Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Issues with Quality of Patient Care and Communication
Hampton VA Medical Center
Hampton, Virginia

Report No. 10-03656-89 **February 15, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

At the request of the Honorable Jim Webb, United States Senator from Virginia, the VA Office of Inspector General Office of Healthcare Inspections reviewed the validity of allegations regarding quality of care and communication. The patient's son (complainant), who is the primary care giver and holds power of attorney for the patient, alleged that his father received poor care at the Hampton VA Medical Center (medical center), Hampton, VA. We reviewed allegations from the complainant that:

- The Emergency Department provided poor care for the patient.
- Inpatient care and discharge planning were not adequate.
- The attending hospitalist did not adequately communicate with the complainant about the patient's care.
- Medical center managers did not promptly respond to the complainant's concerns.

We substantiated that the medical center managers and the hospitalist did not adequately communicate with the complainant. However, we determined that efforts to improve communications between medical center managers, clinical staff and the complainant were effective; therefore, we made no recommendations.

We did not substantiate the allegations that Emergency Department or inpatient staff provided poor patient care. However, we did find lapses in the discharge planning process. The complainant was not involved in the discharge process as required. Further, the patient was discharged home without a discharge instruction sheet or medications. We recommended that the Medical Center Director ensure that medical center staff conduct discharge planning activities according to requirements and provide timely and complete written discharge instructions to patients and family members.

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

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

SUBJECT: Healthcare Inspection –Issues with Quality of Patient Care and Communication, Hampton VA Medical Center Hampton, Virginia

Purpose

At the request of the Honorable Jim Webb, United States Senator from Virginia, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a complainant. The patient's son (complainant) alleged that his father received poor care at the Hampton VA Medical Center (medical center), Hampton, VA. The complainant, who held power of attorney (POA) for the patient, further alleged that medical center staff did not appropriately communicate with him.

Background

The medical center provides primary, specialty, and long-term care services. It has 157 hospital beds and 122 community living center beds. The medical center serves a veteran population of about 220,000 throughout a 15-county region in eastern Virginia and northeastern North Carolina and is under the jurisdiction of Veterans Integrated Service Network (VISN) 6.

In August 2010, the complainant sent a letter to Senator Webb alleging that:

- The Emergency Department (ED) provided poor care for the patient.
- Inpatient care and discharge planning were not adequate.
- The attending hospitalist did not adequately communicate with the complainant about the patient's care.
- Medical center managers did not promptly respond to the complainant's concerns.

Scope and Methodology

On September 27–29, 2010, we conducted a site visit to evaluate the complainant's allegations. We interviewed the complainant, clinical staff, medical center managers, and other medical center employees knowledgeable about the patient's care. We reviewed the patient's medical record, pertinent medical center documents, and applicable medical center and Veterans Health Administration (VHA) policies.

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.

Inspection Results

Issue 1: Emergency Department Care

We did not substantiate the allegations that the ED provided poor care for the patient.

The patient in his eighties received care at the medical center for several chronic medical problems. These problems included dementia[1], seizure disorder, high blood pressure, and swallowing problems. The patient's daughter lived close to the medical center; however, the complainant, who cared for the patient and held POA, lived 2 hours away from the medical center.

In mid-June, 2010, the complainant brought the patient to the ED because of coughing and congestion symptoms. The ED physician ordered several tests. A chest x-ray report showed that the patient's lungs did not have an infection. However, a radiologist noted the presence of plaque, suggestive of asbestosis.[2] The laboratory reports, computerized axial tomography of the head, and the physician's examination did not indicate any new problems or infection. The ED physician prescribed intravenous (IV) fluids and, after several hours, determined that the patient was stable for discharge from the ED. The ED staff provided instructions for the patient to continue his medications, return to the ED if his condition worsened, and keep a primary care (PC) appointment scheduled for the following week.

Six days later, the PC physician examined the patient, found him to be medically stable, and added asbestosis to the patient's problem list as a result of his recent x-ray report. The patient left the PC clinic with prescribed medications.

Nine days later, the complainant brought the patient back to the ED because of an abscess[3] on the patient's back, increased coughing, congestion, and shortness of breath. Because of his medical conditions and chest x-ray results, the ED physician admitted the patient with a diagnosis of aspiration pneumonia.[4] The patient was treated with antibiotics and, after his breathing function improved, he was discharged home 7 days later.

[1]Dementia is a disorder of the brain which causes a progressive loss of memory, reasoning, and thinking.
[2] Asbestosis is a chronic and incurable disease caused by breathing in asbestos over the course of many years. Symptoms of asbestosis include shortness of breath and coughing.
[3] An abscess is a painful, red, and swollen tissue that fills with pus.
[4] Aspiration pneumonia is a lung infection that is caused from inhalation of food, stomach contents, or other foreign matter into the airway.

Six days post discharge, the patient returned to the ED because of coughing, congestion, and shortness of breath. The completed medical tests did not show any new problems or infection, so the ED physician discharged the patient with nebulizer treatments.[5]

One month later, the complainant and the patient returned to the ED because the patient had significant coughing and mucus production. The complainant reported that the patient had the same symptoms as before and may have aspirated.[6] The ED physician examined the patient and ordered laboratory tests and a chest x-ray. The patient was diagnosed with bronchitis and sent home with antibiotic medications. The next day, the complainant again brought the patient to the ED, reporting that his condition was too poor for him to be cared for at home. The ED physician admitted the patient to the acute medical unit with a diagnosis of dehydration and "failure to thrive."[7] Upon examination the patient was reported to also have a pressure sore on the lower back.

We determined that the care given in each of the ED visits was appropriate.

Issue 2: Inpatient Care and Discharge Planning

We did not substantiate the allegations that inpatient clinicians provided poor patient care. However, we did find lapses in the discharge planning process.

In early July 2010, the patient was admitted to the medical center's intensive care unit for treatment of aspiration pneumonia. Treating physicians ordered chest x-rays, laboratory tests, wound care for the abscess on the patient's back, as well as nutrition and speech pathology consultations for swallowing and diet evaluations. The patient's medical treatment included oxygen therapy, nebulizers, IV fluids, and antibiotic medications. Following transfer to a general medical bed, the patient was treated and determined to be medically stable for discharge on hospital day 7.

The pharmacist told us that when she delivered the prescribed discharge medications to the patient's room, he was alone, so she instructed him on his medication, placed the bottles on his bed, and exited the room. Although local policy requires that staff scan printed discharge instructions into the patients' medical records, the scanned list of discharge medications for this patient could not be found. A partial list of scanned discharge instructions documented, "no diet restrictions"; however, because of swallowing problems and aspiration pneumonia diagnosis, the patient required pureed foods and thickened liquids.

The complainant described to us that he was unaware that the medical center intended to discharge the patient until he received a telephone call from a social worker on the morning of the planned discharge. According to the complainant, the patient arrived

[5] This is a treatment with a device for the administration of inhaled medications.
[6] Aspirate is the inhalation of food, stomach contents, or other foreign matter into the airway.
[7] Failure to thrive is a gradual physical decline accompanied by apathy and a loss of willingness to eat or drink.

home by wheel chair van with only a can of Ensure[8] and thickening powder. The complainant reported that no medications (including antibiotics) or printed discharge instructions were sent home with the patient; however, the medication arrived by mail 3 days later.

The Joint Commission requires that a patient's family be involved in decision making or ongoing care and provided information regarding a patient's discharge.[9] Also, VHA requires that staff provide discharge instructions to patients and/or caregivers and document such in the medical record.[10] We found that staff did not involve the complainant who was the caregiver and POA in the July discharge planning process or provide complete and timely discharge instructions and medications to the patient and his son.

Issue 3: Communication Between the Attending Hospitalist and Family

We substantiated the allegation that the hospitalist did not adequately communicate with the complainant about the patient's care during July 2010. Although staff often spoke to the patient's daughter about her father's medical progress, we found that most were not aware that the complainant was the POA and caregiver.

Approximately 1 month after the patient's discharge, a meeting was set up with the medical center's staff and the complainant to discuss problems with patient care. The hospitalist who cared for the patient was present at the meeting along with the Chief of Staff and other managers. The hospitalist apologized for not communicating with the complainant and explained that he had not contacted the complainant because he held discussions with the patient's daughter regarding the patient's medical progress. The hospitalist was not aware that the complainant was the patient's POA to handle the patient's medical affairs and assumed that the daughter would be able to make these decisions.

After the meeting, the patient was re-admitted to the medical center. During our site visit, the complainant told us that the communication with the hospitalist had improved and that he was satisfied with his father's subsequent treatment and long term care plans.

Issue 4: Medical Center Managers Response to Complainant's Concerns

We did substantiate the allegation that the medical center managers did not promptly respond to the complainant's concerns; however, managers took appropriate actions once they became aware of the lapse in communication.

[8] Ensure is an oral nutritional supplement.
[9] JC Hospital Standard: PC.04.01.05.
[10] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 26, 2006.

The complainant alleged that he attempted, without success, to contact medical center managers several times during and after the patient's July admission to discuss concerns about treatment and care. The medical center managers reported they were not aware of the complainant's concerns until they received a letter from Senator Webb's office. Once this complaint was communicated to medical center managers; the Chief of Staff, Hospitalist, Home and Community Care Manager, and the complainant met in August 2010 to discuss and resolve the concerns about the patient's care. During our site visit, the complainant told us that communication and the patient's care were improved after medical center managers met with him and took actions to correct the issues.

We determined that efforts to improve communication between medical center managers, clinical staff, and the complainant were effective.

Recommendation

Recommendation: We recommended that the Medical Center Director ensure that medical center staff conduct discharge planning activities according to requirements and provide timely and complete written discharge instructions to patients and family members.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations (see Appendixes A and B, pages 6–8, for the Directors' 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: January 31, 2011

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

Subject: **Healthcare Inspection – Alleged Issues with Quality of Patient Care and Communication Hampton VA Medical Center Hampton, Virginia**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Thru: Director, Management Review Service (10B5)

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

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

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 31, 2011

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

Subject: **Healthcare Inspection – Alleged Issues with Quality of Patient Care and Communication 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 draft report, *Healthcare Inspection: Issues with Quality of Patient Care and Communication.* I concur with the recommendation for improvement identified in the report.
2. The response and action plan for the recommendation are 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
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 Recommendation

Recommendation 1. We recommended that the Medical Center Director ensure that medical center staff conduct discharge planning activities according to requirements and provide timely and complete patient instructions to patients and family members.

Concur **Target Completion Date: May 12, 2011**

Facility's Response:

The discharge planning process surrounding this incident was reviewed by the Acute Medicine Interdisciplinary Treatment Team. Based on the assessment of the current discharge planning process, it was determined that the discharge process did not include a mechanism that would ensure that the hospital provides timely and complete written discharge instructions to the patient and/or the patients family in a manner that they can understand. A discharge planning worksheet was developed by the team to improve compliance with the Joint Commission's requirement that the patient or next of kin/family/caregiver is involved in the decision-making/treatment-planning and ongoing care, and to provide information regarding the patient's discharge. The worksheet serves as a checklist/verify reminder indicating the set criteria to ensure continuity of quality patient care.

A discharge planning worksheet for each patient is monitored by the Acute Medicine Nurse Manager during the daily discharge planning rounds and analyzed monthly by the chair of the Social Work Professional Committee for trends and opportunities for improvement. A summary is reported to the Social Work Professional Committee and acted upon. The Medical Executive Board will monitor quarterly for 1 year. First report is due to the Medical Executive Board on May 12, 2011.

Status: Open

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Donald Braman Baltimore Office of Healthcare Inspections
Acknowledgments	Jennifer Christensen Myra Conway Melanie Cool Nelson Miranda

Appendix D

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