DEPARTMENT OF VETERANS AFFAIRS

# OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center

## Pennsylvania

HEALTHCARE INSPECTION | REPORT #19-06391-119 | JUNE 11, 2020


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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations related to deficiencies in nursing care in the Community Living Center (CLC) at the Coatesville VA Medical Center (facility), Pennsylvania.

The OIG reviewed allegations submitted in September 2018 regarding improper nursing care at the facility's CLC. The allegations involved 12 patients and included issues with nursing medication administration, answering call bells, patient falls, and nursing wound care processes.[1] While the OIG substantiated an allegation associated with medication administration and confirmed that specific patients experienced falls or developed wounds or both, the OIG was unable to determine that the causes for these falls and wounds were due to alleged inadequate or deficient nursing care.[2]

During the review and site visit, the OIG found nursing documentation and care deficiencies that involved patients from all three CLC units and identified concerns with other facility processes. The deficiencies included inconsistent documentation of nursing compliance with medication order instructions, pain assessments and pain management care plans, inconsistent documentation of fall prevention measures, and post-fall assessments, as well as inaccessible and unanswered patient call bells.

The OIG reviewed 18 patients' electronic health records (EHRs) for medication administration and determined that 5 of the 18 patients had specific nursing instructions for medication administration in the provider orders.[3] Of the five, the OIG identified four instances involving three patients when nursing staff did not consistently document information demonstrating compliance with the provider's medication administration instructions. Although it is unclear why this occurred, the nurses' failures to document and possibly perform the ordered medication related instructions may have resulted in the provider not having enough information to accurately order changes in the patient's medications, thus increasing the risk for poor patient outcomes. One example of inconsistent medication instruction documentation involved a patient whose provider ordered medication to help with the patient's dementia symptoms. Though the

[1] The allegations involved 12 patients. The allegations concerning five patients were related to falls, five patients were related to wound care, and two patients were related to medication administration.

[2] Medication administration includes verifying and reviewing medication orders; identifying the correct patient; assessing the patient and giving medications according to orders; observing the patient for therapeutic and untoward effects; and accurately documenting the administration (giving) of the medication and data related to that administration.

[3] Initially, 12 patients were identified in the allegations. During site visit rounds, OIG staff identified eight additional patients with nursing care deficiencies. However, two patients were excluded from further review as they were no longer at the facility. Therefore, a total of 18 patient's EHRs were reviewed for medication administration, pain assessment, and pain management.

provider's orders were to hold giving the medication to the patient if systolic blood pressure was less than 100, blood pressure measurement documentation was missing for 12 of 40 (30 percent) doses given by the nurses. Therefore, the provider did not have accurate information to assess whether the medication produced an adverse effect, such as a low blood pressure, and could not determine whether the dosage was too high or low. In addition, inconsistent documentation of pain assessments and pain care plans was identified, which again may have affected the provider's knowledge of the patient's pain and influenced medication dosing.

To review patient fall concerns, OIG staff evaluated the rounding processes and documentation of fall prevention measures as well as post-fall documentation. The facility rounding process was performed hourly by staff and included assessment and documentation of fall prevention measures such as lowered bed rails and bed position. Of the 33 rounding forms reviewed by OIG staff, 22 did not contain complete assessment information. OIG staff also evaluated and compared the number of reported falls in the three CLC units and the number of post-fall assessments in the patient's EHRs. Although the facility reported 75 falls, 32 did not have documented post-fall assessments as required by facility policy.

OIG staff observed call bells that were at times inaccessible to patients, and identified facility CLC Community Meeting minutes that described incidents in which facility staff did not answer call bells.[4] A staff member informed the OIG that, from their understanding, the facility addressed this by disabling the function to turn off the call bell at the nursing station so staff would have to go into a patient's room to disengage the alarm (ensuring the alarm was answered); however, while on-site, the OIG observed a patient use the call bell and a nurse responded by contacting the patient through an intercom system broadcasted in the patient's room rather than going into the patient's room to turn off the alarm and check on the patient.

During rounds of the CLC units and review of patient EHRs, the OIG found inconsistent documentation of wound prevention nursing processes including patient weight and skin integrity measures, such as turning patients while in bed, and toileting. Documentation of weight within eight hours of admission was not found for 9 of 45 patients admitted between September 1, 2018, and February 28, 2019. Of those patients whose initial weight was taken, there was no documentation that 17 of 32 weights were retaken in accordance with Veterans Health Administration (VHA) and facility policy when patients experienced a weight gain or loss during the same period. Upon reviewing rounding documentation collected from February 18 through February 20, 2019, and on March 12, 2019, the OIG found that 32 of 33 forms for 24 patients at risk of or with wounds did not have documentation by nursing staff of turning or toileting or both, as required by the facility. The OIG could not establish why nurses did not consistently document on the rounding forms. Without consistent documentation, the measures to reduce

[4] Community Meetings are monthly CLC resident meetings.

risks of wound development or worsening of an existing wound may not be accurately developed.

The OIG identified other findings not specifically related to the allegations, including the failure to follow the approval procedure for a new hourly rounding form, and ineffective implementation of a new nurse rounding procedure, incomplete fact-finding reviews, inconsistent facility committee documentation, and inoperable CLC safety equipment.

The Geriatric and Extended Care Director and CLC nurse managers replaced an approved nursing practice procedure for performing rounds with a new rounding form in an effort to improve patient care outcomes.[5] However, the new form did not have an approved procedure that would provide guidance and instruction on the use of the form. Although nurse managers reported training was provided, the OIG found that staff were not following the directions given during the training, increasing the chance of incorrectly completing the forms.[6]

The OIG determined that 10 of the 13 CLC fact-findings reviewed did not identify actions to resolve issues or contain documentation that the identified issues were sent on for further review as facility supervisors were not trained on the fact-finding process. A facility leader told the OIG that facility supervisors received training on fact-finding reviews in November 2018. If facility leaders and staff are unaware of the prevalence of events and complaints because fact-findings are not followed to resolution or identified and tracked as needing further review, more structured reviews that might be indicated by the fact-findings (such as root cause analyses or administrative investigations) may not be conducted.

The OIG found that the Executive Leadership Board and the Geriatric Extended Care Executive Council did not consistently document resolution of issues and, for the Executive Leadership Board, recommendations. OIG staff found no clear reason why resolutions and recommendations were not consistently documented. In addition, a communal tub lift and emergency Hoyer lift intended to provide safe transfer of patients was inoperable during both site visits.

One possible contributing factor for the identified deficiencies was an outdated facility staffing methodology policy that did not follow all VHA staffing methodology requirements regarding calculating adequate staffing levels. VHA updated the staffing methodology policy on December 20, 2017. The updated policy added "[s]itters performing direct patient care" (in proportion to assignment) to the list of staffing categories included in the calculations for determining the nursing hours per patient day.[7] Failure to include the sitters performing direct patient care in

[5] The facility used rounding forms to document required hourly encounters and interventions.

[6] The training discussed the "4 P's of Hourly Rounding," identified as personal needs, position, placement, and prevention of falls. The training addressed the importance of completing and documenting each hourly task and highlighted that the process required the form be placed inside each patient's closet door to ensure staff entered the patient's room.

[7] VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017. A sitter provides direct patient observation.

calculating the nursing hours per patient day could cause an underestimation of the number of staff needed to provide patient care. The facility staffing methodology policy did not include the 2017 VHA addition of "[s]itters performing direct care" as part of the staffing calculations. Without accurate information to incorporate into the staffing projections and plans, it would be challenging to ensure adequate staff to provide safe and effective patient care.

The OIG made nine recommendations related to reviewing nursing processes and ensuring required documentation of medication administration, pain assessments and pain management plans, fall prevention assessments, post-fall assessments, use of call bells, and wound prevention processes; ensuring new rounding forms are in compliance with the facility standard operating procedure for policy approval and monitor compliance; establishing fact-finding review processes that consistently track and resolve issues; ensuring leadership committees track and monitor issues to resolution; ensuring CLC unit equipment used for transfers is operational; and ensuring that the staffing policy and calculations follow VHA requirements.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the OIG's recommendations and submitted acceptable action plans (see appendixes C and D). Based on information provided, the OIG considers recommendations 6 and 9 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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# Contents

# Abbreviations

| | |
|---|---|
| CLC | Community Living Center |
| EHR | electronic health record |
| GEC | geriatrics and extended care |
| OIG | Office of Inspector General |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations related to deficiencies in nursing care in the Community Living Center (CLC) at the Coatesville VA Medical Center (facility), Pennsylvania.

## Background

The facility, part of Veterans Integrated Service Network (VISN) 4, includes two community based outpatient clinics located in Newtown Square and Spring City, Pennsylvania. From October 1, 2017, through September 30, 2018, the facility served 19,250 patients and operated 302 inpatient and residential beds, which included 28 medical beds, 148 domiciliary beds, and 126 CLC beds with a hospice unit. Veterans Health Administration (VHA) categorizes the facility as Level 3, low complexity.

### Community Living Centers

VHA CLCs provide short and long-term care to residents who require assistance with skilled nursing and activities of daily living. According to VHA, the CLC's mission is to promote excellent health care and quality of life by providing person-centered services in a home-like environment.[8] CLC interdisciplinary teams address a patient's required level of functional support in a care plan completed through individualized interviews and assessments.[9] The functional support needs include skilled nursing such as wound care and administration of medication, and activities of daily living such as eating, grooming, and bathing.[10]

The facility CLC has three operational units: a unit for long-term stay residents; a locked unit for residents with wandering behaviors, acute dementia, and psychiatric issues; and a hospice unit.[11]

[8] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. This handbook was scheduled for recertification on or before the last working day of August 2013, but has not been recertified.

[9] VHA Directive 1142.01. CLC interdisciplinary teams meet for the purposes of care and treatment planning and "the following staff must be in attendance: medical provider, nurse, dietician, social worker, and therapeutic recreation member."

[10] VHA Handbook 1142.01.

[11] Hospice is a "program designed to provide palliative care and emotional support to the terminally ill." https://www.merriam-webster.com/dictionary/hospice. (The website was accessed on May 3, 2019.)

## Allegations, Related Concerns, and Other Findings

On September 27, 2018, and September 28, 2018, the OIG received allegations regarding deficiencies in nursing care at the facility's CLC. The allegations involved 12 patients and included issues with nursing medication administration, answering call bells, and nursing wound care processes.[12]

On November 29, 2018, the Office of Healthcare Inspections completed a review of the allegations and on January 2, 2019, opened an inspection. While reviewing the 12 patients' electronic health records (EHRs), OIG staff identified issues with nursing documentation of fall prevention and post-fall assessments (see appendix A).

As a result of an on-site unannounced visit February 18–21, 2019, review of patient EHRs, and review of relevant facility documentation such as policies and rounding forms, the OIG identified the following concerns related to the allegations:

- Inconsistent documentation of compliance with medication order instructions by nursing staff.[13]
- Inconsistent documentation of pain assessments and management by nursing staff and the CLC interdisciplinary team.[14]
- Inconsistent documentation of fall prevention/post-fall assessments and use of fall prevention measures by nursing staff.
- Inconsistent documentation of wound prevention processes by nursing staff.

Based upon these concerns and the site visit, the OIG also identified eight additional patients whose EHR documentation and care warranted further review.

In addition, the OIG identified other findings not directly related to the allegations but affecting patient care:

- Failure to follow the facility's approval process, and ineffective implementation of a new rounding procedure.

[12] Medication administration includes verifying and reviewing medication orders; identifying the correct patient; assessing the patient and giving the medications according to orders; observing the patient for therapeutic and untoward effects; and accurately documenting the administration (giving) of the medication and data related to that administration. Through review of the allegations, the OIG determined 12 patients were relevant to this hotline inspection: five with falls, five with wounds, and two with medication administration concerns. During the OIG staff site visit, eight additional patients were identified with possible medication issues. The OIG review for medication assessment and compliance included 10 of the original 12 patients (two were not reviewed as the patients were not currently in the facility) and the eight additional patients identified during rounds.

[13] Nursing staff includes licensed nurses and any staff trained to perform direct nursing or personal care, such as nurses' aides and health care technicians.

[14] An interdisciplinary team includes providers, nursing staff, social work staff, rehabilitative staff, and other facility staff as assigned, such as pharmacists.

- Incomplete facility fact-finding reviews.
- Inconsistent committee documentation.
- Inoperable CLC safety equipment.

# Scope and Methodology

The OIG initiated a healthcare inspection on January 2, 2019, and conducted an unannounced site visit February 18–21, 2019. OIG staff conducted an additional announced site visit on March 12, 2019.

The OIG interviewed a complainant, the Facility Director, Chief of Staff, Associate Director for Patient Care Services, Directors of Quality Improvement and Geriatrics and Extended Care Services (GEC), quality improvement staff; a physician assistant; CLC nurse managers and nursing staff; and other CLC staff knowledgeable about nutrition services, occupational therapy, recreation therapy, pharmacy, and social work. In addition, the OIG consulted with the VHA Office of the Medical Inspector.

The OIG reviewed relevant VHA and facility policies and procedures, nurse assessment documents and schedules, committee meeting minutes, internal and external reviews, human resources documents, and facility data. The OIG completed rounds on the three CLC units during the site visits on February 18-20, 2019, and on March 12, 2019. The OIG also completed EHR reviews of the 12 individual cases brought forward in the allegations and an additional eight patients identified during the inspection rounds.

This report focuses on patient harm in terms of adverse clinical outcomes. Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level of care. The OIG recognized that, in addition to the potential for adverse clinical outcomes, avoidable delays and cancellations associated with the deficiencies discussed in this report might have impacted the convenience and quality of care received.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

# Inspection Results

## 1. Allegations: Deficiencies in CLC Nursing Care

The OIG received multiple allegations regarding deficiencies in nursing care at the facility's CLC, including leaving medications in patients' rooms without ensuring the patients took the medications intended for them, patient falls that could have been prevented or were not addressed by nursing staff, and inconsistent wound care (see appendix A).

The OIG was unable to determine that deficient nursing care resulted in five patient falls as outlined in appendix A based upon the available documentation. One patient reported the fall occurred while getting out of bed to go to the bathroom alone because of a delayed call bell response. However, the OIG was unable to determine whether the call bell had been activated; if it had been activated, how long it was activated before the patient got out of bed; whether nursing staff failed to respond in a timely fashion, and if this caused or contributed to the fall. The OIG was also unable to determine that deficient nursing care resulted in the development or worsening of the wounds for five identified patients due to inconsistent documentation of wound prevention practices.

The OIG substantiated the allegation that a CLC nurse left medication in a patient's room but was unable to determine whether a medication was found in a soda can in a patient's room. Further discussion of medication administration practices can be found below.

### Medication Administration

VHA requires CLCs to implement measures "to reduce the likelihood of intentional or unintentional untoward use of…medications," such as leaving medications unattended.[15]

The substantiated allegation was identified in facility documentation of the incident; however, no information was found regarding the second allegation. Although OIG staff found no evidence that an adverse event occurred in this instance, leaving medication unattended in a patient's room increased the risk of an adverse outcome by allowing a medication meant for one patient to be available to other patients who may have entered the room.

To ensure additional medications were not left in patients' rooms, OIG staff conducted an observation of 35 CLC patient rooms during the February 18 unannounced site visit and did not find any medications left in the rooms or the hallways of the CLC nursing units other than two creams that were left on a bedside table.

[15] VHA Directive 1108.06, *Inpatient Pharmacy Services*, February 8, 2017.

## 2. Related Concerns: Nursing Documentation and Use of a Fall Prevention Measure

While the OIG was unable to determine the validity of many of the allegations due to a lack of information from the complainants or in the patients' EHRs, the OIG identified nursing documentation deficiencies in the CLC related to the allegations. These deficiencies included inconsistent documentation of compliance with medication order instructions; pain assessments and pain management plans; fall prevention and post-fall assessments; fall prevention measures; nursing wound prevention processes; and inconsistent use of the fall prevention measure of answering call bells.

### Inconsistent Documentation of Compliance with Medication Order Instructions

The OIG determined licensed nursing staff did not consistently document the information needed to comply with medication order instructions.

Medication administration is part of a licensed nurse's daily routine. The essential components of medication administration include verifying and reviewing medication orders; identifying the correct patient; assessing the patient to obtain pertinent data; administering the medications according to the orders; observing the patient for therapeutic and untoward effects; and accurately documenting medication administration and data related to that administration.[16] An effective and safe medication management system is dependent on the implementation of these processes.[17]

The OIG identified that 5 of the 18 patients selected for the medication review had specific medication nursing administration instructions. Nursing staff were required to follow these instructions to determine whether the patient should receive a medication or to monitor the patient's reaction to the medication. After reviewing the five patients' EHRs, the OIG found that CLC nursing staff did not consistently document information demonstrating that the nurse had followed or complied with the provider's medication order instructions in four instances involving three patients:[18]

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[16] Huynh, N, et al, Journal of Healthcare Engineering*, Assessment of Nurse Medication Administration Workflow Process*, July 17, 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5058570/. (The website was accessed May 10, 2019.) Hughes RG, editor, *Patient Safety and Quality: An Evidenced Based Handbook for Nurses.* Rockville, MD: Agency for Healthcare Research and Quality(US); April 2008.

[17] The Joint Commission, *Medication Management,* January 1, 2019.

[18] Initially 12 patients were identified in the allegations. During site visit rounds, OIG staff identified eight additional patients with nursing care deficiencies. However, two patients were excluded as they were no longer at the facility. Therefore, in total, 18 patients' EHRs were reviewed for medication administration and pain assessment and management.

- A provider increased Risperidone for a patient with dementia, with special instructions to complete daily blood pressure and heart rate checks prior to administering the medication for the first eight days. The patient received the medication for seven days, however, facility CLC nursing staff documented blood pressure and heart rate for only two of the seven days.[19]
- A different provider ordered Seroquel for a patient with dementia associated with Parkinson's disease and instructed nursing staff to hold medication administration if the patient's systolic blood pressure was less than 100. The patient received 30 scheduled doses, however, 12 (40 percent) lacked documentation of a blood pressure measurement to determine if the systolic blood pressure was appropriate prior to giving the medication.[20]
- Additionally, this provider ordered Rivastigmine for the same patient, with the same instructions to hold giving the medication to the patient if systolic blood pressure was less than 100. Blood pressure measurement documentation was missing for 12 of 40 (30 percent) doses given by the nurses.[21]
- The same provider decreased the dosage of Bumex for a patient with congestive heart failure and ordered daily weights for three days. However, the patient's EHR had no documented weight on the last day as ordered.[22]

CLC staff also told the OIG about concerns that nurses did not always follow providers orders or document actions taken.

Although it is unclear why this occurred, the nurses' failures to document and possibly perform the ordered medication related instructions, such as vital signs and weights, may have resulted in the provider not having enough information to accurately order changes in the patient's medications, thus increasing the risk for poor patient outcomes including unnecessary side effects.

[19] Risperidone is used to treat mental health disorders. Mayo Clinic, *Risperidone*, 2019. https://www.mayoclinic.org/drugs-supplements/risperidone-oral-route/description/drg-20067189. (The website was accessed on May 3, 2019.)

[20] Seroquel is used to treat bipolar disorder and schizophrenia. https://www.mayoclinic.org/drugs-supplements/quetiapine-oral-route/description/drg-20066912. (The website was accessed on May 3, 2019.)

[21] Rivastigmine is used to treat dementia. Mayo Clinic, *Rivastigmine*, 2019. https://www.mayoclinic.org/drugs-supplements/rivastigmine-transdermal-route/description/drg-20071170. (The website was accessed on May 3, 2019.)

[22] Bumex is a diuretic used to treat fluid retention. Mayo Clinic, *Bumetanide,* 2019. https://www.mayoclinic.org/drugs-supplements/bumetanide-oral-route/description/drg-20071274. (The website was accessed on May 3, 2019).

## Inconsistent Documentation of Pain Assessment and Management

The OIG found inconsistent pain assessment documentation by nursing staff and pain management care plan documentation by the facility interdisciplinary team.

VHA requires facility leaders to establish pain management procedures that encompass early recognition of pain and appropriate pain management treatment.[23] Facility policy requires pain assessments to be documented as a vital sign along with the patient's temperature, pulse, respiration, and blood pressure.[24] Facility CLC policy requires all staff to "inquire about or observe for pain and discomfort as part of routine care and whenever a full set of vital signs is obtained for any reason."[25]

Additionally, the facility interdisciplinary clinical team must document a pain management care plan for each patient, and nursing staff must complete a pain reassessment within four hours following a pharmacological or non-pharmacological intervention for pain. All clinical team members maintain responsibility for screening, ongoing evaluation of pain, initiating appropriate pain management treatment, and addressing pain management for each patient's plan of care.[26]

OIG staff reviewed the facility CLC nursing staff pain assessment and reassessment documentation and the CLC interdisciplinary team's pain management care plans for the 18 patients identified. Based on a review of 166 full sets of vital signs (from the 18 patients' EHRs) performed by nursing staff from February 10, 2019, through March 12, 2019, 30 of the 166 (18 percent) did not include an assessment of the patient's pain. Four of the 18 (22 percent) patients' EHRs did not have a pain management care plan as required.

During interviews, facility management and CLC staff reported concerns about inadequate pain assessments and improper pain medication administration but no specific reason why this would occur.

Without accurate pain assessments and reassessments, and pain management care plans, patients may have an increased risk for inadequate pain management, which places patients at risk for adverse physical and psychological outcomes, ineffective pain treatment, and increased pain levels.[27]

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[23] VHA Directive 2009-053, *Pain Management*, October 28, 2009. This directive expired on October 31, 2014, and has not been updated.

[24] Vital sign assessments include pain as the fifth vital sign along with temperature, pulse, respirations, and blood pressure.

[25] Facility Policy PCS-111-17, *Pain Management,* December 2017.

[26] Facility Policy PCS-111-17.

[27] Hughes, R.G. Patient Safety and Quality: An Evidence-Based handbook for Nurses, *Chapter 17 Improving the Quality of Care Through Pain Assessment and Management*, April 2008. https://www.ncbi.nlm.nih.gov/books/NBK2658/. (The website was accessed on May 3, 2019.)

## Inconsistent Documentation of Fall Prevention/Post-Fall Assessments and Use of a Fall Prevention Measure

The OIG substantiated that five patients identified in the allegations did fall but was unable to determine if the five patients fell due to instances of inadequate or deficient nursing care, such as ignored call bells. The failures in nursing care that were alleged to have caused the falls were not evident through EHR reviews. However, the OIG found that CLC nursing staff did not consistently document fall prevention and post-fall assessments. In addition, during the unannounced site visit, the OIG found call bells that were inaccessible to patients and identified facility CLC Community Meeting minutes that described issues with staff's unresponsiveness to call bells.[28]

### *Inconsistent Fall Prevention Assessment Documentation*

The OIG found inconsistent CLC nursing staff documentation of fall prevention assessments in the hourly rounding forms.[29]

The use of fall prevention measures, such as placement of hand and bed rails, scheduled rounding, and fall risk assessments are important tools for nursing staff to use in decreasing the risk of and preventing patient falls. Scheduled rounding is viewed as a universal fall prevention measure.[30]

Facility CLC nursing staff are required to perform hourly rounding assessments to observe a patient's condition and overall safety of the environment, including ensuring that the room is clear of clutter for safe ambulation, and that the beds are in the appropriate position. Nursing staff must also document the assessments.[31]

The OIG reviewed 33 hourly rounding forms completed from February 18–20, 2019, and March 12, 2019, and determined that 22 (67 percent) of the forms did not contain complete documentation of patient fall prevention measures including position of bed rails, bed in low position, call light within the patient's reach, and fall education.

[28] Community Meetings are monthly CLC resident meetings.

[29] The facility used rounding forms to document required hourly encounters and interventions.

[30] Facility Nursing Practice Policy, NPP-20-16, *Nursing Rounds: Face Checks and General Rounds*, September 2016; Agency for Healthcare Research and Quality: U.S. Department of Health and Human Services, *Preventing Falls in Hospitals, A Toolkit for Improving Quality of Care*, January 2013. https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk3.html. (The website was accessed on January 31, 2019.)

[31] Facility Nursing Practice Policy NPP-20-16.

## Inconsistent Post-Fall Assessment Documentation

The OIG identified discrepancies between the number of patient falls reported and the number of post-fall assessment notes documented by licensed nursing staff.

Facility policy requires that the licensed nurse assigned to a patient at the time of a fall complete a post-fall assessment note. Post-fall assessments enable facility staff to gather data needed to conduct post-fall clinical reviews, which aid in tracking and trending the causative factors of patient falls. This information also enables providers and other interdisciplinary team members to develop and update treatment care plans designed to meet the specific needs of each patient.[32]

Of the reported falls in the CLC between September 2018 and January 2019, 32 of 75 (43 percent) had no documented post-fall assessment notes as found in table 1.

**Table 1. Number of CLC Reported Falls Compared to Post-Fall Assessment Notes**

| Data Source | September 2018 | October 2018 | November 2018 | December 2018 | January 2019 | Total |
|---|---|---|---|---|---|---|
| CLC Reported Falls Data | 9 | 14 | 18 | 14 | 20 | 75 |
| No CLC Post-Fall Assessment Notes | 1 | 4 | 9 | 5 | 13 | 32 |

*Source: OIG analysis of September 1, 2018, through January 31, 2019 facility falls data*

The reason for the documentation discrepancy was not evident in the fall data. Fall prevention plans based on complete data and the accurate identification of issues with fall preventive processes can eliminate or reduce the risk of repeated falls and injuries.[33]

## Inconsistent Use of a Fall Prevention Measure

During the site visit in February 2019, the OIG observed call bells that were inaccessible to 6 of 14 patient beds (43 percent).

The OIG also reviewed CLC Community Meeting minutes from January 2018 through February 2019, and identified a discussion of staff not answering call bells on one CLC unit in the October 2018 meeting minutes. The OIG found no documented actions to remediate or follow up on the described issue in the subsequent meetings.

[32] Facility Policy PCS-60-14, *Accident Prevention Program: Fall Prevention*, April 2014.
[33] Facility Policy PCS-60-14.

Call bells are a universal fall precaution that enable staff to respond to patient assistance requests.[34] At the facility, CLC staff answered audible call bells from a computerized pad in the hallway or the nursing station, that could be activated by patients using a call bell on the bed railing or attached to a cord by the bed.

One staff member told the OIG of patient complaints that staff would turn off the call bells at the nursing station and not respond in person. In response, the staff member informed the OIG that, from their understanding, the facility had disabled the function to turn off call bells at the nursing station, requiring staff to enter a patient's room to disengage the call bell. However, while on-site, the OIG observed a patient use a call bell and staff at the nursing desk contacted the patient through an intercom system (which disengages the alarm) to ask what the patient wanted rather than going into the patient's room to turn off the alarm and check on the patient.

Lack of staff responsiveness to patient call bells increases the risk of falls if calls for assistance are delayed or ignored.

## Inconsistent Documentation of Wound Prevention Processes

The OIG was unable to determine whether the wounds of five patients identified in the allegations had developed or worsened due to inconsistent documentation of wound prevention processes by nursing staff. Wound prevention has multiple elements that were not consistently tracked in the patients' EHRs. Specifically, the OIG found inconsistencies with the documentation of CLC wound prevention nursing processes: (1) the measurement of patient weights, (2) turning, and (3) toileting.

### *Documentation of Weights*

The OIG found that CLC nursing staff did not consistently document patient weights as required by VHA and facility policy.[35]

[34] Agency for Healthcare Research and Quality: *U.S. Department of Health and Human Services*. https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk3.html. (The website was accessed on March 27, 2019.)

[35] VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011. This handbook was in effect for a portion of the timeframe of the events discussed in this report; it was rescinded and replaced by VHA Directive 1352, *Prevention and Management of Pressure Injuries*, March 21, 2019 and contains similar language related to documentation of weights; Facility Policy, MCP-GEC-25, *Community Living Center Weight and Measurement Policy*, April 2014. This policy was scheduled for recertification on or before the last working day of February 2016, but has not been recertified; Facility Policy, MCP-GEC-01-13, *Documentation Guidelines for Geriatrics and Extended Care (GEC)*, September 2013. This policy was scheduled for recertification on or before the last working day of September 2015, but has not been recertified.

Adequate nutrition and maintenance of skin integrity are preventive measures of wound development.[36] Unplanned or unintentional weight loss is a risk factor for malnutrition and may lead to the development of wounds.[37] For this reason, VHA identifies a specific risk factor for wound development as "weight loss of greater than or equal to 5 percent in 30 days or greater than or equal to 10 percent in the previous 180 days."[38]

Facility policy requires nursing staff to weigh patients within eight hours of admission and at least monthly thereafter, and to reweigh patients who have gained or lost three pounds in one week or five pounds in one month. Documentation of weight is crucial for the assessment of nutritional status.[39]

Although CLC nursing staff recorded monthly patient weights, 9 out of 45 patients (20 percent) admitted to the CLC from September 1, 2018, through February 28, 2019, did not have a weight recorded within eight hours of admission as required.[40] During the same time frame, CLC nursing staff did not record a retake of the weights of 17 of 32 patients (53 percent) who had a gain or loss of three pounds in one week or a gain or loss of five pounds in one month.[41]

If there are incomplete or incorrect weight measurements, or weights are not recorded in a patient's EHR, providers cannot develop an accurate treatment plan, specifically with the management and prevention of wounds.

None of the CLC staff interviewed reported broken equipment or inadequate staffing having a direct impact on obtaining patient weights, and no reasons for the inconsistent documentation were given by staff.

### *Documentation of Turning and Toileting*

The OIG determined that CLC nursing staff did not consistently document turning or toileting patients or both to prevent skin breakdown.[42]

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[36] VHA Handbook 1180.02; VHA Directive 1352.

[37] VHA Directive 1180.02; Mary Litchford, Becky Dorner and Mary Ellen Posthauer. 2014. "Malnutrition as a Precursor of Pressure Ulcers." *Advances in Wound Care* 3 (1): 54-63.

[38] VHA Handbook 1180.02; VHA Directive 1352.

[39] Facility Policy MCP-GEC-25; Facility Policy, MCP-GEC-01-13.

[40] Facility Policy MCP-GEC-01-13.

[41] The OIG team did not include hospice patients in this calculation as an expectation of a significant change in weight is likely. Facility Policy MCP-GEC-25.

[42] Facility Policy MCP-PCS-69-15, *Prevention and Management of Tissue Trauma/Pressure Ulcers*, January 2016. The Tissue Trauma team is an interdisciplinary team charged with "developing a care plan, initiating interventions, and evaluating outcomes." This policy was scheduled for recertification on or before the last working day of July 2017, but has not been recertified.

VHA and facility protocols for maintenance of skin integrity and prevention of skin breakdown include the process of repositioning. For patients with high-risk wounds, the frequency of turning increases and includes small position changes between turns.[43]

Facility policy also established weekly CLC tissue trauma team rounds. During rounds, the trauma team reviews and revises interdisciplinary care plans for patients who had or were at risk for wounds.[44] CLC nursing staff recorded preventive measures, such as turning and toileting on hourly patient rounding forms (see appendix B).

The OIG reviewed 33 completed hourly rounding forms for 24 patients who were at risk of or had wounds. The forms were collected during the February 18–20, 2019, and March 12, 2019, site visits. The OIG determined that 32 of the 33 forms (96 percent) did not have documented either hourly turning or toileting preventive interventions:

- For 15 patients without wounds, CLC nursing staff did not fully complete documentation indicating patients were turned every two hours on 13 of 19 forms (68 percent) and toileting indicators on 16 of 19 forms (84 percent).
- For nine patients with wounds, CLC nursing staff did not fully complete documentation of every two-hour turning on 10 of 12 forms (83 percent) and toileting indicators on 7 of 12 forms (58 percent).[45]

Inconsistent application of wound prevention measures may increase the risk of wound development or worsening of an existing wound. Although the OIG could not establish why nurses did not consistently document preventive measures for wounds on the rounding forms, without consistent documentation, the measures to reduce risks may not be accurately developed.

## 3. Other Findings

While reviewing the identified concerns, the OIG discovered other findings not specifically related to the allegations but related to CLC patient care and facility oversight processes. These included a failure to follow the approval procedure for a new hourly rounding form, ineffective implementation of a new rounding procedure, incomplete fact-finding reviews, inconsistent committee documentation, and inoperable CLC safety equipment.

[43] VHA Handbook 1180.02; VHA Directive 1352; Facility Policy MCP-PCS-69-15. High risk refers to a scaled measurement called the Braden scale, which identifies risk for developing a pressure sore or ulcer and the tasks that should be done to prevent a sore or ulcer from developing or getting worse. The scales identify 9 or below as being very high risk, 10 to 12 as high risk, 13 to 14 as moderate risk, and 15 to 18 as at risk. These risks include but are not limited to patient mobility, incontinence, ability to respond and eat or take fluids.

[44] Facility Policy MCP-PCS-69-15.

[45] For the information reviewed, some patients had more than one form.

## Approval and Implementation Issues with New Rounding Form

The OIG determined that an approved nursing practice procedure for performing rounds was replaced by a new form that did not have an approved procedure to guide and provide instructions on the use of the form. Although nurses were given training on using and documenting on the new form, the OIG found nursing managers did not have a process to evaluate compliance, and nursing staff were not following the directions provided in the training.

### *Failure to Follow Approval Procedure*

The facility established and maintained a system to prepare and distribute standard operating procedures for each patient care service line. Service lines were responsible for following the policy guidance to prepare, publish, and maintain these procedures.[46]

Patient care service line leaders of GEC, Mental Health, and other facility services review and approve newly developed or revised standard operating procedures. Once approved, the service representative presents the revised procedure to the Clinical Nurse Practice Council and the Nurse Practice Executive Council for additional approval. When the final approval is given by the Nurse Practice Executive Council, the approval date is added to the standard operative procedure. The Associate Director for Patient Care Services signed all nurse practice policies and standard operating procedures as the chair of the Nurse Practice Executive Council. Nursing policies/standard operating procedures are then uploaded to an internal facility website and provided to all applicable nursing staff.[47]

The CLC had an approved nursing practice policy that required nurses to perform hourly face checks. According to OIG observation and interviews with the Associate Director for Patient Care Services, the GEC Director, and CLC nurse managers, a new hourly rounding form replaced CLC face checks and turning schedules; however, the Associate Director for Patient Care Services did not approve a new policy/procedure associated with the new form.[48] Facility CLC managers informed the OIG that the new rounding form was developed by CLC nurse managers and the GEC Director to improve patient care outcomes.

### *Ineffective Implementation*

Facility policy states that nurse managers and supervisors "are responsible for ensuring all employees have access and are oriented to" new or revised standard operating procedures, and that employees follow those procedures.[49]

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[46] Facility Standard Operating Procedure, *Preparation of Standard Operating Procedures*, November 2017.

[47] Facility Policy *Preparation of Standard Operating Procedures*.

[48] Facility *Nursing Practice Policy* NPP-20-16.

[49] Facility Policy *Preparation of Standard Operating Procedures*.

The new rounding form was divided into hourly delineated tasks such as status checks, positioning, toileting/incontinence care, preventive interventions such as positioning of bed rails, and a reminder to ask "[i]s there anything I can do for you?" The registered nurse assigned to the patient was responsible for completing and initialing the first and last rounds of each shift and the caregiver assigned completed and initialed the remaining rounds (see appendix B).

CLC nurse managers reported all staff had recently received training on the new hourly rounding form, however, a standard of practice or procedure to provide instructions and guidance on the hourly rounding was not developed.[50] In addition, nurse managers did not develop methods to evaluate, review, and monitor staff compliance when the new hourly rounding form was implemented. One unit nurse manager stated they were not consistently tracking the progress or use of the forms and described not having time to assess the forms' use.

The OIG reviewed 33 rounding forms from three CLC units, 26 rounding forms from February 18–20, 2019, and seven additional forms from March 12, 2019.[51] The OIG determined none of the forms reflected up-to-date documentation or complete information based on the requirement in the training presentation to initial, check, and circle items hourly in the applicable boxes upon task completion. In addition, the OIG found that CLC nursing staff on one unit kept the hourly rounding forms on a clipboard at the nurse's station rather than the back of the patient's closet door as instructed during the training.

The lack of a standard practice or procedure to provide instructions and guidance for the use of the form, and the lack of a method to monitor and evaluate the rounding forms to ensure staff were following the correct process, increased the chance that incorrect completion and placement of the forms would occur.

## Incomplete Fact-Finding Reviews

The OIG found the facility fact-finding reviews, which staff used to document patient care and staffing issues and that form the basis of possible facility system and issue reviews, were unstructured and had limited follow-up and resolution.

VHA developed system processes to analyze and review safety reports essential to identifying causal and contributing factors of adverse events to mitigate system vulnerabilities and prevent

[50] The training discussed the "4 P's of Hourly Rounding," identified as personal needs, position, placement, and prevention of falls. The training addressed the importance of completing and documenting each hourly task, "…we are still 100% accountable for every resident at all times (hourly rounding is in place of face checks)." Additionally, the training highlighted the process of a new form's placement inside each patient's closet door during night shift to ensure staff entered the room.

[51] The OIG found several issues in the inspection that centered around the incorrect implementation of the hourly rounding process. These issues are discussed in the following sections related to specific concerns.

future occurrences.[52] Often, informal information gathering processes are sufficient as a response to an issue; however, when a more systematic approach is needed, a more formal process of review should be used.[53] While informal, fact-findings are administrative investigations and should meet the general policy objectives of an administrative investigation.[54] Specifically, administrative investigations are conducted to determine what happened and why "so that individual and systemic deficiencies can be identified and effectively corrected." "Determining the facts and the appropriate response to matters within their…responsibility is an inherent duty of VA executive leadership."[55] Without structured processes to review the results of informal fact-findings, facility leaders are unable to track and trend administrative investigation complaints and resolutions, compromising their ability to identify individual and systemic issues and ensure identified issues are corrected.

The OIG reviewed 13 facility CLC fact-findings. The OIG determined that 10 of the 13 fact-findings did not identify appropriate responses to resolve issues or contain documentation that the identified issues were sent on for further review. The directors of GEC and quality improvement reported they were unaware of any current fact-finding reviews related to patient care. A facility leader told the OIG that facility supervisors received training on fact-finding reviews in November 2018.

If facility leaders and staff are unaware of the prevalence of events and complaints because fact-findings are not completed or identified and tracked as needing further review, more structured reviews that might be indicated by the fact-findings (such as root cause analyses or administrative investigations) may not be conducted.

## Inconsistent Committee Documentation

The OIG determined that the Executive Leadership Board did not consistently document evidence that issues and recommendations identified and discussed by the committee were followed through to resolution. In addition, the GEC Executive Council minutes reflected

[52] Adverse events are "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services." VHA Handbook 1050.-01, *National Patient Safety Improvement Handbook*, March 4, 2011. This VHA Handbook was scheduled for recertification on or before the last working date of March 2016, but has not been recertified. Facility Policy QI-08-17 *Patient Safety Program and Reporting Requirements for Sentinel Events, Adverse Events, and Unplanned Clinical Occurrences*, July 2017.

[53] Facility Policy QI-08-17. A root cause analysis is a "process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls" and is a "specific type of focused review." VA Directive 0700, Administrative Investigations, March 25, 2002. This VA Directive does not have an expiration or recertification date.

[54] VA Directive 0700, Administrative Investigations, March 25, 2002. This VA Directive does not have an expiration or recertification date.

[55] VA Directive 0700.

inconsistent documentation of action plans for issues presented at the committee or resolution of those issues.

VHA requires that facility leaders create and assign a standing committee to review data, information and risks to patients and patient care, and develop recommendations to aid in providing quality care to patients. This committee is chaired or co-chaired by the Facility Director and consists of a multidisciplinary membership. The committee must meet quarterly, record attendance, and track issues and recommendations to resolution.[56]

The facility's Executive Leadership Board is the required standing leadership committee created to review facility data and act as the facility governing body deciding operational processes and services, analyzing quality data to determine performance, and initiating and tracking actions to completion. The committee is scheduled to meet monthly and the Facility Director is the chair of the committee.[57] The OIG reviewed the committee meeting minutes from October 19, 2017, through January 17, 2019, and found that the Facility Director attended each meeting in which attendance was documented.[58]

The Executive Leadership Board meeting minutes contained documentation of issues and recommendations resulting from information and data discussed during the meetings. However, minutes often reflected issues and recommendations as closed although results had not been obtained or the resolution date was the same date as the issue and recommendation (month and year of the meeting). The board committee minutes did not consistently reflect that issues and recommendations were brought to resolution, or the minutes were unclear as to whether an issue was ongoing or closed.

The OIG reviewed the GEC Executive Council's meeting minutes from October 16, 2017, through January 14, 2019, and determined that the committee met monthly. However, attendance was not taken, and the minutes reflected a lack of action plans and committee follow-through upon presentation of an action plan. Though no reason for inconsistent documentation was found, when leadership committee documentation is inconsistent or unclear, actions may not be taken, and identified CLC concerns may not be resolved.

[56] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. This VHA Directive was scheduled for recertification on or before the last working day of August 2018, but has not been recertified.

[57] Facility Policy LD-12-16, *Executive Leadership Board (ELB)*, October 2016.

[58] The January 2019 meeting did not reflect parties in attendance. Facility Policy LD-12-16.

### Inoperable CLC Safety Equipment

During the OIG site visit in February 2019, the OIG asked a CLC nurse to demonstrate the use of the emergency Hoyer lift and tub lift located in the communal shower room. [59] The OIG staff observed that neither lift was operating. The nurse who was asked to demonstrate the use of the equipment was unaware that both lifts were inoperable; maintenance tags reflected the lifts were examined within the past six months.

The OIG asked the nurse to follow up by reporting the inoperable lift to nursing management. The Hoyer lift remained non-operational during the March 12, 2019, site visit. Without functioning lifts, the potential for harm increases for both patients and staff in the event of a patient fall or other emergencies.

## 4. Contributing Factor

The OIG determined that a possible contributing factor to the nursing care and management deficiencies may have been an outdated facility staffing methodology policy that did not follow all VHA staffing methodology requirements.

### Outdated Policy and Inaccurate CLC Nurse Staffing Calculations

Correct staffing levels are essential to meeting the needs of patients and providing quality care. To provide safe and accessible healthcare to patients, VHA requires medical centers to use a standardized staffing methodology to calculate the nursing hours per patient day for each nursing unit, and determine the number of nursing care hours needed to manage patients' direct care needs.[60] VHA updated the staffing methodology policy on December 20, 2017. The updated policy added "[s]itters performing direct patient care" (in proportion to assignment) to the list of staffing categories included in the calculations for determining the nursing hours per patient day.[61] Failure to include the sitters performing direct patient care in calculating the nursing hours per patient day could cause an underestimation of the number of staff needed to provide patient care. VHA CLCs are required to follow the staffing methodology policy.[62]

The March 2015 facility staffing methodology policy did not include the new 2017 VHA addition of "[s]itters performing direct patient care" as part of staffing calculations.[63] This may

[59] A Hoyer lift is a fall prevention tool used to transfer and lift patients moved from area to area. A communal tub lift assists in transferring patients in and out of a shared bathtub.

[60] VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017.

[61] VHA Directive 1351. A sitter provides direct patient observation.

[62] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[63] Facility Nursing Practice Policy NPP-06-15, *Nursing Staffing Methodology*, March 2015; VHA Directive 1351.

have led to insufficient staff because the policy for staffing calculations did not accurately represent and account for all the nursing staff necessary to meet patient care needs.

The OIG found that, as of May 23, 2019, the facility policy for nurse staffing methodology, dated March 2015 and identified as a nursing practice policy available to nursing and administrative staff, did not include all the categories of staff that should be used to calculate staffing needs.[64] When nursing practice policies were reviewed by OIG staff on September 4, 2019, this policy had been removed and no additional policies on staffing methodology were found on the facility nursing practice site.

The facility does have a policy regarding patient observation by staff, dated May 2018, including direct line of sight and one to one sitter staff; however, this policy does not address staffing levels or the VHA staffing methodology.[65]

To assess how much caregiver time is assigned to sitting/observing and caring for one patient throughout a shift, the OIG staff reviewed shift assignment forms for a CLC locked unit that housed dementia and psychiatric elderly/disabled patients. This unit generally had two to three direct line of sight patients (patients required to be within the sight of an assigned staff member). Each direct line of sight patient had a staff member or caregiver specifically assigned to them, 24 hours a day, seven days a week, who kept the patient in sight at all times and performed care giving tasks. OIG staff observed the assigned caregiver toileting, sitting with patients, assisting with feeding the patients, and transferring patients.

Assignments showed that caregivers assigned to a patient for direct line of sight observation provided care for that patient. However, the caregiver did not participate with other patient care or other tasks and did not have more than one direct line of sight patient. If unit staff were not available to care for direct line of sight patients, nurses or caregivers would be borrowed from other units or the assignments would only be for a half of a caregiver's shift with another caregiver replacing the first caregiver to finish the shift. Staff would also cover each other if needed, but direct line of sight patients always had to be within the sight of a caregiver and the caregiver needed to be available for care of that patient. Because these assignments generally restricted the direct line of sight to one patient, that assigned staff member was not available to care for other patients. However, this was not reflected in the facility's staffing methodology

[64] Facility Nursing Practice Policy NPP-06-15.

[65] Facility Policy PCS-113-18, *Patient Observation Levels*, May 2018.The three levels of observation are: (1) one to one for patients who may harm themselves or others and need constant observation–staff must be within six feet of the patient, no other responsibilities are assigned for this staff member; (2) direct line of sight observation for patients who are required to be within the sight of a staff member for a specific period of time or specific identified situation–staff member may observe more than one patient (acute mental health–no more than two patients at one time) but must remain in the area with the patient at all times; and (3) close observation patients who must be observed by staff every 15 minutes.

policy as part of the calculations to determine how many staff are needed to care for the patients on the unit. [66]

According to nurse managers on the dementia unit, one direct line of sight staff is included in the calculations for the dementia unit but other direct line of sight staff, if needed, are not included.

In addition to possible inaccurate staffing calculations identified by the OIG, the facility Human Resources Department noted one nursing vacancy, and a CLC nurse manager reported a high turnover rate due to staff moving to other positions within the facility.

The VHA staffing methodology supports quality patient care in an effective manner by predicting and planning for staffing needs.[67] Without accurate information to incorporate into the staffing projections and plans, it would be challenging to ensure adequate staff to provide safe and effective patient care.

# Conclusion

While the OIG substantiated an allegation associated with medication administration and confirmed that specific patients experienced falls or developed wounds, or both, the OIG was unable to determine that the causes for these falls and wounds were due to alleged inadequate or deficient nursing care. The OIG identified related concerns including inconsistent documentation of compliance with medication order instructions, pain assessment and pain management care plans, fall prevention/post-fall assessments, wound prevention processes, and inconsistent use of fall prevention measures.

The OIG determined that nursing staff did not consistently document compliance with medication orders and pain assessments and reassessments, which may result in under or over medication or side effects for patients. In addition, OIG staff found that the facility CLC interdisciplinary team did not consistently document pain management care plans. Nursing staff also did not consistently document fall prevention assessments in the facility rounding forms, and clinical factors such as weights and skin integrity measures, which assists in the prevention of worsening or development of wounds.

Furthermore, the OIG found that the director of GEC and CLC nurse managers implemented an unmonitored and unapproved rounding form that replaced an approved procedure. Though nurse managers reported that training occurred for this form, the management staff had not completed an approved procedure to guide and provide instructions on the use of the form. Upon review of the rounding form use, the OIG found that nursing staff incorrectly completed and placed the rounding forms. The OIG also identified that the facility fact-findings were unstructured and did not address or escalate identified issues, which raised concerns that facility leaders were unaware

[66] Facility Nursing Practice Policy NPP-06-15.
[67] VHA Directive 1351.

of issues and missed opportunities to perform formal reviews. In addition, the OIG found that the CLC leadership committee and Executive Leadership Board did not document resolution of issues, and that some CLC safety equipment was inoperable.

A factor that may have contributed to patient care concerns included an outdated staffing methodology policy, which may indicate inaccurate and insufficient staffing levels and compromise the provision of safe and effective patient care.

## Recommendations 1–9

1. The Coatesville VA Medical Center Director reviews and monitors staff compliance with the Community Living Center required nursing processes and documentation for medication administration, pain management assessments, and care plans.
2. The Coatesville VA Medical Center Director examines Community Living Center nursing processes and ensures that required documentation for fall prevention assessments, which include measures such as bed positions, call bell access, and post-fall assessments, is completed and monitored.
3. The Coatesville VA Medical Center Director reviews and monitors staff compliance with Community Living Center call bell processes and practices.
4. The Coatesville VA Medical Center Director evaluates Community Living Center wound prevention processes and ensures that required wound documentation, including the measurement of patient weights and maintenance of skin integrity, is completed and monitored for compliance.
5. The Coatesville VA Medical Center Director ensures that the newly developed Community Living Center hourly rounding form and process is approved in accordance with the facility's standard operating procedure and aligns with the facility's rounding policies, and monitors compliance.
6. The Coatesville VA Medical Center Director makes sure that the fact-finding review process includes tracking and documenting issues through resolution and monitors compliance.
7. The Coatesville VA Medical Center Director ensures that the Executive Leadership Board and the Geriatric and Extended Care Executive Council review, document, and track identified facility issues and, for the Executive Leadership Board, recommendations through resolution.
8. The Coatesville VA Medical Center Director reviews and monitors the maintenance and functionality of essential safety equipment on Community Living Center units.
9. The Coatesville VA Medical Center Director updates the facility staffing methodology policy and staffing methodology calculations to comply with current Veterans Health Administration staffing methodology requirements.

# Appendix A: Allegations

Through EHR review of patients with allegations, the OIG identified 12 patients with nursing care concerns: five with falls, five with wounds, and two with nursing medication administration issues.

**Table A.1. Nursing Care Concerns: Falls**

| | Patient | Allegations and Concerns from EHR Review[68] | Documented Facility Actions | OIG Review |
|---|---|---|---|---|
| 1 | A patient in their 70 s with schizophrenia, dementia, drug induced parkinsonism, and dysphagia.[69] The patient died in summer 2018. | Patient fell and hit their head in late spring 2018. The charge nurse "failed to comply with the proper fall procedure…[and] report it properly" and "never was taken to X-ray or Cat Scan [computerized tomography] [the patient] passed away about a week later." | A fact-finding review was conducted on the patient's fall in late spring 2018.<br>Post-fall assessments were completed by the nurse and physician.<br>The physician documented assessing benefits and risks of head CT. | The OIG determined that the patient fell.<br>The OIG was unable to determine whether nursing care was inappropriate based upon the available documentation.<br>Imaging was not done. Follow-up included post-fall assessments and discussion of benefits and risks of imaging. |
| 2 | A patient in their 90 s with legal blindness and history of cardiac issues. | Patient fell in fall 2018, "when no one would come to help [the patient] up to go to the bathroom ([staff] had turned off the call bell)." Roommate had to go tell staff because they "wouldn't answer the call bell." | The patient reported waiting and fell when trying to go to the bathroom without assistance.<br>The post-fall assessment team documented in the EHR, but no other reviews were completed. | The OIG determined that the patient fell, however was unable to determine whether nursing care was inappropriate based upon the available documentation.<br>Available documentation does not describe the circumstances of the fall other than the patient's report of getting up alone when no one came to help. No documentation related to call bell activation. |

[68] Allegations and concerns from EHR review were compiled from a combination of the complainants' allegations and the OIG team's EHR review.

[69] The OIG uses the singular form of they in this instance for privacy purposes.

| | | | | |
|---|---|---|---|---|
| 3 | A patient in their 80 s with dementia, Parkinson's disease, depression, high blood pressure, and posttraumatic stress disorder. | Patient fell down the stairs while in a wheelchair on a recreational trip in spring 2018. | In early spring 2018, a patient safety report was completed.<br>A fact-finding review was conducted and an issue brief was completed a few days after the patient's fall.<br>A root cause analysis was conducted approximately one month after the patient's fall. | The OIG determined that the patient fell on a recreational trip.<br>The OIG was unable to determine whether nursing care was inappropriate based upon the available documentation.<br>The OIG found the patient did not have documentation of the required turning for one day in February 2019. |
| 4 | A patient in their 70 s on hospice with Parkinson's disease and psychotic disorder with delusions. | Patient had a fall with scalp laceration visualized in winter 2019. | A patient safety report was completed in winter 2019.<br>The day of the patient's fall, a code blue was completed, and the patient was transferred to a community hospital for assessment.<br>A post-fall huddle was completed two days later. | The OIG determined that the patient fell.<br>The OIG was unable to determine whether nursing care was inappropriate based upon the available documentation.<br>When reviewing the patient's EHR, the OIG found the patient did not have a required pain assessment for one day in March 2019. |
| 5 | A patient in their 70 s with congestive heart failure. | Patient allegedly had a wound. The OIG found a knee skin tear resulting from a fall in winter 2019, when the patient was attempting to transfer from a wheelchair. | Tissue trauma rounds performed the day of the patient's fall.<br>Post-fall assessment completed on the day of the patient's fall. | The OIG determined that the patient fell.<br>The OIG was unable to determine whether nursing care was inappropriate based upon the available documentation. |

*Source: OIG team, April 5, 2019*

## Table A.2. Nursing Care Concerns: Wounds

| | Patient | Allegations and Concerns from EHR Review | Documented Facility Actions | OIG Review |
|---|---|---|---|---|
| 6 | A patient in their 80 s with a history of stroke. | Patient developed a facility acquired pressure injury in fall 2018. | Orders placed to "Reposition [patient] every 2 hours" in late summer 2018.<br>Tissue trauma reports completed with foot cradle and cleansing of wound in fall 2018. | The patient had a pressure injury resulting in a wound, but due to the lack of documentation, the OIG was unable to determine if it was due to inconsistent wound prevention nursing processes. |
| 7 | A patient in their 70 s with congestive heart failure and history of stroke. | Patient developed a facility acquired pressure injury on the right medial coccyx in early fall 2018. The complainant alleged the wound was from not being turned. Starting in winter 2019, the wound was assessed to be stage 4 with exposed bone. | Wound care rounds were performed periodically.<br>A provider ordered a pressure relieving mattress in winter 2019, and for wound cleansing one month later.<br>Patient died early spring 2019, and an autopsy noted multiple ulcers, including the stage 4 with underlying softening of the bone. | The OIG determined that the patient had a pressure injury resulting in a wound but was unable to determine if it was due to inconsistent wound prevention nursing processes.<br>However, the OIG found the patient did not have documentation of required turning for two days in February 2019. |
| 8 | A patient in their 90 s with dementia. | Patient developed a facility acquired wound in winter 2018. | Nursing skin care assessments were performed beginning winter 2018. Interventions included turning and repositioning every two hours while in bed and a pressure relieving mattress. | The OIG determined that the patient had a wound, but due to the lack of documentation, the OIG was unable to determine if it was due to inconsistent wound prevention nursing processes. |
| 9 | A patient in their 90 s with spinal stenosis and atrial fibrillation. | Patient developed a facility acquired pressure injury on the right buttock in fall 2018. | A tissue trauma note was completed approximately one week after the patient developed the pressure injury with cleansing and turning interventions. | The OIG determined that the patient had a wound, but due to the lack of documentation, the OIG was unable to determine if it was due to inconsistent wound prevention nursing processes. |

| | | | | |
|---|---|---|---|---|
| 10 | A patient in their 70 s with a history of stroke and metastatic pancreatic cancer. | Patient developed a facility acquired wound on the left buttock in late summer 2018. The complainant alleged the wound had progressed. As of the patient's death in winter 2019, the wound was stage 4. | Tissue trauma notes were completed in late summer 2018 and in late winter 2019, with orders for interventions such as cleansing and turning every two hours.<br>In fall 2018, the patient was hospitalized for osteomyelitis of the wound. | The OIG determined that the patient had a wound but was unable to determine if it was due to inconsistent wound prevention nursing processes.<br>However, the OIG found the patient did not have documentation of the required turning and toileting for two days in late winter 2019. |

*Source: OIG team, April 5, 2019*

## Table A.3. Nursing Care Concerns: Medication Administration

| | Patient | Allegations and Concerns from EHR Review | Documented Facility Actions | OIG Review |
|---|---|---|---|---|
| 11 | A patient in their 70 s with coronary artery disease, and chronic obstructive pulmonary disease, and dementia. | A nurse left medications in the patient's room in fall 2018. | A fact-finding review was performed a few days after the medication was left in the patient's room. | The OIG substantiated the allegation of medication left in patient's room according to a facility fact-finding review, however, no actions were documented. |
| 12 | A patient in their 90 s with dementia and posttraumatic stress disorder. | Nurses administered medications to patient in a soda can left in the room. | No review was conducted. | The OIG was unable to determine if the allegation was founded. |

*Source: OIG team, April 5, 2019*

# Appendix B: Hourly Rounding Form

The hourly rounding document was developed to improve patient care outcomes and workload by eliminating the need for multiple tracking forms. The document included face checks, turning, toileting, and monitoring equipment use and function, such as the use of a low bed position and an operative wheelchair. Each time it is used, for each hourly round, staff must record, using language and codes in the rounding form, the patient's presence on the unit and assessment, and initial the processes completed. [70]

**Hourly Rounding**

**Resident Name:** **Date:**

Assigned Caregiver Completes All Rounds/RN Initials First & Last for Status Checks

| Time | RN Initials | Caregiver Initials | Status Checks | | | Positioning | Provide Toileting/Incontinence Care | Preventative Interventions (Ensure Items Are Functioning Properly) | Ask |
|---|---|---|---|---|---|---|---|---|---|
| | | | Awake | Asleep (Respirations Checked) | Out of Room (Specify Where) | Note Position of Resident. Turn q 2 Hours. Ensure positioning devices are in place. | C = Clean/Dry, U = Urinary Incontinence, B = Bowel Incontinence, T = Toilet with Results, N = Toileted With No Results, R = Refused | SR = Side Rails Down (NEVER 4), BL = Bed in Low Position, CL = Call Light in Reach, HA = Hearing Aids, F = Fall Education, W = Walker, C = Cane, PB = Protective Boots, WC = Wheelchair, CR = Clutter Removed, LT = Lines & Tubing | "Is there anything I can do for you? |
| 00:00 | | | ☐ | ☐ | ☐ | L B R OOB | | | ☐ |
| 01:00 | X | | ☐ | ☐ | ☐ | L B R OOB | | | ☐ |
| 02:00 | X | | ☐ | ☐ | ☐ | L B R OOB | | | ☐ |
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| Initials | Signature | Initials | Signature |
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[70] Facility Nursing Practice Policy NPP-20-16. A face check is a "direct observation and assessment of each [patient]." The face check is documented on the rounding sheet under status checks (asleep, respirations, awake), and includes recording whether the patient is in the room and, if not, where the patient is.

# Appendix C: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: February 21, 2020

From: Director, VA Healthcare (10N4)

Subj: Healthcare Inspection—Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center, Pennsylvania

To: Director, Office of Healthcare Inspections, (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have reviewed the draft report Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center, Pennsylvania.
2. I concur with the responses and actions submitted by the Coatesville VA Interim Medical Center Director.

(*Original signed by*:)

Signed by: Mr. Charles Thilges
Deputy Network Director, VISN 4

*For*

Mr. Timothy W. Liezert
Network Director, VISN 4

# Appendix D: Facility Director Memorandum

## Department of Veterans Affairs Memorandum

Date: February 21, 2020

From: Director, Coatesville VA Medical Center (542)

Subj: Healthcare Inspection—Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center, Pennsylvania

To: Director, VA Healthcare, (10N4)

1. Thank you to the OIG Healthcare Inspection Team for the professional review of the organization that was completed. I have reviewed the draft report and concur with nine findings and recommendations.

2. Attached are the facility responses to the nine recommendations, including actions already taken and ones in progress to correct the identified opportunities for improvement.

(*Original signed by*:)

Jennifer Harkins
Interim Medical Center Director

# Facility Director Response

## Recommendation 1

The Coatesville VA Medical Center Director reviews and monitors staff compliance with the Community Living Center required nursing processes and documentation for medication administration, pain management assessments, and care plans.

Concur.

Target date for completion: November 30, 2020

### Director Comments

The medical center Pain Management policy, PCS-111, has been revised and is routing through the concurrence phase. Staff will be trained on the new policy and auditing of documentation will occur. Compliance with nursing documentation for medication administration, pain management assessments and care plans as defined by policy will be monitored through monthly chart audits until compliance reaches 90% for six consecutive months.

## Recommendation 2

The Coatesville VA Medical Center Director examines Community Living Center nursing processes and ensures that required documentation for fall prevention assessments, which include measures such as bed positions, call bell access, and post-fall assessments, is completed and monitored.

Concur.

Target date for completion: Request Closure

### Director Comments

CLC Falls Prevention Program goal is to reduce the risk of resident harm resulting from falls. Registered Nurses complete post-fall assessment notes after each fall. Post-fall assessments are not completed on the hourly rounding tool. The hourly rounding tool may not have been utilized fully to document fall prevention interventions. Staff will be re-educated on the use of the hourly rounding tool. Compliance with completing the rounding tool will be monitored, and data aggregated, to reach a benchmark of 90% for six consecutive months. Refer to Recommendation 5 for more information.

Post-fall assessment documentation audits show the benchmark of 90% compliance for 6 consecutive months has been met. The team members on the CLC Falls Prevention Program proactively assess safety and place acceptable interventions to mitigate fall risks. In addition, to help develop an interdisciplinary team (IDT) focus on a multi-component fall and fall-related

injury prevention program, the Director for Geriatrics reports fall data monthly to the CLC Quality Assurance Performance Improvement (QAPI) Committee and Quarterly Geriatric Executive Council. In addition, all fall data is reviewed at the facility Fall Prevention Committee which meets monthly. This program has sustained meeting the goal as shown through marked improvement in reducing in CLC Compare the Falls with Major Injury rate. For fiscal year (FY)18 quarter(Q) 4, the Falls with Major Injury rate was 3.86, with the VISN rate at 3.86 and the VA rate at 2.27. Marked improvement is noted in FY19Q3 and carried into FY19Q4. FY19Q4 data shows a Falls with Major Injury rate of 1.3, with a VISN rate of 2.27 and VA rate of 2.44.

### OIG Comment

The OIG will keep this recommendation open to allow time for the facility to monitor compliance.

## Recommendation 3

The Coatesville VA Medical Center Director reviews and monitors staff compliance with Community Living Center call bell processes and practices.

Concur.

Target date for completion: November 30, 2020

### Director Comments

The Community Living Center will develop a standard operating procedure for answering call bells. Compliance will be monitored through observation to achieve a benchmark of 90% for six consecutive months.

## Recommendation 4

The Coatesville VA Medical Center Director evaluates Community Living Center wound prevention processes and ensures that required wound documentation, including the measurement of patient weights and maintenance of skin integrity, is completed and monitored for compliance.

Concur.

Target date for completion: January 31, 2021

### Director Comments

The CLC wound prevention processes, including documentation, measurement of patient weights and maintenance of skin integrity, will be defined in local policy. Staff will be trained,

and policy compliance will be monitored. Specifically, the Community Living Center policy for admission documentation is under revision to rewrite the requirement for weights within 24 hours of admission. Policy revisions were completed and approved by the oversight nursing committees to the "Community Living Center Weights and Measurements" standard operating procedure to define weight intervals, documentation of weights and when to report unexpected or unusual weight changes. Medical record audits will be conducted to ensure a benchmark of 90% for six consecutive months.

## Recommendation 5

The Coatesville VA Medical Center Director ensures that the newly developed Community Living Center hourly rounding form and process is approved in accordance with the facility's standard operating procedure and aligns with the facility's rounding policies, and monitors compliance.

Concur.

Target date for completion: November 30, 2020

### Director Comments

The Community Living Center rounding tool has been developed and is routing through the nursing committee approval process. Staff will be provided with education on the new rounding tool. Compliance with completing the rounding tool will be monitored, and data aggregated, to reach a benchmark of 90% for six consecutive months.

## Recommendation 6

The Coatesville VA Medical Center Director makes sure that the fact-finding review process includes tracking and documenting issues through resolution and monitors compliance.

Concur.

Target date for completion: Request Closure.

### Director Comments

Coatesville VAMC [VA Medical Center] employs fact-findings and root cause analyses to investigate patient care and staffing concerns raised by staff. Since March 2019, allegations leading to fact-findings have been tracked to completion by the Human Resources Department. In the event this process is not sufficient to determine a conclusion; an administrative investigation is chartered in accordance with VA Directive 0700. From March 2019 to date, there were 25 fact-finding cases and 3 cases were referred to an administrative investigation board. The allegations from 12 cases were unfounded and closed, 6 cases led to

disciplinary action, and 4 investigations remain active. The Human Resources Department reviews the tracking sheet with the Medical Center Director on a regular basis.

### OIG Comment

The facility provided sufficient supporting documentation, and the OIG considers this recommendation closed.

## Recommendation 7

The Coatesville VA Medical Center Director ensures that the Executive Leadership Board and the Geriatric and Extended Care Executive Council review, document, and track identified facility issues and, for the Executive Leadership Board, recommendations through resolution.

Concur.

Target date for completion: November 30, 2020

### Director Comments

The Coatesville VA Medical Center committee governance structure was recently revised to realign clinical committees to report directly into the Medical Executive Board. The Geriatrics and Extended Care Executive Committee reports to the Medical Executive Board. The Medical Executive Board reports to the Executive Leadership Board. The Geriatrics and Extended Care Committee will report issues and recommendations identified and discussed by the committee to the Medical Executive Board through a reporting tool that will serve as a cover sheet with the submission of minutes. The Geriatrics and Extended Care Executive Committee will track the progress of recommendations and follow through to closure through a tracking tool that will be added to the minutes. The Medical Executive Board minutes will report to the Executive Leadership Board the issues identified and the status of recommendations as detailed by the Geriatrics and Extended Care Committee. Compliance will be monitored to reach a benchmark of 90% for six consecutive meetings.

## Recommendation 8

The Coatesville VA Medical Center Director reviews and monitors the maintenance and functionality of essential safety equipment on Community Living Center units.

Concur.

Target date for completion: November 30, 2020

### Director Comments

A policy will be developed to define the procedure for identifying broken equipment, removing the equipment from service (as able), and reporting procedures. Staff will be trained on the

procedure. Compliance will be monitored to reach a benchmark of 90% for six consecutive months.

## Recommendation 9

The Coatesville VA Medical Center Director updates the facility staffing methodology policy and staffing methodology calculations to comply with current Veterans Health Administration staffing methodology requirements.

Concur.

Target date for completion: Request Closure

### Director Comments

The VHA Directive 1351 for Staffing Methodology for Nursing Personnel is followed by Coatesville VA Medical Center. The policy was updated and signed in September of 2018. Staffing methodology completed in June of 2018 utilized the revised policy from September 2018, and included observations within the staffing methodology plan. Coatesville concurs that the policy was not uploaded timely and there was a delay in rescinding the 2015 nursing staffing methodology nursing practice policy from the Medical Center Plans and Procedures section; however, the staff involved in completing the staffing methodology plan were aware of the updated VHA Directive 1351. The policy also changed from a Nursing Practice Policy to a Medical Center-wide Nursing Policy with a newly assigned number. The nursing hours per patient day were increased to account for increased observation needs of patients, including one to one observation of patients, and the Medical Center Director approved additional hiring of nursing staff for 138B in the Community Living Center to meet the revised staffing methodology plan expectations in June 2018.

### OIG Comment

The facility provided sufficient supporting documentation, and the OIG considers this recommendation closed.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
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