Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care
South Texas Veterans Health Care System
San Antonio, Texas

Report No. 08-01825-20 **November 6, 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 cancellation of procedures, poor care, and neglect of a patient at the South Texas Veterans Health Care System (the system), San Antonio, TX.

We did not substantiate allegations of poor care and neglect before, during, or after open heart surgery. The patient's care was highly complex, beginning with the inability to complete a three-vessel bypass intra-operatively due to the patient's particular coronary artery anatomy, to post-operative complications, such as infection and sternal wound separation. Specifically, we did not substantiate the allegations of failing to provide proper respiratory therapy after surgery and of allowing the patient to suffer inattentively in pain.

We substantiated that two cancellations of procedures occurred but found that at least one of these cancellations was associated with extenuating clinical and administrative circumstances. There was a cancellation of a scheduled cardiac catheterization appointment that appeared to be justified, since emergent cases always take priority over routine procedures. In addition, all plans for the wound closure were tentative based on the patient's clinical status and culture results.

We substantiated that there was a delay in responding to a call light but did not substantiate that this lack of response nearly caused the patient's death. The system acknowledged there was a delay responding to the patient's call light on one occasion during his inpatient admission. Although the delay did not worsen the patient's condition, it was unacceptable. In addition, the complainant noted an incident where a nurse admonished the patient for repeated use of the call light while in isolation status. The nurse allegedly complained about the requirements of putting on protective clothing to enter the patient's room, which we could not substantiate or refute.

Finally, we substantiated that the patient suffered pain consistent with his overall condition but did not substantiate that he was neglected.

We recommended that the Veterans Integrated Service Network (VISN) Director ensure that the System Director implements processes for timely response to patient call lights. The VISN and System Directors agreed with our findings and recommendation and submitted appropriate action plans. We will follow up on the planned actions until they are completed.

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

TO: Veterans Integrated Service Network Director (10N17)

SUBJECT: Healthcare Inspection – Quality of Care, South Texas Veterans Health Care System, San Antonio, Texas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding cancellation of procedures, poor care, and neglect of a patient at the South Texas Veterans Health Care System (the system), San Antonio, TX.

Background

The complainant contacted the VA OIG Hotline Division and made allegations of poor care and negligence in the care of a 63-year-old patient at the South Texas Veterans Health Care System (the system), San Antonio, TX.

The complainant alleged that the system repeatedly cancelled procedures and failed to provide breathing treatments after surgery, that nursing staff ignored her father's calls for help when he was having difficulty breathing, and that a nurse was inconvenienced by the protective clothing requirements of his isolation status. She stated he went from a functioning person with mild chest pain to near death at the hands of the system. She also stated that he continued to be an inpatient and that she did not want to lose him due to the system's negligence.

The system is a tertiary care medical facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 15 community based outpatient clinics. The system is part of Veterans Integrated Service Network (VISN) 17 and serves a veteran population of about 333,000 in a primary service area that includes 62 counties in Texas.

Scope and Methodology

Prior to our site visit on June 2–4, 2008, we interviewed the complainant and obtained requested documents from the system. We also conducted a detailed review of the patient's electronic medical record and all case related documents.

During the site visit, we interviewed physicians, nurses, respiratory therapists, the patient advocate, and the cardiology clinic's patient services assistant. We also reviewed additional documents and assessed the quality of care provided before and after the patient's surgery.

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

Case History

The patient is a 63-year-old male with multiple diagnoses, including coronary artery disease, diabetes, post-traumatic stress disorder, hyperlipidemia, and hypertension. The patient initially complained of chest pain in November 2007. He described the pain as pressure/tightness in the chest that was relieved with rest. He denied other new symptoms at that time.

On December 19, 2007, the patient underwent an exercise tolerance test (ETT). Physicians terminated the ETT after 4 minutes because the patient developed chest pain, dyspnea, and ST segment depression.[1] He was sent home and told that the system would contact him to schedule a cardiac catheterization procedure.

On January 11, 2008, the system contacted the patient by telephone to schedule a cardiac catheterization. He informed the scheduler that he would be out of town that month and would prefer a date in February. The patient was scheduled for February 15, but the procedure was cancelled due to time constraints as a result of emergent cases added to the schedule. The patient was rescheduled for March 5, but this procedure was also cancelled. The cardiology record did not note a reason for the cancellation, but a review of the appointment book indicated that the procedure was cancelled by the cardiology clinic.

On March 18, the patient underwent a cardiac catheterization, coronary angiography, and femoral angiography and received a final diagnosis of three-vessel coronary artery disease. The physician recommended a thoracic surgery service evaluation and ordered an echocardiogram. On that same day, the thoracic surgeon determined that the patient would likely need a two-vessel open heart coronary repair with bypass grafting. The

[1] The ST segment in electrocardiogram tracing is important in identifying pathology. ST segment depression may indicate a decreased level of oxygen to the heart muscle.

patient agreed to undergo this procedure and was discharged home the following day to wait for an appointment to be scheduled.

On March 21, the patient underwent open heart surgery for coronary artery bypass with grafting. The patient tolerated the procedure well. He was transferred to the surgical intensive care unit (SICU) in stable condition and intubated on mechanical ventilation. The patient's respiratory status improved, and staff weaned him off mechanical ventilation the next day. Respiratory therapy notes indicate that the patient received breathing treatments as ordered. An Anesthesiology Service note dated March 24 documented concerns regarding the circumflex graft during surgery. The note further stated that there was a plan for heart catheterization to examine the graft.

On March 25, the patient's heart rate increased to 160 beats per minute with an abnormal rhythm. The patient received intravenous medications that decreased the rate; however, the abnormal rhythm continued. The following day, the patient underwent a cardiac catheterization for stent implantation to the circumflex heart vessel without complications. Two days later, the surgeon noted that the patient had a period of disorientation; however, the abnormal heart rhythm had resolved. The surgeon also documented a sternum malunion with some sero-hemorrhagic drainage.

On March 30, the patient experienced an increased respiratory rate with difficulty breathing. He required urgent intubation with mechanical ventilation. The patient received medications and a chest x-ray. The following day, a computed tomography scan of the chest showed atelectasis[2] of the lower lobes with an underlying hospital acquired pneumonia. It was also noted that there was no evidence of abscess formation.

On April 1, the patient underwent surgical procedures for sternal exploration, wire removal, debridement, and washout. The patient tolerated the procedures well, and staff transferred him to the SICU in stable condition. The following day, the patient was awake and responding appropriately. The surgeon documented that the patient required minimal ventilator support. Later that day, the patient was extubated and placed on oxygen at 50 percent on a breathing mask. The surgeon also placed the patient on contact isolation because of positive sputum cultures for methicillin resistant *Staphylococcus aureus* (MRSA). On April 4, the surgeon reported that the patient was recovering slowly with continued treatment for MRSA in the sputum and *Klebsiella*[3] in the urine.

On April 7, the surgeon again reported that the patient was recovering slowly. However, the surgeon further noted that there was improvement in respiratory status and that the patient's heart remained in a normal rhythm with medication. The patient required a decreased intensity of care and was transferred to a telemetry unit the next day.

[2] Atelectasis is a condition involving partial or total collapse of the lung.
[3] *Klebsiella* is a gram-negative bacterium.

On April 11, the thoracic surgeon's note at 12:42 p.m. indicated that the patient was uncomfortable when breathing and to consider transfer to the SICU for aggressive diuresis and management of his respiratory function. The patient was transferred non-emergently to the SICU around 8:45 p.m. but was in respiratory distress shortly after admission. His breathing status required intubation with mechanical ventilation, and aggressive medical treatment continued. The following day, the patient was alert and responsive. He was extubated, removed from mechanical ventilation, and placed on a breathing mask. Nursing documentation indicated the presence of purulent drainage from the incision site.

On April 16, staff transferred the patient from the SICU to the cardiology unit at the family's request. The patient remained on contact isolation precautions because sternal wound cultures showed vancomycin resistant *Enterococcus* (VRE). The patient's thoracic surgeon noted some improvement in breathing and energy level; however, the patient continued to recover slowly. The surgeon also noted that the patient's main issues were because of his respiratory and nutritional statuses. The patient's respiratory status continued to improve, and by April 20, he was feeling well.

On April 22, the thoracic surgeon reported that the chest wound was healing nicely, as the tissue was pink and healthy without drainage. The following day, the surgeon noted that the patient had not experienced a flare-up of recurrent or chronic health problems in the previous 7 days and submitted a consult to Geriatrics Skilled Nursing.

On April 26, the patient became apprehensive and expressed that he felt something bad was going to happen. He requested that staff look in on him frequently.

The patient's condition continued to improve, and he felt his strength slowly return. Physicians scheduled the patient for sternal exploration on May 1 and planned to discuss a possible plastic surgery date for sternal wound closure. The patient remained stable; however, surveillance culture of the sternal wound continued to show heavy growth of VRE and light growth of *Enterobacter cloacae*.[4] From May 7 through May 12, the patient successfully underwent surgical procedures three times for exploration, irrigation, and debridement of his sternal wound.

On May 14, the patient underwent surgical procedures for sternal debridement with a pectoralis myocutaneous advancement flap. Staff transported the patient to the SICU in stable condition. On May 18, the plastic surgeon noted that the wound looked good and that the patient's temperature had been normal the previous 24 hours. On May 21, the patient remained afebrile, and his condition continued to improve. Physicians discharged the patient home in stable condition on May 23.

[4] *Enterobacter cloacae* is a clinically significant gram-negative, rod-shaped, anearobic bacterium.

Inspection Results

Issue 1: Multiple Cancellations of Procedures

We substantiated that two cancellations of procedures occurred but found that at least one of them was associated with extenuating clinical and administrative circumstances.

We reviewed the cardiac catheterization appointment book for January through March 2008 and found that the patient had initially been offered a date in January, which he declined at that time. The procedure was then scheduled for February 15 and cancelled due to time constraints when emergent cases were added to the schedule. The procedure was rescheduled for March 5 and cancelled without a reason noted in the medical record. A note in the appointment book indicated that it was cancelled by the cardiology clinic. Therefore, we found two cancellations of scheduled cardiac catheterization appointments, at least one of which appeared to be justified since an emergent case always take priority over routine procedures.

During our interview, the complainant also expressed concerns regarding multiple cancellations of the sternal wound closure that was recently performed on the patient. Our review of the patient's medical record and our interview with the plastic surgeon revealed that the patient underwent debridements, washouts, and surveillance cultures on the sternal wound prior to closure. All plans for the wound closure were tentative based on the patient's clinical status and culture results. The plastic surgeon did not want to proceed with the wound closure until the patient was infection free and conditions were optimal for a successful outcome.

Issue 2: Failure to Provide Ordered Breathing Treatments

We did not substantiate that the system failed to provide ordered breathing treatments.

The complainant alleged that the system failed to provide the patient with ordered breathing treatments after undergoing coronary artery bypass surgery on March 21, 2008. We reviewed the electronic medical records and bar code medication administration log reports for March 21–31, the timeframe of the patient's post-surgical admission. All documents reviewed indicated that respiratory treatments were administered by respiratory therapists as ordered by the physician.

Issue 3: Lack of Response to Call Light Nearly Caused Death

We substantiated that there was a delay in responding to a call light but did not substantiate that this lack of response nearly caused the patient's death.

We reviewed the patient's electronic medical record for the care received from April 8–11, 2008, during his stay on the telemetry unit. We found that on April 11, there may have been a delay of approximately 30–40 minutes in responding to a call light

during evening shift change. However, this delay did not jeopardize the patient's clinical status or outcome. According to the Associate Chief of Nursing Service, the telemetry nurse is supposed to respond verbally to the call light and use the overhead paging system to notify the registered nurse on duty. The expectation is for nursing staff to go to the patient's room within 3–5 minutes.

In addition, the complainant mentioned an incident where a nurse admonished the patient for repeated use of the call light while in isolation status. The nurse complained about the requirements of putting on protective clothing to enter the patient's room, which we could not substantiate or refute.

The patient had been wheezing, and his breathing had been uncomfortable since his admission to the telemetry unit. According to a note in the medical record, the thoracic surgeon was concerned about fluid overload and wanted to transfer the patient to the SICU for aggressive diuresis and management of respiratory function. The patient was transferred to the SICU the evening of April 11, 2008, when a bed became available. After admission to the SICU that night, the patient's respiratory status declined. He required intubation and mechanical ventilation but was able to be extubated the following morning.

Overall, we did not find that a lack of response to a call light or negligence by the nurses on the telemetry unit nearly caused the patient's death. However, while a possible delay in response to the patient's call light did not jeopardize the patient's clinical status or outcome, it was unacceptable.

Issue 4: Patient Continued to Suffer Pain and Neglect

We substantiated that the patient suffered pain consistent with his overall condition but did not substantiate that he was neglected.

The patient had an extraordinarily difficult post-operative course, which was complicated by infection and sternal wound dehiscence.[5] He was, indeed, in distress during this hospitalization. Nevertheless, a review of the case and the documents pertaining to the patient's care revealed that the patient's medical care was appropriate. Each of the patient's complications was recognized by the system's clinical staff and treated within standards of care. Due to the patient's co-morbidities and post-operative complications, multiple additional procedures and a long recovery period were required. However, the patient was followed closely by medical staff, and his needs were addressed. When the patient complained of pain, he was treated appropriately. Overall, we found no evidence to support the allegation that the patient was systematically neglected while an inpatient at the system.

[5] Dehiscence is the separation of the layers of a wound.

Conclusions

We did not substantiate the allegations of poor care and neglect by the system in caring for the patient before, during, or after open heart surgery. As noted, the patient's care was highly complex, from the inability to complete a three-vessel bypass intra-operatively due to the patient's particular coronary artery anatomy to post-operative complications, such as infection and sternal wound dehiscence. Specifically, we did not substantiate the allegations of failing to provide proper respiratory therapy after surgery and of allowing the patient to suffer inattentively in pain.

We found two cancellations of scheduled cardiac catheterization appointments, at least one of which appeared to be justified since emergent cases always take priority over routine procedures. In addition, all plans for the wound closure were tentative based on the patient's clinical status and culture results.

The system acknowledged there was a delay responding to the patient's call light on one occasion during his inpatient admission. Although the delay did not worsen the patient's condition, it was unacceptable. In addition, the complainant noted an incident where a nurse admonished the patient for repeated use of the call light while in isolation status. The nurse allegedly complained about the requirements of putting on protective clothing to enter the patient's room, which we could not substantiate or refute.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the System Director implements processes for timely response to patient call lights.

Comments

The VISN and System Directors agreed with the findings and recommendation and provided acceptable improvement plans. (See Appendixes A and B, pages 8–11, for the full text of 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: September 29, 2008

From: VISN Director

Subject: **Healthcare Inspection – Quality of Care, South Texas Veterans Health Care System, San Antonio, Texas**

To: Assistant Inspector General for Healthcare Inspections

1. Thank you for the opportunity to review the draft report from the Hotline Division of the South Texas Veterans Healthcare System, (671), June 2–4, 2008. I concur with the recommendation and will ensure that it is completed as described in the attached plan by the established target dates.

2. The medical center carefully reviewed all items identified as opportunities for improvement and has concurred in the recommendation that was made. The Network concurs with the recommendation contained in this report.

3. If you have additional questions, or need additional information, please contact Deborah Antai-Otong, 817 385 3794.

(original signed by:)
Timothy P. Shea, FACHE

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 Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the System Director implements processes for timely response to patient call lights.

Concur **Target Completion Date:** December 31, 2008

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 26, 2008

From: Director, South Texas Veterans Healthcare System

Subject: **Healthcare Inspection – Quality of Care, South Texas Veterans Health Care System, San Antonio, Texas**

To: Director, VA Heart of Texas Healthcare Network, VISN 17 (10N17)

On behalf of the South Texas Veterans Healthcare System, I would like to thank you for the informative and constructive OIG Hotline review performed June 2–4, 2008. Attached you will find comments, corrective action plans, and completion date for the recommendation.

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 ensure that the System Director implements processes for timely response to patient call lights.

Concur **Target Completion Date:** December 31, 2008

1. All Telemetry nurses have been educated in the process of being responsive to patient call lights. The process is as follows: Telemetry nurse responds to patient call lights within 60 seconds; immediately upon answering the call light pages the nurse responsible for the patient; the nurse who has been paged must respond in person to the patient's room within 5 minutes of receiving the page; and responds via call system back to the Telemetry nurse that they are present in the patient's room and responding to the patient's needs.

2. Education on this process is provided to all new staff oriented to the Unit.

3. Education on this process has been provided to all assigned staff via one-on-one instruction by the Nurse Manager of the Unit.

4. All Unit staff are re-educated on this process monthly by the Nurse Manager at staff meetings.

5. This process is monitored as follows:

(a) On day shift, Nurse Manager/designee conducts random/documented observations on a monthly basis. On evening and night shift these observations are conducted/documented by the Unit organizer.

(b) On day shift, Nurse Manager/designee conducts random/documented, monthly patient inquiries to determine if patient call lights are responded to according to the process. On evening and night shift these inquiries are conducted/documented by the Unit organizer.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Wilma Reyes Dallas Office of Healthcare Inspections (214) 253-3334
Acknowledgments	Reba B. Ransom George Wesley, M.D.

Appendix D

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