Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Emergency Room Discharge of a Hospice Patient
Hampton VA Medical Center
Hampton, Virginia

Report No. 10-04043-136

March 30, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

In September 2010, a confidential complainant contacted the VA Office of Inspector General Office of Healthcare Inspections (OHI) regarding a complaint concerning the care a patient received at the Hampton VA Medical Center (facility), Hampton, VA. OHI evaluated the validity of the following allegations:

- The emergency room (ER) provider did not perform a complete evaluation of the patient's condition prior to discharging the patient home.
- Staff treated the patient and spouse poorly during the ER visit.
- When the patient's spouse asked facility staff to admit the patient to the hospice unit or hospital, the staff informed the spouse that the patient did not meet criteria for hospital admission and that the hospice unit was full.
- On the day of the ER visit, the complainant stated that a staff member told the complainant that there were four hospice beds available.

We substantiated the allegation that the ER provider did not perform a complete evaluation of the patient during his last ER visit. Review of the records indicated there were other possible causes for the patient's condition that were not evaluated. The ER provider's note did not assess the veteran's functional status. Better awareness of this deficit may have prevented some of the difficulties this veteran experienced. Additionally, when the patient arrived home after leaving the VA ER, paramedics transported the patient to a non-VA hospital where an ER provider admitted the patient.

We could not confirm or refute the allegation that the staff treated the patient and spouse poorly. We did not substantiate the allegation that hospice beds were available on the day of the patient's last ER visit. We substantiated the allegation that the patient was not provided hospice care when requested. The Palliative Care Consult Team (PCCT) did not see the patient when informed that the family requested their services nor help to facilitate the hospice care process. During our interviews, we asked staff if they were aware of VA hospice guidelines and with the exception of PCCT members, staff denied knowledge of the directive or requirements. Facility staff missed numerous opportunities to initiate hospice care services earlier in the patient's course of treatment.

We recommended that all ER staff receive training in hospice and palliative care related to patients with advanced life-limiting diseases, the facility put in place methods that actively seek patients needing hospice and palliative care, and the facility provides hospice and palliative care education activities for all clinical staff.

The VISN and facility Directors agreed with our findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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

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

SUBJECT: Healthcare Inspection – Emergency Room Discharge of a Hospice Patient, Hampton VA Medical Center, Hampton, Virginia

Purpose

In September 2010, a confidential complainant contacted the VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) regarding a complaint concerning the care a patient received at the Hampton VA Medical Center (facility), Hampton, VA. OHI evaluated the validity of the allegations of poor customer service and that a provider inappropriately discharged a patient from the emergency room (ER) at the facility. The purpose of the inspection was to determine if the allegations had merit.

Background

The facility provides acute care in primary, specialty, and long-term care services. The facility is part of Veterans Integrated Service Network (VISN) 6 and serves a veteran population of about 220,000 throughout 15 counties in eastern Virginia and 10 counties in northeastern North Carolina. The 468-bed facility provides comprehensive healthcare through primary, acute inpatient, psychiatric, chronic spinal cord injury, long-term, domiciliary rehabilitative residential, and hospice and palliative care.

The goal of hospice and palliative care (HPC) is to improve end-of-life care by enhancing the quality of life for the terminally ill and their loved ones. It is a team-oriented approach that includes medical care; pain management; and emotional, social, and spiritual support. HPC care teams can provide in-home or inpatient care for people diagnosed with an incurable disease with less than 6 months to live. Hospice care focuses on enhancing the quality of life remaining for patients by providing care 24 hours a day, 7 days a week. In addition, hospice care includes bereavement and counseling services to surviving family and friends. Hospice care strives to allow patients to die with dignity, pain-free.[1]

[1] National Hospice and Palliative Care Organization, www.nhpco.org, accessed October 15, 2010.

The Veterans' Health Care Eligibility Reform Act[2] mandates facilities provide hospice services to all veterans meeting hospice criteria. The facility should provide in-home or inpatient hospice care. Hospice services should be readily available to the patient. For facilities that cannot provide inpatient hospice care, community inpatient hospice will provide care. All facilities should assemble a Palliative Care Consult Team (PCCT) to ensure veterans with serious, life limiting illnesses have hospice and palliative care services available. The VISN director should encourage PCCTs to have service agreements with departments in the facility that generate referrals.[3]

The complainant alleged that a facility provider inappropriately discharged a patient from the ER when requesting admission for hospice care. The complainant specifically alleged that:

- The ER provider did not perform a complete evaluation of the patient's condition prior to discharging the patient home.
- Staff treated the patient and spouse poorly during the ER visit.
- When the patient's spouse asked facility staff to admit the patient to the hospice unit or hospital, the staff informed the spouse that the patient did not meet criteria for hospital admission, and that the hospice unit was full.
- On the day of the ER visit, the complainant stated that a staff member told the complainant that there were four hospice beds available.

Scope and Methodology

We interviewed the complainant and patient's spouse by telephone prior to the site visit October 25–26, 2010. While onsite, we interviewed managers, clinicians, and other staff pertinent to the complaints. We reviewed the patient's medical record, relevant facility and Veterans Health Administration (VHA) policies, as well as a peer review of the case.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The complaint concerned the care of a service connected male in his fifties, who transferred care to the facility in August 2010 after previously receiving treatment from private care providers. Non-VA physicians diagnosed the patient with lung cancer with metastasis[4] to the brain in January 2010 and treated the patient with chemotherapy and

[2] Public Law 104-262 [HR 3118], *Veterans' Health Care Eligibility Reform Act of 1996*, October 9, 1996.
[3] VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT),* October 23, 2008.
[4] Metastasis is the spread of a disease in an individual, from one organ or part to another non-adjacent organ or part.

radiation. The patient's medical history included low blood cell counts and a recent pulmonary embolism for which the patient was taking blood-thinning medication.

In August 2010, the patient presented to the facility's ER to establish care and obtain refills on medications. The ER provider and a mental health provider filled the medications and documented the patient's current mental and physical status including high risk for falls. The patient's speech was coherent and relevant, thoughts were organized and goal directed, and insight and judgment were good. The patient required a walker for mobility. During this visit, the patient had a follow-up primary care appointment scheduled for early September 2010.

Nine days later, the spouse brought the patient to the facility's ER with complaints of pain, weakness, and change in mental status over the previous 5 days. The ER provider admitted the patient for 23-hour medical observation. Once admitted, further testing showed the patient's blood to be too thin and possible bleeding in the brain. The attending physician converted the patient's admission to an acute care admission. The physician temporarily stopped the patient's blood thinning medication and gave the patient medication to reverse the blood thinning effects. Based on the patient's medical history, and signs and symptoms, the physician deemed the possibility of bleeding in the brain to be minimal. During the 2-day hospitalization, the patient's pain was treated, weakness resolved, and a follow-up appointment with hematology-oncology was scheduled.

Three days later, a primary care clinic case manager called the patient's home and spoke to the spouse. Documentation revealed that during this call the patient's spouse asked about home hospice care. The case manager did not submit a hospice referral, but documented it could be done at either the primary care provider or oncologist appointments within the next 2 weeks.

Six days later, the patient's spouse brought the patient back to the ER stating the patient had fallen twice and now had altered mental status. The spouse required assistance from the ER staff to get the patient out of the car; the patient could not use the walker and required a wheelchair to get into the facility. Documentation revealed that the patient was weak with altered mental status and listed the patient's triage level as level II, imminent.[5] During the ER visit, the patient was confused, incontinent, attempted to get out of bed without required assistance, and the spouse requested an evaluation of the patient's condition and palliative care. The provider's progress note listed the patient's chief complaint as confusion. The provider was unable to get a history from the patient and the progress note stated the family was not available. The provider documented the lung exam as normal, neurologic exam as grossly intact, and motor strength as normal. The provider documented the laboratory results as stable, and the chest x-ray showed

[5] This condition is a potential threat to life, limb, or function and requires rapid medical intervention.

possible pneumonia or collapsed lung. The provider treated the patient with an intravenous antibiotic for pneumonia.

Documentation showed the provider determined the patient did not met criteria for an acute care admission to the facility. Because the spouse had requested palliative care, the provider contacted a coordinator to assist the family. The coordinator's documentation noted that the spouse was having difficulty managing the patient at home and could no longer provide care in the home, the spouse understood the patient was terminal and hospice care only provides comfort care, and there were no hospice care beds available. The coordinator arranged facility community living center admission for the next morning and the patient's spouse was to call a family member to assist in caring for the patient that night. The provider discharged the patient home with oral antibiotics to treat the pneumonia.

Once home, the spouse and a family member were unable to get the patient out of the vehicle and had to call 911 for assistance. Paramedics transported the patient to a local ER where the physician admitted the patient to an acute care unit. Because of the patient's confused mental status, the spouse provided the history. The medical record shows that the patient had become increasingly difficult to manage at home due to falls and confusion. The physician at the private hospital noted the family's request for comfort care and no resuscitation. The physician also noted the patient was eligible for VA hospice and would transfer the patient when a bed became available. Records documented the reason for admission as behavior, increasing combativeness and confusion, falls, and the family's inability to care for the patient at home.

Two days after admission to the private hospital, the VA received a request for hospice from the private hospital physician. The PCCT submitted a palliative care consult. The patient was scheduled to be admitted to the VA inpatient hospice unit 5 days later. However, he died 2 days before the scheduled transfer date.

Inspection Results

Issue 1: The ER provider did not perform a complete evaluation of the patient's condition prior to discharging the patient home.

We substantiated the allegation that the ER provider did not do a complete evaluation of the patient prior to discharging the patient home.

The patient had a known history of lung cancer that had metastasized to the brain. The 3 weeks prior to the last visit were notable for two ER visits and a hospital admission. The nurse triage note on the last ER visit noted return with the same symptoms of weakness and confusion from the prior ER visit. The ER provider's note stated that the history was based on the triage sheet, noting the spouse was not available for interview

and the history could not be obtained from the patient; however, it did not reflect review of the patient's recent medical history.

The provider's progress note did not document significant decline in the patient's function over the last 3 weeks as noted in the medical record, nor did it reflect exploring complications associated with brain metastasis, blood thinning medication, and falls as possible causes of altered mental status.

Despite the complaint of significant weakness, the patient's physical exam, other than altered mental status, was documented as unremarkable. The neurological examination was noted to be grossly intact but did not document sensation, reflexes, or coordination. There was no documentation of an assessment of the patient's ability to transfer or walk.

The ER provider did obtain laboratory studies that had not changed significantly from prior studies. The patient's chest x-ray showed pneumonia which was treated with an antibiotic. An admission to the CLC was arranged for the veteran the next morning.

Issue 2: Staff treated the patient and spouse poorly.

We could not confirm or refute the allegation that the staff treated the patient and spouse poorly during the ER visit.

During our interview with the spouse, she stated that when they arrived at the facility's ER, the vehicle was valet-parked, she requested help twice, and had to wait 15 minutes for assistance. On discharge, the spouse asked for assistance to get the patient to the vehicle. However a staff member only put the patient in a wheelchair, no one helped get the patient to the vehicle or in the vehicle. Further, the valet who retrieved the vehicle did not offer to assist the patient into the vehicle or offer to get someone else to help. The spouse reported getting assistance from non-staff members to get the patient into the vehicle.

During our interviews with facility staff, a staff member informed us that valets do not normally assist with veteran transfers, and ER staff members always provide assistance when asked. No one interviewed involved with the case recalls being asked to assist this patient.

The facility leadership reported recent investments in customer care to include hiring patient flow coordinators as care liaisons.

Issue 3: The facility did not provide hospice care to the patient when requested.

We substantiated the allegation that the facility did not provide hospice care to the patient when requested.

VHA Directive 2008-066 states:

> The mission of the VA HPC program is to honor the veteran's preferences for care at the end of life. Facilities are required to have in place a mechanism to identify veterans who may be appropriate for HPC and determine their specific preferences for care. Facility staff should strive to meet veterans' needs in the setting that best accommodates their needs and preferences.[6]

The patient had an admission to the facility through the ER less than 2 weeks prior to this ER visit. During that hospitalization, several of the staff were aware of the patient's condition and should have entered a consult to the PCCT. The facility had templates in place to trigger hospice consults. However, there was no hospice consult initiated for the patient by anyone at the facility prior to contact from the outside hospital.

At the last ER visit, the ER provider contacted a coordinator. The coordinator contacted the PCCT to request a hospice admission that day. The team member told the coordinator no beds were available on the hospice unit. The PCCT team member did not make contact with the patient or initiate a hospice consult. Further, when facility staff discovered the patient was an inpatient at an outside hospital, no one attempted to coordinate a transfer or initiate a hospice consult. Only after the private hospital's physician's request did the PCCT initiate a palliative care consult. The PCCT scheduled the patient for admission to the facility's inpatient hospice 5 days after the private hospital physician contacted them. The patient died 2 days before the scheduled transfer to the facility PCCT.

Issue 4: On the day of the ER visit, four hospice beds were available.

We did not substantiate the allegation that hospice beds were available on the day of the patient's last ER visit.

The facility has 10 allocated inpatient hospice beds; however, during our interview, a staff member informed us that only 8 of the beds are active due to staffing. Review of the gains and losses report[7] for the day of the patient's ER visit showed that patients occupied seven of the eight beds. Staff informed us that the remaining bed was for a patient previously scheduled for transfer from outside of the facility, who was to arrive the following morning.

[6] VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT),* October 23, 2008.
[7] The gains and losses report is the facility tracking record for daily bed usage.

Conclusions

We substantiated the allegation that the ER provider did not perform a complete evaluation of the patient during his last ER visit. Review of the records indicated there were other possible causes for the patient's condition that were not evaluated. The ER provider's note did not assess the veteran's functional status. Better awareness of this deficit may have prevented some of the difficulties this patient experienced. Additionally, when the patient arrived home from the VA ER, paramedics transported the patient to a non-VA hospital where an ER physician admitted the patient.

We could not confirm or refute the allegation that the staff treated the patient and spouse poorly. We did not substantiate the allegation that hospice beds were available on the day of the patient's last ER visit. We substantiated the allegation that the patient was not provided hospice care when requested. The PCCT did not see the patient when informed that the family requested their services nor help to facilitate the hospice care process.

During our interviews, we asked staff if they were aware of VA hospice guidelines and with the exception of PCCT members, staff denied knowledge of the directive or requirements. Facility staff missed numerous opportunities to initiate palliative care services earlier in the patient's course of treatment.

Recommendations

Recommendation 1. We recommend that the facility ensure all ER staff receive training in hospice and palliative care related to patients with advanced life-limiting diseases.

Recommendation 2. We recommend that the facility put in place methods that actively seek patients needing hospice and palliative care.

Recommendation 3. We recommend that the facility provides hospice and palliative care education activities for all clinical staff.

Comments

The VISN and System Directors' concurred with our findings. See Appendixes A and B, pages 8–11 for the full text of their comments. The implementation plans are acceptable, and 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: February 24, 2011

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

Subject: **Healthcare Inspection – Emergency Room Discharge of a Hospice Patient, Hampton VA Medical Center, Hampton, Virginia**

To: Director, Operations Division, Office of Management & Administration (53B)

Thru: Director, Management Review Service (10B5)
Director, Washington, DC Office of Healthcare Inspections (54DC)

I concur with the response by the Medical Center Director, and with the recommendations for improvement identified in the report.

(*original signed by*:)
Daniel F. Hoffman, FACHE
VA Mid-Atlantic Health Care Network Director, VISN 6

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 11, 2011

From: Director, Hampton VA Medical Center (590/00)

Subject: **Healthcare Inspection – Emergency Room Discharge of a Hospice Patient, Hampton VA Medical Center, Hampton, Virginia**

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

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Healthcare Inspections – Emergency Room Discharge of a Hospice Patient draft report. I concur with the recommendations for improvement identified in the report.

2. The response and action plan for the recommendation is enclosed.

3. Should you have any questions regarding the comments or implementation plan, please contact me at (757) 722-9961 extension 3100.

(*original signed by*:)
Deanne M. Seekins, MBA
Hampton VA Medical Center Director

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 recommend that the facility ensure all ER staff receive training in hospice and palliative care related to patients with advanced life-limiting diseases.

Concur **Target Completion Date:** March 2 and 3, 2011

Facility's Response:

Review of Allegation #1: Hampton VAMC is conducting a formal "End of Life/Palliative Education Resource Center" (EPERC) on March 2 and 3, 2011. This two-day continuous training consists of 16 modules. The course will be instructed by the Medical Director of the Palliative Care Unit and the VISN Geriatrics Service Line Champion. The target audience for this training is all clinicians, including physicians, nurses, social workers, nursing assistants, chaplains, and other ancillary services as appropriate. All Emergency, Spinal Cord Injury, and Medicine physicians will be expected to attend.

Hampton VAMC has also developed a pocket card identifying conditions when Palliative Consult may be considered.

These cards were distributed to Primary Care, Medicine, and Emergency Room providers with the Medical Director of Palliative Care Unit's phone number available for any questions.

Status: Underway

Recommendation 2: We recommend that the facility put in place methods that actively seek patients needing hospice and palliative care.

Concur **Target Completion Date:** Completed

Facility's Response: Hampton VAMC's Palliative Care team has established relationships with community partners. The Palliative Care

team is working toward strengthening these relationships by holding quarterly meetings with representatives from local hospital and local home health agencies. During these meetings, the Palliative Care team educates the community partners on services available to Veterans and how to obtain a Palliative Care Consult. In addition, the team provides education on how to assist a Veteran in enrollment for VA benefits if appropriate. Printed information and pamphlets with contact phone numbers are distributed to the community partners for their reference.

Status: Completed.

Recommendation 3: We recommend that the facility provides hospice and palliative care education activities for all clinical staff.

Concur **Target Completion Date:** March 2 and 3/ongoing

Facility's Response:

All clinical staff will complete the VISN6 Hospice and Palliative Care (HPC) Training module number V06 VA 1367764 on the Learning Management System (LMS). The HPC training requirement will be added to each clinical staff's training requirements in LMS.

Status: Ongoing

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Cathleen King, RN, Associate Director Dallas Office of Healthcare Inspections
Acknowledgments	Gayle Karamanos, PA, Team Leader Larry Ross, MS Maureen Washburn, RN George Wesley, MD Robert Yang, MD Misti Kincaid, Program Support Assistant

Appendix D

Report Distribution

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