Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Patient Care and Communication Issues VA Medical Center Fayetteville, North Carolina

Report No. 06-00140-148

May 23, 2006

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

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

TO: Director, Mid-Atlantic Healthcare Network (10N6)

SUBJECT: Healthcare Inspection – Alleged Patient Care and Communication Issues, VA Medical Center, Fayetteville, North Carolina

Executive Summary

The purpose of the review was to determine the validity of allegations regarding patient care and communication between medical center staff and a patient's family. We did not substantiate the allegation that the discontinuation of intermittent oxygen resulted in the patient's transfer to the intensive care unit (ICU) or in his subsequent death. We found no evidence of orders for the initiation or discontinuation of oxygen for 5 days, although the patient received oxygen intermittently during this period. We found no medical center policy that provided procedures for the initiation or discontinuation of oxygen in the absence of an order. While we substantiated the allegation that the patient was dehydrated upon admission to the ICU, he was not dehydrated at the time of his death. We did not substantiate the allegation that the patient developed a large bruise while hospitalized. We could not confirm or refute the complainant's allegation of poor communication and lapses in courtesy by medical center staff.

We recommended that the medical center establish policies and procedures describing the circumstances under which oxygen may be initiated or discontinued in the absence of an order, and the method for documenting interventions. The VISN and Medical Center Directors concurred with the recommendation and revised current policy accordingly.

Purpose

The Department of Veterans Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted a review to determine the validity of allegations regarding patient care and communication issues at the VA Medical Center (the medical center) in Fayetteville, North Carolina.

Background

The medical center is part of Mid-Atlantic Healthcare Network 6 and provides medical, surgical, mental health, geriatric, rehabilitation, and dental services. The medical center has 90 hospital beds and 69 nursing home beds.

The complainant is the daughter of a veteran who died while an inpatient at the medical center. The patient had a complex medical history and was treated on various units of the medical center between April 14–May 20, 2005. The complainant alleged deficiencies both in patient care and in communication between medical center staff and the veteran's family. The complainant specifically alleged:

- The patient received poor medical care because: (1) medical center staff abruptly discontinued oxygen, which resulted in his transfer to the intensive care unit (ICU) and subsequent death; (2) the patient was dehydrated when he was admitted to the ICU; and (3) the patient developed a "big, black bruise" while hospitalized.

- Medical center staff communicated poorly with the veteran's family. The complainant maintained that a nurse practitioner (NP) in the Nursing Home Care Unit (NHCU) "got into her (the complainant's) face and said, without compassion, 'Your father is an old man, and he has cancer, and he is going to die.'" The NP told the patient's treatment team she did not want him (the patient) back on her unit.

Scope and Methodology

We visited the medical center January 30–February 1, 2006. In performing this review, we interviewed staff members regarding the patient's care and communications with his daughter. We reviewed quality management and patient representative documentation and examined the patient's medical and administrative records. We reviewed medical center policies and procedures related to oxygen ordering, administration, and treatments.

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

Medical Case Summary

This 85-year-old patient had a history of lymphoma, chronic lymphocytic leukemia, hypertension, cerebrovascular accident, anemia, gastroesophageal reflux disease, chronic obstructive pulmonary disease (COPD), and chronic debilitation. The patient's daughter was his power of attorney and requested resuscitation in the event of cardiac or respiratory failure. The patient presented to the medical center emergency room on April 15, 2005, with weakness and fatigue. He was admitted to the observation unit, diagnosed with pneumonia, and started on intravenous antibiotics. His admission oxygen saturation level (the measure of oxygen in the blood) was 96 percent[1] on two liters (2L) per nasal cannula (NC - the flow of oxygen delivered by nasal prongs). There were no physician orders for the initiation of oxygen.

On April 18, respiratory therapy staff recorded the oxygen saturation level at 94 percent on room air (without supplemental oxygen). The patient, however, intermittently received oxygen between April 18–23, as documented by occasional oxygen saturations and recorded oxygen flow rates. Respiratory therapy staff recorded oxygen saturation levels ranging from 93 percent to 100 percent on 2L NC on April 22 and April 23, and 97 percent on room air on April 25. On this same date, the daughter requested the patient's oxygen be restarted to help him breathe better. The nurse explained to the daughter that the most recent oxygen saturation level of 99 percent did not indicate the need for oxygen, and reassured the daughter that oxygen saturation level monitoring would continue. The patient's oxygen saturation levels ranged from 93 to 100 percent while on room air from April 28–May 3. The patient was not receiving oxygen or respiratory treatments upon transfer to the NHCU on May 4.

The patient's NHCU stay was uneventful from May 5–9. While in the NHCU, the patient received tube feeding that provided more than 2,000 calories per day and more than 2 liters of water. On May 10, at approximately 2:30 p.m., the patient developed lethargy, slightly labored respirations, and an oxygen saturation level of 91 percent. Nursing staff initiated oxygen at 2L NC with a resulting improvement in the oxygen saturation level to 100 percent. However, shortly thereafter, the patient's vital signs and degree of responsiveness declined. The NP ordered an increase in oxygen to 4L NC to maintain an oxygen saturation level of 93 percent, and the patient was transferred to the ICU at 3:20 p.m.

On arrival in the ICU, a physician note documents that the patient was dehydrated. Lab work drawn at the time of the patient's admission to the ICU included a blood urea nitrogen (BUN) and creatinine, which were both elevated. These lab tests are markers of kidney function that, when elevated, can be consistent with dehydration.

[1] Oxygen saturation levels between 93 and 99 percent are considered to be within normal limits.

By May 11, the patient's condition improved and the oxygen saturation level was 99 percent with oxygen at 2L NC. The patient received antibiotics to treat a urinary tract infection, and he remained on oxygen. In addition, the patient received fluid boluses and continuous intravenous fluids with marked improvement in kidney function within 24 hours. The patient's ICU stay was without incident from May 12–19.

On May 20 at 9:05 a.m., respiratory therapy staff documented an oxygen saturation level of 93 percent on 2L NC, and nursing notes described the patient as alert and oriented with stable vital signs. At 11:59 a.m., the patient's physician noted the patient did not have a fever and was in no acute distress. At 12:30 p.m., the daughter arrived at the patient's room at the same time the nurse arrived to administer medications. They found the patient unresponsive, pulseless, and not breathing. The nurse called a Code Blue at 12:35 p.m. to initiate resuscitative efforts. The cardiology physician documented the patient did not have a heartbeat. Resuscitative efforts were unsuccessful and the patient expired at 12:55 p.m. An autopsy was requested by the medical center but was declined by the family.

Inspection Results

Issue 1: Alleged Patient Care Issues

Discontinued Oxygen

We did not substantiate the allegation that the discontinuation of oxygen resulted in the patient's transfer to the ICU or in his subsequent death. There were no orders for oxygen until May 10. While administering albuterol treatments, respiratory therapy staff noted that the patient was also intermittently receiving oxygen between April 18–23. We were unable to determine who initiated the NC oxygen between those dates.

As a general practice, the facility allows nurses to initiate oxygen as needed in response to respiratory symptoms; however, none of the nurses we interviewed recalled starting the NC oxygen. The facility has no written policy concerning the initiation or discontinuation of oxygen by nursing staff without physician orders, nor does it have a policy specifically requiring documentation of the use of oxygen in nursing notes. It cannot be determined from the medical record the precise intervals that the veteran received oxygen between the dates of April 18–23, who applied the oxygen, or why the oxygen was intermittently initiated and discontinued.

The patient did not receive oxygen between April 23–May 10. All oxygen saturations were on room air and within normal limits during this interval. On May 10, the NP promptly addressed the patient's lower oxygen saturation level (91 percent) by writing an order for supplemental oxygen to increase the oxygen saturation level to 93 percent. The patient was transferred to the ICU because his vital signs and responsiveness were

declining. The patient continued to receive oxygen while in the ICU from May 10–20. His oxygen saturation level was 93 percent on May 20 with no evidence of breathing difficulties. We found no correlation between the discontinuation of intermittent oxygen on April 23 and the patient's transfer to the ICU on May 10, nor to his subsequent death on May 20.

Patient Dehydration

While we did substantiate the allegation that the patient was dehydrated, there is no evidence that this resulted in or contributed to the patient's demise 10 days after his admission to the ICU. By May 12, the patient's BUN and creatinine were nearing his baseline and his blood pressure was stable. There is no indication of continuing dehydration from May 12 until the date of the patient's death on May 20.

Patient Bruising

We did not substantiate the allegation that the patient developed a "big, black bruise" while hospitalized. We reviewed the medical records for the entire patient hospitalization to identify any documented bruising. A review of the patient's medical record, incident reporting data, and staff interviews provided no evidence the patient had any bruising during his inpatient stay.

Issue 2: Alleged Poor Communication

We could not confirm or refute the complainant's allegation of poor communication and lapse of courtesy by medical center staff. We found several discussions between the medical team and the daughter regarding the patient's serious condition documented in the medical record. Staff told us that the daughter had many questions throughout the patient's inpatient stay and they attempted to address each concern. The NP recalled discussing the difficult news of the patient's condition with the daughter. We interviewed a staff member who overheard the discussion and did not witness any lapses of courtesy. While we found no clear evidence of poor communication or lapses in courtesy between the complainant and medical center staff, courtesy is by definition subjective. It is possible that the complainant perceived a lack of courtesy.

In addition, based on medical record review and interviews, there was no evidence of NHCU treatment team discussion regarding the patient's readmission to the NHCU upon his discharge from acute medical care.

Conclusion

We determined that the discontinuation of oxygen did not precipitate the patient's admission to the ICU, nor did it result in the patient's death. The discontinuation of

oxygen occurred several days prior to the patient's admission to the ICU, and his oxygen saturation levels were adequate during this time.

We found no evidence of orders for the initiation or discontinuation of oxygen between April 18–23, although the patient received oxygen intermittently during that period. We could not establish who initiated or discontinued the oxygen during this period. We did not find a medical center policy permitting initiation or discontinuation of oxygen in the absence of a health care provider's order.

While we did substantiate that the patient appeared dehydrated when admitted to the ICU on May 10, we found no evidence that this contributed to the patient's death on May 20, 10 days later. We did not substantiate the existence of a large bruise. We could not confirm or refute the allegation of poor communication and lack of courtesy by medical center staff. It appeared that medical center staff provided appropriate treatment to this complex patient with multiple comorbidities.

Recommended Improvement Action. The VISN Director should require that the Medical Center Director establishes policies and procedures describing the circumstances under which oxygen may be initiated or discontinued in the absence of an order, and the method for documenting interventions.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with our findings and provided documentation of action taken. Medical Center Memorandum 11-31, *Patient Assessment/Reassessment*, has been changed to reflect the circumstances under which oxygen may be initiated or discontinued in the absence of an order and the method for documenting interventions.

Inspector General Comments

The VISN and Medical Center Directors agreed with our findings and recommendations and provided a copy of the revised medical center policy reflecting the changes. We consider this issue to be resolved.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 8, 2006

From: Director, Mid-Atlantic Healthcare Network (10N6)

Subject: **Alleged Patient Care and Communication Issues, VA Medical Center, Fayetteville, NC**

To: John D. Daigh, Jr., MD, Assistant Inspector General for Healthcare Inspections

Thru: Director, Management Review Service (10B5)

1. I have reviewed and support the facility's responses to the recommendation, which has been addressed and included in the attached document.

2. If you have any questions or require further clarification, please contact Janet S. Stout, Director, VAMC Fayetteville, via MS Exchange or at (910) 822-7059.

(original signed by:)

Daniel F. Hoffmann, FACHE

Attachment

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: 4/28/06

From: Director, VA Medical Center, Fayetteville, North Carolina (565/00)

Subject: **Alleged Patient Care and Communication Issues, VA Medical Center, Fayetteville, NC**

To: Network Director, VA Mid-Atlantic Health Care Network, VISN 6

1. Attached is Fayetteville's response to the Office of Inspector General (OIG) for the recommendation from the healthcare inspection conducted regarding alleged patient care and communication issues.

2. A response indicating concurrence is due via electronic submission to the Director, Management Review Service (10B5) by May 13, 2006 as prescribed by VA Policy MP-1, Part II, Chapter 23.

(original signed by:)

JANET S. STOUT

Attachment

Director's Comments to Office of Inspector General's Report

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

OIG Recommendation

Recommended Improvement Action. The VISN Director should require that the Medical Center Director establishes policies and procedures describing the circumstances under which oxygen may be initiated or discontinued in the absence of an order, and the method for documenting interventions.

Concur **Target Completion Date:** 4/24/06

With collaboration among Patient Care Services, Respiratory Therapy, and Medical Service, Medical Center Memorandum No. 11-31, *Patient Assessment/Reassessment* has been changed to reflect describing the circumstances under which oxygen may be initiated or discontinued in the absence of an order, and the method for documenting interventions. Attached is Medical Center Memorandum No. 11-31. This recommendation should be closed because it has been completed.

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates, Director, Atlanta Office of Healthcare Inspections
Acknowledgments	Toni Woodard, Healthcare Inspector Andrea Buck, MD

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Mid-Atlantic Healthcare Network 6 (10N6)
Director, VA Medical Center, Fayetteville, North Carolina (565/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U. S. Senate: Elizabeth Dole, Richard Burr
U. S. House of Representatives: Bobby Etheridge, Walter B. Jones, Jr., Mike McIntyre, Robert (Robin) Hayes

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.