Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Review of Hospice Care Issues
VA Maryland Health Care System
Baltimore, Maryland

Report No. 08-01634-38 **December 8, 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 VA Office of Inspector General, Office of Healthcare Inspections, reviewed allegations of inadequate pain management, poor hospice care, and ineffective communication at the VA Maryland Healthcare System (VAMHCS), Baltimore Rehabilitation & Extended Care Center (BRECC). The purpose of this review was to determine the validity of the allegations.

The complainant, the patient's wife, alleged that:

- The patient did not receive adequate pain medication.
- The clinicians did not provide the patient hospice care.
- The patient's physician did not communicate effectively with family members.

We did not substantiate or refute the first allegation. We found that the patient's physician did prescribe pain medications for the patient; however, we were unable to determine if the patient's pain was appropriately managed because medical record (the record) documentation did not reflect pain assessments after each dose of pain medication. We recommended that pain assessments are documented in patients' medical records according to the system's policy.

We substantiated the second allegation. We found that a majority of the staff who cared for the patient was not trained in end of life issues and the interim plan of care did not include hospice care. We recommended that BRECC staff caring for hospice patients receive the required training.

We did not substantiate or refute the last allegation. We found that the patient's physician and other clinicians documented education in the record with the family regarding hospice care; however, the family believed that the physician did not keep them adequately informed of the patient's plan of care. We recommended that a dedicated interdisciplinary hospice team provide care for hospice patients.

The Veterans Integrated Service Network 5 and VAMHCS Directors concurred with the findings and recommendations. They submitted acceptable action plans, which include policy review and education of staff, compliance monitoring of pain assessments, staff education on end of life hospice care, and a dedicated hospice interdisciplinary team providing care to hospice patients. We find the action plans acceptable and will follow up until the plans have been implemented.

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

TO: Director, Veterans Integrated Service Network 5 (10N5)

SUBJECT: Healthcare Inspection – Review of Hospice Care Issues, VA Maryland Health Care System, Baltimore, Maryland

Purpose

The VA, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection of the quality of care provided to a hospice patient at the VA Maryland Health Care System's (the system) Baltimore Rehabilitation and Extended Care Center (BRECC). The complainant, the patient's wife, alleged that the patient did not receive adequate pain medication, clinicians did not provide acceptable hospice care, and the patient's physician did not communicate effectively with family members. The complainant sent a letter outlining these allegations to a Member of Congress, Veterans Integrated System Network (VISN) 5, system and BRECC staff, and the OIG Hotline. The purpose of this inspection was to determine the validity of these allegations.

Background

The system is comprised of the Baltimore VA Medical Center (VAMC), the Perry Point VAMC, the BRECC, and multiple community based outpatient clinics (CBOCs). The BRECC has 120 beds and provides geropsychiatry services, rehabilitation services, post-acute care, and hospice/palliative services for the system's patients.

Hospice is a mode of palliative care that generally signifies the presence of a terminal condition. Palliative care is a broad term that includes hospice care. The primary goal of palliative care treatment is comfort rather than cure in a person with an advanced disease.[1]

[1] VHA Directive 2003-008, *Palliative Care Consult Teams (PCCT)*, February 4, 2003; VHA Directive 2002-038, *Hospice and Palliative Care Workload Capture*, July 5, 2002.

VA's Office of Geriatrics and Extended Care (GEC) requires that "all medical centers assure that hospice care is made available to all enrolled veterans who need and select this type of care."[2] GEC defines hospice and palliative care as:

> …a coordinated program of palliative and supportive services provided in both home and inpatient settings for persons in the last phases of incurable disease so that they may live as fully and as comfortably as possible. The program emphasizes the management of pain and other physical symptoms, the management of the psychosocial problems, and the spiritual comfort of the patient and the patient's family or significant other. Services are provided by a medically-directed interdisciplinary team of health care providers and volunteers. Bereavement care is available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week.
>
> Hospice care generally requires the acknowledgment of the patient, the family, and the physician that the illness is terminal, that the primary focus of treatment is on comfort rather than cure, and that aggressive attempts at curative treatment are relinquished.[3]

Scope and Methodology

On May 27, 2008, OHI inspectors interviewed the complainant to obtain additional information and clarify issues pertinent to her complaint. On May 28–29, OHI inspectors conducted an onsite inspection and interviewed system and BRECC senior managers, physicians, nurses, and other employees knowledgeable about the patient's care. We reviewed the patient's medical record, system policies and procedures, and other pertinent documents. We toured the BRECC campus, including the ward where the patient received his care. Our review focused on the care provided to the patient during his admission to the BRECC. We referred other issues brought to our attention during employee interviews to system managers for appropriate action.

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

Case Summary

In 2003, the patient, a 59-year-old male, presented to a system CBOC complaining of persistent hoarseness. CBOC clinicians evaluated and treated the patient, but

[2] VA Office of Geriatrics and Extended Care, "Hospice and Palliative Care," http://10.2.51.79/geriatricsshg/docs/HPcare.DOC , accessed on July 15, 2008; Veterans' Health Care Eligibility Reform Act of 1996 (38 CFR §17.38).
[3] VA Office of Geriatrics and Extended Care, "Hospice and Palliative Care."

approximately 2 weeks later, he returned with complaints of continued hoarseness. He was referred to the ear, nose, and throat (ENT) clinic. ENT clinicians noted left vocal cord paralysis but saw no obvious tumor. Computed tomography (CT) scans showed a mass in the left lung suspicious for a neoplasm, and the patient was ultimately diagnosed with advanced lung cancer.

Oncology clinicians managed the patient's care from 2004 through 2007. The patient had chemotherapy and radiation treatment and CTs to monitor the progression of his disease. He was in remission from March 2005 until August 2006, when he presented to the system's emergency department with confusion and speech problems. An imaging study showed changes in his brain that were indicative of metastatic cancer. The patient was given additional chemotherapy and radiation treatment.

A March 2007 CT scan of the chest showed that the patient's cancer had progressed, and treatment options (chemotherapy versus hospice care) were discussed with the patient and his wife. They decided to pursue more chemotherapy. A July chest CT scan showed continued progression of his disease, and hospice care was again discussed with the patient and his wife. At that time, they elected to try oral chemotherapy and more radiation treatments.

In October 2007, a physician noted that the patient had decreased cognitive and physical functioning. That physician discussed palliative care with the patient's wife, and she decided that she would care for the patient at home with the possibility of hospice care if his mental status did not improve. Later that month, the patient had a brief hospitalization at the Baltimore VAMC for ataxia[4] and multiple falls. At discharge, the physician recommended that the patient and his wife contact their oncologist to discuss further treatment options.

Two days later, because the patient's mental status was deteriorating and he was becoming increasingly difficult to manage at home, the oncologist referred him for inpatient hospice care. The patient was admitted the next day to the BRECC's inpatient nursing home care unit for hospice care. However, the patient's wife had concerns about his care and pain management and decided to take him home on day 3 of his admission. The patient received home hospice services and was subsequently admitted to a non-VA inpatient hospice unit where he died in late November 2007.

[4] Ataxia: Incoordinaton. S*tedman's Medical Dictionary*, 25th ed., 1990, p. 147.

Inspection Results

Issue 1: Pain Management

We did not substantiate or refute the allegation that the patient did not receive adequate pain management. We found that nursing staff documentation of pain monitoring did not meet the requirements of the system's policy.[5]

The complainant told us that on the second day of the patient's BRECC admission, a nurse told her that he was receiving 30 milligrams (mg) of morphine every 8 hours. Pharmacy records show that prior to the BRECC admission, the patient was receiving morphine 75 mg SR (sustained release) every 8 hours along with oxycodone—another narcotic medication—for breakthrough pain.[6]

The attending physician reviewed the patient's medication orders at the time of his admission to the BRECC. The physician's admission orders for pain medications included morphine 60 mg SR every 8 hours and acetaminophen 650 mg every 4 hours as needed. The physician told us that he spoke to the complainant and discussed the patient's treatment regimen and medication changes at that time. The physician documented in the patient's medical record that he explained to the patient, with his wife and son present, that "…we would adjust his medications based on our observations at BRECC." In addition, he documented that the patient "…is on a number of medications that could contribute to his confusion and impulsiveness and we will assess to taper over the admission." The physician told us that his rationale was to decrease medications to evaluate whether the changes would improve the patient's mental status. On the day of discharge, the attending physician documented that the patient's wife "…stated that he [the patient] was not getting as much pain medications here as at home…I [attending physician] explained that the nursing staff and I had not observed that he was having pain except when swallowing – that he was started on a treatment for possible candida esophagitis…."

The system's pain management policy states that patients are to be screened for pain on admission and discharge, when vital signs are taken, when there is a clinically significant change, before and after initiation of pain relief measures, and when transitioning from one type of pain control to another.[7] The patient's pain level was documented as zero (no pain) on admission. However, his pain level was not assessed again for over 24 hours even though he received pain medications and had an additional vital sign check. Because the pain assessments were not done according to the system's policy, we were unable to determine if the patient's pain was appropriately managed.

[5] VAMHCS (VA Maryland Health Care System) Policy Memorandum 512-127/NEU-004, *Pain Management*, October 2005.
[6] Breakthrough pain: A transient increase in pain intensity from a baseline pain level. *Dorland's Illustrated Medical Dictionary*, 30th ed., 2003, p. 1351.
[7] VAMHCS Policy Memorandum 512-127/NEU-004, p. 3.

A manager told us that because the patient's admission pain assessment was zero, a pain management plan was not initiated. She told us that the computerized nursing assessment has now been modified to capture patients on scheduled narcotics who do not have complaints of pain at the time of admission but who obviously have pain control issues.

Issue 2: Hospice Care

We substantiated the allegation that the patient did not receive hospice care.

The patient's wife alleged that the patient did not receive adequate hospice care. In her letter she stated that "…during my time there no one came in to see him except to give him medicine and to take him to the dining room." She was concerned that the patient would not receive proper care when the family was not present and that he would fall.

Prior to October 2007, a palliative care physician was on staff, and specific beds on the first floor of the BRECC were designated as the hospice unit. However, a clinical manager told us that when the patient was admitted to the BRECC, a hospice program was not in place; rather, hospice services were being offered. The system did not have a palliative care physician on staff at that time,[8] and hospice patients were no longer assigned to designated hospice beds but were dispersed throughout the BRECC.

The system's policy[9] requires that all staff caring for hospice patients receive hospice training. We reviewed the training records of 21 BRECC staff who provided care for this patient and found that 16 had not received the required training.

On the day of admission, the attending physician examined the patient, completed an admission note and an Advance Care Planning note,[10] and requested that the patient be admitted to a nursing home bed with a hospice level of care. Initial patient assessments were completed by recreational therapy, social work, pastoral services, and nursing. However, the nursing interim plan of care[11] did not address hospice care.

Issue 3: Communication

We did not substantiate or refute the allegation that there was poor communication by the attending physician.

The complainant alleged that the attending physician did not appropriately communicate with her and her family. She said that when she tried to talk to the physician while he

[8] According to system management, a physician was hired for the Hospice/Palliative Care Program, GLTC (Geriatric Long Term Care Clinical Center), in September 2008.
[9] VAMHCS Policy Memorandum, 512-11/COS-013, *End-of-Life/Palliative Care Policy*, August 2007.
[10] Advance Care Planning note: "This note includes discussions of the patient's wishes regarding life-sustaining treatments, quality of life, hospice care and related comfort care issues." VAMHCS Policy Memorandum 512-11/COS-013.
[11] Interim plan of care: Registered nurses develop the interim plan of care within 24 hours of admission. VAMHCS SOP No. 102/GLTC-010, *Developing a GLTC Interdisciplinary Treatment Plan*, October 2005, p. 2.

was interviewing the patient, the physician told her not to talk, that there would be no other hospital visits for her husband, and that his condition was terminal.

The attending physician documented that he had "…reviewed the advance directives, the terminal nature of his [the patient's] condition, the goals of hospice care and the limitations of interventions that we would use in his care (including no transfer to hospital and no tubes), they [the wife and son] expressed understanding and agreement." Documentation supports that other health care providers had also discussed hospice care with the patient's family and that family members expressed an understanding of end-of-life care.

Despite documentation of patient and family education in the patient's medical record outlining the care that would be provided to the patient, the complainant told OHI inspectors that it seemed that "terminal care" was equivalent to "no care."

Conclusions

We could not substantiate or refute that the patient's pain was appropriately managed because pain assessment and relief measures were not documented according to the system's policy. Because the patient was not in a designated hospice bed, the majority of staff members caring for him were not trained in hospice care, and his nursing interim plan of care did not address hospice issues, we concluded that the patient did not receive hospice care. While the patient's medical record contains documentation that the physician communicated treatment and end-of-life care issues with the complainant, she believed that the physician did not keep her informed.

Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the System Director ensure that pain assessments are documented in patients' medical records according to the system's policy.

Recommendation 2. We recommend that the VISN Director ensure that the System Director ensure that BRECC staff caring for hospice patients receive the required training.

Recommendation 3. We recommend that the VISN Director ensure that the System Director ensure that patients admitted for hospice care are provided that care by a dedicated trained interdisciplinary hospice team.

Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable plans to ensure that contract revisions are identified, addressed, and upheld. We find the action plans acceptable and will follow up until the plans have been implemented.

(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 3, 2008

From: Director, Veterans Integrated Service Network 5

Subject: **Healthcare Inspection - Review of Hospice Care Issues, VA Maryland Health Care System, Baltimore, Maryland**

To: VA Office of Inspector General

1. I have reviewed the comments provided by the Medical Center Director, VAMHCS and I concur with their response below.

2. If further information is required, please contact Dennis Smith, Medical Center Director, VAMHCS, at (410) 605-7016.

(original signed by:)

SANFORD M. GARFUNKEL, FACHE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 3, 2008

From: VA Maryland Health Care System Director

Subject: **Healthcare Inspection - Review of Hospice Care Issues, VA Maryland Health Care System, Baltimore, Maryland**

To: Network Director, VISN 5 (10N5)

1. Attached please find the action plans for the three (3) recommendations from the Office of the Inspector General Healthcare Inspection Review conducted May 28-29, 2008.

2. The professionalism and cooperative manner demonstrated by your team during this review process was appreciated by all.

4. If you have any questions regarding this report, please contact Iris E. Pettigrew, Director Accreditation and Performance Improvement at 410-605-7009.

(original signed by:)

DENNIS H. SMITH

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

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommendation 1. We recommend that the VISN Director ensure that the System Director ensure that pain assessments are documented in patients' medical records according to the system's policy.

Concur **Target Completion Date:** Multiple

The VAMHCS views this corrective action into several activities.

1. The first is to provide additional understanding and clarification of the expectations for pain assessment documentation in the patients' medical records as specified in the organization's policy. There will be a review of the policies regarding pain assessment, care planning and documentation with all the Loch Raven VA Community Living Center (LR CLC), previously referred to as the BRECC, staff. In Nursing, staff identified as pain liaisons to the Nursing Inpatient Pain Committee will provide resources and ongoing information to the staff. Further, all new staff will receive this information during new employee orientation. The Director, Geriatrics Long Term Care Clinical Center (GLTC) and the GLTC Associate Chief Nurses and Nurse Managers are charged with assuring review of the policies with their staff. **Target Completion Date:** November 15, 2008

2. Nursing is in the process of developing a Nursing Standard Operating Procedure to specifically outline expected documentation for GLTC Nursing in addition to the organizational policy. It will be published and reviewed with staff. **Target Completion Date:** January 5, 2009

3. Compliance will be determined using chart reviews. This review will include: the initial pain assessment on admission by nursing and providers, inclusion on the initial plan of care by providers and nursing staff, documentation of the effectiveness of chronic pain medication, if applicable, and the documentation of prn medication effectiveness, when applicable. The cohort sample will include all admissions for hospice service during October to December 2008 at the LR CLC and the Perry Point (PP) CLC up to a maximum of 30 patients at each site. The findings will be tracked, analyzed and reported monthly by PI to the Director, GLTC, the GLTC Performance Improvement Sub-Council and reported bi-monthly through the Executive Performance Improvement Committee (EPIC) to the Executive Committee of the Medical Staff and the Executive Committee of the Governing Body. A compliance rate of 90 percent is the target. **Target Completion Date:** February 28, 2009

Recommendation 2. We recommend that the VISN Director ensure that the System Director ensure that BRECC staff caring for hospice patients receive the required training.

Concur **Target Completion Date:** February 28, 2009

Staff currently assigned to the LR CLC/Hospice area will receive a minimum of 5 initial hours of end of life or hospice care related training (including pain). The education will have specific venues targeted to all staff disciplines. After this initial training, a minimum of three hours education related to end of life or hospice care will be required. The hospice palliative medicine physician, who started 9/7/08, is a recognized end of life care education expert with over 25 years of clinical practice and instruction and will be available for ongoing education for all staff. Compliance goal will be that 90 percent of staff will have the initial training in 4 months.

Recommendation 3. We recommend that the VISN Director ensure that the System Director ensure that patients admitted for hospice care are provided that care by a dedicated trained interdisciplinary hospice team.

Concur **Target Completion Date:** Multiple

1. The VAMHCS is committed to providing veterans with excellent and compassionate hospice and palliative care, which includes end of life care. Presently, the LR CLC hospice interdisciplinary team (IDT) is comprised of a trained and dedicated physician with board certification in Hospice and Palliative Medicine having over 25 years of clinical and instructional experience, registered nurse, a social worker, a chaplain, pharmacist, and recreational therapist. The IDT will be fully functional within a month at both LR and PP CLC. **Target Completion Date:** November 1, 2008

2. Compliance with the IDT rendering hospice and palliative care will be accomplished through chart review to determine attendance or review of identified issues based on the notation in CPRS as additional signer. Compliance will be that 90 percent of the team reviewed the note as indicated. **Target Completion Date:** February 28, 2009

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Annette Acosta, MN, FNP, RN, Team Leader 781 687-2135
Acknowledgments	Kathy Gudgell, JD, BSN, RN Nelson Miranda, MSW

Appendix D

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