# Department of Veterans Affairs
# Office of Inspector General

# Healthcare Inspection

# Alleged Neglect by a Social Worker
# Charles George VA Medical Center
# Asheville, North Carolina

**Report No. 08-02335-33** **December 3, 2008**

**VA Office of Inspector General**
**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Executive Summary

The purpose of the inspection was to evaluate allegations that a social worker at the Charles George VA Medical Center in Asheville, NC, neglected a patient by not providing adequate social services and as a result, the veteran suffered a series of mishaps that endangered his life.

We did not substantiate the allegation that the social worker neglected the veteran's care. In March 2008, the complainant called the social worker reporting that her father needed "geriatric services – someone to look in on him." As the veteran was not homebound and could manage his own activities of daily living, the social worker advised the complainant that her father did not meet clinical criteria for the medical center's home care program. The social worker encouraged the complainant to contact local services that might be appropriate for the veteran. We found no evidence that the complainant arranged home care services at this point.

In late March, the complainant called the social worker again to report that her father had "poisoned himself" recently by taking the wrong medication, and was weaker and less able to ambulate distances. A possible home care referral was discussed. The plan was that the complainant would discuss home care with the veteran, and if he agreed to the services; the complainant would call the social worker back to initiate the referral. It appears that the complainant left a message for the social worker later that morning; however, for a variety of reasons, the social worker did not realize that the message referred to the complainant's father, and her telephone log reflected that she was unable to resolve the message. We confirmed that the complainant, who was in regular contact with her father between late March and late May (when he was hospitalized) did not make further attempts to contact the social worker or any other providers at the medical center to report any concerns. We did not conclude that a singular lapse in following up on a telephone message constituted neglect.

We did not substantiate that the social worker's actions contributed to the patient's hospitalization 2 months after the March 2008 telephone contact. As the veteran lived alone, there is no reliable way to independently verify the nature and extent of his debility at various stages between March and May or what precipitated his hospitalization in late May.

We did not substantiate that the social worker made improper statements when questioned by the complainant; however, the communications were clearly unsatisfactory to the complainant, the social worker, and the social work supervisor. We also did not substantiate that the medical center Director failed to return phone calls from the complainant. The medical center Director assigned the Chief of Staff as the point of contact for the complainant to ensure that the she received consistent information and that her concerns were adequately addressed. We made no recommendations.

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

**TO:** Director, VA Mid-Atlantic Health Care Network (10N6)

**SUBJECT:** Healthcare Inspection – Alleged Neglect by a Social Worker, Charles George VA Medical Center, Asheville, North Carolina

## Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation in response to a complaint that a social worker at the Charles George VA Medical Center (the medical center) neglected a patient by not providing adequate social services, and as a result of this neglect, the patient suffered a series of mishaps that endangered his life. The purpose of the review was to determine whether the allegations had merit.

## Background

The medical center is a tertiary care facility that serves veterans in western North Carolina and portions of South Carolina, Tennessee, and Georgia. The medical center has 112 hospital beds and 120 Extended Care and Rehabilitation (ECR) beds, and also provides services through several outpatient programs for frail and homebound veterans. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 6.

The Hospital Based Primary Care (HBPC) program provides primary care services to veterans with complex healthcare needs who are housebound and reside within a 30-mile radius of the medical center. An interdisciplinary team of professional staff conduct home visits to assess patients' needs and to provide services including nursing, physical therapy, and medication management. Depending on the needs of the patient, HBPC staff may visit anywhere from several times per week to once every few months. When HBPC staff determines that a patient does not meet clinical criteria for admission, the patient is referred for other services. Due to staffing limitations, the medical center's HBPC program capacity is limited to 35 patients.

Clinical social workers are Master's level graduates who provide veterans and their families with supportive and discharge planning services such as housing, meals, employment, financial benefits, and nursing home or other community-based placements. Some social workers also provide individual and family counseling and specialized therapy. The subject social worker provides services to patients and their families in the primary care clinic and emergency room. She has a clinical license that was issued by the State of North Carolina in the mid 1980s.

The complainant contacted the OIG Hotline in mid June 2008, regarding her displeasure with her father's social worker. The complainant alleged that the social worker neglected her father because she (the social worker) knew he was unable to care for himself but did not take action to secure supportive services for him. She alleged that he was near death when he was later admitted to a private hospital.

## Scope and Methodology

We interviewed the complainant by phone, since she lives in Arizona. We conducted a site visit on July 16–17, 2008, and interviewed the veteran, medical center Director, Chief of Staff, subject social worker, subject social worker's supervisor, inter-facility transfer coordinator, HBPC program director, social workers assigned to the ECR, the veteran's current physician, and the veteran's current nurse practitioner. In addition, we interviewed the Oconee County sheriff's deputy who responded to the residential welfare check in late May 2008. We attempted to talk with the veteran's son, who lives in Virginia, at a prescheduled time without success; we also tried again later but were unable to reach him. We reviewed the veteran's medical record, and medical center and national policies associated with home care and social services. We also evaluated the HBPC clinical performance measure reports and the Geriatric & Extended Care screening committee minutes.

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

## Case Summary and Sequence of Events

The veteran is a man in his 70s who is 100-percent service-connected for heart disease. He has a significant medical history that includes chronic alcoholism, depression, cardiac dysfunction, hypertension, and gout. The veteran had been residing alone in his own home in North Carolina and had received primary care services at the medical center for at least 10 years. The veteran was last seen by his primary care provider (PCP) in late December 2007 for a follow-up appointment and routine laboratory work. The PCP documented that the patient had been hospitalized overnight the previous month while visiting Arizona. The Arizona hospital had faxed the summary, which reflected that the veteran was diagnosed with venous stasis ulcer (right lower extremity), diarrhea,

dehydration secondary to a diuretic medication, acute renal failure, weakness, falling secondary to dehydration, hypokalemia,[1] chronic atrial fibrillation, and alcoholism. The PCP documented that the veteran was currently in no acute distress; she continued him on his current medications with instructions to return to clinic in May 2008 for his annual physical examination. She further noted that the patient was compliant with taking his medications.

An early March 2008 social work progress note reflects that the complainant, who is the veteran's daughter, first contacted the subject social worker to report that her father was in need of "geriatric services – someone to look in on him." The complainant reported that her father was driving but had had five recent fender-benders. While he was not homebound and could manage his own personal care, he needed assistance with housekeeping and meal preparation. The social worker advised the complainant that her father did not meet clinical criteria for the medical center's home care programs. The social worker encouraged the complainant to contact local agencies that could help meet her father's needs, and told her to call back if his condition changed.

A late March progress note reflects that the complainant called the subject social worker to report her father's car insurance had been cancelled after another accident and he was no longer driving. The complainant also told the social worker that her father exercised poor judgment, had trouble using the microwave, had food in his refrigerator that expired in 2006, and relied on neighbors to assist him with transportation and other things. She further reported that he had "poisoned himself" recently by taking the wrong medication and was weaker and less able to ambulate distances. The medical record reflects that the social worker discussed the possibility of HBPC services and encouraged the complainant to talk to her father. If he agreed, the complainant would call the social worker back to initiate the HBPC referral.

The complainant told us that she spoke to her father the same day to obtain his consent to pursue HBPC services. While some of the details of this return phone call are unclear, the social worker's telephone log did show a message was received in late March referencing the veteran's middle and last name. The complainant had no further contact with the social worker after leaving the message in late March.

At some point, the veteran drove himself from his primary home in North Carolina to his lake home in South Carolina. In late May, the complainant contacted the Oconee County, SC, police department to request a residential welfare check since she had not heard from her father for several days.[2] A sheriff's deputy told us that he found the veteran sitting in a chair, nearly non-responsive, with wounds on both of his forearms. It

[1] Low concentration of potassium in the blood.
[2] Some documentation and the deputy's recall of the event suggest that the veteran's son requested the welfare check.

was the deputy's perception that he had been in the chair for "several days." The complainant reported that he had a note pad next to him with the social worker's name and number on it in anticipation of a call to start services. The veteran was admitted to the Oconee Medical Center where he received treatment for altered mental status, atrial fibrillation with rapid ventricular response,[3] and bacterial cellulitis.[4] The veteran's blood alcohol level at the time of admission was .05mm/dl.[5]

The veteran was transferred to the medical center's ECR in early June for wound care and to follow up a new diagnosis of normal pressure hydrocephalus (NPH).[6] The veteran had developed ataxia[7] and urinary and bowel incontinence requiring restorative rehabilitation services.

In late June, the veteran underwent a neurosurgery consultation for NPH at the Durham VA Medical Center. The surgeon discussed lumbar drainage and surgical insertion of a shunt with the veteran's family. A follow-up appointment was scheduled for late July. In mid-July, the family canceled the late July appointment and sought a consultation with a private group of neurological surgeons. The neurosurgical group recommended shunt placement.

In early August, the veteran was transferred to a private healthcare facility and underwent a shunt insertion. A few days later, he returned to the ECR with clean sutures in two areas of his head and in his right upper abdominal quadrant. The healing of the surgical areas was unremarkable. After the surgery, the veteran's mental status, gait, and bowel and bladder function improved; however, he continued to exhibit signs of short-term memory loss and poor judgment. The medical record shows that on the day before his discharge, he got lost in the medical center.

The medical record reflects that the treatment team talked with the veteran and his family multiple times throughout August to discuss discharge planning options. While the treatment team voiced their impressions that the veteran would be safest in an assisted living setting, the veteran reported his desire to return home, to which his family agreed. Providers also recommended that the veteran not be permitted to drive due to cognitive deficits; however, family members felt that he was able to drive and the veteran indicated his intent to do so once he returned home. Per the complainant's request, the treatment team provided information on in-home services, but the veteran stated that he did not want to commit to services at that time. Treatment team members attempted to notify the

[3] Heartbeat irregularity: an often-fatal heartbeat irregularity in which the muscle fibers of the ventricle work without coordination and cause a loss of effective pumping action of the heart.
[4] Skin infection characterized by redness, pain, and tenderness.
[5] The .00mm/dl level reflects no alcohol in the system; .08mm/dl reflects legal intoxication in some states.
[6] A condition in which there is too much cerebrospinal fluid in the ventricles surrounding the brain, which eventually causes gait, bladder, and cognitive deficits.
[7] Loss or impairment of muscular coordination.

complainant of this development, but they did not receive a return call. The veteran was discharged to the care of his son in late August. He was scheduled for a follow-up appointment with his PCP in late September.

## Inspection Results

### Issue 1: Alleged Neglect by a Social Worker

We did not substantiate the allegation that the social worker neglected the veteran. The complainant presented two primary complaints in support of the allegation.

**Complaint (a): The social worker failed to contact the veteran despite having access to his record and knowing that he was unable to care for himself.**

We confirmed that the social worker did not make contact with the veteran; however, the details provided by the complainant did not fully describe all aspects of the case. Central to this issue was whether (i) the social worker was diligent in her efforts to follow up on the late March phone message, and (ii) the social worker had information suggesting that the patient was unable to care for himself and required immediate services.

(i) Follow Up to Late March Phone Message

The social worker's telephone log showed that she received a message in late March that referred to the veteran by his middle and last names rather than his first and last names. The log showed two telephone numbers and an annotation about HBPC. Fifteen other message entries on the log were crossed through, but this entry was circled with a question mark.

The social worker told us that based on the information in the message she did not make a connection to the veteran at the time. She stated, and the phone log appeared to confirm, that the messenger did not leave his or her name. In addition, the social worker reported that the middle name had not been used as an identifier for the veteran during previous conversations with the complainant. In a report of contact regarding the phone message, the social worker documented that, "Although I do not recall the details of this event, my routine is to call the phone number given in the message to better understand the message. If unable to reach anyone at the number, I then have no recourse for follow-up. The question mark on my log reflects an inability to resolve the call." The social worker reported that in cases like this, she hopes the messenger will call back to clarify their issues and requests.

Because the social worker did not specifically recall whether she attempted to contact the two numbers listed on the message, it is difficult to say whether she exercised due diligence in following up on the message. One number listed belonged to the veteran's

son. When we attempted to contact him at that number for a prescheduled interview, we were unable to leave a message because his voicemail was full. The second listed number was for the veteran at his SC lake home. When we tried this number, we received a recording stating that the person we were calling was unavailable, and that the call would be forwarded to an automated message system. The veteran was not identified by name in the automated recording. Due to confidentiality issues, healthcare providers are sometimes reluctant to leave messages on answering machines without prior approval.

As in any service industry, telephone calls and messages in the healthcare arena are occasionally "lost to follow-up," and the degree to which individual providers pursue those cases depends greatly on their knowledge of the case, urgency of the situation, and other workload demands. The social worker attested that she did not draw a connection between the phone message and the veteran at the time. While the veteran's last name, which is slightly uncommon, and the HBPC reference might normally be sufficient information to prompt the social worker's recall of the case, this lapse could have been due to a myriad of factors which we cannot adequately evaluate retrospectively. And since we do not know what time the social worker retrieved her messages, it is possible that several hours had elapsed between the initial phone call and retrieval of her messages.

In any event, we did not conclude that this singular lapse in following up on a telephone message constituted neglect.

(ii) Social Worker Knew the Veteran Was Unable to Care for Himself

The social worker did have full access to the veteran's electronic medical record; however, the information contained within, along with the information provided by the complainant, did not necessarily reflect an emergent need for intervention.

The social worker documented in an early March progress note that the complainant told her that her father needed "geriatric services – someone to look in on him." The complainant said that he had several minor car accidents (described as fender-benders) recently, and she was seeking assistance with housekeeping and meal preparation. She also mentioned that he could perform all his own personal care and was not homebound. As the veteran did not meet clinical criteria for a VA home care program, the social worker encouraged the complainant to contact local services that might be appropriate for the veteran. We found no evidence that complainant arranged home care services for her father at this point.

The medical record reflects that during the late March call, the complainant told the social worker that her father's automobile insurance had been cancelled and he was no longer driving. She also reported that he had "poisoned" himself recently taking the wrong medication, and that he exercised poor judgment, had food in his refrigerator that

expired in 2006, had trouble operating the microwave, and continued to rely on neighbors for transportation and other assistance. She stated that he was weaker and was only ambulating within his house. The social worker told us that based on the veteran's possible need for medication management (secondary to his taking the wrong medicine), she suggested that HBPC might be an appropriate service. The progress note reflects that the complainant agreed with this plan.

We evaluated the veteran's medical record and information provided by the complainant to determine whether there was evidence reflecting the veteran couldn't take care of himself and required immediate intervention. We found no documented evidence that the veteran was incompetent; therefore, he had the right to make his own decisions. Further, he had been living independently, maintained frequent contact with his adult children, and had neighbors who assisted with transportation. Documentation from the veteran's December 2007 primary care appointment showed that he was stable with no mention of cognitive or functional debility. There was no documentation in the medical record reflecting that the patient sought treatment for medication "poisoning;" thus, it was unclear what precisely happened, when it happened, or what the effects on the veteran were. The complainant's statements that he had food in his refrigerator that expired in 2006 and had trouble operating the microwave were not likely to have been new conditions that developed since the March 6 call. We could not tell, based on the medical record, whether poor judgment was a new condition.

The social worker told us that had she believed the veteran's situation was emergent, she would have referred the case to Adult Protective Services for immediate assessment and intervention.

We also could not confirm the complainant's statement that the veteran had the social worker's name and number on a pad next to him in anticipation of the call to start services. The sheriff's deputy who conducted the welfare check could not recall seeing any note pads or loose papers with phone numbers near where the veteran was found.

**Complaint (b): The social worker's failure to contact the veteran and arrange supportive services led to a series of mishaps that resulted in his hospitalization 2 months later.**

We could not confirm that the social worker's actions contributed to the patient's late May hospitalization. As outlined above, it does not appear that the veteran's condition in late March required emergent intervention.

The veteran's declining cognitive and functional abilities described by the complainant in late March would not have been solely suggestive of an acute medical problem. While NPH is typically a slow and progressive disorder, its course is variable as are the severity of symptoms. The complainant told us that her father was doing his taxes on April 15, which reflects that he had both cognitive and physical abilities on that date. As the

veteran lived alone, there is no reliable way to independently verify the nature and extent of his debility at various stages between March and May or what precipitated his hospitalization in late May.

The complainant confirmed to us that she did not re-contact the social worker after leaving the message in late March, because she believed it was the social worker's responsibility to follow up. We conclude, however, that if the complainant, who spoke regularly with her father between late March and late May, had significant concerns about his well being, she would have made additional efforts to contact the subject social worker, her supervisor, or the PCP.

## Issue 2: Medical Center's Response to Complaints

The complainant alleged that medical center staff did not appropriately or adequately respond to her complaints.

**Complaint (c): The social worker made improper statements when questioned about the reasons for her failure to follow up with the veteran.**

Upon the veteran's admission in early June, the social worker and her supervisor met with the complainant (who was visiting her father) to address her concerns. The complainant alleged that when she asked the social worker why she did not intervene, the social worker responded "We rely on family" and "We cannot call 22,000 veterans every day." The complainant also reported that the social worker did not apologize for failing to provide adequate intervention to assure the wellbeing of her father. The complainant was dissatisfied with the outcome and left the meeting.

The social worker confirmed to us that during the June meeting, she did make the statement that "We rely on family." The social worker told us that she was attempting to convey the importance of developing a partnership between family members, who see the veteran daily and know his current condition, and the social worker, who generally does not know the veteran's day-to-day functional status. However, it appears that the social work supervisor, not the social worker, said "We can't call all 22,000 veterans every day." We believe that this was an unfortunate choice of words that did not calm the complainant.

**Complaint (d): The medical center Director would not return phone calls.**

The medical center Director reported that she had returned the complainant's phone calls on multiple occasions. However, the Chief of Staff was later assigned as the point of contact for the complainant to assure that she received consistent information and that her concerns were being adequately addressed. The medical record reflects ongoing communication between the complainant and the Chief of Staff beginning shortly after the veteran's admission to the ECR.

It is our conclusion that medical center personnel have made appropriate efforts to address the complainant's concerns, yet she continues to be dissatisfied with these efforts. During an interview with us in late June 2008, she expressed her dissatisfaction with the social worker and stated that an apology would bring this complaint to a resolution.

The following month, the social worker sent an apology letter to the complainant. In this letter, she told the complainant that although she had fulfilled her duties as prescribed by facility guidelines and practice, she had clearly not met the complainant's expectations, for which she was sorry. The social worker stated that she wished it were possible to "turn the clock back." She closed her letter by expressing her commitment to be more diligent in the future to clarify and understand patient and family expectations.

Subsequent to sending the letter, the social worker completed a report of contact reflecting that the complainant called her at 12:50 a.m. and left a message. The message blamed the social worker for her father's mishaps and expressed outrage toward the content of the apology letter. In early September, the social worker completed another report of contact based on a conversation she had with the complainant. The report of contact reflects that the complainant contacted her to say that just because her father was no longer at the medical center, "does not mean that this situation is ended. Until you say you're sorry you did not call my father, I'll do whatever it takes. You just can't say you're sorry." In an e-mail to the social work supervisor, the complainant reported that she had called the North Carolina Social Work Licensing Board to pursue sanctions against the social worker.

In mid-September, medical center police contacted the complainant to notify her that future contacts should be made through the medical center's Executive Office; she should not contact the social worker directly. Based on additional contacts made by the complainant, it appears that she may be considering some type of legal action relative to this instruction.

## Conclusions

We did not substantiate the allegation that the social worker neglected the veteran. While it appears that the social worker did not make contact with the veteran following the late March 2008 call, this singular lapse did not constitute neglect. In addition, we could not say with certainty that initiation of HBPC evaluation services at the veteran's NC residence would have prevented the incident at his SC lake home. We found that the medical center has made appropriate efforts to address the complainant's concerns. The VISN and medical center Directors agreed with our report. We made no recommendations.

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

**Appendix A**

# OIG Contact and Staff Acknowledgments

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|---|---|
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**Appendix B**

# Report Distribution

## VA Distribution

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