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Healthcare Inspection

Patient Care Concerns at the Community Living Center Hampton VA Medical Center, Hampton, Virginia

May 11, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection at the request of Senator Mark Warner made in 2015 in response to complaints about the delivery of care at the community living center (CLC) located on the campus of the Hampton VA Medical Center (facility), Hampton, VA.

The allegations were mainly about the care of a single resident (the term used for patients in the CLC); however, the complainant also expressed concerns about care of other residents. The complainant alleged the following:

1. The resident had to go to the Emergency Department on two separate occasions because CLC staff were not competent and failed to properly care for his suprapubic catheter (SPC).
2. CLC staff often failed to carry out physician orders as written for bladder irrigation for the resident.
3. CLC staff failed to conduct regular checks for well-being of residents.
4. CLC staff failed to conduct regular skin assessments, take vital signs, or obtain weights for residents as required.
5. CLC staff failed to check on the resident during mealtimes and to provide meal set-ups and dining assistance.
6. CLC staff failed to offer the resident morning care.
7. CLC unit staff left the building during their shifts for 45 minutes to an hour at a time, often during mealtimes, regardless of whether residents could get to their food.
8. During shift change and lunch, staff made residents wait to be helped back to bed and cleaned.
9. CLC staff who worked on weekends were not keeping the same daily routines for the residents.
10. Residents were not informed of special events or cookouts.
11. The resident had to pay the barber for a shave.
12. CLC resident call lights were ignored.
13. CLC staff left medications at the resident's bedside, ignored the resident's need to be cleaned after bowel incontinence, and tried to give the resident a second dose of medications while the original dose was still sitting on his bedside table.
14. CLC staff were not routinely cleaning or sanitizing reusable medical equipment on the units as required.
15. CLC staff failed to timely provide the appropriate specialty mattress to the resident.

We substantiated that CLC staff did not consistently have competency validations completed for care of residents with SPCs. Because the resident's indwelling SPC predisposed him to bladder infections and stones, we could not conclude that lack of staff competence in caring for residents with SPCs contributed to the resident's Emergency Department visits and urinary tract infections after admission to the CLC.

We substantiated that CLC staff failed to carry out some physician orders as written for SPC irrigation for the resident. We also substantiated that CLC staff did not consistently document checks for well-being and skin assessments.

We did not substantiate that CLC staff failed to weigh residents as required, take vital signs as ordered, or address residents' dining assistance needs. We did not substantiate that the resident was never "offered a.m. care."

We did not substantiate that during shift change and lunch time, CLC staff took breaks and made residents wait to be cleaned and/or assisted back to bed. We could not substantiate that staff who work on the weekends were not keeping the same daily routines for the residents. We did not substantiate that residents were not informed of special events.

We substantiated that in the past, residents had to go to the facility barbershop to be shaved; however, at the time of our visit June 16–18, 2015, nursing staff had assumed that duty.

While we could not determine if call lights were ignored, we found that resident call lights could be turned off at the nurses' desk without staff actually checking on the patients. Biomedical staff reconfigured the system while we were onsite so that a call light could only be shut off at a resident's bedside.

We could not substantiate that CLC staff left medications at the resident's bedside, ignored the resident's need to be cleaned, and later tried to give the resident another dose of medications that were still sitting at his bedside.

We did not substantiate that CLC staff were not routinely cleaning or sanitizing reusable medical equipment (such as beds, bedside tables, stretchers, and wheelchairs) on the units as required.

We substantiated that an appropriate mattress was not obtained in a timely manner for the resident and that facility policy was not followed and processes were not in place for obtaining and maintaining special care beds and mattresses.

We recommended that the Facility Director:

- Ensure that CLC staff have competency assessments and validations completed for care of residents with suprapubic catheters, including catheter insertion and irrigation.
- Ensure that CLC staff carry out physician orders.

- Ensure that CLC staff conduct and document resident checks for well-being, skin assessments, and activities of daily living assistance as required.

- Ensure that procedures are followed for obtaining special care beds and mattresses.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan for all recommendations. (See Appendixes A and B, pages 15–19 for the Directors' comments.) We consider recommendations 1 and 4 closed. We will follow up on the planned actions for the remaining recommendations until they are completed.

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Assistant Inspector General for
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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senator Mark Warner made in 2015 in response to complaints about the delivery of care at the community living center (CLC) located on the campus of the Hampton VA Medical Center (facility), Hampton, VA. The allegations were primarily about the care of a single resident (a term commonly used for a patient in the CLC); however, the complainant also expressed concerns about care of other residents.

Background

Facility. The facility has a 122-bed CLC consisting of two units called neighborhoods (A and B Units) and a separately located 10-bed unit that houses the palliative care/hospice program. The A Unit also includes an eight-bed secured Geriatric Special Care Unit for residents who require care and services for dementia and/or mental illness.

Competency Validation. The Joint Commission defines competence as the knowledge, skills, ability, and behaviors to perform a job correctly, skillfully, and appropriately. A hospital cannot provide safe, reliable, and appropriate health care if its staff members are not competent.[1] Competency assessment and validation is the process of verifying an individual's ability to perform and to apply knowledge and skills.

CLC. VA CLCs are long-term care facilities that provide nursing care, rehabilitation services, and other specialty programs for residents. CLCs strive to provide patient centered care tailored to residents' needs and preferences.

Activities of Daily Living. Activities of daily living (ADL) are specific personal care activities or tasks required for daily maintenance and sustenance. Residents may require the assistance of others to complete essential activities such as grooming, bathing, dressing, personal hygiene, toileting, eating, and mobility.

Suprapubic Catheter and Bladder Irrigation. The presence of a catheter increases the chances of developing a urinary tract infection (UTI), and the longer the period of catheterization, the greater the risk of other problems, including internal pressure sores and development of bladder stones. Different techniques have been used to prevent or treat catheter-associated complications, including bladder irrigation. In addition, placing a suprapubic catheter lowers the rate of infection as compared to a urethral catheter.

A suprapubic catheter (SPC) is a hollow, flexible tube used to drain urine from the bladder and is inserted into the bladder through an incision in the abdominal wall. It is held in place by a balloon inflated in the bladder and attached to a urine collection bag.

[1] Joint Commission Resources, Assessing Hospital Staff Competence, Joint Commission E-Edition, 2016, https://e-dition.jcrinc.com/MainContent.aspx. Accessed December 21, 2016.

Allegations

On January 21, 2015, OIG received a letter from Senator Mark Warner with complaints about the delivery of care in the CLC. While most of the allegations were related to a specific resident's care, some were about residents' care in general. The complainant alleged:

1. The resident had to go to the Emergency Department (ED) on two separate occasions because CLC staff were not competent and failed to properly care for his suprapubic catheter (SPC).
2. CLC staff often failed to carry out physician orders as written for bladder irrigation for the resident.
3. CLC staff failed to conduct regular checks for well-being of residents.
4. CLC staff failed to conduct regular skin assessments, take vital signs, or obtain weights for residents as required.
5. CLC staff failed to check on the resident during mealtimes and to provide meal set-ups and dining assistance.
6. CLC staff failed to offer the resident morning ("a.m.") care.
7. CLC unit staff left the building during their shifts for 45 minutes to an hour at a time, often during mealtimes, regardless of whether residents could get to their food.
8. During shift change and lunch, staff made residents wait to be helped back to bed and cleaned.
9. CLC staff who worked on weekends were not keeping the same daily routines for the residents.
10. Residents were not informed of special events or cookouts.
11. The resident had to pay the barber for a shave.
12. CLC resident call lights were ignored.
13. CLC staff left medications at the resident's bedside, ignored the resident's need to be cleaned after bowel incontinence, and tried to give the resident a second dose of medications while the original dose was still sitting on his bedside table.
14. CLC staff were not routinely cleaning or sanitizing reusable medical equipment on the units as required.
15. CLC staff failed to timely provide the appropriate specialty mattress to the resident.

Scope and Methodology

We conducted our review from February 20, 2015 through May 16, 2016. We made a site visit June 16–18, 2015. We interviewed the complainant; the resident; CLC providers, managers, and staff; facility leadership; the Resident Council President; and Environmental Services and Biomedical staff. We also conducted unannounced dining room and general unit environment inspections.

We reviewed a previous allegation made by the complainant to the OIG Hotline in 2014 and the facility's response on January 15, 2015. We reviewed community hospital visits documentation for April, June, and December 2013, and the resident's VHA electronic health record (EHR). We reviewed documentation of resident rounds and interdisciplinary care plans for 20 randomly selected residents for May 17–23, 2015. We also reviewed resident EHR skin care documentation, vital signs, weights, and routine care for the month of May 2015. We reviewed CLC manager round checklists for 1 day per week from August 26, 2014 through June 15, 2015.

We reviewed VA/VHA handbooks and directives, facility policies and procedures, and nursing competency validation records for 13 CLC staff. We reviewed mattress request documentation, January–June 2015 cleaning schedules, June 2014–May 2015 Resident Council meeting minutes, and January–April 2015 CLC staff meeting minutes.

We reviewed medical literature to evaluate the relationship between catheter irrigation and occurrence of infections and found that medical research shows no clear link between catheter irrigation and a decrease in SPC complications.

Two VHA policies that we cited in this report have expired:

- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009, (expired February 28, 2014)
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers*, August 13, 2008, (expired August 31, 2013)

We considered both policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[2] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[3] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[4]

We substantiate allegations when the facts and findings support that the alleged events or actions took place. We do not substantiate allegations when the facts show the allegations are unfounded. We cannot substantiate allegations when there is no conclusive evidence to either sustain or refute the allegation.

[2] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[3] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document,* June 29, 2016.
[4] Ibid.

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.

Patient Case Summary

The resident was a male in his mid-fifties with a chronic neurological disorder and a neurogenic bladder.[5] The resident was essentially bedridden.

In 2013, while still living at home, the resident was admitted to a non-VA community hospital for treatment of a UTI. An SPC was placed at the resident's request because of frequent UTIs, and because he no longer wanted to do self-catheterization. Twice in the next 8 months, he was re-admitted to the same non-VA hospital for UTI and urosepsis.[6] After the third admission, the resident was transferred to an acute care unit at the facility from the non-VA community hospital and 6 days later, he was admitted to the facility CLC for long-term care. The resident requested admission to the CLC as he felt his declining medical condition was too challenging for home care.

Following are pertinent changes in the resident's condition related to his SPC during his CLC stay from the time of admission (month 1) through the next 11 months:

- Month 4, a urologist was consulted because the resident complained of pain and felt that the SPC was not correctly placed. The urologist performed a cystoscopy, removed two bladder stones, and confirmed that the SPC was in excellent position.
- Month 5, the urologist ordered SPC irrigations every 48 hours.
- Month 6, the resident's primary care provider increased the frequency of irrigation to every 24 hours.
- Month 8, the resident complained of pain around the SPC, and the SPC could not be irrigated. The resident was sent to the ED and was found to have a UTI and bladder stones adhered to the SPC. The resident was treated with antibiotics, and the urologist changed the catheter and ordered daily irrigations of the catheter with oxychlorosene[7] solution.
- Month 9, the resident had abdominal pain, and the SPC could not be irrigated. He was sent to the ED, and staff in the ED were able to unblock the SPC with flushing. A urine culture was obtained. The urine culture report showed multiple types of bacteria, and the primary care provider ordered a prophylactic antibiotic treatment regimen.

[5] Neurogenic bladder is the name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem. http://www.urologyhealth.org/urologic-conditions/neurogenic-bladder. Accessed November 6, 2015.
[6] Urosepsis is a severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream. Urosepsis can be life threatening if it is not treated immediately. http://www.sw.org/HealthLibrary. Accessed November 10, 2015.
[7] Oxycholorosene is a stabilized organic complex of hypochlorous acid used as a topical antiseptic in the treatment of localized infections. http://www.merriam-webster.com/medical/oxychlorosene. Accessed September 30, 2015.

- Month 11, the resident was seen by an Infectious Disease physician because of a history of chronic UTIs. The physician reported the resident had an asymptomatic colonization of bacteria in the genitourinary tract[8] and recommended no further antibiotic treatment.

Inspection Results

Allegation 1. Staff Competency

We substantiated that CLC staff did not consistently have competency validations completed for care of residents with an SPC. However, because the resident's indwelling SPC predisposed him to bladder infections and stones, we could not conclude that lack of staff competence in the care of SPCs contributed to the resident's ED visits and UTIs after admission to the CLC.

In a previous complaint to the OIG in September 2014, a complainant alleged that the resident had a UTI because CLC staff used nonsterile technique when cleaning and irrigating the resident's SPC. In response to the complaint, facility managers responded that all CLC licensed staff would receive retraining and competency validation on the care of SPC. We evaluated the merits of the current allegation in part by examining evidence of whether this training had been accomplished.

We reviewed training and competency documentation for 13 CLC nursing staff (4 Registered Nurses and 9 Licensed Practical Nurses) for fiscal years 2013 through 2015. Our review of the training and competency validation records showed the following:

- All 13 employees had completed training for insertion, replacement, and irrigation of SPC.
- The competency validation record did not include irrigation of an SPC catheter as a required skill.
- None of the 13 competency validation records reflected the appropriate validation method (demonstration) for insertion of an SPC.
- All 13 records were missing at least some of the required signatures, including employee, validator, and supervisor.

We could not conclude that CLC staff were uniformly competent in SPC care; but could not determine that this reflected an absence of competence on the part of the nursing staff. Further, it would be difficult to establish that a lack of competence, even if demonstrated, led to UTIs as this is a recognized complication of SPCs.

[8] Genitourinary tract is the system of organs comprising those concerned with the production and excretion of urine and those concerned with reproduction. Merriam-webster.com. Accessed September 30, 2015.

Allegation 2. Physician Orders

We substantiated that CLC staff failed to carry out some physician orders for SPC irrigation for the resident as written. Our review of the resident's EHR documentation showed that catheter irrigations were not completed as ordered.

We reviewed EHR documentation of the resident's irrigation orders and Bar Code Medication Administration[9] for a 14-week timeframe in 2014 to evaluate whether physician orders for the resident's catheter irrigation were followed. We found orders for the first 7 weeks of the 14-week time frame for daily flushing of the SPC. Bar Code Medication Administration documentation showed that irrigation was only done every other day as had been previously ordered.

Allegation 3. Checks on Well-Being of CLC Residents

We substantiated that CLC staff did not consistently document that resident checks for well-being were completed as required. In the records we reviewed, hourly rounds were not documented as having been completed approximately 15 percent of the time.

Facility policy required that CLC staff perform observational rounds hourly[10] and document them in CareTracker.[11] CLC nursing leadership told us that nursing rounds were expected to be performed every 30 minutes.

We randomly selected 20 residents (10 from each CLC neighborhood) and reviewed CareTracker documentation of rounding for the week of May 17–23, 2015. Seventeen of 20 (85 percent) residents' records contained documentation that hourly rounds were performed during the shift, and 3 had no entries. We also reviewed the CLC Manager Observation Rounds checklist for a shift for 1 day per week from August 26, 2014 through June 15, 2015, and found that CLC Nurse Managers (NM) documented that staff performed rounds on 40 of 46 (87 percent) of the checklists.

Allegation 4. Skin Assessments, Vital Signs, and Weights

Skin Assessments. We substantiated that CLC staff failed to document monthly skin assessments for the resident for 4 of 18 months. However, the resident did not have complications related to poor skin care, such as pressure ulcers.[12]

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[9] Barcoded Medication Administration is an inventory control system that uses barcodes to prevent human errors in the distribution of prescription medications at hospitals. SearchHealthIT.techtarget.com. Accessed September 30, 2015.
[10] Memorandum 118-37, *Nursing Safety Program*, April 2015.
[11] CareTracker is a computer based software system used by long-term care facilities for documentation of care and to improve their quality of their care, reduce risk, and increase reimbursement. http://www.cerner.com/Solutions/Extended_Care_Providers/Long_Term_Care/CareTracker/ . Accessed January 19, 2017.

Medical research shows that skin assessments are best practices in the prevention of pressure ulcers, especially of patients in nursing homes who are at higher risk for skin breakdown.[13] Facility policy required a skin assessment to be performed on admission, when changes occurred in the patient's condition, and upon readmission to the unit.[14] Monthly skin assessments were required for patients with initial Braden Scale[15] scores of less than 18 and weekly for all patients with pressure ulcers. The CLC NM told us that, although not required by facility policy, CLC staff were expected to do weekly skin care checks.

The resident's care plan[16] identified the resident as being at high risk for skin breakdown. CLC staff consistently documented a Braden Scale score at a level that indicated the resident should have monthly skin assessments.

We reviewed the resident's EHR for evidence of skin assessment documentation for an 18 month timeframe. EHR documentation reflected that 14 (78 percent) of the expected 18 monthly skin assessments were completed.

To further evaluate skin assessment documentation, we randomly selected 20 CLC residents and reviewed their respective care plans and EHR documentation of skin assessments for a month in 2015. We found that skin assessments were not documented consistently for the residents. For weekly skin assessment documentation, 29 of 80 (36 percent) were completed. For monthly skin assessment documentation, 16 of 20 (80 percent) were completed.

Vital Signs. We did not substantiate that CLC staff failed to take the resident's vital signs (pulse, blood pressure, temperature, respiration, and pain level) as required. Facility policy that was in effect for the time frame at issue provided for monthly documentation of vital signs for CLC residents unless changes in the residents'

[12] Pressure ulcers are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. http://www.mayoclinic.org/diseases-conditions/bedsores/basics/definition/con-20030848. Accessed January 7, 2016.
[13] Agency for Healthcare Research and Quality, *Pressure ulcer prevention and treatment protocol* http://www.guideline.gov/content.aspx?id=36059. Accessed April 5, 2016.
[14] Memorandum 118-04, *Pressure Ulcer Management and Prevention (PUMP),* June 8, 2012. This policy was in effect during the time of the events discussed in this report.
[15] The Braden Scale is used for predicting pressure sore risk and is one of the most widely used tools for predicting the development of pressure ulcers. Summing risk items yields a total overall risk, ranging from 6–23. A score from 0–18 indicates risk for pressure ulcer development.
[16] The care plan is the road map for the entire team to communicate an individualized, interdisciplinary plan to meet the physical, spiritual, and psychosocial needs of the resident. Goals are resident-centered and reflect the resident's preferences, needs, and habits. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008. This Handbook was scheduled for recertification by the last working day of August 2013 and has not yet been recertified.

conditions prompted more frequent reassessment.[17] Vital signs were documented for the resident 16 of 17 months (94 percent).

We also evaluated EHR documentation of May 2015 vital signs for the 20 CLC residents we had previously randomly selected. We found that vital signs were documented for 19 of 20 (95 percent) of these residents.

Weights. We did not substantiate the allegation that the resident was rarely weighed. The resident was weighed monthly, his weight was evaluated, and his food preferences were addressed.

We reviewed documentation for a 17-month time frame and found the resident's weight was documented 16 of 17 months (94 percent). Nine monthly nutrition assessments were completed for a similar timeframe. EHR documentation reflected that fluctuations in the resident's weight were noted, and efforts were made to address the resident's food preferences and weight changes.

We further evaluated EHR documentation of weights for the 20 randomly selected CLC residents during May 2015. Weights were documented for 18 of 20 (90 percent) residents.

Allegation 5. Meal Set-Ups and Dining Assistance

We did not substantiate the allegation that the resident's meal set-ups and dining assistance needs were not being addressed.

When we interviewed the resident while we were onsite, he denied problems with receiving assistance with meals.

Allegation 6. Morning Care

We did not substantiate the allegation that the resident was never "offered a.m. care." However, we found that documentation of morning care provided to the resident was inconsistent.

The resident's care plan reflected that he liked to get up mid-morning. CLC staff did not consistently document that morning care was offered; however, we reviewed 18 months of the resident's EHR, and found documentation that morning care was offered but declined on 20 days.

Allegation 7. Staff Breaks

We could not substantiate that CLC staff left the building during their shifts for 45 minutes to an hour at a time, often during mealtimes. Managers were not aware of

[17] Memorandum118-32, *Documentation of Patient Care,* December 2012.

this occurring, and we did not observe this while onsite. However, we learned that prior to April 2015, certified nursing assistants were all taking lunch breaks at the same time.

A CLC NM told us that when NMs realized all of the nursing assistants were taking breaks at the same time, changes were made to make sure staff were available at meal times. As of April 2015, staff break assignments were staggered, and staff were permitted 30 minutes for lunch.

Allegation 8. Shift Changes and Lunch Coverage

We did not substantiate the allegation that during shift change and lunch time the staff made CLC residents wait to be cleaned and/or assisted back to bed. The CLC NM stated that the practice in the CLC is that during shift changes, residents' care needs come first. A review of 11 months of Resident Council[18] meeting minutes did not identify that residents had ongoing complaints about staff care during shift changes or mealtimes.

Allegation 9. Weekend Routines

We could not substantiate the allegation that staff who worked on weekends were not keeping the same daily routines for residents; however, we found that documentation of ADL care for CLC residents on weekends did not meet the CLC goal of 90 percent.

Eleven months of Resident Council meeting minutes documentation did not identify ongoing patterns of problems with care on the weekends.

To further evaluate the allegation of disparity of care on weekends, we reviewed CareTracker documentation of ADLs for the week of May 17–23, 2015 for the same 20 residents, and compared the shift entries completion rate for Monday through Friday to that of the weekend. We found that 243 of a possible 300 (81 percent) shift entries were completed for the weekday shifts and 84 of a possible 120 (70 percent) shift entries were completed for the weekend shifts. The CLC goal of 90 percent completion of ADL documentation was not met for weekday or weekend shifts; however, CLC managers had implemented actions to improve documentation prior to our visit.

Allegation 10. Special Events

We did not substantiate the allegation that residents were not informed of special events and cookouts.

We reviewed Resident Council meeting minutes for 11 months, and residents who attended the meetings did not identify this as a problem. We also noted postings throughout the unit common areas of upcoming recreational events.

[18] Resident Councils refer to monthly meetings of CLC residents, staff, volunteers, and family to discuss issues, provide education, and voice ideas. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

Allegation 11. Shaving Residents

We substantiated that at the time the allegations were submitted, CLC residents had to go to the facility barbershop to be shaved and pay for the service. However, this practice has been changed and the nursing staff shave the residents without fees attached.

A CLC NM told us that residents previously had to go to the barber for a shave and that many residents enjoyed this experience. However, she reported that this practice changed, and nursing staff are now expected to shave residents as a part of daily care if needed. Observing whether the residents had been shaved was also a part of the daily CLC Manager Observation Rounds checklists.

Allegation 12. Call Lights

We substantiated the allegation that CLC resident call lights were not answered timely. Specifically, the complainant alleged that call lights were often turned off without being answered, and that staff did not identify themselves when answering.

Resident Council meeting minutes for 8 of 11 months reviewed reflected residents' ongoing concerns with staff responsiveness to call lights. We interviewed the Resident Council President, who stated that it took staff about 15 minutes to respond to call lights and on occasion longer.

CLC NMs told us the goal was for staff to go to a resident's room within 2 minutes after the resident called for assistance. The call-light system that was in use at the time of our visit in June 2015 had the ability to generate reports of response times. Data from June 2014 to June 2015 showed a response time of less than 2 minutes. The response time was determined from the time the call light was turned off at the nursing station and not from when staff went to the resident's room, making response time data invalid. While we were onsite, Biomedical Service staff made changes to the system so that the only way to turn off the call light was from a resident's room. The system was tested in our presence and appeared functional.

Allegation 13. Hygiene and Medication Management

We could not substantiate that a nurse left medications at the resident's bedside, ignored the resident's need to be cleaned, and later tried to give the resident another dose of medications that were still sitting at his bedside. The complainant did not include specific dates or times when these events allegedly occurred. The resident could not recall such occurrences, and facility management was not aware of incidents of this nature.

Allegation 14. Reusable Medical Equipment Cleaning

We did not substantiate the allegation that CLC staff failed to routinely clean or sanitize reusable medical equipment on the units as required.[19] Facility managers demonstrated that a process was in place for routine cleaning of rooms and equipment.

Facility Environmental Management Service (EMS) is responsible for cleaning all durable medical equipment monthly. EMS staff provided us with cleaning schedules for all of the reusable medical equipment in the resident rooms and common areas from January 2015 to June 2015. During our site visit, we conducted environmental rounds and observed that the units were generally clean, well maintained, and did not contain dirty or unsanitary durable medical equipment.

Allegation 15. Procurement of Special Care Mattress

We substantiated the allegation that facility staff did not obtain an appropriate mattress for the resident in a timely manner. The table below reflects the chronology of the status of the resident's mattress requests.

Table. Chronology of Resident's Mattress Status

Date	Action
Admission: Week 1	Order placed for low air loss mattress.
Week 3	Resident received a low air loss mattress.
Week 7	Resident's low air loss mattress is working with no problems.
Week 10	Mattress not functioning properly. Nurse to contact provider for another type of mattress.
Week 14	Resident requested a new air mattress.
Week 34	Resident expressed extreme discomfort from mattress.
Week 38	Resident expressed desire to change current air mattress. Resident was shown and agreed to new bed and mattress.
Week 47	Provider note documented a new mattress was ordered for resident.
Week 50	Resident inquired about new mattress status.
Week 52	Mattress was delivered to resident.

Source: VA OIG Analysis of EHR Documents

[19] Reusable medical equipment is any medical equipment designed by the manufacturer to be reused for multiple patients. VHA Directive 2009-004, *Use and Reprocessing Of Reusable Medical Equipment (RME) In Veterans Health Administration Facilities,* February 9, 2009. This VHA Directive expired February 28, 2014, and had not yet been updated.

Reasons for the delay in obtaining a mattress the resident was satisfied with were difficult to ascertain and probably multifactorial. Facility policies in place during the time of the resident's request for a new mattress required the placement of an electronic consult, entitled "Wound/Ostomy/Continence Care," to request new mattresses or beds.[20] We found no evidence that a consult was placed for the resident. Other reasons we were given for the delay included that mattresses were ordered but delivered to the wrong area, and the wound care specialist position was vacant during this time.

Conclusions

The resident was in a difficult and complicated situation. He had many medical and personal care needs that could not be managed in the home environment and requested admission to a CLC. He had UTIs and complications from an SPC prior to admission to the CLC, and typical of the nature of an indwelling SPC, problems with UTIs and bladder stones persisted after he was in the CLC.

In general, it was not likely that the resident's ED visits and problems with the SPC were related to SPC irrigation frequency or techniques. However, we did identify inconsistencies in documentation of staff competency in SPC care and documentation of care rendered, including following physician orders, CLC resident checks for well-being, skin assessments, morning care, and ADL assistance on weekends. We also confirmed that facility policy was not followed for obtaining and maintaining special care beds and mattresses.

We identified that resident call lights could be turned off at the desk without staff checking on the resident. Biomedical staff reconfigured the system while we were onsite so that call lights could only be shut off at the residents' bedsides.

Many of the concerns identified in the allegations had already been identified and addressed by CLC managers prior to our visit in June 2015, such as staggering of staff break assignments, documentation of ADLs, and performing resident well-being checks. While we did find inconsistent documentation of care delivery and problems with obtaining a special care mattress timely, we found no evidence of ongoing problems with residents not getting assistance or care as needed.

[20] Hampton VA Medical Center Memorandum 118-03, *Special Care Beds and Mattresses*, July 31, 2014. *See also*, Hampton VA Medical Center Memorandum 118-03, *Special Care Beds and Mattresses*, May 4, 2010, which was in effect during a portion of the timeframe discussed in this report. Both documents required an electronic order and submission of a consult on a specific template for the bed/mattress request entitled "Wound/Ostomy/Continence Care."

Recommendations

1. We recommended that the Facility Director ensure that Community Living Center staff have competency assessments and validations completed for care of residents with suprapubic catheters, including catheter insertion and irrigation.

2. We recommended that the Facility Director strengthen processes to ensure that Community Living Center staff carry out physician orders for bladder irrigation and monitor compliance.

3. We recommended that the Facility Director strengthen processes to ensure that Community Living Center staff conduct and document resident checks for well-being, skin assessments, and activities of daily living assistance as required and monitor compliance.

4. We recommended that the Facility Director strengthen processes to ensure that procedures are followed for obtaining special care beds and mattresses.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: February 28, 2017

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

Subj: Healthcare Inspection—Patient Care Concerns at the Community Living Center, Hampton VAMC, Hampton, Virginia

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10E1D MRS Action)

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

2. If you have further questions, please contact Lisa Shear, QMO, at (919) 956-5541.

MARK E. SHELHORSE, MD
Acting Network Director, VISN 6

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 27, 2017

From: Director, Hampton VA Medical Center (590/00)

Subj: Healthcare Inspection—Patient Care Concerns at the Community Living Center, Hampton VAMC, 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 the 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 recommendation, feel free to call me at (757) 722-9961, extension 3100.

Stephen D. Black, MS, PT, VHA-CM
Interim Medical Center Director

Appendix B

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 ensure that Community Living Center staff have competency assessment and validation completed for care of residents with a suprapubic catheter, including catheter insertion and irrigation.

Concur

Target date for completion: September 2016

Facility response:

July 2016 - the CLC Certified Wound Care Specialist trained 100 percent of CLC staff on suprapubic catheter care.

August 2016 - CLC staff received an additional training by the CLC Clinical Nurse Leader Candidate concerning the care and irrigation of suprapubic catheters.

September 2016 - CLC hired a Nurse Clinician/Educator who updated the suprapubic catheter initial and annual competencies for FY 2017. Competency re-training will be provided annually to 100 percent of licensed staff to include insertion, irrigation and appropriate documentation in CPRS. Training includes a hands-on return demonstration. Completion of the in-service is recorded in TMS for tracking.

OIG Comment: Based on information provided, we consider this recommendation closed.

Recommendation 2. We recommended that the Facility Director ensure that processes be strengthened to ensure that Community Living Center staff carry out physician orders for bladder irrigation and monitor compliance.

Concur

Target date for completion: April 22, 2017

Facility response:

August 2016 - Licensed staff were retrained on carrying out physician orders for bladder irrigation through return demonstration. Ongoing compliance has been monitored by monthly random chart audits verifying that physician orders regarding bladder irrigation

were carried out and documented as ordered. For 2017, the Nurse Clinician/Educator has implemented an additional in-service through TMS.

Recommendation 3. We recommended that the Facility Director ensure that processes be strengthen to ensure that Community Living Center staff conduct and document resident checks for well-being, skin assessments, and activities of daily living as required and monitor compliance.

Concur

Target date for completion: July 3, 2017

Facility response: 100 percent of staff was retrained on documentation in Care Tracker. Additional buttons were added to Care Tracker to monitor check/change and personal grooming. Initial and annual competency validation records were updated to reflect the competency requirement. Monitoring is accomplished through random audits of the Care Tracker system with follow up for individual staff if needed. Education is re-enforced during unit orientation concerning documentation of the activities of daily living in the Care Tracker by the MDS Coordinator.

CLC hired a Certified Wound Care Specialist for Long Term Care (March 2016). Staff is continuously educated and trained on Pressure Injury Prevention, documentation and individualized interventions for our residents. This wound specialist rounds on Residents.

Residents and caregivers are educated on Pressure Injury Prevention upon admission, as well as with any changes in the Resident's condition.

The Resident's skin is assessed upon admission, transfer, change of condition and discharge. Individualized pressure injury prevention interventions are utilized and assessed at intervals for effectiveness.

The Resident's skin is inspected daily for any indication of skin breakdown. Staff use the 24 Hour Pressure Injury and Skin Communication Tool to document skin inspections every tour.

Recommendation 4. We recommended that the Facility Director strengthen processes to ensure that procedures are followed for obtaining special care beds and mattresses.

Concur

Target date for completion: April & November 2016

Facility response:

CLC purchased a supply of low air loss mattresses, and new beds with pressure redistribution surfaces. Specialty surfaces are placed after assessment from the

Certified Wound Care Specialist. If it is determined that a different specialty bed or mattress is needed, it is ordered through a vendor and delivered to the unit within 24 hours.

OIG Comment: Based on information provided, we consider this recommendation closed.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Lauren Olstad, LCSW, MSW Team Leader Darlene Conde-Nadeau, ARNP, MSN Martha Kearns, MSN, FNP Carol Torczon, ACNP, MSN Thomas Wong, DO

Appendix D

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