CLOSE CASE

From: Director, Washington, D.C. Region Office

Oct 15, 06

Subject: Oversight Review and Administrative Case Closure of Alleged Patient Abuse VA Maryland Healthcare System, Baltimore, MD:
Hotline Inspection 2006-02774-HL-0848

To: Director, OIG Hotline Division

Background:

The Department of Veterans Affairs (VA) Office of Inspector General's, (OIG) Washington DC Regional Office of Healthcare Inspections conducted an oversight inspection of the VA Maryland Healthcare System (VAMHCS), Baltimore, MD, in response to allegations by an anonymous complainant. The complainant alleged that a Licensed Practical Nurse (nurse) kicked a disabled veteran, who fell and was lying on the floor. The complainant further alleged that other abuses have occurred and reported to managers who failed to investigate them.
The VAMHCS is composed of three campuses: the main medical center in downtown Baltimore Md, a psychiatric facility in Perry Point, Md, and an extended care unit in Lock Raven, a suburb of Baltimore. The incident is alleged to have occurred at Lock Raven. The purpose of our inspection was to determine if the allegations have merit and to determine whether VAMHCS managers have taken appropriate action regarding these allegations.

Findings:

Our review found that VAMHCS managers independently reviewed the allegations and could not substantiate them. The reviewers found that there were no witnesses to corroborate the allegation made by the veteran; and the nurse who was the subject of the investigation was not on duty when the veteran alleged the abuse occurred. Furthermore, no other incidents of abuse in this unit have been reported by patients, family members, or staff. Despite the findings of the internal review, and because of prior incidents of poor communication with patients, the nurse was subsequently assigned to a different unit in an effort to ensure the best environment for the veteran and to protect the employment rights of the nurse.

Allegation 1: A nurse kicked a patient that had accidentally fallen.

We did not substantiate this allegation.

The patient is 73 years-old, 100% service connected veteran with a history of progressive dementia, stroke, left-eye blindness, chronic obstructive pulmonary disease, and hypertension. He was admitted to the Lock Raven facility in December 2005 for respite care while his wife was undergoing surgery.

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The veteran has a history of multiple falls and was transferred to the Hospice Unit for closer monitoring after it became apparent that his wife could no longer care for him at home. He frequently resists nursing care and has difficulty communicating due to memory loss and slurred speech. On June 3, 2006, two weeks after a reported fall, he complained to his wife that after he had fallen a nurse kicked his forearm. The veteran's wife reported the incident to a staff member, who relayed the information to the unit supervisor. The veteran was examined by a physician and found to be in no pain and injury free.

Management review of the complaint revealed there were no witnesses to the incident; that the accused nurse denied kicking the veteran; and that the nurse was not on duty at the time the incident is alleged (by the veteran and spouse) to have occurred. Time and attendance work sheets; overtime logs and schedules, and nursing documentation failed to show that the nurse was on duty at the time of the incident. Moreover, the alleged kicking was to have occurred in the morning hours, a shift the nurse is not normally scheduled to work (the nurse has consistently been on the evening shift).

Investigative findings did confirm that the veteran becomes agitated when this particular nurse is around him, and staff members interviewed reported that he displays fear and anger towards her. The nurse has been counseled in the past for being rude and abrupt to other patients. The investigation also concluded that because English is a second language for this nurse that it may have been a contributing factor to her misunderstandings with patients.

Medical Center Corrective Actions:

The unit manager met with the veteran's wife regarding this incident. The patient's wife requested that this nurse not care for her husband. VAMHCS managers reassigned the nurse to work in another unit and required her to attend *Communication and Management of the Geriatric Patient* classes.

Allegation 2: That additional similar complaints have been reported to VAMHCS managers, but no investigations have been initiated.

We did not substantiate this allegation.

The VAMHCS's Quality Management office was notified of this veteran's case and conducted a review of this incident as well as the veteran's previously reported falls (Dec 05, Jan 06, and Mar 06). Clinical managers reported two previous incidents involving this particular nurse - both dealing with communications issues – which were handled by the unit supervisor at the time the encounters occurred. There have been no other complaints by patients or staff against this nurse.

Medical Center Corrective Actions:

To optimize patient care, nurse Managers were assigned to make regularly scheduled rounds on the Lock Raven unit to meet with veterans and their families and follow-up on patient concerns. Abuse issues were made part of the agenda items for unit staff meetings and one-on-one nurse interviews.

Conclusions:

Based on our evaluation of the VAMHCS's review and corrective actions taken, and our review of the documentation provided to us, we concluded that the issues identified in the hotline complaint were appropriately addressed. We therefore will administratively close this hotline case.

Nelson Miranda, Director
Veterans Affairs Office of the Inspector General
Washington, DC Region Office of Healthcare Inspections