Agree to closure
8/7/09

Memorandum to the File - Administrative Closure

Allegations that Retaliation Led to a Reduction in the Level of Care and that Patient Safety was Jeopardized
James A. Haley Veteran's Hospital
(2009-02508-HI-0142)

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation in response to allegations that retaliation by staff at the James A. Haley Veteran's Hospital (the medical center) led to reduction in a patient's level of care and that the patient's safety was jeopardized. The purpose of the review was to determine whether the allegations had merit.

Background

The medical center, located in Tampa, FL, is under the jurisdiction of Veterans Integrated Service Network (VISN) 8 and is a tertiary care facility that provides a broad range of medical and surgical services. The medical center operates one of the four specialized polytrauma rehabilitation centers (PRCs) in the VA system. The medical center's PRC is located on unit 5N.

On May 27, 2009, the VA Inspector General received a request from (b)(6) (b)(6) to evaluate issues concerning the care provided to a patient at the medical center. The complainant alleged that:

a. The patient's care was being influenced by nurses charged with his care.

b. Certain nurses had been ignoring the instructions of the doctors.

c. The patient was relocated from his room unexpectedly and his level of care reduced.

The complainant referred us to the patient's wife for further allegations. The patient's wife alleged that:

a. A nurse had been abusive to the patient, and to retaliate against the patient's wife for reporting this, the nurse made a false and slanderous allegation about the patient's wife.

b. Medical center management did not address the false allegation.

c. The patient and his wife were victims of character assassination when staff and families on his unit held an inappropriate meeting to discuss their continued presence on the unit.

d. The Chief of Staff (COS) retaliated against the patient and his wife by moving him off the unit and cancelling his orders for 24 hours a day, 7 days a week (24/7) one to one (1:1) supervision.

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e. The COS violated the patient's attending physician's orders and did not evaluate the patient before discontinuing the 1:1 orders.

f. The patient's health was jeopardized by his transfer from the unit.

g. Nursing staff violated Joint Commission (JC) standards.

Scope and Methodology

We interviewed the patient's wife by phone on (b)(6) We conducted a site visit the week of (b)(6) and interviewed the patient, the Medical Center Director (MCD) and COS, the patient's attending physicians, nursing leadership, members of the patient's treatment team, and other nursing staff on unit 5N. We also interviewed family members of two unit 5N patients by phone. We conducted a total of 21 interviews. We reviewed the patient's medical record, incident reports and reports of contact, patient advocate reports, medical center policies, and any other documents related to the allegations.

Case Summary

The patient is a (b)(6) He is (b)(6) (b)(6) He sustained a penetrating traumatic brain and neck injury. He was transferred from the Presidential Suite at Walter Reed to the medical center on (b)(6) for further rehabilitation.

At the time of admission, he was totally dependent in all activities of daily living (ADLs) except for eating, with which he was only partially independent. His problems at the time of admission included left hemiparesis with spasticity, profound right s

ensorineural hearing loss, right vocal cord paralysis, visual field cut with left neglect, post-traumatic seizure disorder, neurogenic bladder and bowel, fatigue, and deconditioning. He was admitted to unit 5N for intensive rehabilitation, including physical therapy, occupational therapy, visual therapy, cognitive/communication therapy, kinesiotherapy, aquatic therapy, and recreation therapy. In addition to these rehabilitation therapists, he also worked with a neuropsychologist, a psychologist, and a social worker. Due to his high risk of falls and seizures, his attending physician ordered that he have 1:1 supervision by a registered nurse (RN) 24/7. This order was later changed to 1:1 supervision by a certified nursing assistant (CNA).

At the time of our visit, the patient had only experienced one fall and one seizure (when seizure medication was discontinued). He had made considerable progress in therapy and demonstrated a mild cognitive-communication impairment. He continues to work on gaining independence in his ADLs, but still requires assistance with dressing,

bathing, toileting, and transfers. His physical therapy focuses on transfers and improving strength, balance, and trunk stability.

The medical center provided (b)(6) a large two-patient room, a leather sofa, a microwave oven, and a refrigerator. Special meals were provided for a while. When other patients' families complained of special treatment, the medical center provided microwave ovens and refrigerators to all patients on the unit and the patient was moved to a smaller private room near the nurses' station. The patient's wife was extremely concerned about protecting his privacy and did not allow anyone to enter his room without her express permission. Staff new to the patient were not allowed to work with him without her approval. The patient took all meals in his room and his wife chose to not socialize with other families on the unit. As the patient had a CNA to assist him, his wife did not assist with his care. She frequently took him on weekend passes with the assistance of an attendant. The patient had a cell phone and called his wife if issues arose in her absence.

Nursing staff told us they began to resent what they felt were unreasonable demands by the patient's wife. They also told us they felt that for the past 6 months, he had not needed 24 hour 1:1 which pulled from their staffing during the day and created high overtime costs for evening and night shifts. Although 1:1 was frequently ordered for short periods for other patients on the unit (most of whom were also at high risk for falls and seizures), nursing staff felt that it was no longer indicated in his case. The patient was also able to speak and use a cell phone and his call light, unlike many patients on the unit.

The patient's attending physicians were quite responsive to his needs and his wife's concerns. They told us they had several reasons for continuing his 1:1. They acknowledged that continuation was more for the wife's benefit than for the patient's. In keeping with the unit's philosophy of treating the patient and the family, they felt that whatever served to help the patient's wife cope with the situation ultimately helped the patient as well. Another justification physicians provided to us was that the patient was unable to turn himself in bed, and his legs frequently became crossed and painful. The CNA assigned at night would reposition the patient's legs if this occurred. Finally, the physicians told us that the patient and his wife were hoping his workman's compensation benefits would cover 24/7 1:1 assistance after discharge, and they wanted to demonstrate this need at the time of the evaluation for benefits.

Unit 5N has a family-centered philosophy of care, and no visiting hours are imposed. Families and children are encouraged to visit. Toys are kept in the unit's shared family rooms, and children were frequently watched by the nurses at the nursing station when their mothers were assisting in the care of a patient. The patient was exhausted after a full day of therapies and liked to rest between the hours of 4 and 6 p.m. in the evening. As this was a busy time on the unit with recreation therapy, dinner, and visitation, quiet was difficult to maintain, but staff provided the patient with noise blocking earphones

and earplugs. The patient's wife told us she complained many times about the noise and felt that medical center management had promised to enforce quiet time.

In (b)(6) someone threatened to go to the media with allegations of preferential treatment. The COS and nursing leadership composed a "contract" to address some of the patient's needs (such as quiet), and the medical center's needs (including a weaning from 1:1) which was presented to the patient's wife for concurrence and signature on (b)(6) The COS told us the patient's wife never signed or returned the contract.

The patient's wife told us that two nights during the week of (b)(6) the unit remained particularly noisy until after 9 p.m. On the evening of (b)(6) the patient and his wife became particularly agitated by the noise and asked the physician to intervene. After this failed, the patient's wife moved toys from the family room next to the patient's room. While doing this, she and the charge nurse exchanged words. The following day, the physician informed her that the charge nurse had alleged that the patient's wife had "abused" a patient on the unit by yelling at him and his young child to "shut up". He also informed her that nine families on the unit had requested a meeting with staff to complain about the alleged incident and other concerns including preferential treatment. When the patient's wife denied the allegation, the COS joined the meeting and declared that he was transferring the patient to another unit and discontinuing his order for 1:1. On (b)(6) the patient was moved to unit (b)(6) (a rehabilitation floor).

Administrative Review Results

Issue 1: Concerns About Nursing

We did not substantiate the allegation that the patient's care was influenced by nursing staff beliefs. Although the nursing staff did not believe that the patient required 1:1 supervision, they were unable to influence the patient's attending physicians to discontinue these orders.

We also did not substantiate the allegation that nursing staff ignored doctors' instructions regarding the patient. We found no evidence that physician orders were not routinely followed. The patient was assigned a CNA for 1:1 24/7 while he remained on 5N. We learned of only one incident where the patient was left alone for a short time. The CNA called in sick and the RN assigned to the patient left him alone for a few minutes while he was eating with the door open so he could be seen. The patient called his wife who called the physician who called the nurse manager (NM). The NM reminded the RN that the patient should not be left alone at any time.

We did not substantiate the allegations that nursing staff violated JC standards. The (b)(6) alleged that JC Environment of Care (EOC) standards were violated by the noise level of the unit. Although we could not find a policy stating this, nursing staff

told us that PRCs had done away with visiting hours. Visitation by children was encouraged, as was family visitation and participation in unit recreational activities. Therefore, the unit was fairly lively in the evening hours. The unit was quiet during the day (and we found it to be so on the 2 days we visited). The staff we interviewed told us that the unit quieted down by 8:00 or 9:00 in the evening. The patient's wife told us the COS had signed a contract promising to enforce quiet on the unit between the hours of 4 and 6 p.m. The contract was never signed and returned by the wife and was therefore felt to be null and void.

The wife also alleged that JC standards were violated as the patient's call button was not left within his reach. The nursing progress notes we reviewed consistently documented that the call button was left within reach of the patient. Even if this had not occurred, the patient had a CNA with him at all times, was able to call out for help, and had a cell phone with which to call his wife. His safety was not jeopardized at any time.

Issue 2: Slander and Character Assassination

We substantiated that a slanderous allegation was made about the patient's wife; however, we could neither confirm nor refute that the allegation was false. We reviewed several reports of contact (ROCs) from staff regarding the incident. We noted several inconsistencies in the reports, but all documented that the patient's wife had caused the daughter of a unit patient to be very upset. It was unclear whether the patient's wife spoke to the daughter or her father, and whether she yelled or told them to shut up or be quiet. The patient's wife's assertion that she had only prayed with the child's father could not be verified.

The patient's wife told us the RN who made the allegation against her did so to retaliate. This RN did not witness the event, but reported it as she was the charge nurse on duty that night. The patient's wife told us this RN had been abusive to her husband and that she had reported her to the NM. The only incident we heard about did not sound abusive. The RN had asked the patient when he was going to be discharged. We found no patient advocate reports regarding this RN. Other treatment team members we interviewed had received no complaints of patient abuse attributed to this RN.

The patient's wife alleged that medical center management had not addressed the allegation against her. We found that the charge nurse and NM collected witness ROCs and informed the patient's attending physician who informed the COS and the MCD. The physician told the patient's wife about the allegation and listened to her version of the story. When the issue became a "he said/she said" scenario, the COS was called in. He learned that family members had called a meeting to complain about what they perceived as preferential treatment for this patient and felt that the best thing to do at that time was to diffuse the situation by removing the patient from the unit. We did not substantiate that medical center management did not address the allegation.

We did not substantiate the allegation that the patient and his wife were victims of "character assassination." Nurse managers and a psychologist met with several other patients' family members, on (b)(6) The events of (b)(6) the fact that the patient

received 1:1 care, and other issues family members had with the patient and his wife were discussed. The discussions did not constitute "character assassination." It was appropriate for staff to meet with family members to hear their concerns and there was no indication that staff tried to hide their attendance at the meeting. ".

Issue 3: Relocation and Reduction in the Level of Care

We substantiated that the patient was relocated unexpectedly from his unit and that his level of care was reduced. The patient's attending physician had decided that the patient needed to be moved away from the nursing station due to the noise level. However, the decision on (b)(6) to move him to another unit was unexpected. The COS told us that the incident on (b)(6) and the family meeting on (b)(6) precipitated this decision.

We also substantiated that the discontinuation of the 1:1 order constituted a reduction in the patient's level of care. Although the patient was transferred to another rehabilitation unit (2C), he went from having 24/7 1:1 assistance from a CNA one day to no 1:1 at all the next day. The plan to "decrease 1:1 to less frequent observation status based on the patient's progress", as suggested in the (b)(6) contract, was not implemented.

We could not substantiate that the actions of the COS were retaliatory, but we can see how, due to the timing, the patient and his wife could have perceived them to be. The COS and nursing staff had wanted to discontinue the 1:1 for months. This was documented in the contract of (b)(6) written by the COS and nursing leadership. However, this contract was not developed collaboratively with the patient and his wife nor discussed with them and we found no documentation in treatment team progress notes that this was discussed with the patient and his wife at their weekly team meetings. The patient's physician was not in favor of discontinuing the 1:1. One of the complaints brought up by families at the family meeting on (b)(6) was that their family members needed 1:1 more than the patient, yet it was not ordered for them. When the COS met with the patient and his wife on (b)(6), after learning of the meeting and the events of the previous night, he told the patient that he hadn't needed the 1:1 for 6 months and that he was being moved off the unit.

We substantiated that the patient had a standing order for 1:1 when discontinued by the COS. However, a COS may overrule an attending physician when he feels it is appropriate to do so. We also substantiated that the COS did not evaluate the patient before discontinuing the order. This was not necessary, as the patient's medical record contained recent evaluations by his treatment team documenting his current status and level of functioning.

We did not substantiate the (b)(6) allegation that the patient's belongings were thrown in piles in his new room and that the staff on the new unit were not briefed on his care. We learned that several treatment team members stayed late on the evening of (b)(6) to help unpack and organize the patient's room. They also told us that they

provided training to 2C staff that evening and again a few days later. We also found that the transfer was handled according to local policy. Transfer documentation, including hand-off communication and patient assessment, was complete.

We did not substantiate that the relocation and sudden discontinuation of 1:1 jeopardized the patient's health and safety. Although the (b)(6) weekend may not have been the ideal time to move, we reviewed staffing sheets for the weekend and found that staffing levels on unit (b) were at unit standards. We also found that the patient suffered no ill effects from his transfer. He has had no falls or seizures and has shown progress in his therapies. In fact, his physicians told us that since (b) is much quieter than 5N, the patient has actually gotten more rest and has been less stressed. He has also demonstrated increased independence and interest in socialization since his move. We interviewed the patient who told us that he liked his new unit and his larger private room. He said the room location is quiet and he enjoys the privacy afforded by not having an attendant in his room at night. He said he had been asking before the move to not have 1:1 at night as it disrupted his sleep and deprived him of his privacy.

Conclusions

We found that the medical center provided quality care to the patient and made every effort to accommodate his special needs and the requests of his wife. The patient and his wife were complimentary about the medical and therapeutic care he had received during the 8 months he had been a patient at the medical center. We learned that families of other patients became resentful toward the patient and his wife due to what they perceived as preferential treatment, and nursing staff felt the patient's wife made unreasonable demands. After an incident involving the patient's wife, a nurse, and a child on the unit, the situation became untenable. To diffuse the situation, the patient was suddenly transferred to another unit and his 1:1 was discontinued. Although these actions were not detrimental to the patient, a gradual change would have been a more appropriate way to handle the situation.

At this time, the case does not warrant further review and can be closed without the issuance of a formal report.

CHRISTA C. SISTERHEN
Regional Director
St. Petersburg Office of Healthcare Inspections

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