Administrative Closure
Alleged Jeopardized Resident Care in the Long Term Care Spinal Cord Injury Unit
Louis Stokes VA Medical Center (541/00)
Cleveland, Ohio
MCI #2014-01308-HI-0477

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received a complaint from a confidential source alleging poor quality of resident care due to mismanagement by the long term care (LTC) spinal cord injury (SCI) supervisory nurses at the Louis Stokes VA Medical Center (facility), Cleveland, Ohio.

OHI's Hotline Working Group initially referred the allegations back to the facility for review. On March 7, 2014, the facility sent a response to the OIG Hotline Division (53E) stating that:

- All of the allegations were unsubstantiated.
- Resident care is monitored on a consistent basis by multiple disciplines.
- The facility did not find specific evidence presented by the Quality Management department or the Paralyzed Veterans of America oversight group that supported patient neglect even though unit residents complained about the quality of care received on the unit.

The OHI Hotline Working Group determined the facility's response did not address the concerns adequately. On March 28, the Working Group referred the allegation to OHI's Baltimore Office for a formal review. On April 4, OHI inspectors spoke with the complainant to obtain additional information. Many of the allegations mirrored the issues and findings described in our previous report (*Nursing Care in the Community Living Center for Spinal Cord Injury, Louis Stokes VAMC, Cleveland, OH,* Report No. 12-02186-227, June 27, 2013). Since some of the allegations were addressed in the 2013 report and had open recommendations tracked by OIG's Follow-Up Division, we did not reassess them in the current inspection. Additionally, we did not review allegations related to personnel management since they were deemed to be outside the scope of the inspection.

This inspection focused on allegations that supervisory nurses:

- Did not verify that appropriate staff was on the unit in a timely manner.
- Re-assigned workload 2-½ hours into the shift, resulting in delayed dispensing of resident medications and, in some cases, not dispensing medications at all.
- Allowed neglect of residents' care needs, including wound dressings not being changed as ordered.
- Did not communicate with staff on a daily basis.

We conducted an unannounced site visit to the facility on April 23–24; conducted interviews with facility leaders, key employees, and the complainant; and toured the LTC SCI unit. We reviewed Veterans Health Administration and facility policies, memoranda, and procedures.

Beginning in January 2014, the LTC SCI unit underwent a significant change in management, including the retirement of the LTC unit nurse manager (NM). To provide oversight, coaching, and employee development, and to create a sense of team, facility leaders created a new LTC SCI Chief Nurse position. This position was filled by the facility's inpatient acute SCI unit NM who was recognized by leadership and many employees for fairness and excellent SCI unit management within VA and the private sector. In addition to supervising the newly selected LTC SCI NM, the LTC SCI Chief Nurse was also responsible for managing the acute SCI unit (until the new NM was hired), and she had responsibility for the nursing "float pool."

Allegations related to staff not being present on the unit were substantiated. In addition, a 2½-hour delay in medication administration occurred in December 2013 under the previous management, when a float nurse did not report to the unit as assigned. Within the first few months of starting their positions, the new NMs introduced new policies and initiated actions to address several employee conduct and performance problems.

The new NM and LTC SCI Chief Nurse worked with the Paralyzed Veterans of America organization and facility leaders to address LTC SCI unit inefficiencies and work barriers that included, at least:

- Implementing requirements that each shift's charge nurse check on float nurses every 40 minutes, complete a checklist, and promptly report any problems to the NM.
- Assigning paired registered and licensed practical nurses to care for all tasks related to one or more patients instead of assigning staff to one or more tasks, such as bowel care, for several or all patients.
- Initiating union discussions to balance staffing ratios across all shifts.
- Ensuring that float pool nurses have training and competencies to perform all duties required in the LTC SCI Unit.
- Establishing a unit wound coordinator.
- Streamlining hand-off communication to need-to-know information about each staff member's assigned patients.

Since the current LTC SCI management team has been in place for only a few months, not enough time has elapsed to assess the impact of the changes in management and policies on the LTC SCI unit. Based on interviews and documentation review, we did not substantiate that the alleged activities were ongoing. We determined that several allegations were related to conditions that existed in the past, and others reflected reaction of a few staff members to new policies and management. Additionally, we did not find nor received any documentation that the alleged situations resulted in patient harm. Therefore, we recommend administrative closure of this complaint.

Based on our review, I am administratively closing this case.

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