Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Continuity of Care Issues and Questionable Death
Salt Lake City VA Medical Center
Salt Lake City, Utah

Report No. 08-03039-83

March 4, 2009

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The purpose of this review was to determine the validity of allegations regarding failure to provide continuity of care for a patient and the questionable death of that patient at the Salt Lake City VA Medical Center (the medical center), Salt Lake City, Utah. A complainant stated that medical center staff did not provide necessary home care to a laryngeal cancer patient, following a June 2008 hospitalization. The complainant specifically alleged that the medical center did not provide promised tube feeding, pain medications, medical supplies, and a home health nurse to assist him when he arrived at his rural home. The complainant also alleged that the patient was not aware his laryngeal cancer had spread to lymph nodes and would not have consented to extensive throat and neck surgery had he been informed. The complainant further alleged that the clinician who performed a bone marrow biopsy during that hospitalization was incompetent because an artery was "hit" during the procedure, causing severe bleeding and death.

We substantiated that there was a disruption in the continuity of care following the patient's discharge from the medical center. Although a physician wrote appropriate orders before discharge, they were not carried through and the patient did not receive nutritional supplements, medications, medical supplies, or home health services upon his return home. Efforts were made to arrange this complex discharge but it was fragmented and not coordinated among all involved disciplines. It is especially imperative that proper discharge planning occur prior to return home to rural settings.

We did not substantiate that the medical center failed to fully inform the patient prior to the July surgical procedure. Records indicate that the patient was aware that his cancer had spread and discussed the surgery with his family prior to the procedure.

We did not substantiate staff incompetence related to the bone marrow biopsy (the biopsy). We determined the physician who performed the biopsy had completed all the requirements necessary to perform the procedure independently and did not deviate from standard of practice. The patient experienced a rare complication that does not correlate with clinician experience. However, this adverse event resulted in patient death and the medical center had not disclosed the event to the family.

We recommended that clinical staff be educated on rural health care needs and availability of services, and that interdisciplinary discharge planning meetings be coordinated for complex patients. We also recommended that the pharmacist's performance be reviewed for possible administrative action. Finally, we recommended that clinical staff be educated on adverse event disclosure, and the medical center needs to confer with Regional Counsel regarding informing the patient's family about their right to file tort and benefit claims. Veterans Integrated Service Network and Medical Center Directors concurred with our findings and recommendations and offered acceptable corrective action plans.

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

TO: Director, Rocky Mountain Network (10N19)

SUBJECT: Healthcare Inspection – Alleged Continuity of Care Issues and Questionable Death, Salt Lake City VA Medical Center, Salt Lake City, Utah

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding failure to provide continuity of care for a patient and the questionable death of that patient at the Salt Lake City VA Medical Center (VAMC, referred to here as the medical center), Salt Lake City, Utah.

Background

The medical center provides primary and secondary medical, surgical, neurological, psychiatric, and rehabilitative care for veterans in Salt Lake City and the surrounding areas. It is a specialty referral center for Veterans Integrated Service Network (VISN) 19 and is affiliated with the University of Utah School of Medicine. The Greater Montana Healthcare System, part of VISN 19, referred the patient to the medical center for specialty care.

The OIG received allegations from a complainant stating that medical center staff did not provide necessary home care to a laryngeal cancer patient, following a June 2008 hospitalization. The complainant specifically alleged that the medical center did not provide the promised tube feeding, pain medications, medical supplies, and home health nurse to assist him when he arrived at his home that was approximately 500 miles from the medical center. During our interview, the complainant also alleged that the patient was not aware his laryngeal cancer had spread to lymph nodes and would not have consented to July 2008 extensive throat and neck surgery had he been informed. The complainant further alleged that the clinician who performed a bone marrow biopsy during that hospitalization was incompetent because an artery was "hit" during the procedure, causing severe bleeding and death.

Scope and Methodology

We conducted a site visit at the medical center October 20–22, 2008, and interviewed physicians, nurses, pharmacists, a physician's assistant (PA), quality management staff, and medical center management. We reviewed policies, procedures, directives, and medical records. We interviewed the complainant by telephone to obtain clarification of the allegations and we interviewed a social worker, nurse, and physician from the referring VA system.

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

Case Summary

The patient was a male in his 60s who lived alone, approximately 500 miles from the medical center. His medical history included cancer of the larynx, diabetes, hepatitis C, renal insufficiency, and malnutrition. A Community Based Outpatient Clinic (the CBOC) in Montana provided primary care to the patient. The CBOC ear, nose, and throat (ENT) specialists referred him to a medical center ENT specialist for evaluation of a vocal cord lesion noted in October 2007. Following a biopsy in November 2007, the patient was diagnosed with Stage II laryngeal cancer.[1] Based on the standard of care for his cancer, he received radiation therapy that was completed in January 2008. His primary care clinician at the CBOC continued to provide care after radiation therapy was completed, and ENT specialists at the medical center continued to follow him in their clinic.

At an ENT clinic visit at the medical center in mid-June 2008, the patient reported that he had lost weight, noticed a firm mass on the right side of his neck, and was having difficulty breathing and swallowing. Physicians admitted him to the medical center for an emergency tracheostomy to assist his breathing and to perform cancer staging through radiographs and biopsy. A week later, physicians inserted a gastrostomy tube (G-tube) in his abdomen for feeding and administering medication. During this admission, he received physical therapy and was given a walker to assist him with ambulation. Additionally, nurses provided instructions on how to care for his tracheostomy and G-tube. The neck mass biopsy was positive for recurrent cancer, Stage III, and the patient's case was reviewed in Tumor Board.[2] The Chief ENT Resident discussed with the patient the Tumor Board's recommendation for surgical removal of the mass. The patient wanted to return home to discuss the decision about surgery with his family before proceeding with the surgery , which was planned for mid-July.

[1] Cancer is staged from level I-IV based on severity of disease. Patients with lower stage cancers have a better prognosis and chance of survival.
[2] Tumor Board is a group of specialized clinicians who evaluate and discuss treatment options for patients when a multidisciplinary approach is considered. The group collectively designs the best course of action for each patient.

Three days before discharge at the end of June 2008, the ENT Chief Resident wrote discharge orders to the pharmacy for G-tube nutritional supplements, medications, and tracheostomy supplies. Per the physician's orders, the supplies and medications were to be mailed to the patient's home. The Nurse Liaison (the liaison), assigned to manage patient care, made a home health referral to the CBOC to coordinate home care for the patient. The liaison telephoned a clinician at the CBOC to verify responsibility for arranging the patient's pulmonary and home health care needs. The liaison also faxed a discharge referral to the CBOC regarding the patient's home health and pulmonary needs. The discharge referral stated that the services should be provided "as soon as can be arranged" and included the following:

- the patient would need skilled nursing to assist with, and to teach, G-Tube care and feedings.
- the patient would need skilled nursing to assist with, and to teach, tracheostomy care, which included daily cleaning of the skin around the tracheostomy and daily cleaning of the inner cannula of the tracheostomy tube.

The liaison noted commercial flight arrangements had been made for the patient's return home and that supplies and medications were to be mailed to his home as soon as possible. This plan, including home health services, was conveyed to the patient and his family.

On the day of discharge, the liaison telephoned the CBOC to verify they had received the faxed patient information. The same day, the patient was discharged from the medical center to his home with the understanding that he would return to the medical center in mid-July if he decided to proceed with surgery. A certified nurse aid escorted him to the airport gate and he arrived in Montana on that day via commercial airline.

One day after discharge, the patient's son called the liaison and reported his father did not have his medications, G-tube nutritional supplements, or tracheostomy supplies. He also stated the patient had not received home health services. According to medical record documentation, the liaison contacted the pharmacy and was informed that the supplies would be mailed out overnight. The liaison also telephoned the CBOC and was reassured that home health would be arranged, starting that day (1 day after discharge). However, the following day (2 days after discharge), the liaison received a telephone call from a VA social worker in Montana informing her that there were no home health services available in the patient's town. The Chief ENT Resident telephoned the patient that same day and discussed his nutritional and pulmonary care, and told him to go to the nearest local hospital if he needed assistance. (During our review, we learned that the nearest hospital was more than 100 miles from the patient's home.) The patient told the Chief ENT Resident that he felt better since his supplies had arrived, but he still had not received his pain medications.

In mid-July, the patient returned to the medical center for the planned surgery. He underwent a total laryngectomy, bilateral neck dissection, right pectoralis flap reconstruction, and cricopharyngeal myotomy.[3] Following surgery, he was admitted to the surgical intensive care unit (SICU). There were no intra-operative complications noted; however, the patient's recovery was complicated by wound dehiscence, ileus, pneumonia, pectoralis hematoma, deep vein thrombosis (DVT), and thrombocytopenia.[4]

The day before surgery, the patient's blood platelet count was 162,000 platelets per microliter; 6 days post-surgery, the count had dropped to 83,000.[5] The Hematology/Oncology (Hem/Onc) department was consulted and there was concern he had developed heparin induced thrombocytopenia (HIT).[6] Heparin was the anticoagulant administered for treatment of the DVT. Physicians discontinued the heparin and placed the patient on an alternative intravenous anticoagulant, Argatroban®, because he remained at risk to develop thrombosis.[7] They observed the patient with the expectation that the thrombocytopenia would resolve. During the 3 weeks that followed, the patient remained in SICU and his clinical status improved. His activity level increased, he received physical therapy, and was able to walk when accompanied by a physical therapist. However, the thrombocytopenia did not resolve over time as would have been expected in HIT. Twenty-seven days post surgery, the patient's platelet count was 76,000, which was stable but not improved. Consequently, a bone marrow biopsy was ordered to determine if there was an underlying bone marrow process causing the blood disorder.

In mid-August, approximately a month after surgery, between 10:30–11:30 a.m., a Hem/Onc fellow performed a bone marrow biopsy. The bone marrow was obtained from the right iliac crest of the pelvis. Upon removal of the trocar,[8] a spurt of blood was observed and a pressure dressing was applied to the site. Blood loss was estimated to be approximately 5 cubic centimeters.[9] The patient tolerated the procedure well and was without distress until approximately 12:15 p.m., when he requested assistance to use the bedside commode and a nurse helped him to the side of the bed. He was alert, but suddenly became unresponsive and hypotensive with a systolic blood pressure of 50 millimeters of mercury (mm Hg).[10]

[3] Removal of the larynx, the lymph nodes, and surrounding areas of the neck; neck reconstruction utilizing the patient's pectoralis muscle; and treatment to muscles in the neck that improves the ability to swallow.
[4] An opening of the surgical wound at the suture site; intestinal blockage; lung infection; collection of blood with bleeding at the pectoralis muscle; potentially life threatening blood clot; and low platelets, a component of the blood that is important for blood clotting and hemostasis.
[5] Normal – 130,000 or above.
[6] HIT – a rare occurrence where thrombocytopenia is caused by an autoimmune reaction to heparin therapy. Thrombocytopenia is a deficiency of blood platelets, cells produced in the bone marrow – needed for clotting.
[7] Blood clot.
[8] The center portion of the needle used in the bone marrow biopsy procedure.
[9] Equivalent to a teaspoon.
[10] Hypotension is considered to be present when the systolic blood pressure falls below 90 mm Hg.

Attempts were made to resuscitate and stabilize the patient as the physicians worked to determine the cause of the patient's unstable condition. Clinicians noted an increase in the patient's abdominal circumference, and an abdominal ultrasound showed fluid/blood in the anterior peritoneal space.[11] After consultation with other clinicians and telephone consent from the patient's son, he was taken to the operating room for exploratory abdominal surgery. The attending surgeon (the surgeon) identified a massive retroperitoneal hematoma, resulting from injuries to the right internal iliac artery and external iliac vein. The patient remained critically unstable throughout the surgery as the surgeon attempted to repair the damaged artery and vein. Surgical efforts lasted from 2:00–4:40 p.m., during which time the patient received 13 liters of fluid and multiple units of red blood cells, frozen plasma, and platelets.

He was returned to SICU where resuscitative attempts continued. Despite the administration of large amounts of blood products and medication, the patient's condition was dire and the surgeon did not believe he could survive, in spite of further resuscitative attempts. Consequently, the surgeon contacted the patient's sons, who agreed it would be appropriate to discontinue life support measures. The patient expired at 5:33 p.m. Physicians requested an autopsy, but the family declined.

Issue 1: Continuity of Care

We substantiated that there was a disruption in continuity of care following discharge from the medical center, as the patient did not have the ordered nutritional supplements, medications, medical supplies, or home health care upon his arrival home on June 30.

Although the ENT physician wrote appropriate orders before discharge, they were not carried through for the patient upon his return home. The medical record documents that the patient's discharge planning needs were referred to the medical center liaison 3 days before discharge, at the end of June. The liaison assured airline reservations had been made for the day of discharge and sent the physician orders to the pharmacy with instructions that they were to be mailed to the patient's home by overnight mail. The liaison also contacted the CBOC to verify that home health care was available to assist the patient with his pulmonary and feeding needs.

When the patient's son called the medical center the day after discharge and reported that his father did not have his medications, nutritional supplements, or tracheostomy supplies, the liaison instructed the patient to use Carnation Instant Breakfast via the G-tube until the nutritional supplements arrived. The ENT Chief Resident also called the patient, gave instructions for nutrition, and told the patient to go to the nearest hospital if he had any care issues. The liaison contacted the discharge pharmacist who informed her that he had received the order for mail-out before the patient was discharged. However, he changed the order to a pick-up order because, in his experience, clinicians frequently

[11] An area of the abdomen that extends from the diaphragm to the pelvis.

enter the request for mailing by mistake when they mean pick-up. The pharmacist told us he did not contact the physician or the liaison to notify them he had changed the delivery status. After the liaison contacted the discharge pharmacist, he mailed the patient's nutritional supplements and medications by overnight delivery the day after discharge. They arrived the following day, but the tracheostomy supplies were not in stock, so they were not mailed with this delivery. The patient received the tracheostomy supplies about a week later. It is unclear when the pain medications arrived.

The liaison called the CBOC on the day after the discharge, after the patient's son informed her that there were no home health services. She spoke with the physician who informed her that home health care services were not available in the area where the patient resided. That same day, a Licensed Social Worker (LSW) from the VA Montana Health Care System in Ft. Harrison called the liaison to discuss the patient's home health needs; the LSW stated home health services were not available to the patient due to the location of his residence. The LSW indicated that she should be the contact for coordinating patient care needs in eastern Montana in the future. During our interview, the LSW stated she did not believe the liaison would have known to call her about the home health needs of the patient. She stated the staff at the CBOC might not have been aware home health care services were not available in the area where the patient lived. She stated "people that live in populated areas don't always grasp what very rural areas are like."

We found the pharmacist failed to communicate with the ENT physician and the liaison when he changed the order from mail-out to pick-up. Because the patient flew by commercial airline home, it was particularly important that the pharmacy items be mailed due to their weight and size. Additionally, due to airline flight restrictions, the patient could not have carried liquid nutritional supplements on the plane. Medical center policy states that pharmacy can mail patient medications or patients can pick them up at the pharmacy when they are discharged. When clinicians complete pharmacy discharge orders, a discharge consult is to be sent to the pharmacy and the unit coordinator is supposed to make a discharge counseling appointment. At that appointment, the discharge pharmacist counsels the patient and provides written instructions for each medication. The discharge pharmacist informed us that not all patients come to the pharmacy for the required counseling but the pharmacy still dispenses their medications to them from the pick-up window. In those cases, no pharmacist provides counseling. If patients do not pickup their medications when they are discharged, they are mailed to them within a week. There was no apparent attempt to procure the out of stock tracheostomy supplies that were requested to be mailed overnight.

Although efforts were made to arrange this complex discharge, it was fragmented and not coordinated among all involved disciplines. It may have been unrealistic to finalize discharge arrangements with weekend days involved. Clinicians were not clear on

inpatient or outpatient services that were available. An interdisciplinary meeting to discuss discharge planning would have been beneficial.

Issue 2: Quality of Care

Informed Consent

We did not substantiate the medical center failed to fully inform the patient prior to the surgical procedure.

During a telephone interview, the complainant alleged the patient would not have consented to the procedure had he been aware his laryngeal cancer had spread. The patient was diagnosed in November 2007 with squamous cell carcinoma of the larynx that had not spread. He was appropriately treated with radiation therapy for Stage II laryngeal cancer. The Chief ENT Resident reported that in June discussions with the patient, he related treatment options because the cancer had spread. Because the patient was now a Stage III, surgery was indicated. He stated he informed the patient that without the procedure there was only a 50 percent 5-year survival rate. The Chief ENT Resident stated he had spoken with the patient's sons as well, and they were aware the cancer had spread. The patient voluntarily returned to the medical center in mid-July and signed a surgical consent the day before surgery that included the diagnosis as "cancer of the larynx (voice box) with spread to lymph nodes in neck."

We concluded that the physician did inform the patient of the extent of his disease and that the patient was fully informed prior to consenting to the mid-July surgery.

Staff Competence

We did not substantiate staff incompetence related to the bone marrow biopsy (the biopsy). However, we did substantiate occurrence of an adverse event that resulted in patient death.

We reviewed the clinical experience of the physician who performed the bone marrow biopsy and determined the physician had completed requirements to perform the procedure independently. The physician was a first year fellow in the Hem/Onc Fellowship Training Program at the University of Utah School of Medicine. He had successfully completed medical school and residency training in internal medicine. He was licensed to practice medicine in Utah. The fellow was under the supervision of an attending Hem/Onc physician. The attending physician reported that fellows or PAs perform most bone marrow biopsies. The University of Utah School of Medicine requires that fellows complete a minimum of five supervised bone marrow biopsies. After that, the attending physicians determine if the fellow can perform biopsies independently. The fellow had performed at least five supervised bone marrow biopsies, and the attending physician had personally supervised three of them. Following the observed bone marrow biopsies, the fellow was allowed to perform biopsies without

supervision. The fellow had reviewed the patient's case with the attending physician prior to performing the procedure, and the attending told us he had no reason to believe the fellow could not perform the procedure. Additionally, a PA who had performed over 100 independent bone marrow biopsies was present for the procedure.

Because the patient remained thrombocytopenic despite having been off heparin for 3 weeks, we found the biopsy was indicated to adequately diagnose and treat the cause of the thrombocytopenia.

We interviewed the attending Hem/Onc physician regarding the administration of Argatroban®, which was not discontinued prior to performing the biopsy. The attending stated the practitioners did discuss discontinuing the anticoagulant prior to the procedure, but the consensus was that the risk of the patient developing another blood clot outweighed the risk of a complication from remaining on the drug. The attending physician reported that other patients had remained on the medication and had bone marrow biopsies without any bleeding complications. The complication that the patient experienced was extremely rare and the attending physician did not feel it was related to medication.

The procedure was without incident with the exception of a spurt of blood that came from the site when the trochar was removed. The blood loss was reportedly small, and it stopped soon after a pressure dressing was applied. The fellow had not ever seen a spurt of blood following a biopsy, and he attributed it to the fact that the patient was on Argatroban®. When he left the patient at approximately 11:50 a.m., the biopsy site was not bleeding and the patient was resting and in no distress. He was "shocked" when he received a phone call from the Chief ENT Resident at approximately 1:15 p.m. informing him the patient's condition had deteriorated.

The PA, who observed the procedure, stated fellows perform most inpatient bone marrow biopsies. According to the PA, the fellow followed all procedures appropriately and the PA reported that she would not have done anything differently. She did not recall anything unusual about the procedure with the exception of the spurt of blood after the trochar was removed. She confirmed that the bleeding stopped soon after pressure was applied and that the patient was resting and without distress after the procedure. She was also "shocked" when she learned the patient had died later that day.

Review of the medical record revealed the cause of death was massive retroperitoneal hemorrhage and right internal iliac artery and vein injury. The surgeon who performed the emergency surgery stated the vein appeared to be punctured and the artery was "macerated." He reported being able to repair the vein but not the artery. He believed that the vein and artery damage was from the bone marrow biopsy since there was no other apparent cause. The attending Hem/Onc physician stated the incidence of bleeding is a rare complication of bone marrow biopsy. He did believe it would be possible for the biopsy needle to inadvertently go through the iliac crest and into the retroperitoneal

space. He had never seen this complication in over 30 years of his practice. His research found one published article in which retroperitoneal hemorrhage was reported as a result of needle penetration through the iliac crest during a bone marrow biopsy. He informed us the article notes 2 of 60,000 cases with similar complications. The article notes that morbidity does not correlate with clinician experience. [12]

The attending was not aware of the spurt of blood following the biopsy until after the patient died. If he had been informed, he stated he might have gone to SICU to assess the patient, but the patient may not yet have been exhibiting symptoms. Finally, he was unsure that notifying him would have changed the outcome. Neither the fellow nor the PA thought there was anything unusual to report to the attending at the time of the biopsy.

We reviewed the facts surrounding the bone marrow biopsy and found that providers did not deviate from the standard of practice. Although there was a very tragic outcome, retroperitoneal hemorrhage is a recognized rare complication of bone marrow biopsy.

Issue 3: Institutional Adverse Event Disclosure

Adverse Event Disclosure

During the course of this investigation, we determined the medical center failed to properly disclose the adverse event to the family. Clinical disclosure is the forthright, empathetic discussion of clinically significant facts of an adverse event that involves actual or potential harm to a patient sustained during his or her care. Institutional disclosure is required in cases resulting in serious injury or death and in cases involving potential liability. These disclosures include an apology and information about procedures available to provide compensation.[13] Local policy states that disclosure will be communicated promptly with patients and/or patients' families and that these events will be documented in a template progress note in the electronic medical record

We were unable to find documented evidence of the required disclosure and the template progress note. Interviews with medical center management confirmed that institutional disclosure had not been completed. Medical center management had not informed the family of their right to possible compensation. The attending surgeon informed us that he discussed the event with the family as part of normal clinical interactions and his communication with a family, but that he was not aware of the local adverse event disclosure policy.

[12] Bain, B. J. (2005). *Bone marrow biopsy morbidity: review of 2003*. Journal of Clinical Pathology. 58: 406–408.
[13] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

Conclusions

We determined that the patient's June 2008 discharge planning process was ineffective. Patients in this VISN travel large geographical distances for care, and it is especially imperative that proper discharge planning occur prior to their return home to rural settings. Coordination of care is particularly important between referring facilities. Considering the patient's condition and the fact that he lived alone, approximately 100 miles from the nearest hospital, it was unrealistic for the ENT Chief Resident to instruct the patient to go there for problems. The discharge planning process needs to be individualized, comprehensive, and initiated early to ensure continuity of care. The pharmacy needs to follow written orders or contact clinicians for clarification.

The medical center did perform a comprehensive root cause analysis (RCA) for the adverse event that occurred from the bone marrow biopsy to determine contributing causes of variation. However, results of the RCA were not shared with the clinicians involved in the care of this patient. For performance improvement, it is important to share results with medical center staff.

Finally, the medical center needs to educate clinical staff regarding adverse event disclosure and inform the family of their right to possible compensation for this adverse event.

Recommendations

Recommendation 1. We recommended that the VISN Director ensures that clinical staff are educated on rural healthcare needs and availability of services.

Recommendation 2. We recommended that the VISN Director ensures that the Medical Center Director requires that the discharge planning policy be revised to include interdisciplinary meetings to coordinate complex patient discharges and the documentation of those meetings.

Recommendation 3. We recommended that the VISN Director ensures that the Medical Center Director reviews the pharmacist's performance in this case and takes appropriate administrative action.

Recommendation 4. We recommended that the VISN Director ensures that the Medical Center Director requires that clinical staff are educated regarding VHA and local policy for adverse event disclosure.

Recommendation 5. We recommended that the VISN Director ensures that the Medical Center Director confers with Regional Counsel regarding informing the patient's family about their right to file tort and benefit claims.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations of the inspection and provided acceptable action plans (see Appendixes A and B, pages 14–15, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(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: February 12, 2009

From: Director, Rocky Mountain Network (10N19)

Subject: **Healthcare Inspection – Alleged Continuity of Care Issues and Questionable Death, Salt Lake City VA Medical Center, Salt Lake City, UT**

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

Director, Management Review Office (10B5)

I have reviewed and concur with the recommendations and responses from the VA Salt Lake City HCS.

(original signed by:)

Glen W. Grippen, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 12, 2009

From: Acting Director, Salt Lake City VA Medical Center (660/00)

Subject: **Healthcare Inspection – Alleged Continuity of Care Issues and Questionable Death, Salt Lake City VA Medical Center, Salt Lake City, Utah**

To: Director, Rocky Mountain Network (10N19)

I have reviewed and concur with the recommendations. VA Salt Lake HCS action plans with target dates of completion are attached.

(original signed by:)

Robin L. Korogi, MS HRM

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 Recommendations

Recommendation 1. We recommended that the VISN Director ensures that clinical staff are educated on rural healthcare needs and availability of services.

Concur **Target Completion Date:** February 13, 2009

Immediate Plan: The transfer coordinator will directly communicate with the staff at the receiving site to ensure the proper handoff has taken place. The discharge discussion will include the services that the patient needs and an assurance that those services are available in the community. The handoff discussion will be noted in the patient's medical record.

Recommendation 2. We recommended that the VISN Director ensures that the Medical Center Director requires that the discharge planning policy be revised to include interdisciplinary meetings to coordinate complex patient discharges and the documentation of those meetings.

Concur **Target Completion Date:** March 16, 2009

The discharge planning policy will be revised to reflect daily discharge rounds and patient care coordination planning that involve the nurse physician liaisons, social workers, pharmacists, and the dieticians. Other disciplines will be included in the patient care coordination planning depending on the individual patient needs.

Recommendation 3. We recommended that the VISN Director ensures that the Medical Center Director reviews the pharmacist's performance in this case and takes appropriate administrative action.

Concur **Target Completion Date:** Completed

[Appropriate administrative action was taken.]

Recommendation 4. We recommended that the VISN Director ensures that the Medical Center Director requires that clinical staff are educated regarding VHA and local policy for adverse event disclosure.

Concur **Target Completion Date:** February 13, 2009

The station policy on Adverse Event Disclosure will be sent to all staff via outlook with the instructions to read and consult with the patient safety coordinator for any needed clarifications or questions.

Concur **Target Completion Date:** April 30, 2009

Each clinical area will include in their monthly staff meeting a discussion regarding Adverse Event Disclosure. This discussion will be documented in the meeting minutes.

Recommendation 5. We recommended that the VISN Director ensures that the Medical Center Director confers with Regional Counsel regarding informing the patient's family about their right to file tort and benefit claims.

Concur **Target Completion Date:** Completed

Medical Center Director met with Legal Counsel and and the Adverse Event Disclosure was completed with patient's family about their right to file tort and benefit claims.

Concur **Target Completion Date:** Completed

The Patient Safety Coordinator will immediately brief Executive Leadership when an adverse event has been identified and discuss whether or not an AIB, Peer Review, RCA or another quality focused review should be done. This change in process will be communicated to the Patient Safety Coordinator.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 997-6971
Acknowledgments	Dorothy Duncan Stephanie Hensel Michael Shepherd, M.D. Marilyn Stones

Appendix D

Report Distribution

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