Administrative Closure
VA Salt Lake City Health Care System (660/00)
Salt Lake City, Utah
MCI # 2013-00945-HI-0435

In November 2012, VA's Office of Inspector General's (OIG's) Office of Healthcare Inspections reviewed allegations regarding scope of practice, patient abuse, and medication management in the Surgical Intensive Care Unit (SICU) at the George E. Wahlen VA Medical Center ("the facility"), Salt Lake City, UT.

A complainant alleged:

- *Overmedication of Patients:* In order to regulate behavior, patients are medicated with Benadryl® without a prescription.
- *Patient Abuse:* Patients are being restrained without provider orders by Nurse A and unidentified nursing students during the third shift.
- *Receipt of Unauthorized Care:* Nurse A used a scalpel, lidocaine, and suture to remove a lesion from Nurse B's leg.

These three allegations were sent to the facility in December 17, 2012, for review, and on February 17, 2013, OIG's Hotline Division (53E) received a response from the facility. The allegations were investigated by the facility's Associate Director of Quality and Safety Systems.

The facility did not substantiate that patients were medicated with Benadryl® to regulate behavior. There is one automated dispensing machine (ADM) in the SICU. The facility reviewed the ADM's records for Benadryl® and the Controlled Substance RN-specific reports for the period of June-December 2012. Nurses can access Benadryl® in override status and sometimes do this before the order has reached pharmacy. The facility interviewed SICU Providers, NPs and a Physician Assistant (PA) who did not report inappropriate use of Benadryl® or evidence of over sedation in patients.

The facility did not substantiate the allegation of patient abuse. The facility reviewed its daily restraint audits and found nothing amiss in this regard and interviewed several SICU staff who did not corroborate that restraints were used without orders.

The facility did not substantiate that Nurse A removed a lesion from Nurse B's leg. However, Nurse A did admit to removing a lesion from the neck of an employee in 2012.

In March 2013, OIG's Hotline Division referred two additional allegations that were mistakenly left off the December 2012 original request for information. The two additional allegations included:

- *Patient Abuse:* A patient accidently threw up on Nurse B. Nurse B used profane language and called the patient offensive names.
- *Unprofessional Behavior:* Nurse B took a written complaint, regarding an alleged incident where Nurse B stood over an intubated, partially sedated patient and shouted, "fight it you gomer", as a "trophy" and posted it on her locker.

The facility did not substantiate that Nurse B abused a patient. However, the Associate Chief of Nursing Service did find that it was not uncommon for nurses to use inappropriate language when speaking with one another. Human Resources and the facility's Union Representative conducted a presentation for the SICU staff regarding appropriate conduct in the workplace. The facility did substantiate that Nurse B demonstrated unprofessional behavior by posting a photocopy of a patient's complaint on her locker.

OIG made a site visit to the facility the week of May 28, 2013. We interviewed facility human resources staff, medical, and pharmacy leaders and providers, SICU staff, and the facility's Chief of Police. We reviewed relevant local and VHA policies, procedures, SICU orientation guides, and documentation of disciplinary actions. We also obtained and reviewed the facility's documentation relating to its internal reviews of the above allegations. Upon review of documents provided by the facility, we identified additional allegations related to receipt of unauthorized care exceeding SICU staff nurses' scope of practice and medication management. Specifically, these additional allegations included the following:

- *Receipt of Unauthorized Care:*
  - Staff administers intravenous (IV) fluid to each other when they have the flu, and, in one instance, during a staff member's pregnancy.
  - Toradol® was administered by a Nurse to a PA without an order.
- *Medication Management:* A nurse did not follow proper VHA procedures in disposing of excess narcotic medication ("waste of a narcotic").

Prior to our site visit, the facility had conducted a fact finding review of these allegations. Their review did not substantiate that staff were administering IV fluid to other staff members in SICU. However, they did find that administration of IV fluid to a staff member in the MICU had occurred. The facility substantiated that Toradol® was administered to a SICU PA. However, they could not determine whether the SICU nurse or the PA administered the injection. The facility also substantiated the allegation that an SICU nurse did not observe waste of a narcotic as required by VHA policy.

During our interviews with various staff, we were provided four cases where the following concerns were expressed regarding care provided by (b)(6)

- (b)(3): 38 U.S.C. 5701.(b)(6): A Bumex®[1] Drip was continued despite the patient simultaneously receiving fluid boluses and increasing norepinephrine dosages to maintain the patient's blood pressure.
- (b)(3): 38 U.S.C. 5701.(b)(6): Patient only had one kidney and now requires hemodialysis due to renal damage. Patient spent 4-5 hours in PACU hypotensive, and then transferred to SICU for further management. Patient was hypotensive over 16 hours. Patient had systolic blood pressure (SBP) in 70's all night. Arterial line placed and fluid volume given. It was stated that general surgery did not want fluids to be given, and that (b)(6): was concerned he was not contacted during the night.
- (b)(3): 38 U.S.C. 5701. - Oral dose of levothyroxine 112 micrograms was changed to intravenous dose of levothyroxine 112 micrograms. Dose adjustment between PO and IV should be 50% of the PO dose, so the IV dose was double what the patient needed.
- (b)(3): 38 U.S.C. 5701.(b)(6): - High lactate level was not addressed. Left Ventricular Assist Device (LVAD) was removed per family request without physician order.

An OHI physician reviewed these cases and recommended that two (b)(3): 38 U.S.C. 5701.(b)(6): of the four be referred to the facility Peer Review Committee. The two referred cases were reviewed by the facility Peer Review Committee (b)(3): 38 U.S.C. 5705. These peer reviews were conducted according to VHA guidelines.

SUMMARY

We found that the facility was aware of the allegations and concerns described in this Administrative Closure prior to our site visit and had thoroughly investigated the issues and administered disciplinary action where appropriate. In addition, the facility found an additional incident of *Receipt of Unauthorized Care,* which was not substantiated, and two incidents related to *Medication Management.* The facility was in the process of addressing the additional *Medication Management* incidents through disciplinary action. Two of the four referred cases were referred to the facility Peer Review Committee and (b)(3): 38 U.S.C. 5705. Peer reviews were conducted according to VHA guidelines. We made no recommendations and therefore, are administratively closing this case.

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[1] Bumex® is a diuretic medication used for the treatment of edema associated with congestive heart failure, hepatic, and renal disease.