Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Patient Abuse Issue
Dwight D. Eisenhower VA Medical Center
Leavenworth, Kansas

Report No. 04-03348-102 **March 10, 2005**

VA Office of Inspector General
Washington, DC 20420

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Veterans Integrated Service Network Director (10N15)

SUBJECT: **Final Report** – Healthcare Inspection – Alleged Patient Abuse Issue, Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas – Project Numbers: 2004-03348-HI-0020/2004-03348-HL-1193

1. Summary

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) reviewed an allegation of patient abuse at the Dwight D. Eisenhower VA Medical Center (medical center), Leavenworth, Kansas. The purpose of the inspection was to determine the validity of the allegation.

2. Introduction

The complainant, a community nursing home (NH) administrator, alleged that a resident returned from a medical center admission with carvings on his left leg. The resident was admitted to the medical center on September 7, 2004, for psychiatric evaluation, and when he was discharged back to the NH on September 14, nursing staff noted initials described as "HXK carved into the patient's left leg." The NH administrator contacted the state board who instructed her to take photographs and to contact the OIG Hotline.

3. Scope and Methodology

We conducted a site visit of the medical center and interviewed quality management (QM) staff and clinicians assigned to care for the patient. We reviewed relevant medical records and other related documents. We toured the psychiatric unit where the patient had been admitted.

We also conducted a site visit of the NH and interviewed the complainant, administrative personnel, the patient, and the clinicians assigned to care for the patient. We reviewed relevant medical records and other related documents.

The inspection was conducted in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

4. Case History

The patient is an 86-year-old male with a history of Schizophrenia and Bipolar Affective Disorder since 1944, with one documented suicide attempt in the 1970s. He also has hypertension, osteoarthritis of the hands, skin cancer, and Parkinson's disease. The patient has been a resident at the NH since September 2001.

On September 7, 2004, the patient was transferred from the NH to the medical center because of increased aggressive behavior towards the staff and refusal of food and medication. The patient had also verbalized that he would starve himself to death. Prior to the transfer, his nurse gave him a bath and did a head to toe assessment. She documented in the medical record a rash on the left side of his face, two bruises on the left arm, and a bruise on the left calf. The patient was transferred to the medical center emergency room (ER) for medical screening before admission to psychiatry. The ER clinicians documented that he had a five-inch diameter bruise with a small abrasion in the center of his left calf and a half-inch laceration on his left ankle. They documented that the injuries seemed to be recent, but the causes were unknown. After determining that the patient was medically stable, the patient was admitted to the acute psychiatric unit.

During the hospital stay, the patient was bedridden and dependent on others for his care and mobility. Because of the Parkinson's disease, the patient had involuntary limb movements. He was placed on a close observation status to monitor his behavior during his hospital stay. Medical center clinicians noted that his behavior was not consistent with the NH report of aggressive behavior. The patient took fluids and medications crushed in fluids, and ate 40 percent of his food. Medical center records did not contain activity of daily living flow sheets, but nurses' notes documented that skin care, incontinence care, and personal hygiene with total assistance had been given. There was no mention of initials on the patient's left leg in the medical record.

On September 14, he was discharged, accompanied by an escort, to the NH with a follow-up outpatient appointment in four weeks. The admitting NH nurse assessed the patient and noted an area on his "left inner shin with 3 scabbed areas that are shaped as HXK with a large faded bruised area surrounding this area." The NH administrator was contacted, and digital pictures were taken of the area and sent to VA OIG Hotline.

5. Inspection Results

Issue 1: Patient Abuse

We did not substantiate patient abuse. While we did observe initials etched in the patient's left leg, we were unable to determine who made the marks.

On November 9, we visited the NH and interviewed the NH administrator, clinical staff, and the patient. The clinicians and administrator stated they did not feel the patient could have self-inflicted the wound due to his involuntary movements from Parkinson's disease. When they asked the patient who had done this, he stated, "I don't know." We interviewed the patient with the assistance of a nurse. He was alert and oriented and answered our questions in a coherent way but with garbled speech. When asked who did this, he stated that he had "fallen out of bed at the hospital and that his legs were cut underneath the bed." When asked if someone did this, he stated "No" several times. At the end of the interview he stated he "was sorry to have caused this." An examination of his left leg revealed the left calf area had healed with faint initials HY (or X) K apparent.

On November 10, we visited the medical center and interviewed QM staff, the nurse manager, and clinicians who provided care to the patient. The ER physician and nurse both stated that there were no initials on the patient's left leg at the time of the admission assessment. They both documented a large bruise with an abrasion on the left calf. When shown the photograph of the initials on the patient's leg, both clinicians stated this was not present when they examined the patient's leg on September 7. The nurse manager stated that the patient never fell during the hospital stay and that no injury to the patient was reported to her. The nurses and nursing assistants who cared for the patient on the unit did not document any wound or initials on the patient's left calf nor could they recall specifics about personal care provided to this patient. The psychiatrist stated she did not examine the patient's skin and relied on the nursing staff to alert her to patient injuries. QM staff stated that they did not receive an incident report regarding a fall or wound on the patient. We were told nurses do not use a skin integrity assessment tool and that use of the activity of daily living (ADL) sheet was not the practice in psychiatry. There was no policy regarding skin assessment and documentation of ADLs on psychiatric patients.

6. Conclusion

We concluded that the initials on the patient's left leg were made while he was admitted at the medical center, but we were unable to positively determine who inflicted them. The NH documented a skin assessment and prior to his transfer to the medical center on September 7, and noted a bruise to the patient's left calf. Both ER clinicians who examined the patient on September 7, noted a left calf bruise with a small abrasion, but they denied the patient had initials carved into his leg at the time of admission to psychiatry. Psychiatry notes documented the left calf bruise until September 8, after which there was no mention of the bruise or any leg markings. The nurse manager stated that it was not the psychiatry policy to document skin integrity or ADLs. The photographs and documentation of the initials by the NH clinicians clearly substantiate that the initials occurred while the patient was at the medical center. We were unable to determine if the wound was self-inflicted or done by another person.

We concluded that despite being placed on close observation, the psychiatry staff did not monitor the patient properly. If skin care and bathing had been monitored, then clinicians would have been alerted to the initials on the patient's leg.

7. Recommendations

The VISN Director needs to ensure that the Medical Center Director:

Recommended Action 1. Develop a skin integrity program for psychiatric patients who are mobility impaired.

Recommended Action 2. Document ADLs for all psychiatric patients.

Recommended Action 3. Use this case to reinforce the importance of careful monitoring and documentation of care for psychiatric patients. Such documentation would have provided a better understanding of the sequence of events in this case.

On November 29, we recommended that the NH obtain blood samples for Hepatitis B and C and Human Immunodeficiency Virus (HIV) because of the inability to positively identify who inflicted the markings and potential risks to the patient.

8. VISN Director Comments

The VISN Director concurred with recommendations 1 and 3 and concurred in part with recommendation 2. (See Appendix A for full text.)

9. Assistant Inspector General Comments

The VISN Director concurred with recommendations 1 and 3 and concurred in part with recommendation 2. We agree that documentation of ADLs for non-independent psychiatric patients meets the intent of the recommendation.

(original signed by:)
JOHN D. DAIGH JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 22, 2005

From: VISN Director

Subject: **Healthcare Inspection - Alleged Patient Abuse Issue, Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas**

To: Management Review Service (10B5)

(See attached comments.)

(*original signed by:)*

Peter L. Almenoff, MD., FCCP

VISN Director's Comments to Office of Inspector General's Report

The following VISN Director's comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

The VISN Director needs to ensure that the Medical Center Director:

Recommended Action 1. Develop a skin integrity program for psychiatric patients who are mobility impaired.

Concur **Target Completion Date:** February 1, 2005

Immediately following the investigation, nursing staff received training related to the use of a skin assessment worksheet where they utilize anterior and posterior diagrams to mark and describe any alterations in skin integrity. This assessment is completed upon admission with follow-up assessments as needed. A skin integrity template is utilized for any skin alterations that require follow-up and/or monitoring. Patients assessed to have an alteration in skin integrity at the time of admission will have an additional skin assessment worksheet completed immediately prior to discharge.

Recommended Action 2. Document ADLs for all psychiatric patients.

Concur, In Part **Target Completion Date:** March 7, 2005

All patients will be assessed for ADL function. An ADL template currently in place in Long Term Care will be individualized according to patient needs and used for non-independent psychiatric patients.

The primary nurse assigned each patient will monitor completion of the ADL template weekly.

Recommended Action 3. Use this case to reinforce the importance of careful monitoring and documentation of care for psychiatric patients. Such documentation would have provided a better understanding of the sequence of events in this case.

Concur **Target Completion Date:** November 10, 2004

This case was immediately shared with staff for lessons learned.

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia Solana, Associate Director, Dallas Regional Office of Healthcare Inspections, (214) 253-3332.
Acknowledgments	Linda Delong, Director, Dallas Regional Office of Healthcare Inspections Shirley Carlile Marnette Dhooghe Dorothy Duncan J. Douglas Metzler Roxanna Osegueda Marilyn Walls

Appendix C

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