Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Substandard Patient Care
Atlanta VA Medical Center
Decatur, Georgia

Report No. 09-00275-173 **July 22, 2009**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

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

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections, conducted an evaluation in response to allegations that veterans received substandard care in the medical specialty outpatient clinics and on a medical/telemetry unit at the Atlanta VA Medical Center located in Decatur, Georgia.

The complainant provided limited information in support of the allegations. We evaluated the care of those patients specifically identified, and also reviewed quality management, infection control, mortality, and patient complaint data. We did not substantiate allegations of substandard care in the medical specialty clinics or on the medical/telemetry unit. We made no recommendations.

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

TO: Director, VA Southeast Health Care Network (10N7)

SUBJECT: Healthcare Inspection – Alleged Substandard Patient Care, Atlanta VA Medical Center, Decatur, Georgia

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) received allegations of substandard patient care at the Atlanta VA Medical Center (the medical center) in Decatur, GA. The purpose of the review was to determine whether the allegations had merit.

Background

The medical center is a teaching hospital that provides a full range of medical, surgical, mental health, and long term care services, and has 173 inpatient beds and 100 nursing home care beds. The medical center is part of Veterans Integrated Service Network (VISN) 7.

The complainant initially made allegations to the OIG Hotline Division on February 25, 2008, regarding alleged improper personnel actions. The complainant made reference to substandard patient care but did not provide any specific patient information. As the OIG does not have authority over personnel-related issues, the complainant was directed to contact the medical center's Human Resources office.

The complainant subsequently contacted the OIG on several more occasions and also contacted Congressman Tim Price. In these contacts, the complainant reiterated allegations about improper personnel actions but also provided more specific information that the complainant felt supported the patient care-related allegations. We again advised the complainant that, in general, OIG does not have authority or jurisdiction over personnel issues; the complainant was advised to pursue these concerns through an alternate venue. We did provide copies of the complainant's allegations to another OIG division for review; however, that referral was declined. OHI evaluated only the patient care-related allegations.

The complainant, in correspondence to the Medical Center Director in February 2008, alleged that due to unsafe practices, veterans in the outpatient medical specialty clinic received substandard care, as follows:

- A veteran developed an infection on her arm after receiving a flu shot because staff used poor hand hygiene.
- A veteran with recurrent breast cancer experienced a reaction to chemotherapy, but the nurse did not respond promptly.
- A veteran had an unsatisfactory laboratory experience because the staff used the wrong sized needle to draw blood samples.
- A veteran had chronic shoulder pain which was not addressed.

The complainant also alleged that the nursing care on the seventh floor (medical/telemetry unit) was substandard and made the following allegations:

- A veteran did not have an intravenous (IV) site changed while an inpatient.
- A female veteran developed pressure ulcers after a hip replacement.
- Veterans made numerous complaints regarding poor care.
- Some veterans may have died as a result of poor care.

Scope and Methodology

The complainant initially did not provide any specific patient information to the OIG. We repeatedly requested patient names, identifiers, and dates of events to enable us to evaluate the validity of his claims. We interviewed the complainant by phone on November 13, 2008; the complainant subsequently provided us with additional documents that allowed us to further assess the allegations.

We evaluated the medical center's quality of care reviews and conducted an independent review of the complainant's allegations. We also reviewed patient advocate reports for the medical specialty clinics and the seventh floor. We reviewed documents related to infection control, pressure ulcer incidence, and mortality data on the seventh floor of the medical center.

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

Inspection Results

Allegation 1: Infection related to a flu shot.

We confirmed that a veteran developed an infection in her arm after a flu shot; however, we did not substantiate that this infection was related to a nurse's hand hygiene or

technique. Approximately 9,000 doses of flu vaccine were administered by staff in the clinics in the Fall of 2007. The incidence of infection related to flu shots is not officially tracked; in fact, medical center staff would only know of these events if they were reported. However, a small number of vaccine-related infections would not be uncommon. The patient in question was a female veteran with a complex medical history that included lupus, an autoimmune disease, which would render her more susceptible to infection. A review of the care could not confirm that the nurse's hand hygiene or the technique used to administer the vaccine caused the infection.

Allegation 2: Response to chemotherapy reaction.

We confirmed that a veteran experienced a reaction to chemotherapy at the start of treatment; however, we did not substantiate the allegation that the nurse did not respond promptly to the event. This veteran presented with advanced, recurrent breast cancer. The nurse documented that she started the chemotherapy at 1:00 p.m. The veteran began exhibiting symptoms of a reaction shortly after the infusion began; therefore, the nurse stopped the infusion, notified the physician, and at 1:15 p.m., administered IV medications to counteract the reaction as ordered. The chemotherapy infusion was resumed at 2:15 p.m. The veteran completed the treatment at 4:15 p.m. without further incident.

Allegation 3: Laboratory experience related to a blood draw.

We could not confirm or refute the allegation that a veteran had an unsatisfactory laboratory experience because laboratory staff used the wrong sized needle to draw blood samples. The complainant did not provide the veteran's name; therefore, we were unable to complete a review of the alleged incident.

Allegation 4: Treatment of chronic shoulder pain.

While we confirmed that a veteran with multiple medical problems, including diabetes and heart disease, complained of chronic shoulder pain, we did not substantiate the allegation that his pain was not addressed. The veteran was seen in the Pain Clinic 14 times between June 2003 and November 2005. He continued to be followed in various medical specialty clinics and Primary Care over the next several years. In October 2008, he was seen by his Primary Care provider who renewed his pain medication and ordered shoulder x-rays. In January 2009, the veteran was told via letter that his shoulder x-rays did not reflect any significant disease and that he should take over-the-counter calcium supplements. While the veteran may have continued to experience shoulder pain, we determined that his pain was addressed.

Allegation 5: Changing of IV site.

We substantiated that a veteran's IV site was not changed per policy. Infection control guidelines at the time required IV sites to be changed every 72 hours; however,

in this veteran's case, the site was not changed for 96 hours. Medical record documentation reflected that the IV site was free of any signs of infection. Because policy was not followed, clinical managers discussed the case with seventh floor staff and re-educated them on the infection control guidelines for IV sites. The veteran suffered no harm as a result of the delayed IV site change.

Allegation 6: Development of pressure ulcers after hip replacement surgery.

We could not confirm or refute that a female veteran developed pressures ulcers after a hip replacement due to poor care as the complainant did not identify the veteran or the date of the alleged incident. We did evaluate the medical records of the two female veterans who received hip replacement surgeries between October 1, 2006, and March 31, 2008. Neither of those female veterans developed pressure ulcers.

Allegation 7: Complaints of poor care on the seventh floor.

We could not confirm or refute that veterans made numerous complaints of poor care on the seventh floor. The complainant did not provide any patient names or specific episodes of care. Therefore, we reviewed patient advocate reports for the period October 1, 2007, to September 30, 2008. We found two complaints related to care on the seventh floor; both appear to have been addressed and resolved. We have no way to identify or quantify complaints veterans may have made through unofficial channels.

Allegation 8: Alleged deaths resulting from poor care.

We could not adequately evaluate the allegation that some veterans may have died as a result of poor care as the complainant did not provide us with patient names or specific episodes of care. In an effort to identify negative patient care trends, we reviewed documents related to infection control, pressure ulcer incidence, and mortality data on the seventh floor. We did not identify any patterns, trends, or other concerns that would be indicative of substandard patient care.

Conclusions

We did not substantiate or could not fully evaluate allegations of substandard care in the medical specialty clinics and on the seventh floor of the medical center; therefore, we made no recommendations. The VISN and Medical Center Directors agreed with our findings.

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

OIG Contact and Staff Acknowledgments

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