Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Inpatient Care Issues
Tennessee Valley Healthcare System
Alvin C. York Campus
Murfreesboro, Tennessee

Report No. 08-01993-177

July 31, 2008

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The purpose of the review was to determine the validity of allegations regarding a patient's care while hospitalized at the Tennessee Valley Healthcare System, Alvin C. York Campus, in Murfreesboro, Tennessee. At the request of the Chairman, U.S. House Committee on Veterans' Affairs, we reviewed allegations from a patient and his wife that during an April 24, 2008, medical center admission:

- the inpatient unit reeked of feces.
- the patient was not given any food or fluids for several hours.
- the patient had to request that a catheter be removed because it was painful.
- the patient never received pain medication for a pre-existing condition.
- the patient did not receive a nicotine patch he was promised.
- a physician was rude and uncaring.

We did not substantiate any of the allegations. On June 5, 2008, we toured the unit where the patient had been hospitalized and found it was clean and well maintained; there was no odor present at the time of our inspection. Medical records document that the patient received intravenous fluids while in the emergency room and when admitted. Nursing notes document that the patient was taking oral fluids during the inpatient admission. A bladder catheter was removed because the patient complained of discomfort and burning at the insertion site, but there was no indication in the medical record that the patient was upset or demanded the removal. Nurses documented that they had informed the patient of the rule regarding no self-administered medications and noted that the patient verbalized understanding of this rule. The patient complained of back and leg pain on admission, but frequent notes document that he was pain free during the 2-day hospitalization. However, nurses became aware that the patient had been taking his own medications for chronic back and leg pain. Due to these medications, the patient was not able to give permission for a diagnostic test or to tolerate conscious sedation. Clinicians had to cancel the procedure. There was no evidence to support that a physician was rude or uncaring. The patient advocate did not have any reports regarding the physician, and the nursing staff commented that the physician was especially caring with patients.

Because we did not substantiate any allegations, we made no recommendations.

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

TO: Director, Veterans Integrated Service Network (10N9)

SUBJECT: Healthcare Inspection – Alleged Inpatient Care Issues, Tennessee Valley Healthcare System, Alvin C. York Campus, Murfreesboro, Tennessee

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, conducted an inspection to determine the validity of allegations regarding the inpatient care provided to a patient at the Tennessee Valley Healthcare System (TVHS), Alvin C. York Campus in Murfreesboro, Tennessee.

Background

The Alvin C. York Campus (the medical center) provides primary care and subspecialty medical, surgical, and psychiatric services to veterans. The medical center provides long-term rehabilitation and nursing home care and serves as a Veterans Integrated Service Network (VISN) 9 resource for the long-term inpatient care of psychiatric patients. The medical center has 347 hospital beds and 245 long-term care beds. TVHS is affiliated with the graduate medical education programs of Vanderbilt University School of Medicine and Meharry Medical College.

At the request of the Chairman, U.S. House Committee on Veterans' Affairs, we reviewed allegations from a patient and his wife that during an April 24, 2008, medical center admission:

- the inpatient unit reeked of feces.
- the patient was not given any food or fluids until 8:00 pm.
- the patient had to demand that clinicians remove the foley catheter they inserted because it was causing serious pain.
- the patient never received pain medication for his severe back pain.
- the patient did not receive a nicotine patch he was promised when clinicians told him they did not want him to smoke.

- a physician was rude and uncaring.

The complainants also stated concerns regarding Social Security disability payments.

Scope and Methodology

We interviewed the complainant by phone. We conducted a site visit at the medical center on June 5, 2008, and interviewed physicians, nurses, and quality managers who were knowledgeable about this patient's care. We reviewed quality management documents, patient advocate data, and the complainant's medical records. This review addresses the complainants' VA patient care concerns; it does not address concerns regarding Social Security disability payments, because that is not within the scope of our authority.

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

Inspection Results

Case History

The patient presented to the Emergency Department (ED) on the morning of April 24, 2008, with complaints of inability to urinate for 12 hours, abdominal distention, and stating he "forced him self to vomit and it was black." The patient has a history of hypertension, gastroesophageal reflux disease,[1] lumbosacral spondylosis[2] without myelopathy,[3] and cerebral vascular accident. A foley catheter inserted into his bladder drained concentrated urine; and a nasogastric (NG) tube was inserted with immediate return of dark colored emesis, guiac positive for blood.

That afternoon, he was taken to the Gastrointestinal (GI) Laboratory for an emergent esophagogastroduodenoscopy (EGD).[4] After conscious sedation was administered, the procedure was performed without complication. The clinical assessment was esophagitis[5] versus Mallory-Weiss tear.[6] The patient was taken back to the ED with recommendations to admit for observation, give no food or oral fluids, and start intravenous (IV) fluids. The patient was scheduled for a repeat EGD the next morning.

The patient was admitted to a medical unit at approximately 3:00 pm. The physician examined the patient shortly after he arrived on the unit. The physician documented that the patient complained of burning and pain at the catheter insertion site, he was alert and

[1] Reflux of gastric contents into the esophagus resulting in mucosal damage.
[2] Anterior or posterior slipping or displacement of one vertebra on another.
[3] A general term denoting functional disturbances and/or pathological changes in the spinal cord.
[4] Endoscopic examination of the esophagus, stomach, and duodenum.
[5] Inflammation of the esophagus.
[6] A linear mucosal laceration in the juxtaesophageal gastric mucosa.

oriented, and he was on nothing per mouth (NPO) status because of the scheduled repeat EGD in the morning. Approximately 1 hour later, a nursing note documents that the catheter was removed. The nurse also documented that the patient asked to go for a smoke but was told not to leave the unit until his physician approved. A nursing note written just before 10:00 pm states that the patient "…Knocked IV out…IV restarted and taped well." A nursing note written just after 10:00 pm states "Vet will watch the IV and IV site and be careful of both."

An April 25 nursing note written at about 5:00 am states that the patient had no complaints of pain and that IV fluids were infusing. A day shift nursing note documents that the patient was very lethargic during initial rounds and that the patient's wife told her that the patient had his own supply of pain medications from home and that she believed he had been taking the pills during the night. The nurse took the pills and instructed the patient that it was against policy to take medications from home during inpatient admissions.

Later that morning, the patient was taken to the GI Laboratory for a repeat EGD. However, the gastroenterologist documented in the patient's medical record that the "Patient presented to the GI lab intoxicated appearing this am. Patient told me that he has been taking his own hydrocodone from a bottle he brought with him. This was confirmed by the …nursing staff...He is in no way suitable for IV conscious sedation today and could not give consent for the procedure…I suspect there may be other substances involved as well, likely brought from home." The EGD was canceled with instructions to reschedule if the patient resumes bleeding or as an outpatient. The gastroenterologist also noted that the patient "…confessed to taking naproxen [a non-steroidal anti-inflammatory drug (NSAID)] which he denied yesterday."

The patient was discharged on April 25 with instructions to be compliant with his medication, follow up with GI as an outpatient if he resumes bleeding, stop taking NSAIDs, follow up with his primary care provider in 1–2 weeks, and return to the ED if he develops any GI bleeding, shortness of breath, or chest pain. Patient verbalized understanding of his discharge instructions and apologized for the circumstances. His condition on discharge was stable.

Issue 1: Environment of Care

We did not substantiate unclean conditions on Ward 1A.

Ward 1A is a combined medical surgical unit that is split into separate wings. The unit has a total of 32 beds with telemetry capability for 17 beds. We toured the entire unit and found that the unit was clean, well maintained, and that there was no odor present at the time of our inspection. We noted that the patient was assigned a private room directly adjacent to the nurses' station. Corridors were clean, and equipment was kept to one side of the hallway. Supply closets and the dirty utility rooms were locked, as appropriate.

We noted that staff was interacting with patients and families and not congregated at the nurses' stations. We spoke with several patients and families during the inspection, and none voiced concerns with the cleanliness or care.

Issue 2: Food and Fluids

We did not substantiate that the patient was not given food or fluids from the time he arrived in the ED until 8:00 pm.

The patient presented to the ED on the morning of April 24. Blood was drawn and sent to the lab, a foley catheter was inserted and he was taken to radiology for x-rays. Two hours after his arrival, a nasogastric tube was inserted, and 180 cubic centimeters (cc) of dark colored emesis was removed from his stomach. Twenty minutes later, an IV was inserted and fluids were administered at 125 cc an hour for approximately 2 hours. The IV and NG tube were discontinued after his emergent EGD. Further, while we did not find a diet order or an order for the patient to be on NPO status, a nursing end of shift note documents that his oral intake for the shift was 500 cc. We could not substantiate or refute that the patient did not receive any of the reported oral fluids before 8:00 pm. There is no indication he received solid foods.

During our review, we noted that on April 24 at approximately 3:00 pm the patient was ordered to receive IV sodium chloride 0.9% solution at a rate of 100 cc an hour. However, there is no indication in the medical record that the patient received IV fluids until a nursing note written at around 10:00 pm documents that the patient was told to "…watch the IV and IV site and be careful of both." Further, an 11:00 pm end of shift nursing note documents that the patient's IV fluid intake was 265 cc. This means that if the IV was infusing at 100 cc an hour, as ordered, it could not have been started until after 8:00 pm, which may explain the complainants' allegation.

The patient received IV fluids in the ED and some oral fluids after admission to Ward 1A. It is unclear when IV fluids were initiated on Ward 1A.

Issue 3: Foley Catheter

We did not substantiate that the patient had to demand the urinary catheter be removed.

The patient was seen and examined by a physician shortly after he arrived on the inpatient medical unit. The patient complained of discomfort and a burning sensation at the catheter site. A nursing note, written approximately 1 hour later, documents that the patient was given pain medication and the catheter was removed per physician order. There was no indication in the medical record that the patient was upset and demanding the catheter be removed.

Issue 4: Pain Medications and Nicotine Patch

We did not substantiate that the patient was not given pain medications. A nicotine patch was not ordered because the patient declined.

According to the Nursing Admission Intake form, the patient reported having back and leg pain at a level 5 on a scale of 1 to 10 with duration being all the time. However, there was no documentation in the medical record that the patient complained of back or leg pain during this admission. The only complaint he voiced was the discomfort of the catheter, and he was given pain medication. There are frequent notes from physicians and nurses stating the patient is in "no distress" and that the patient has "no complaints of pain." On the morning of April 25, nurses became aware that the patient had been taking his own pain medications that had been prescribed for his chronic back and leg pain. That may explain why he did not ask clinicians for pain medications.

The complainants' letter also states that "…no one advised us that no medications from home should be taken." However, the April 24 Nursing Admission Intake form documents that the patient was told "… No self administered medications" and that the patient verbalized understanding of this rule.

The physician told us that the patient was offered a nicotine patch but stated the patches "did nothing for him." Therefore, it was not ordered.

Issue 5: Physician Rudeness

We did not substantiate that a physician was rude or uncaring.

We interviewed the resident physician, attending physician, and gastroenterologist. Staff reported that the patient was angry that the second EGD was cancelled due to the patient being "intoxicated and unable to consent for the test." The patient threatened to leave against medical advice when a nurse removed his prescribed hydrocodone pills from him. The patient admitted to the staff that he had self medicated during the night shift. The GI and attending physicians recalled speaking with the wife to explain that they could not do the test with the patient in a medicated state and when he was unable to consent for the test. The physicians reported that the wife seemed cooperative and understanding of their discussions.

We interviewed nurses who cared for the patient. They did not observe any physician being rude or uncaring with the patient. Nurses stated that the resident physician is known to be especially caring with patients. However, they did comment that at times the resident physician's accent made it difficult for some patients to understand.

The attending physician stated she had not received any complaints regarding the resident's care or communication with patients. Additionally, the patient advocate had received no complaints regarding this family or resident. The Nurse Manager, who was on leave April 24 and 25, had no reports of contact from any of the nursing staff for those 2 days. She told us that the usual procedure if patients or families complain would be to generate a report of contact so she could follow up when she returned to duty.

Conclusions

Because we did not substantiate any of the complaints in this hotline, we made no recommendations.

Comments

The VISN and Healthcare System Directors agreed with the findings (see Appendixes A and B, pages 7–8 for the full text of their comments).

(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: July 3, 2008

From: Director, Veterans Integrated Service Network (10N9)

Subject: **Healthcare Inspection – Alleged Inpatient Care Issues, Tennessee Valley Healthcare System, Alvin C. York Campus, Murfreesboro, TN**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Office (10B5)

The report by the Office of the Inspector General conducted by Virginia Solana on June 5, 2008, has been reviewed and I concur with the report. There were no recommendations to be addressed.

If you have any questions or need additional information, please contact Pamela Kelly, Health Systems Specialist, Staff Assistant to the Network Director or me at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 26, 2008

From: Director, Tennessee Valley Healthcare System (626A4/00)

Subject: **Healthcare Inspection – Alleged Inpatient Care Issues, Tennessee Valley Healthcare System, Alvin C. York Campus, Murfreesboro, TN**

To: Director, Veterans Integrated Service Network (10N9)

We have reviewed the report by the Office of the Inspector General conducted by Virginia Solana on June 5, 2008, and concur with the report. There were no recommendations to address. We appreciate the opportunity to confirm the good care and treatment provided by our staff. If you have any further questions or concerns, please contact me at 615-327-5332.

(original signed by:)

Juan A. Morales, RN, MSN

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 997-6971
Acknowledgments	Pat Christ, Director, Program Administration and Special Projects Dorothy Duncan, Associate Director Marilyn Stones, Program Support Assistant

Appendix D

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