



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Quality of Care Issues VA Gulf Coast Health Care System Biloxi, Mississippi

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Executive Summary

The VA Office of Inspector General conducted an inspection to determine the validity of allegations of patient mistreatment, lack of communication, and denial of family rights at the VA Gulf Coast Veterans Health Care System (the system) in Biloxi, Mississippi.

The complainant alleged that: (1) the patient was mistreated as evidenced by the appearance of multiple bruises, swelling, and burns. Staff told the family that the patient fell and reported that he had been violent (hitting and kicking). After his discharge, a private-sector emergency room physician found that the patient had burns and bruises; (2) the staff refused to take the patient to chemotherapy treatments; (3) staff members were rude and uncooperative; (4) the staff refused to explain the patient's bruises and did not address the family's concerns; (5) the physician and social worker refused to transfer the patient to Mobile, Alabama; and (6) although the patient's sister was his surrogate decision-maker, staff would not discharge the patient at her request.

We did not substantiate the allegations that the patient was mistreated or that staff refused to transport the patient to chemotherapy treatments, were rude and uncooperative, refused to explain the patient's bruises and address the family's concerns, refused to transfer the patient, and would not discharge the patient at the sister's request.

We did find the medical record documentation was inconsistent and contradictory, which made it difficult to determine when and how the patient sustained bruises. We also found that the explanation of bruises the staff provided to the family was inadequate and not sufficiently documented.

We recommended that: (1) skin integrity assessments accurately reflect the patient's condition; and (2) appropriate system personnel follow up on patient and family concerns and document the findings in the medical record. Management agreed with our findings and recommendations and provided acceptable improvement plans.



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

TO: Director, South Central VA Health Care Network (10N16)

SUBJECT: Healthcare Inspection – Quality of Care Issues, VA Gulf Coast Health Care System, Biloxi, Mississippi

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to evaluate allegations of patient mistreatment, lack of communication, and denial of family rights at the VA Gulf Coast Health Care System (the system) in Biloxi, MS. The purpose of the review was to determine whether the allegations had merit.

Background

The system consists of a tertiary care hospital in Biloxi, MS, and three community based outpatient clinics in Mobile, AL, and Pensacola and Panama City, FL. The system provides acute inpatient medical, surgical, mental health, geriatric, and rehabilitation services. The system has 90 hospital beds and 81 long-term care beds and is part of Veterans Integrated Service Network (VISN) 16.

In February 2008, the complainant, who was the patient's niece, contacted the OIG Hotline and made multiple allegations related to her uncle's hospitalization at the Biloxi facility from July 22–26, 2007. The complainant specifically alleged that:

- The patient was mistreated as evidenced by the appearance of multiple bruises on his legs, arms, and elbows, a swollen hand, and scratches on his back the day after his admission. Staff told the family that the patient fell, and also reported that he had been violent (hitting and kicking). After his discharge from the Biloxi facility, the patient was found by an emergency room (ER) physician in Mobile to have burns and bruises.
- The staff refused to take the patient to chemotherapy treatments.
- Staff members were rude and uncooperative.
- Staff members initially refused to explain the patient's bruises, and they did not address the family's concerns.

- The physician and social worker refused to transfer the patient to Mobile, AL.
- Although the patient's sister was his surrogate decision-maker, staff would not discharge the patient on July 23 at her request.

Scope and Methodology

We visited the system April 14–16, 2008. We interviewed the complainant, medical center clinical care providers, administrative staff, and others with direct knowledge about the patient's care. We reviewed relevant Veterans Health Administration (VHA) and system policies, as well as the patient's medical records, patient advocate reports, and other internal reviews of the patient's care.

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

Case Summary

The patient was a veteran in his late 50s with a medical history of end-stage lung cancer with multiple brain metastases, weakness of the left upper extremity, anemia, major depression, post-traumatic stress disorder, and polysubstance abuse. The patient was terminally ill and was scheduled for admission to the Transitional Care Unit (TCU) on July 23, 2007, for palliative radiation therapy. However, he experienced an abrupt change in his physical and cognitive functioning that included an inability to walk or use his right side, incontinence, and behavioral outbursts. He was seen in the ER and admitted to the TCU on July 22, 1 day earlier than originally scheduled. Due to the patient's behavioral issues, he was unable to participate in radiation therapy treatments. His revised care plan included provision of comfort measures and transfer to an inpatient hospice unit. On July 24, a psychologist evaluated the patient and determined that he lacked decision-making capacity. The patient's sister had previously been designated as the surrogate decision-maker should her brother become incapacitated.

On July 24, the patient's sister called the Mobile outpatient clinic (MOPC) social worker and reported that she wished to have the patient transferred to a facility in Mobile; she also noted that the patient told her he had bruises. The MOPC social worker told the sister to discuss her concerns with the TCU treatment team. The sister and niece participated in a meeting with TCU staff later on July 24. Later that evening, the patient's daughter, who had not participated in any of the previous treatment planning meetings, presented a document to system staff showing that she had been granted temporary guardianship over her father. Early on July 26, TCU providers met with the sister and daughter to discuss discharge planning. The family agreed with the plan to place the patient in hospice care, and the TCU social worker sent the patient's application to two inpatient hospice units for possible placement. However, both the sister and daughter later requested immediate discharge, and the patient was released to the family

on July 26 without a confirmed hospice bed. The complainant told us that the patient passed away a few weeks later at a private-sector inpatient hospice center in Mobile.

Inspection Results

Issue 1: Patient Mistreatment

Bruises, Swelling, and Burns.

We did not substantiate the allegation that the patient was mistreated by medical center staff, and as a result, suffered unexplained bruises, swelling, and burns. The family's description of the events differed from the staff's recall. However, we did find that medical record documentation was inconsistent and, in some cases, contradictory, which made it difficult to determine when and how the patient sustained these alleged injuries.

Progress notes completed by the ER physician, attending physician, physician's assistant (PA), and nursing staff did not reflect any skin integrity concerns at the time of the patient's admission on July 22. On July 24 at 5:09 a.m., a nurse documented that "during a bed bath, noticed large bruised area on left side, yellowish purple in color [and] 4 reddened areas with abrasions, left hand swollen. Veteran lets arm hang [and is] propped up on pillow at present." However, another nurse documented at 7:52 a.m., "Skin is intact no problems," and a PA documented in his history and physical (H&P) exam note at 8:57 a.m. that "skin [is] warm and dry no obvious lesions."

A nurse documented on July 25 at 13:25 p.m. that "Skin is intact no problems." On July 26 at 12:21 p.m., the attending physician wrote in the patient's H&P, "Skin-intact." Contrarily, though, a nurse documented on a long-term care referral form dated July 27 (after the patient's discharge) that, "The patient has experienced troubling skin problems such as burns, bruises, or itching, in the last 30 days." She told us that she did not evaluate the patient; rather, she completed the form after the patient was discharged based on a review of his medical record.

We interviewed TCU nursing and physician staff who could not explain these discrepancies. The TCU physician told us that the bruises may have occurred before the patient's admission, as the yellow and purple coloring suggested that they were older bruises that were healing. Staff also suggested that the abrasions may have resulted when the patient fell or when he was agitated and violent (kicking and thrashing) while in his gerichair.¹ However, none of the providers interviewed reported or documented that the patient had fallen, nor was a patient incident report completed. We found no documentation that the patient injured himself during this hospitalization.

¹ Wheelchair with safety features including a high back and a tray table to prevent injuries.

The complainant alleged that after the patient's discharge, he was found by a private-sector physician to have burns and bruises; however, she was unable to provide us with the private-sector medical records to support her allegation. The Biloxi facility's July 27 long term care evaluation noted "skin problems, such as burns..." but did not specifically identify the type, location, or apparent age. We found no other reference to these alleged burns.

It was not clear from the documentation whether the patient was admitted to the Biloxi facility with the injuries or developed them after admission. Further, system employees did not document accurate skin assessments and did not have a satisfactory explanation for the injuries. The TCU physician conceded that the documentation was incomplete and inconsistent. Without accurate assessments and ongoing documentation of the patient's condition, coordination among providers and quality of care cannot be assured.

Chemotherapy.

We did not substantiate the allegation that staff improperly refused to take the patient for chemotherapy treatments. The medical record shows that the patient was admitted for palliative radiation therapy, not chemotherapy. However, the patient's agitation and altered mental status would not permit him to cooperate with the radiation therapy. The decision to forgo this treatment regimen with a terminally ill patient was reasonable.

Issue 2: Poor Communication

Staff Rudeness.

We could not confirm or refute the allegation that staff were rude and uncooperative with the family. We are unable to evaluate how the family perceived staff attitudes, responses, and communication styles. We found no evidence that the family complained to the patient advocate about this issue.

Family Complaints.

We did not substantiate the allegation that staff refused to explain the patient's bruises or that staff did not address the family's complaints; however, we believe that the explanation provided to the family was inadequate. The MOPC social worker suggested the family meet with the TCU staff to discuss their concerns about the patient's care. TCU staff met with the patient's sister and niece on July 24 to discuss the family's concerns and address discharge planning issues, yet this note did not explain the outcome or resolution of the concerns. While staff surmised that the injuries could have occurred when the patient fell or when he was acting out, medical record documentation did not reflect that either of these possibilities was explored.

Patient Transfer.

We did not substantiate the allegation that the physician and social worker refused to transfer the patient to Mobile, AL. Documentation shows that during the July 24 telephone call to the MOPC social worker, the sister requested the patient be transferred to a Mobile-area facility. After a discharge planning meeting on July 26, the TCU social worker sent two referral packets to Mobile-area hospice centers. Community-based hospice placements often take several days to accomplish, as providers must complete appropriate referral forms and hospice providers must evaluate the referral package, determine whether the patient's care needs can be met, and then ensure bed availability. On July 26, at the request of the sister and daughter together, the patient was discharged without a confirmed hospice bed. The complainant told us that the daughter cared for the patient at home for 1 night and took him to an ER in Mobile because she could not manage his needs. The patient was then admitted to a local hospice unit arranged by staff at the private-sector hospital.

Issue 3: Denial of Rights

We did not substantiate the allegation that the sister's rights, as the surrogate decision-maker, were violated. The patient designated his sister as his durable power of attorney for healthcare (DPOA/HC) decisions on July 6. This designation allowed the sister to make healthcare decisions on her brother's behalf when it was determined that he was mentally incapacitated. The complainant alleged that despite the sister's DPOA status, staff refused to discharge the patient on July 23; however, we found no documentation reflecting this request. According to the medical record, the first time the sister expressed her desire to transfer the patient was on July 24 when she contacted the MOPC social worker. Per the DPOA/HC's wishes, it appeared that the referral paperwork was initiated to place the patient in hospice.

The complainant implied that despite the DPOA/HC, staff only agreed to discharge the patient after the patient's daughter presented temporary guardianship papers from a court in Alabama. We found that when the patient's daughter met with staff the first time on July 26 regarding the guardianship papers, facility staff contacted the court to determine the legal entitlements of both the sister and the daughter. The social worker documented that in such cases, children take precedence over siblings. Facility staff appropriately deferred decision-making to the daughter, who was the legal guardian. At the sister's and daughter's insistence, staff agreed to discharge the patient to the family's care on July 26.

Conclusion

While we did not substantiate that the patient was mistreated by staff, we found that medical record documentation was inconsistent and contradictory, which made it difficult to determine when and how the patient sustained bruises. We did not substantiate that staff refused to take the patient to chemotherapy. Rather, the patient was supposed to

receive palliative radiation therapy but was unable to proceed with these treatments due to behavioral issues. We could not confirm or refute the allegation that staff were rude, as this is a perception that cannot be effectively evaluated.

We also did not substantiate the allegation that facility providers refused to explain the patient's bruises; however, we agree that the explanation provided to the family was inadequate and not sufficiently documented. We found that staff made appropriate efforts to transfer the patient to a Mobile-area hospice (until the sister and daughter requested the patient be discharged to the family's care). According to the medical record, staff collaborated with the proper surrogate decision-makers—first with the DPOA/HC and later with the guardian, when this new authority was presented.

Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Health Care System Director requires that skin integrity assessments accurately reflect the patient's condition.

Recommendation 2. We recommended that the VISN Director ensure that the Health Care System Director requires that appropriate facility personnel follow up on patient and family concerns and document the findings and outcomes, as indicated.

Comments

The VISN and System Directors concurred with the findings and recommendations and provided acceptable improvement plans. Skin integrity documentation changes will be fully implemented and resident/family concerns will be addressed at the time of awareness and documented accordingly. Audits will be conducted to verify compliance. (See Appendixes A and B, pages 7–10 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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 27, 2008

From: Network Director, South Central VA Health Care Network (10N16)

Subject: **Quality of Care Issues, VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi**

To: Associate Director, St. Petersburg Office of Healthcare Inspections (54SP)

Thru: Director, Management Review Service (10B5)

The South Central VA HealthCare Network submits the following responses to recommendations resulting from the Office of Inspector General visit dated April 14-16, 2008. We concur with the findings and have initiated processes to prevent any future occurrences.

(Original signed by:)

George H. Gray Jr.

Health Care System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 25, 2008

From: Director, VA Gulf Coast Veterans Health Care System,
Biloxi, Mississippi (520/00)

Subject: **Quality of Care Issues, VA Gulf Coast Veterans Health
Care System, Biloxi, Mississippi**

To: Director, South Central VA Health Care System (10N16)

1. The VA Gulf Coast Veterans Health Care System submits the following responses to recommendations resulting from the Office of Inspector General visit dated April 14-16, 2008. We concur with the findings and have initiated processes to prevent any future occurrences.
2. Thank you for providing me the opportunity to review the document and respond.
3. If you have any questions and/or concerns, please feel free to contact Margaret Givens at 228-523-4937.

(Original signed by:)

Charles E. Sepich, FACHE

Health Care System 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 Health Care System Director requires that skin integrity assessments accurately reflect the patient's condition.

Concur **Target Completion Date:** August 1, 2008

Skin integrity documentation changes for all Community Living Center (CLC) units will be fully implemented by August 1, 2008. Skin integrity will be documented daily. Compliance will be monitored via a monthly compliance audit conducted by our Wound Ostomy Care Nurse. Additionally, the Wound Ostomy Care Nurse attends the weekly Interdisciplinary Treatment Team (IDT) and addresses skin integrity issues.

Recommendation 2. We recommended that the VISN Director ensure that the Health Care System Director requires that appropriate facility personnel follow up on patient and family concerns and document the findings and outcomes, as indicated.

Concur **Target Completion Date:** August 1, 2008

The Community Living Center (CLC) interdisciplinary staff will address Resident and/or family concerns at the time of awareness through use the of the CLC Resident Advocate, the daily Nurse Manager rounds or referral from the facility Patient Advocates. The format and process for the Interdisciplinary Treatment Team

meeting and documentation of the treatment planning meeting will be fully implemented by August 1, 2008. Compliance will be monitored via a monthly compliance audit.

OIG Contact and Staff Acknowledgments

OIG Contact	Carol Torczon, Associate Director St. Petersburg Office of Healthcare Inspections (727) 395-2415
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Acknowledgments	David Griffith Andrea Buck, M.D. Victoria Coates
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