breathing problems, and documented that the staff was to monitor the patient.

About 3 hours later, the day shift nurse recorded in the EHR that during the noon medication administration, the patient was sleeping but easily awakened, conversed with the nurse, and took his routine medications including the pain medication. The nurse also recorded vital signs taken earlier in the day.

The wound care nurse documented a note in the EHR mid-afternoon that when she changed the pressure ulcer dressings at noon and observed the conditions of the ulcers, the patient was awake and alert with no complaints of pain or discomfort.

After the change of shift in the afternoon, the evening charge nurse went into the patient's room and turned him on his side; the patient was breathing but unresponsive. The charge nurse did a sternal rub, but the patient did not respond to the stimuli. The charge nurse initiated the RRT.

Within 5 minutes, the RRT arrived in the patient's room and began treatment, monitoring his heart rate and blood pressure. They were unable to arouse the patient or to gain access to an intravenous site. The patient was transferred to the ED for further treatment, stabilized, and transported to the ICU shortly thereafter.

On day 1 post-event, the patient was intubated due to his acute respiratory condition.

On day 2 post-event, the patient's prognosis was poor; he remained intubated, with no spontaneous breathing, and was unresponsive to other stimuli. The ICU physicians diagnosed the patient with septic shock and aspiration pneumonia.

On day 3 post-event, the infectious disease team saw the patient, documented that he had a fever of 101 degrees Fahrenheit, and was infected with a multi-drug resistant organism infection.

On day 4 post-event, the medical staff met with the next-of-kin regarding the patient's critical condition and told them there was little brain function detected on the neurological examination and that the patient had anoxic brain injury (lack of oxygen to the brain). The medical staff also told the family they could not determine exactly how long the patient had been unresponsive before he was discovered by the nursing staff in the SCI center. The patient was not expected to survive without mechanical ventilation and medications to maintain his blood pressure.

On day 5 post-event, in accordance with the patient's advance directive, comfort care was continued and mechanical ventilation was withdrawn. Later that evening, the patient died.

Inspection Results

Issue 1: Timely Patient Rounds

We substantiated that the SCI nursing staff did not perform routine patient rounds in accordance with the facility policy.[4] A nursing staff member is required to make rounds every 30 minutes and observe the patient's condition, assess for environmental hazards, ensure the patient's call signal and personal items are within reach, and take any necessary corrective actions. Our review of the EHR and staff interviews revealed gaps in patient rounding by nursing staff. Additionally, the nursing staff on the SCI unit had an inconsistent understanding of the facility's policy regarding the frequency of

[4] Nursing Service Memorandum 118-37, *Nursing Safety Program*, January 2013.

rounds. Some reported a standard of every 20 minutes, while others reported a standard of every 3 hours.

Issue 2: Nursing Response

We could not substantiate that SCI staff failed to take appropriate actions when non-nursing staff informed the SCI staff that something was wrong with the patient, as the evidence we found was incomplete concerning what, if any, nursing actions were taken. Some witnesses could not specifically recall or identify which nursing staff were notified. We could not determine that a delay in nursing response was the cause of the patient's death.

All staff members interviewed were familiar with the patient and his condition, as he had been a long-time resident of the SCI center. Staff provided the following chronology, not found in the EHR.

On the day at issue, a staff member from another department was visiting the SCI unit in the early afternoon and recalled entering the patient's room and observing the patient sleeping on his back. The staff member called out to the patient, but the patient did not answer.

The same staff member returned to the patient's room about 30 minutes later and observed that the patient was on his back with vomit around his mouth. The patient did not respond to questions. The staff member became concerned and promptly reported the observation to the nursing staff member at the nursing station desk, who got up and walked toward the patient's room.

An off-duty staff member, who was a friend of the patient, stated that upon entering the patient's room mid-afternoon, she observed a Nursing Assistant (NA) leaving the room. The friend observed that the patient was breathing, but could not elicit a verbal response from the patient. The friend went to the nurses' station and reported to two staff members that something was wrong with the patient. The staff members referred the friend to the day shift nurse.

According to the friend, the day shift nurse explained that the patient's unresponsiveness was likely due to pain medication that had been given at noon. The friend went back to the patient's room and sat for a few minutes and did not observe anyone come into the room. The friend left the room and called the patient's next-of-kin to tell them of the patient's change in condition. After the conversation with the friend, the day shift nurse recalled observing the patient from the doorway and that the patient appeared to be sleeping.

At the time of the 8-hour shift change that afternoon, the evening shift charge nurse remembered observing the patient sleeping when walking by the patient's room. The evening nursing staff then received a change of shift report from the day nursing staff.

About 30 minutes after shift change, an NA recalled entering the patient's room and checking the patient, who was breathing and appeared to be sleeping. The same NA

returned to the patient's room about 15 minutes later to feed him. The patient did not wake up. The NA observed vomit in the patient's mouth. The NA went to get assistance from the charge nurse and to get the vital signs machine.

The charge nurse recalled initiating resuscitation efforts and calling the RRT.

Common nursing practice requires that signs of a patient's deteriorating condition shall be recognized, documented, and communicated to a physician. We could not determine whether nursing staff did or did not take corrective action in response to these reports since none is documented in the EHR. After the shift change, nursing staff recognized the patient's unresponsive condition and took corrective action by initiating therapy and calling the RRT—this action is properly recorded in the EHR.

Issue 3: Incomplete EHR Documentation

We substantiated that the EHR lacked critical information regarding the patient's change in condition, but we found no inconsistency in the EHR regarding the patient's cause of death, which was listed as aspiration pneumonia with anoxic brain injury, secondary to sepsis. When SCI patients are admitted to the facility, a Care Plan is instituted and documented in the EHR. The required frequency of documentation in CPRS progress notes for SCI patients is at "least monthly and as needed (based on unexpected changes in the patient's condition)."[5] On the day at issue, EHR documentation of wound care and medication administration was made by nursing staff during the day shift. SCI nursing staff told us that "charting by exception" in the EHR would be required when signs of the patient's deteriorating condition were reported. We did not find documentation in the EHR noting that the nursing staff checked on the patient or took corrective action when they were told of a change in the patient's condition.

Conclusions

We substantiated the allegations that the required patient rounds were not conducted or documented in accordance with facility policy and determined that nursing staff had an inconsistent understanding of the standard of practice and the policy for conducting and documenting patient rounds. We could not substantiate that SCI staff failed to take appropriate actions when non-nursing staff informed the SCI staff that something was wrong with the patient, as the evidence we found was incomplete concerning what, if any, nursing actions were taken. We substantiated that SCI staff failed to document in the EHR significant changes in the patient's condition or corrective nursing actions taken. However, we could not substantiate that a lack of nursing response was the cause of the patient's death.

[5] Nursing Service Memorandum, *Documentation of Patient Care*, 118-32, December 2012.

Recommendations

1. We recommended that the Facility Director conduct and document a review to evaluate patient rounds and documentation policies.

2. We recommended that the Facility Director educate and train all staff regarding patient rounds policies.

3. We recommended that the Facility Director consult with Regional Counsel regarding institutional disclosure to the patient's next-of-kin in accordance with VHA Handbook 1004.08.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 5, 2014

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

Subject: **Draft Report**—Healthcare Inspection – Alleged Nursing Care Deficiencies Led to a Patient's Death, Hampton VA Medical Center, Hampton, Virginia

To: Director, Washington DC Office of Healthcare Inspections (54DC)

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

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the Hampton VA Medical Center (VAMC), Hampton, VA, and concur with the facility's responses.

2. If you have further questions, please contact Michael H. Dunfee, Director, Hampton VAMC, at (757) 728-3100.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 4, 2014

From: Director, Hampton VA Medical Center (590)

Subject: **Draft Report**—Healthcare Inspection – Alleged Nursing Care Deficiencies Led to a Patient's Death, Hampton VA Medical Center, Hampton, Virginia

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

1. Thank you for the opportunity to review the OIG report on the Review of Hampton VA Medical Center. We concur with the recommendations, and will ensure completion as described in the implementation plan.

2. Please find attached our responses to each recommendation provided in the attached plan.

3. If you have any questions regarding the response to the recommendations, feel free to call me at (757) 722-9961, extension 3100.

MICHAEL H. DUNFEE, MHA

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director conduct a review to evaluate patient rounds and documentation policies.

Concur

Target date for completion: July 25, 2014

Facility response:

A review was conducted to evaluate patient rounds policies. It was concluded that the existing policy governing patient rounds provides appropriate guidance to conduct patient rounds.

A review was conducted to evaluate documentation policies. It was concluded that the policies for documentation, to include documentation requirements when there is a change in patient's condition, provide appropriate guidance for documentation of care.

We acknowledge that further education and training is required to clarify expectations for the rounding process, to include the timing of rounds and expectations for staff to document when there is a significant change in the patient's condition, diagnosis, or status.

Recommendation 2. We recommended that the Facility Director educate and train staff regarding patient rounds policies.

Concur

Target date for completion: September 30, 2014

Facility response:

The policy governing rounds is Nursing Service Memorandum No. 118-37 – Nursing Safety Program. Focused staff education and training on Nursing Service Memorandum No. 118-37 – Nursing Safety Program was conducted for SCI staff on November 20, 2013.

The topic "Rounds" - HAM-MAR Safety - is a Talent Management System (TMS) mandatory annual training for Nursing Service.

Further education and training to clarify expectations for the rounding process, to include the timing of rounds and expectations for staff to document when there is a

significant change in the patient's condition, diagnosis, or status, was initiated August 1, 2014.

Recommendation 3. We recommended that the Facility Director consult with Regional Counsel regarding institutional disclosure to the patient's next-of-kin in accordance with VHA Handbook 1004.08.

Concur

Target date for completion: July 31, 2014

Facility response:

A consultation was conducted with Regional Counsel regarding institutional disclosure to the patient's next-of-kin in accordance with VHA Handbook 1004.08 on July 31, 2014.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Myra Conway, RN, MS, Team Leader Randall Snow, JD Julie Kroviak, MD George Wesley, MD Natalie Sadow, MBA, Lead Program Assistant

Appendix D

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