Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care, Courtesy, and Communication Issues
VA Medical Center
St. Louis, Missouri

Report No. 08-01359-165 **July 11, 2008**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of the review was to evaluate multiple allegations regarding a patient's experience with the Ambulatory Evaluation and Treatment Center (AETC) and an inpatient surgery ward at the VA Medical Center, St. Louis, Missouri. The complainant alleged quality of care concerns related to staffing, post-operative monitoring, pain management, and discharge orders. In addition, he alleged lapses in courtesy and inadequate communication with family members regarding a delay in surgery.

We did not substantiate allegations that the AETC was understaffed, that the patient was not evaluated for 45 minutes after his transfer to the inpatient surgery ward, or that the patient did not receive pain medication upon his request. We also found that with one minor lapse in taking vital signs, nurses appropriately followed physician's orders. Although the patient perceived the staff members were rude to him and his family, we could not confirm or refute these allegations. We did not substantiate that medical center staff did not communicate a delay in surgery to his family members. We made no recommendations.

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

TO: Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Quality of Care, Courtesy, and Communication Issues, VA Medical Center, St. Louis, Missouri

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation in response to alleged quality of care, courtesy, and communication issues at the VA Medical Center (the medical center), St. Louis, Missouri. The purpose of the review was to determine whether the allegations had merit.

Background

The medical center is a full-service health care facility providing medicine, surgery, psychiatry, neurology, and rehabilitation services. The medical center includes the Jefferson Barracks division and the John Cochran division and serves veterans in east-central Missouri and southwestern Illinois. The allegations included in this complaint involved the John Cochran division Ambulatory Evaluation and Treatment Center (AETC) and an inpatient surgery ward. The medical center is part of Veterans Integrated Service Network (VISN) 15.

The complainant contacted the OIG Hotline on February 12, 2008, regarding his experiences during ambulatory surgery and hospitalization on January 30–31, 2008. The complainant alleged quality of care concerns related to AETC staffing, post-operative monitoring, pain management, and discharge orders. In addition, he alleged lapses in courtesy and inadequate communication with family members regarding a delay in surgery.

Scope and Methodology

We conducted a site visit on April 23–24, 2008. Prior to our visit, we interviewed the complainant by telephone. During our visit, we interviewed the physician, nurses, and administrative staff involved in the patient's care and administrative processing. We

reviewed the patient's medical record, relevant medical center policies and procedures, and AETC and operating room log sheets.

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

Inspection Results

Issue 1: Quality of Care Concerns

We did not substantiate the allegation that the AETC was understaffed. We reviewed the medical center's AETC staffing standards and compared them with actual staffing levels on the day of the patient's ambulatory surgery. We found that staffing levels met requirements.

We did not substantiate the allegation that nursing staff did not evaluate the patient's status for 45 minutes after his arrival to the inpatient surgery ward. The patient's procedure ended at 4:32 p.m.; he was transferred to the post-anesthesia care unit (PACU) at 4:43 p.m. and was then transferred to the inpatient surgery ward at 6:00 p.m. According to the patient's medical record, the inpatient surgery ward nurse evaluated the patient at 6:00 p.m., upon his admission to the inpatient surgery ward.

We did not substantiate the allegation that the patient received anti-nausea medication intravenously around 9:00 p.m. but did not receive pain medication. The complainant told us he was offered Tylenol™. Medical record documentation shows, however, that the patient received acetaminophen with hydrocodone (not Tylenol™) as prescribed for his pain at 7:21 p.m. A follow-up assessment, documented at 10:00 p.m., reflected that the pain had resolved. It appears that nursing staff appropriately followed physician's orders for pain management.

We determined that the inpatient surgery ward nurse had not precisely followed the physician's orders to take and record vital signs; however, we found this to be a minor discrepancy that did not negatively impact the patient. At 5:02 p.m. on January 30, the physician ordered vital signs including pulse, respiration, and temperature each shift, with morning vital signs to be recorded by 7:00 a.m. We found that the nurse recorded normal vital signs at 1:30 a.m., at 2:27 a.m., and then again at 8:00 a.m., but not by 7:00 a.m. as ordered.

We determined that the nurse appropriately discontinued the Foley catheter (used to drain urine from the bladder) and intravenous fluids (IVFs) in accordance with the physician's orders. At 10:49 a.m., the physician ordered the patient's discharge once he was tolerating food and drink by mouth. The nursing note documented patient evaluation prior to discharge. The physician finalized the discharge instructions at 10:51 a.m. and,

after the pharmacy prepared the discharge medications, the patient was discharged at 11:50 a.m.

Issue 2: Alleged Lapses in Courtesy

We could not confirm or refute the allegation that administrative support staff continued conversing with another employee rather than attend to the patient's needs during the check-in process. We toured the AETC and interviewed staff responsible for administrative check-in. The staff could not recall any negative or controversial interactions with this patient or his family members. The medical center's patient advocate had not received complaints from the patient or family and had not identified any trends related to lapses in staff courtesy in this area. During our tour, we observed good interactions between the staff, patients, and family members in the AETC. The medical center requires all staff to complete customer service training during orientation and annually thereafter.

We could not confirm or refute the allegation that inpatient surgery ward nursing staff told the patient the delays in post-surgical care were the result of budget cuts and staffing shortages, causing the patient to become "exasperated with rudeness." The patient was unable to provide the staff names or specific times of the alleged statements, and all staff we interviewed denied hearing or making such statements. Again, the patient advocate had no record of this concern. We could not evaluate this complaint further.

We did not substantiate the allegation that the patient requested post-surgery pain medication and was offered two regular Tylenol™ tablets. The complainant claimed that when he objected to taking Tylenol™ by mouth due to his nausea, the nurse said, "Take it or leave it." The complainant reported that after he took Tylenol™, he experienced nausea and vomiting. Medical record documentation shows that the patient received acetaminophen with hydrocodone (not Tylenol™) at 7:21 p.m. The physician documented that the patient vomited one time at around 11:00 p.m.

We were unable to confirm or refute the allegation that inpatient surgery ward nursing staff were rude to the patient and his family on the day of discharge. The complainant reported that his family understood he could be discharged once he was "up and moving." Family members assisted the patient to walk in the hallway, and he finished his breakfast around 8:30 a.m. At approximately 10:00 a.m., the family inquired when the patient could go home and perceived that a staff member at the nursing desk responded rudely. The patient was unable to provide staff names or specific times, so we were not able to assess this complaint further. We toured the inpatient surgery ward and did not witness any staff responding in a discourteous way to patients or family members.

Although the patient perceived that staff members were rude to him and his family, we could not confirm or refute these allegations.

Issue 3: Inadequate Communication

We did not substantiate the allegation that staff did not communicate a 3-hour surgery delay to family members until approximately 6:00 p.m., after the patient was transferred to the inpatient surgery ward. The patient was originally scheduled for surgery at 10:30 a.m. The following time line shows the progression of patient care beginning with the patient's check-in at the AETC until the time anesthesia began.

Time	Event
7:57 a.m.	Patient check in.
9:21 a.m.	Completed pre-screening evaluation.
9:26 a.m.	Checked into AETC by nursing staff.
Unknown	Surgeon contacted to complete signed operative consent form.
9:50 a.m.	Operating room contacted AETC to transport the patient to the pre-operative holding area; patient and family were informed that the signed operative consent form had not been completed.
10:30 a.m.	Patient signed operative consent form.
11:35 a.m.	Patient transported to the pre-operative holding area.
11:45 a.m.	Anesthesia started in pre-operative holding area.
4:45 p.m.	Patient transferred to post-anesthesia care unit (PACU).

The 1 hour 15 minute delay (10:30 a.m. – 11:45 a.m.) was a direct result of the operative consent form not being signed until 10:30 a.m. Usually, the operative consent form is completed at the time the surgery is scheduled. Because paperwork requirements can be overlooked, AETC staff routinely complete a pre-surgery checklist immediately prior to surgery to confirm that all necessary processes have been completed and documents have been signed. In this case, the back-up process worked as designed and the operative consent form was completed. One family member did remain with the patient throughout this time until his transport to the pre-operative holding area at 11:35 a.m.

Clinical staff told us that a member of the surgery team informs the family once the patient's surgery is complete. The patient's surgeon confirmed that he routinely discusses surgical outcomes with family members during evening rounds at approximately 7:00 p.m. on the day of surgery. He stated that he could not recall any unusual circumstances involving this patient or his family members.

Although it is clear that the patient's and family members' expectations related to communication were not met, we determined that medical center staff communicated adequately with the patient's family.

Conclusion

We did not substantiate allegations that the AETC was understaffed, that the patient was not evaluated for 45 minutes after his transfer to the inpatient surgery ward, or that the patient did not receive pain medication upon his request. Although the patient was correct that his vital signs were not taken by 7:00 a.m. on January 31, they were taken at appropriate intervals and as frequently as indicated. Therefore, we did not substantiate allegations that the physician's orders were not followed. Although the patient perceived that staff members were rude to him and his family, we could not confirm or refute these allegations. We did not substantiate that medical center staff did not communicate a delay in surgery to his family members. We made no recommendations.

Comments

The VISN and Medical Center Directors agreed with our findings. No follow-up actions are planned.

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

Appendix A

OIG Contact and Staff Acknowledgments

OIG Contact	Toni Woodard, Senior Healthcare Inspector Atlanta Office of Healthcare Inspections (404) 929-5961
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Appendix B

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