Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Community Living Center Quality of Care Issues
VA Palo Alto Health Care System
Palo Alto, California

Report No. 10-03526-13 **October 26, 2010**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The purpose of this review was to determine the validity of an allegation that a resident of the community living center (CLC) at the VA Palo Alto Health Care System, Palo Alto, CA was left unattended on the patio of his living unit and as a result was sunburned on over 36 percent of his body. We partially substantiated the allegation. We substantiated that the resident was left unattended on the patio, but we did not substantiate that he was sunburned as a result.

An occupational therapy student left the resident unattended on an un-shaded patio without alerting nursing staff. When staff discovered him approximately 2 hours later, he was experiencing a heat reaction. Clinical staff responded appropriately and the resident sustained no long-term effects. The resident, fully clothed and wearing a hat, was not sunburned during this event. Prior to our review, CLC managers implemented appropriate actions to address supervision and heat related needs of residents on the patio.

During our review, we identified a process needing improvement. Nursing students at the CLC received safety training, but students of other disciplines did not receive the same training. We recommended that students of all disciplines who provide care to CLC residents receive safety training applicable to the CLC resident.

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

TO: Director, Sierra Pacific Network (10N21)

SUBJECT: Healthcare Inspection – Alleged Community Living Center Quality of Care Issues, VA Palo Alto Health Care System, Palo Alto, California

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations by a complainant regarding the quality of care provided to a resident of the community living center (CLC) at the VA Palo Alto Health Care System (the system), Palo Alto, CA.

Background

The system is a multi-division, tertiary facility located in Palo Alto, CA. It consists of three inpatient facilities, which are located in Palo Alto, Menlo Park, and Livermore. The system has 277 hospital beds, 100 domiciliary beds, 96 Psychosocial Residential Rehabilitation Treatment Program beds, and 424 CLC beds.

We reviewed allegations that a veteran (the resident) who resides at the Menlo Park CLC was left unattended on the patio of his living unit and as a result was sunburned on over 36 percent of his body.

Scope and Methodology

We interviewed the CLC Nurse Manager, the CLC nurse practitioner, the Risk/Safety Manager, the resident, the resident's conservator, physicians, and other staff knowledgeable about the complaint. We also reviewed VA directives, system policies and procedures, and other documents related to this case.

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

Case Summary

The resident is a wheelchair-dependent male in his 70s. His medical history is significant for physical and psychiatric impairment. Occasionally, he is confused and requires staff assistance with wheelchair locomotion.

One day in July 2010, at the resident's request, an occupational therapy student assisted him to an un-shaded CLC patio without informing the nursing staff. The resident was wearing multiple layers of clothing and a hat. Approximately 2 hours later, staff discovered him on the patio, unresponsive in his wheelchair. His skin was warm and flushed, his recorded temperature was 104 degrees, and his pulse rate was 120 beats per minute. CLC staff immediately brought him inside, administered oxygen, wrapped his head and neck with iced wet towels, and removed his clothing. The CLC nurse practitioner responded immediately. Paramedics transported the resident to the system's emergency department (ED). At the time of transport, his temperature was 100.5 degrees.

The resident's temperature was 100.3 degrees when he arrived at the ED. ED staff performed blood tests, and the resident received intravenous fluids and antibiotics. The ED physician noted that the resident's legs and abdomen had a blotchy, bright red erythema[1] that was not consistent with sunburn. After receiving treatment in the ED, the resident was admitted to the system for evaluation of the erythema. He was discharged 2 days later and returned to the CLC.

Practitioners told us that the resident was not sunburned, and they believed CLC staff responded appropriately. The ED physician told us that he thought the 104 degree temperature recorded at the CLC might have actually been 100.4 degrees because the temperature decreased faster than he would have expected. The resident did not remember the incident and the conservator was satisfied with the resident's care.

Inspection Results

Issue 1: Resident Supervision

We did substantiate that the resident was left unattended on the patio.

Older adults are at a greater risk from injury caused by extreme heat and cold exposure.[2] Because of this risk, CLC residents require frequent supervision and assessment when they are outdoors. The resident was on the un-shaded patio for approximately 2 hours without supervision before staff found him unresponsive in his wheelchair. As a result,

[1] Erythema is a redness of the skin. It may occur with any skin injury, infection, or inflammation.
[2] P. Potter, A. Perry, *Fundamentals of Nursing* (Fifth Ed.), Mosby, St. Louis, 2002, p. 1020.

he had an elevated body temperature, an altered mental state, and required emergency medical treatment.

After the incident occurred, the CLC Manager initiated multiple safety measures that included providing sunscreen, additional hydration, and umbrellas for residents who use the patio. The manager also provided heat exposure education to staff and revised procedures to assure staff assess all patients at least once an hour.

Because the CLC manager took appropriate actions and initiated additional safety measures prior to our review, we made no recommendations.

Issue 2: Sunburn

We did not substantiate that the resident received sunburns on over 36 percent of his body as a result of being left unattended on the patio.

The resident was wearing multiple layers of clothing and a hat, and practitioners told us that the resident was not sunburned. The ED physician noted erythema on the resident's abdomen and legs that was not consistent with sunburn and admitted him to the system for further evaluation of the erythema.

Issue 3: Other Issue Identified

During this review, we identified that CLC student safety training needed improvement.

The CLC must assure resident safety. Nursing students at the CLC receive safety training; students of other disciplines do not receive the same training. An occupational therapy student left the resident on the patio without informing nursing staff. The resident was in the sun for approximately 2 hours and experienced a heat reaction before staff discovered him. To ensure resident safety, all students who interact with CLC residents require safety training.

Conclusions

We partially substantiated the allegation. We substantiated that the resident was left unattended on the patio, but we did not substantiate that he was sunburned. Clinical staff responded appropriately, and the resident sustained no long-term effects. CLC managers implemented appropriate actions after the incident to address supervision and heat related needs of residents on the patio.

We identified an aspect of care that needed improvement. Not all students who interact with CLC residents received safety training.

Recommendation

We recommended that the System Director ensure that students of all disciplines who provide care to CLC residents receive safety training applicable to the CLC resident.

Comments

The VISN and Medical Center Directors agreed with the finding and recommendation (see Appendixes A and B, pages 5–7, for the Director's comments). Because the medical center addressed the issue identified in the recommendation, we consider this recommendation closed.

(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: October 19, 2010

From: Director, Sierra Pacific Network (10N21)

Subject: **Healthcare Inspection – Alleged Community Living Center Quality of Care Issues, VA Palo Alto Health Care System, Palo Alto, California**

To: Director, Denver Office of Healthcare Inspections (54DV)

Thru: Director, Management Review Service (10B5)

1. Thank you for the opportunity to comment on the draft report regarding the OIG Hotline Inspection at the VA Palo Alto Health Care System.

2. I concur with the findings and the action plan submitted by the VA Palo Alto Health Care System. I am confident that the plan put into place will prevent an incident of this type from occurring in the future.

(*original signed by*:)
Sheila M. Cullen
Director, VISN 21

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 19, 2010

From: Director, VA Palo Alto Health Care System (640/00)

Subject: **Healthcare Inspection – Alleged Community Living Center Quality of Care Issues, VA Palo Alto Health Care System, Palo Alto, California**

To: Director, Sierra Pacific Network (10N21)

1. VA Palo Alto Health Care System appreciates the opportunity to review the OIG Report on the Alleged Community Living Center Quality of Care Issues.

2. Please find attached our response to the recommendation provided in the report.

3. If you have any questions regarding the response to the recommendation in the report, feel free to call me at (650) 858-3939.

(*original signed by Joanne Krumberger for*:)
Elizabeth Joyce Freeman
Director, VA Palo Alto Health Care System

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

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

OIG Recommendation

We recommended that the System Director ensure that students of all disciplines who provide care to CLC residents receive safety training applicable to the CLC resident.

Concur **Target Completion Date:** Completed

Facility's Response:

During the VA Office of Inspector General (OIG) Office of Healthcare Inspection review at the VA Palo Alto Health Care System, it was found that nursing students at the CLC receive safety training and students of other disciplines do not receive the same training. After this event, student education has been standardized for all disciplines. The occupational therapy (OT) student involved was counseled and re-educated on the importance of clinical communication between all disciplines and appropriate patient hand-off.

Effective immediately, OT supervisors will document all students' understanding related to safe patient hand-off at week 2, 4, and 8 of their 12-week internship on the student evaluation tool.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana Director, Denver Office of Healthcare Inspections (303) 270-6500
Acknowledgments	Ann Ver Linden, Team Leader Laura Dulcie Stephanie Hensel

Appendix D

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