Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues
Huntington VA Medical Center
Huntington, West Virginia

Report No. 07-02599-199 September 10, 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, conducted an inspection to determine the validity of allegations that a patient was prematurely discharged from the intensive care unit (ICU), improperly monitored and treated on the medical-surgical unit, and assaulted by medical-surgical unit staff and that medical staff failed to communicate with and withheld information from the patient's family.

We did not substantiate that the patient was inappropriately discharged from the ICU to the medical-surgical unit. The patient had a history of chronic obstructive pulmonary disease and other health problems. He developed a bowel obstruction during his admission, had surgery, and recovered in the ICU without complications. He was appropriately transferred from the ICU to the medical-surgical unit.

We did not substantiate that medical staff failed to monitor the patient's vital signs and clinical status. We found that staff appropriately monitored vital signs and clinical status. Cardiopulmonary arrest lead to this chronically ill patient's eventual but not unanticipated death. Therefore, we did not substantiate that the patient's death was suspicious.

We did not substantiate or refute that the patient was assaulted. We reviewed medical records and interviewed staff and family and found no evidence of an assault.

We did not substantiate that the physicians were uncooperative in providing information to the patient's family or that information was intentionally withheld. We found documentation to support that physicians and nurses appropriately communicated with the patient's family. However, at times the information provided conflicted from one service to another, resulting in family frustration and mistrust of medical center staff. Initiating a palliative care consult for the patient and his family would have been appropriate.

We recommended that all physicians review existing palliative care policies to ensure that a palliative care consult is initiated whenever indicated. Management agreed with our recommendation and provided an acceptable improvement plan.

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

TO: Director, Veterans Integrated Service Network 9

SUBJECT: Healthcare Inspection – Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, reviewed allegations that a patient at the Huntington VA Medical Center (the medical center), Huntington, WV, was prematurely discharged from the intensive care unit (ICU), improperly monitored and treated on the medical-surgical unit, and assaulted by medical-surgical unit staff.

Background

The medical center is an 80-bed acute medical and surgical care facility offering primary care, outpatient mental health services, and subspecialty outpatient care. VA-staffed community based outpatient clinics are located in Charleston, WV, and in Prestonsburg, KY. The medical center is part of Veterans Integrated Service Network (VISN) 9.

The complainant, a family member of the veteran, alleged the following:

- The patient was discharged from the ICU to a medical floor 5 days post-operatively and he was then taken off vital monitoring.
- The patient told his wife he was assaulted by three men and the medical center did nothing about this allegation.
- The patient went into cardiac arrest, suffered undeterminable brain damage, and was essentially dead but was resuscitated either as a consolation to the family or as a cover-up to a criminal act. The family conducted a personal investigation and found that the doctors were uncooperative in providing information and that much information was intentionally withheld.

Scope and Methodology

In performing this review, we examined the medical center's policies and procedures, ICU admission and discharge criteria, patient advocate reports, police reports, the patient's medical record, and other clinical reviews of the patient's care. We conducted a site visit August 27–30, 2007. We interviewed the patient's family, medical center clinical care providers, and administrative and other staff knowledgeable about the patient's care.

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

Case Summary

The patient was a veteran in his mid-sixties who received treatment at the medical center from January 1995 through May 2007. His past medical history was significant for chronic obstructive pulmonary disease (COPD), leukocytosis,[1] Graves' disease,[2] cerebrovascular accident,[3] right upper lobe cystic lesion, alcohol and tobacco abuse, and hypertension.

The patient presented to the Emergency Department on May 5, 2007, with shortness of breath (SOB) and chest pain. He was admitted to a telemetry floor for COPD exacerbation, a rapid worsening of symptoms.

On May 8, he developed right lower quadrant abdominal pain. A surgical consult was initiated, and a computed tomography of the abdomen (CT scan) showed a possible bowel obstruction.

On May 9, the primary care physician (PCP) discussed the need for surgery with the patient. The PCP also told the patient that his wife was requesting help with nursing home placement because she could not care for him by herself. That same day, the social worker called the patient's wife to discuss nursing home placement and to provide the forms and necessary information. At 6:02 p.m., the surgical resident documented that the patient developed respiratory distress due to compression of his thorax[4] secondary to abdominal distension and that he notified the patient's wife of the possibility of emergency surgery.

[1] An abnormally large number of leukocytes (white blood cells, which defend the body against infections) as observed in acute infections, inflammation, hemorrhage, and other conditions.
[2] First described by Sir Robert Graves in the early 19th century, Graves' disease is one of the most common of all thyroid problems. It is also the leading cause of hyperthyroidism, a condition in which the thyroid gland produces excessive hormones.
[3] The sudden death of some brain cells due to the lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain.
[4] The chest.

On May 10, the patient was transferred to the ICU where he had a nasogastric (NG) tube[5] placed; his pain was controlled with a morphine intravenous drip. The patient was taken to the operating room for a scheduled exploratory laparotomy,[6] a decompressive colonoscopy,[7] a cecectomy,[8] a right colostomy,[9] and a mucus fistula ileostomy.[10] The patient recovered in the ICU from May 10 through May 14. Staff noted episodes of SOB on exertion and mild confusion.

On May 14, the patient attempted to get out of bed without assistance three times. At 2:43 a.m., a nurse documented that the patient woke up "hollering out for help" and that he appeared very anxious with slight SOB. When questioned, the patient stated that he had a bad dream, and when he saw his abdomen and ostomy bag, he thought he was bleeding. The nurse reassured and calmed the patient, resolving the anxiety. The nurse documented continuous monitoring and frequent visual checks for safety.

At 11:50 a.m., the patient was transferred to 5-South, a medical-surgical floor. He was placed in a private room on methicillin-resistant Staphylococcus aureus[11] precautions. His family was present at the transfer. The receiving nurse on 5-South charted that the patient had occasional confusion and that frequent monitoring was required.

At 8:59 p.m., the nurse noted that the patient had SOB with vomiting. The surgical resident evaluated the patient and ordered increased breathing treatments and laboratory tests.

On May 15, the patient became increasingly confused. This was documented by the nursing staff as follows:

- 4:30 a.m.: Says he's afraid of anyone who is tall and big. Patient is orientated to person and place but will start yelling and say that someone tall is going to kill him. Attending physicians were notified of the patient's behavior.

- 8:30 a.m.: Patient refused his bath and has been very agitated and threatening to staff members stating, "If you touch me, I will kill you, enough people have touched me."

[5] A tube that is passed through the nose down into the stomach.
[6] An operation to open the abdomen.
[7] A procedure in which a long, flexible viewing tube (a colonoscope) is threaded up through the rectum for the purpose of inspecting the entire colon and rectum and, if there is an abnormality, taking a biopsy of it or removing it.
[8] Excision of the cecum, the beginning of the large intestine.
[9] Colostomy refers to a surgical procedure where a portion of the large intestine is brought through the abdominal wall to carry stool out of the body.
[10] An artificial opening (stoma) created in the small intestine (ileum) and brought to the surface of the abdomen for the purpose of evacuating feces.
[11] A biological agent responsible for difficult-to-treat infections in humans.

- 9:00 a.m.: Family requested to talk with surgical service. Discussed plans to transfer the patient from surgical services to medical as the patient's surgical recovery was going well but medically the patient has exacerbation of his COPD and confusion.

- An interdisciplinary meeting was held with surgery, nutrition, social services, and case management. The group recommended transfer from surgical service to medical service because the patient' main health care needs were respiratory and confusion. Rehabilitation was consulted to assist with ambulation, and Social Work Service planned for placement in a nursing home.

- 10:50 a.m.: Patient not oriented to person, place, or time. Patient continues to be confused this morning, talking about being watched, family at bedside. Surgery service here and discussed condition with family.

- 11:39 a.m.: Chaplain documented that the patient was confused and disoriented. Met and prayed with the patient's wife and three sisters - patient's wife said the patient is confused.

- 12:45 p.m.: Social worker documented that the patient's wife came to her for help with the nursing home paper work.

- 3:34 p.m.: Patient assessed by staff physician, who ordered the start of nasal bactroban and fluconazole, adding acetylcysteine to nebulizer, replacing potassium, and complete blood count test.

- 9:08 p.m.: Patient became anxious and complained of chest pain, physician examined the patient and ordered an EKG which was normal. The patient was medicated for anxiety and monitored.

On May 16, the nurse documented that at the beginning of the shift the patient was very anxious and that his blood oxygen saturation was 88 percent (normal oxygen saturation for this patient with COPD ranged from 84 percent to 96 percent). The doctor was notified, and Xanax was prescribed. At 2:30 a.m., the nurse left the patient sitting up on the side of the bed with no complaints of SOB or pain. At 4:03 a.m., the patient was checked by the nursing assistant.

At 6:00 a.m., a nursing assistant took the patient's vital signs, repositioned him, and noticed that copious amounts of blood came out of the patient's mouth. The patient went into cardiopulmonary arrest, and a "Code Blue" was called. Subsequently, the patient was intubated[12] and transferred to the ICU. The family was informed by the ICU

[12] Tracheal intubation is the placement of a flexible plastic tube into the trachea to protect the patient's airway and provide a means of mechanical ventilation.

physician that the patient’s prognosis was poor. The family requested he remain a “full code.”

From May 17 through May 23, the medical record documents daily discussions between the ICU, neurology, surgery, primary care, and the patient’s family concerning the patient’s condition and ongoing treatment.

On May 18, the attending physician, the ICU nurse manager, and a member of the surgical staff met with the family to discuss concerns expressed by the family about a lack of communication between the family and the surgical service as well as the family’s perception that some of the ICU nurses were rude.

On May 19, the NG tube was checked, and tube feedings were started.

On May 23, after a repeat CT scan, the neurologist told the family that it remained difficult to predict ultimate recovery with any certainty. The patient developed increased secretions secondary to aspiration pneumonia acquired after his cardiac arrest. The patient was fighting his endotracheal[13] tube. The neurologist advised the family against extubation[14] because the patient could not protect his own airway. The patient did not tolerate the tube feedings. They were stopped, and total parenteral[15] nutrition (TPN) was started.

On May 24, the surgical resident documented that the surgeon examined the patient’s ileostomy because of increased small bowel dilation. Upon examination, the patient’s ileostomy was found to be nonviable. The surgeon documented in a progress note that he discussed options extensively with the family. The decision was made to not return the patient to the operating room and to manage the post-operative ileus[16] conservatively. A limited ileostomy revision was performed at the bedside per the family’s request.

On May 25, the staff physician discussed the patient’s code status with his wife. She was advised that the patient would need a tracheostomy[17] due to the length of time he had been intubated. The wife told the physician that she did not want him to have a tracheostomy or to be reintubated if he failed extubation. A “Do Not Resuscitate” order was placed. The patient was extubated, and his condition was listed as guarded.

[13] An endotrachial tube is inserted into a patient's trachea in order to ensure that the airway is not closed off and that air is able to reach the lungs. The endotracheal tube is regarded as the most reliable available method for protecting a patient's airway.

[14] Extubation is the removal of the tube after intubation of the larynx or trachea.

[15] Parenteral means not in or through the digestive system. Parenteral nutrition is given through the veins of the circulatory system rather than through the digestive system.

[16] An ileus is a partial or complete non-mechanical blockage of the small and/or large intestine

[17] A tracheostomy is an opening through the neck into the trachea through which a tube may be inserted to maintain an effective airway and help a patient breathe.

From May 26 through May 29, the patient's condition continued to decline, with increased episodes of panic attacks when the patient experienced SOB and increased secretions. Documentation in the nursing and physician notes reflects that the family was upset that the patient could not be made more comfortable.

On May 29, the primary care physician and the family agreed to transfer the patient out of the ICU to 4-South, where staff would provide comfort measures only. He was given a morphine intravenous drip for pain control and Ativan, as needed, for agitation.

On May 30, the social worker found the family grieving and concerned that the patient was not being made comfortable. The social worker recommended that the medical team consult the Palliative Care Team. Although this consult was not ordered, the medical resident documented that he spoke with the family and that together they formulated an acceptable treatment plan to keep the patient comfortable.

On May 31, the patient died at 4:35 a.m. with his family present.

Results

Issue 1: Premature Discharge from the Intensive Care Unit

We did not substantiate that the patient was inappropriately transferred from the ICU to the medical-surgical unit.

While in the ICU, the patient recovered from his abdominal surgery without complications. Medically, his chronic COPD and confusion remained problems, which were closely monitored by a team of specialists. As there was no indication that the patient required an ICU level of care, it was appropriate to transfer him to a medical-surgical unit at that time.

On 5-South, the patient's vital signs, which included blood pressure, pulse, temperature, and oxygen saturation, were monitored and documented at least every shift, in accordance with medical center policy. In interviews with 5-South staff, we learned that visual checks were conducted at a minimum of every hour and that nurses carried phones to alert them when a patient called. In addition, the patient received nebulizer treatments every 4 to 6 hours. The respiratory therapist checked the patient's pulse, respirations, and oxygen saturation and documented the results in the medical record. The chronology of care recounted above reflects appropriate staff monitoring of the patient's vital signs and clinical status while on 5-South.

Issue 2: Patient Assault

We did not substantiate or refute the allegation that the patient was assaulted.

There are frequent entries in the patient's medical records that refer to the confused state of the patient, which ranged from mild confusion to paranoia. On May 15, the day of the alleged assault, the patient was noted to be agitated and threatening to staff. We interviewed 5-South staff, including the Associate Nurse Manager who investigated the alleged assault, and found no evidence supporting the allegation. Also, the nurse on duty on May 15, documented that the wife agreed that the patient was confused, and no formal complaint was filed. We reviewed patient advocate complaints for 5-South and police reports. We found no history of patient abuse allegations against any of the staff members nor did we find evidence that an assault took place. We interviewed various members of the family and determined that there was disagreement among family members as to what happened and as to the mental state of the patient at the time of the alleged assault.

Issue 3: Suspicious Death

We did not substantiate the allegation that the patient's death was suspicious.

The patient was chronically ill with multiple co-morbidities and frequent hospital admissions. The patient's wife was unable to care for him at home, and he was scheduled to be placed in a nursing home after discharge. After his cardiopulmonary arrest, he developed aspiration pneumonia and in addition to his chronic COPD, required mechanical ventilation as he could not breathe on his own. He had other systemic failures that contributed to his demise; his death was not considered unexpected.

Issue 4: Withholding Clinical Information and Poor Communication

There is documentation of physicians and nurses providing clinical information to the family. Albeit sporadic and at times conflicting from one service to another, the record indicates routine and regular communication between staff and family.

Some miscommunication occurred while the patient was in the ICU after his cardiopulmonary arrest. The ICU physicians told the family that his prognosis was poor while the neurologist continued to say it was too early to tell if the patient would recover.

The family believed that the patient was unable to digest for over 12 hours before a family member pointed out to medical staff that something was wrong. We interviewed the ICU registered dietician (RD) and asked if she spoke with the family about the patient's nutritional needs and treatment modalities. She said that she communicated with the physicians and nurses and when possible, the patient. In the patient's medical record, the RD documented the initial tube feedings, the ileus that developed, and the need for TPN for nutrition; however, she did not discuss this with the family.

Additionally, early on the day of surgery, the patient's family was told that he would need emergency surgery. The family waited all morning, and no one told them why they

were waiting or why the patient didn't have surgery until the afternoon. Documentation in the medical record on that day describes how the patient developed respiratory distress secondary to abdominal distention and was transferred to the ICU where he had an NG tube placed and received pain medication, which stabilized his condition. He did not have emergency surgery in the morning but was a scheduled surgery for the afternoon. No documentation was found to show that this information was communicated to the family.

The family's frustrations over the patient's situation were evident. According to the complainant, the family conducted a personal investigation and found that the doctors were uncooperative in providing information and that much information was intentionally withheld. The family's distrust of the medical center and staff could have been mitigated by recognition that the family may have benefited from a palliative care consult.

Palliative care is described as both a philosophy of care and an organized, highly structured system for delivering care to persons with life-threatening or debilitating illness. Palliative care is patient- and family-centered care that focuses upon effective management of pain and other distressing symptoms while incorporating psychological and spiritual care according to patient and family needs, values, beliefs, and cultures. The goal of palliative care is to prevent suffering and to support the best possible quality of life for patients and their families regardless of the stage of the disease or the need for other therapies.

Although the nurses employed at the medical center receive palliative care and end-of-life training, a palliative care consult was never requested.

Conclusions

We concluded that clinical information was not intentionally withheld from the family but that communicating information to the family was sporadic and at times conflicting. Initiating a palliative care consult for the grieving family would have been appropriate.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that all physicians review existing palliative care policies to ensure that a palliative care consult is initiated whenever indicated.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable plans to ensure that opportunities for palliative care improvements are identified and addressed. (See Appendixes A and B, pages 10–11, for the full text of the 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: July 28, 2008

From: VISN Director

Subject: **Healthcare Inspection – Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia**

To: Director, Operation Support Division (53B), Office of the Inspector General, Washington, DC, 20420

Thru: Director, Management Review Service (10B5), Office of the Inspector General, Washington, DC, 20420

1. I concur with the recommendations of the Office of Inspector General as well as the actions which have been implemented by the VA Medical Center Huntington, WV.

2. If you have any questions or need additional information, please contact Ed Seiler, Director, Huntington VA Medical Center or Pamela Kelly, Staff Assistant to the Network Director, VISN 9.

(original signed by:)
John Dandridge, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 18, 2008

From: Director, VA Medical Center Huntington, West Virginia

Subject: **Healthcare Inspection – Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia**

To: Director, VA Mid-South Healthcare Network, (10N9)

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

OIG Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that all physicians review existing palliative care policies to ensure that a palliative care consult is initiated whenever indicated.

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

The organization has two (2) Medical Center Memorandums (MCM) that guide Palliative Care: MCM PCI-40, Palliative Care Planning; and MCM PCI-10, Palliative Care Consult Team. Both MCMs will be distributed to all physicians for their review.

Quality Management will provide a quarterly report to the Medical Staff Council, beginning with the July 2008 meeting, to provide regular updates on activities of the Palliative Care Consult Team and to ensure opportunities for further improvement are identified and addressed.

(original signed by:)
EDWARD H. SEILER
Medical Center Director

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Gail Bozzelli, RN Washington, DC ,Office of Healthcare Inspections 202-461-4705

Acknowledgments	Donna Giroux, RN, CPHQ

Appendix D

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