Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Medical Management and Nursing Care, VA Boston Healthcare System, Boston, Massachusetts

Report No. 06-00741-173 **July 21, 2006**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The Department of Veteran Affairs, Office of Inspector General, Office of Healthcare Inspections, reviewed allegations of poor medical management and nursing care at the VA Boston Healthcare System (system), Brockton Campus, located in Brockton, Massachusetts. The purpose of this inspection was to determine the validity of the allegations.

The complainant, the patient's wife, alleged that:

- The primary care provider (PCP) overdosed the patient with lithium and narcotics, and the patient died as a result.
- The PCP did not place appropriate consults for specialty medical services.
- The PCP did not communicate effectively with the complainant (the patient's wife).
- The PCP allowed the patient, who was allegedly incompetent, to make medical decisions.
- The PCP discouraged the complainant from having an autopsy performed on her husband.
- The death certificate was falsified.
- Nursing employees neglected the patient's basic needs and abused the patient.
- Employees stole personal items and money from the patient.

We did not find that the patient was overdosed with medications. He had complex medical needs. The primary care provider managed those needs within the realm of acceptable medical practice based on his clinical judgment and the recommendations from specialty services, such as cardiology, psychiatry, and the pain clinic. We concluded that the complainant had adequate opportunity to communicate with the physician and was given the opportunity to have an autopsy performed after the patient's death. We did not find evidence that the death certificate was falsified. We did not find that the patient's nursing care needs were neglected or that he was abused. We could not substantiate allegations of theft of money and personal items. Consequently, we made no recommendations.

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

TO: Director, VA New England Healthcare System (10N1)

SUBJECT: Healthcare Inspection - Quality of Medical Management and Nursing Care, VA Boston Healthcare System, Boston, Massachusetts

1. Purpose

The Department of Veteran Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), reviewed allegations that a physician caused the death of a patient by overdosing him with lithium carbonate (lithium) and narcotics; it was also alleged that the patient received poor quality nursing care and experienced patient abuse at the VA Boston Healthcare System (system), Brockton Campus, located in Brockton, Massachusetts. The purpose of this inspection was to determine the validity of the allegations.

2. Background

The VA Boston system consists of three divisions with locations in Brockton, West Roxbury, and Jamaica Plain, MA. The Brockton Campus provides long-term care, mental health services, primary care, and chronic spinal cord injury care; it also has a domiciliary for homeless veterans. The West Roxbury Campus provides tertiary care and is the referral site for Veterans Integrated Service Network (VISN) 1. The Jamaica Plain Campus provides ambulatory and primary care services.

The complainant, the patient's wife, contacted the U.S. Attorney's (USA) Office alleging that a physician at the Brockton Campus caused the death of her husband. The USA's office referred the complainant to the OIG Office of Criminal Investigations located in Bedford, MA. On December 6, 2005, the complainant telephoned that office and spoke with an investigator. After an extensive conversation regarding the patient's care, the investigator referred the case to OHI for further review. Notes taken by the investigator during the conversation with the complainant were provided to OHI.

The complainant's allegations regarding the patient's medical care were that:

- The patient's primary care provider (PCP) poorly managed the patient's psychiatric and medical conditions. Specifically, the complainant alleged that the PCP overdosed the patient with lithium and narcotics, did not appropriately address the patient's oxygen dependence, did not place appropriate consults to Cardiology and Ophthalmology services, and did not monitor the patient's significant weight loss.
- Communication between the complainant and the patient's PCP was poor for the entire time the patient was under the PCP's care.
- The PCP allowed the patient to make medical decisions even though the patient was allegedly not competent.
- The PCP allegedly discouraged the complainant from having an autopsy performed on her husband. The autopsy report did not list the cause of death, and the death certificate was allegedly falsified.

The complainant's allegations regarding nursing care were that:

- Nursing employees neglected the patient's activities of daily living (ADLs), such as feeding, bathing, and toileting.
- A nursing employee abused the patient.
- Nursing employees charged the patient for laundry services.
- Employees stole personal items and money from the patient.

Two days after the patient's death, the record shows the complainant called the Manager of Geriatrics and Extended Care (GEC), nursing staff, and an administrative officer. She requested that the cause of death be changed to lithium toxicity. She indicated that if the cause of death did not reflect a correlation to the patient's service connected disability (bipolar disease), she would lose her VA widow's benefits and this would create a financial hardship. Additionally, in a telephone voice mail message to the OIG on December 28, 2005, she stated that if she received a letter from "you people" stating that her husband's medication for bipolar disease and post-traumatic stress disorder exacerbated his death then "this case is over."

3. Scope and Methodology

We interviewed the complainant and reviewed the patient's medical record and other pertinent documents. We visited Brockton on January 17–18 and February 6, 2006, and interviewed the patient's PCP and nursing staff who were familiar with the patient's care. We visited the nursing home care unit (NHCU) where the patient resided and the outdoor smoking area where he spent time.

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

4. Inspection Results

Case Study: The patient was 62 years old and was 100 percent service connected for bipolar disorder[1] since 1998. He served in the U.S. Army from 1961–1964. According to the medical record, the patient had a Ph.D. in American history and was employed until his first "nervous breakdown" in 1974. He was unemployed since that time. He was married with two children. The medical record shows evidence of disagreements between the patient and the complainant related to financial issues and medical decisions.

The patient's psychiatric and medical conditions included bipolar disorder and multiple chronic medical conditions, including coronary artery disease (CAD),[2] congestive heart failure (CHF),[3] and chronic obstructive pulmonary disease (COPD).[4] He also had cataracts and osteoarthritis and suffered from chronic back pain. The patient had a history of smoking two packages of cigarettes per day for more than 30 years.

The patient's medications included lithium 150 milligrams (mg) twice a day for bipolar disorder, oxycodone 5 mg every 3 hours as needed (not to exceed 7 doses in 24 hours), and morphine sulfate 30 mg in the morning and 45 mg in the evening for chronic pain. He was also prescribed other psychotropic medications and medications for his cardiac, pulmonary, and cholesterol conditions.

The medical record shows the patient initially accessed VA care at the Providence VA Medical Center (VAMC). The patient had six psychiatric inpatient admissions from 1996–1998 at the Providence VAMC, which were related to exacerbations of his bipolar disorder. He was discharged home after each of these admissions, except after the September 1998 admission. At that time, he was discharged to a non-VA nursing home due to his psychiatric and medical care needs.

In November 1998, the patient was transferred from the non-VA nursing home and admitted to the Psychiatry Service at Brockton. According to the medical record, the patient hit staff, smoked in undesignated locations, and started a fire at the community nursing home; he could no longer be managed in that setting. The patient remained on a psychiatry unit at Brockton until May 2000, when he was evaluated for sleep apnea; it was determined that he required continuous oxygen during the night. He was then admitted to the Transitional Care Service Unit at Brockton, where the PCP became the

[1] Bipolar disorder: Mood disorder which includes cycles of depression and high-energy activities.
[2] CAD: Plaque in the heart's blood vessels inner lining.
[3] CHF: Decreased ability of the heart to circulate blood throughout the body resulting in fluid retention in the lungs, abdominal organs and peripheral tissues.
[4] COPD: Disease of the lungs which reduces ventilation.

patient's attending physician. The patient was admitted to the NHCU in February 2001 for long-term care, and the PCP remained the attending physician.

The medical record shows that the PCP and other clinicians regularly monitored the patient's psychiatric and medical conditions and nutritional status. Through the years, the patient required acute medical admissions for pulmonary and cardiac problems, urinary tract infections, and admissions possibly related to medication toxicity. The patient's last acute medical admission was in November 2004 for dehydration.

The PCP's monthly summary note written September 30, 2005, indicates that the patient was considered medically stable. From September 30–October 12, the day the patient died, progress notes and staff interviews show that the patient maintained his usual level of activity. No acute changes in his behavior, mental status, or medical condition were noted. He was ambulatory in his wheelchair on and off the unit, and he went to the smoking area independently. We did not find documentation that the patient complained of feeling ill. On October 12, a nursing progress note shows that the patient received oxycodone 5 mg for pain at 12:11 a.m. and slept for 2 hours. The note shows that the patient then got up and left the unit, presumably to go to the smoking area; he returned around 4:00 a.m. At that time, he requested and was given oxycodone 5mg. He left the unit again and returned at approximately 5:45 a.m. At approximately 6:35 a.m., a nurse approached the patient to administer morning medications. The patient was unresponsive. The nurse called an emergency code and initiated cardio-pulmonary resuscitation. The Medical Officer of the Day (MOD) and the code team responded. Unfortunately, resuscitation efforts were not successful; the patient was pronounced dead by the MOD at 7:06 a.m.

The medical record shows that the MOD notified the complainant of the patient's death by telephone and asked the complainant at that time if she wanted an autopsy performed. Documentation shows that she declined; consequently, the patient's body was released to the funeral home at 4:00 p.m. on October 12. According to documentation, the complainant called the system's pathology department on October 14 and requested that an autopsy be performed. The system contacted the funeral home, and the patient's body was returned to the system that day at 1:50 p.m. The funeral home had already embalmed the body; this limited the amount of blood that could be used for laboratory testing.

The medical record shows the pathologist performed the autopsy that evening at 8:30 p.m. The pathologist obtained blood from the patient's right pulmonary artery, and a test to check the patient's lithium level was performed. The result showed that the lithium level was 0.2 millimoles/Liter.[5] The autopsy report noted that "advanced

[5] Lithium: Normal range is 0.5–1.5 mmol/L.

ischemic cardiomyopathy,[6] a left ventricular aneurysm, three vessel occlusive coronary artery disease, and papillary muscle cell[7] changes were a strong possibility for a cardiac arrest event."

Findings:

Issue 1: Medical Care and Medication Management

Alleged Medication Overdose: We did not substantiate the allegation that the patient's PCP caused the patient's death by overdosing him with lithium and narcotics.

The complainant alleged that the patient died from lithium toxicity. On June 5, 2003, the medical record shows the PCP negotiated with the patient to keep his lithium levels in the low range of 0.5–0.6 mmol/L because the patient had a history of developing lithium toxicity. Since May 2000, the patient was evaluated twice in the system's urgent care department for symptoms of lithium toxicity, which would have required medical attention. The first time was January 5, 2002, and the lithium level was 1.9 mmol/L. The second time was March 4, 2005. The patient's lithium level at that time was 1.3 mmol/L. This level was within normal limits but high for the patient. According to the medical record, the patient admitted to surreptitiously taking two additional oxycodone pills that he obtained from another patient. On March 4, the PCP noted that the extra oxycodone appeared to cause a decrease in the patient's mental status with subsequent decrease in his oral intake, which led to an increase in the lithium level.

The medical record shows that the patient's lithium levels were monitored at least monthly and were kept in the low range to avoid toxicity. The last lithium level on September 27, 2005, was 0.3 mmol/L. The lithium level taken during the autopsy was 0.2 mmol/L.

Additionally, the complainant alleged that the patient was taking narcotics that were "wearing down his heart." At the time of the patient's death, the patient was taking morphine sulfate 30 mg twice a day and oxycodone 5 mg every 3 hours as needed (not to exceed 7 doses in 24 hours). Both medications were taken orally for chronic back pain.

Beginning in 2002, the PCP initially treated the patient's pain with non-narcotic medication (Tylenol® and Motrin); but the patient reported his pain was not adequately controlled. In September 2002, the PCP prescribed codeine 30–60 mg every 4–6 hours. On September 8, 2002, the patient was lethargic, and nursing staff had the patient evaluated by a physician in urgent care. The physician determined that the patient was most likely over-sedated with codeine (the record shows the patient received six doses of

[6] Advanced ischemic cardiomyopathy: Inadequate circulation of blood to the heart usually caused by CAD.
[7] Papillary muscle cell: Group of muscles within the lower heart chambers.

codeine in 24 hours); and that interactions with lithium, risperidone (an anti-psychotic medication), and gabapentin (an anticonvulsant medication sometimes used for bipolar disorder) may have contributed to the patient's symptoms.

The patient was treated and returned to the NHCU that evening. The medical record shows that on September 9, 2002, the PCP discontinued codeine and treated the patient's back pain with non-narcotic analgesics. Three days later, the patient complained of back pain, and the PCP and the patient agreed to try a reduced dose of codeine (30 mg every 4–6 hours). On September 13, the patient continued to complain of persistent pain and of not being able to sleep. The PCP and the patient discussed the difficulty of managing the patient's pain, given the earlier episode of lethargy. The PCP added one tablet of oxycodone 5 mg/acetaminophen 325 mg (percocet) to be taken at night and referred the patient to the system's Pain Clinic and Neurology Service for pain management. Additionally, the PCP referred the patient to Orthopedic Service for evaluation of degenerative disk disease.

The record shows that from 2000–2002, the PCP referred the patient for physical therapy; however, the patient did not consistently attend the sessions. On September 20, 2002, the PCP noted that the patient's pain control improved on the percocet and codeine combination. The PCP's December progress note shows the patient complained of increased pain, and the PCP added a daytime dose of percocet. On January 23, 2003, a neurologist recommended increasing the use of non-steroidal anti-inflammatory medications[8] as much as possible and using narcotics as needed to achieve optimal pain control.

During the interval from January 2003–November 2004, the PCP monitored the patient's responses to pain medications and adjusted the medication based on the patient's reported pain level and his physical response to the medications. During this period the patient refused consults to the Pain and Orthopedic Clinics for chronic back pain.

On November 21, 2004, the patient had an acute hospitalization for dehydration. According to the medical record and interviews with the PCP and nursing staff, clinicians believed the patient obtained pills from an unknown source thinking they were pain pills and took them. The pills were found to be diuretics (water pills); consequently, the patient became dehydrated and lethargic. He was also hypotensive (low blood pressure) and had a lithium level of 1.1 mmol/L.

During this hospitalization, the PCP requested another pain management assessment. The clinician who performed the assessment recommended a trial of tramadol (a non-narcotic pain medication). If the tramadol trial was ineffective, the clinician recommended adding morphine sulfate twice a day (no dose specified) and a percocet

[8] NSAID's: Non steroidal anti-inflammatory drugs, for example, Tylenol and Motrin.

tablet every 6 hours. The PCP discontinued the patient's narcotics after the consult and started tramadol during the patient's hospitalization. The patient was discharged back to the NHCU and was kept on tramadol and Tylenol® for 1 month. He continued to complain of pain, and the PCP added morphine sulfate 15 mg twice a day to the patient's pain management regime.

In February 2005, the patient continued to complain of increased back pain, so the morphine was increased to 30 mg twice a day. On April 25, percocet was discontinued; oxycodone 5mg every 4–6 hours (not to exceed 5 tablets in 24 hours) was added. The maximum daily tablets were gradually increased over a several month period to seven tablets in a 24-hour period.

The record shows the patient's chronic pain was well controlled with tramadol, acetaminophen, morphine and oxycodone; also nursing staff and the PCP monitored him for evidence of over-sedation. Additionally, Pharmacy Service and the PCP reviewed the patient's medication profile monthly.

Oxygen Dependence: We did not substantiate the patient was oxygen dependent. The complainant told us during an interview that the patient was dependent on oxygen and that he was moved from a room with wall oxygen to a room without oxygen 3 days prior to his death.

The PCP wanted the patient evaluated for sleep apnea and ordered a sleep study, which was performed on October 12, 2000. This study showed that the patient did not require continuous oxygen. Clinicians recommended that the patient use a continuous positive airway pressure (C-PAP)[9] machine during sleep. Subsequent PCP notes show that the patient was not compliant with the treatment. The record shows the patient had a pulmonary appointment on March 2, 2004, for re-evaluation of C-PAP. He refused to attend the appointment. The patient had an order for oxygen to be used only on an as needed basis.

Specialty Consultation: We did not substantiate the allegation that appropriate consults to specialty services were not placed. The complainant alleged that the patient did not receive appropriate consults for his cardiac condition and for cataracts.

The medical record shows that a cardiologist assessed the patient's heart condition on October 7, 2004; since 2000, the patient had a minimum of annual electrocardiograms and two echocardiograms. The patient had a history of periodically refusing evaluations, including cardiac evaluations, and periodically not taking his cardiac medications. For example, a November 15, 1999, progress note shows the patient refused to go for a cardiology evaluation and refused a cardiac procedure. In October 2000, the patient had

[9] C-PAP: Delivers a constant stream of compressed air from a face mask, which keeps the airway open.

an episode of chest pain. The PCP reviewed the patient's case with a cardiologist, who recommended that the patient have a cardiac catheterization. The medical record shows that the PCP and the cardiologist discussed medical and surgical treatment options for CAD with the patient. The patient refused the catheterization and opted for non-invasive treatment, which included cardiac medication management, cholesterol management, and weight reduction.

Additionally, the complainant alleged there was a delay in evaluation and treatment of the patient's cataracts. The record shows the patient had an Optometry consult for blurred vision in September of 1997 at the Providence VAMC. In March of 1999, the patient had an Optometry consult for cataracts and an eye examination. The record shows that Optometry evaluated the patient again on February 17, 2000, and offered the patient cataract surgery, which he refused.

On September 25, 2003, Optometry again saw the patient and evaluated his cataract condition. The progress note shows the patient had refused cataract surgery in the past because of nervousness but was ready to proceed with the surgery. On December 26, the PCP's progress note shows the patient initially agreed to an Ophthalmology appointment, but he later declined to keep the appointment.

On September 9, 2004, the patient had an Optometry appointment, which the complainant attended; both the complainant and the patient asked about cataract surgery. The complainant asked for an Ophthalmology appointment and had one the same day. The patient agreed to have surgery, and it was scheduled for September 23. However, the patient did not want the surgery done under general anesthesia. Ophthalmology saw the patient the next day and discussed local anesthesia versus general anesthesia with the patient. On September 13, the patient agreed to have an Anesthesiology evaluation to determine what type of anesthesia would be appropriate, based on his medical conditions; but the patient cancelled the appointment for the anesthesia evaluation.

On September 27, the patient agreed to an Anesthesiology evaluation, and his wife requested a cardiology consult prior to surgery. On October 27, the patient had a cardiology consult to determine the risk for general anesthesia for cataract surgery. The assessment concluded that the patient was in a high-risk category, due to his health conditions, for a low-risk procedure. On October 19, Anesthesiology Service saw the patient, and the decision was to proceed with the surgery under local anesthesia. Also, the decision was made to do the right eye first and to complete the left eye at a later date. In October, the patient had an eye infection which delayed the surgery. The patient had surgery performed on the right eye on December 20, 2004.

The record shows Optometry and Ophthalmology Services followed the patient after surgery, although the patient declined to go to some of the appointments. On June 30, 2005, he declined further evaluation for the cataract in his left eye.

Significant Weight Loss: The complainant alleged that the patient had a 50-pound weight loss in 1 month because nursing staff did not feed him. We did substantiate the patient had a substantial weight loss between July and September 2005, but we did not substantiate that the weight loss was due to staff not feeding the patient.

The record shows the patient had a 34-pound weight loss between July and September 2005. The PCP, the dietician, and the nursing staff were aware of the weight loss and monitored it. Prior to that time, the PCP's progress note indicates the patient was not compliant with his fluid restricted diet, causing fluid retention and weight gain. Additionally, during our interviews, nursing staff and the dietician reported that the patient often refused the food prepared by the hospital. He ordered food from fast food restaurants and kept additional food in his room. The dietician routinely assessed the patient, approximately every 1 to 2 months. Progress notes show that during that time, the patient had a 75-100 percent intake of food, and he did not require assistance with feeding.

Nursing notes show that the patient was independent with eating, but he did require occasional assistance with setting up his food tray. Nursing staff did not think that the patient's visual limitations affected his food intake. He was weighed routinely; in September, after the weight loss, his body mass index[10] was within the normal range at 24.4. The patient's electrolytes were also monitored. The PCP, nursing staff, and the dietician attributed the weight loss to improved fluid control and improved adherence with diuretic medications, and compliance with his low salt diet and fluid restriction. The PCP discontinued the diuretic when clinically indicated. When the patient's fluid weight increased, the PCP would put him back on a diuretic, which would result in weight loss.

Issue 2: <u>PCP's Communication with the Complainant</u>

We did not substantiate the allegation that the PCP did not communicate with the complainant while the patient was under his care.

The record shows the PCP first became the patient's physician on May 15, 2000. The medical record, case related documents, and information from staff interviews indicate that there were several ways available for the complainant to communicate with the PCP and the treatment team. When the complainant visited the patient (which was two or three times per month), she had contact with nursing and other clinical staff. Documentation shows that the complainant communicated with the Manager of GEC and had periodic interactions with the PCP. The complainant was also given the opportunity to attend quarterly treatment team meetings, which included the PCP, regarding the

[10] Body mass index: Is a ratio of weight to height estimate of total body mass rather than fat mass. Normal range is 18.5–24.9.

patient's care. Documentation indicates that from January 2003–July 2005, there was no family presence in the quarterly interdisciplinary treatment team meetings. Staff told us the complainant did not regularly attend the meetings but did meet twice with the treatment team outside of the scheduled quarterly treatment team meetings.

Issue 3: Assessment of Patient's Capacity to Make Medical Decisions

The complainant alleged that her husband was incompetent to make medical decisions about his care, and that the PCP prevented her from obtaining a health care power of attorney. A progress note dated December 26, 2003, indicates that the patient told the PCP that he did not want the complainant making medical decisions for him; and that the patient agreed to speak to the social worker about naming a health care proxy other than the complainant. On December 22, 2003, the record shows the PCP attempted to have a telephone conversation with the complainant to explain to her that, in his clinical opinion, the patient was competent to make medical decisions, but the complainant reportedly became verbally abusive and the PCP ended the phone call.

The PCP documented his opinion that the patient was capable of making decisions regarding his medical care. In response to the complainant's belief that the patient was incompetent to make medical decisions, the PCP ordered a neuropsychology consult to assess the patient's competency. The consultant, who performed this evaluation on April 12, 2004, determined "Capacity to make decisions: It is my opinion that the pt. [patient] has the ability to make medical decisions for himself at this time." The PCP also requested an Ethics Advisory Committee (EAC)[11] consult. The EAC concurred with the neuropsychology consultant and noted that "pt. [patient] has not been judged incompetent to make his own medical decisions."

Issue 4: Autopsy Request and Death Certificate Falsification

We did not find evidence that the PCP discouraged the complainant from having an autopsy performed. Additionally, we did not substantiate allegations that the autopsy report did not list the cause of death, or that the death certificate was falsified.

Autopsy: The complainant alleged the PCP persuaded her not to have an autopsy performed so "he could cover up his mistakes." She told us that 2 hours after her initial decision not to have an autopsy performed, she changed her mind and requested an autopsy. She also stated that she requested toxicology tests be completed during the autopsy, and these were not done.

[11] EAC: The EAC is charged with oversight of rights, responsibilities and organizational ethics. Patients, their families and staff may refer issues directly to this committee.

On the morning of October 12, 2005, nurses found the patient unresponsive and called an emergency code at 6:40 a.m. The MOD and the code team responded. Resuscitative efforts were not successful, and the patient was pronounced dead by the MOD at 7:06 a.m. After the code, the MOD notified the wife at 7:35 a.m. by telephone and asked if she would allow an autopsy to be performed. He noted that initially, she was hesitant and phone call ended with the issue undecided. She then called back at 7:53 a.m. and informed the MOD that she did not want an autopsy performed.

The PCP told us in an interview that when the wife and family arrived on the NHCU to view the body, between 9 and 10 a.m., he spoke with the family and suggested that an autopsy be performed. He told us that he described the process, and the complainant declined again to have an autopsy performed. The nurse manager also told us the PCP spoke with the complainant about the benefits of having an autopsy, but that she refused. Two days after the patient's death, on October 14, the complainant requested that an autopsy be performed.

The pathologist who performed the autopsy told us that on autopsy the patient was found to have severe heart disease. The left anterior descending coronary artery was 100 percent occluded and the circumflex coronary artery was 50 percent occluded. There was a ventricular aneurysm that had not yet ruptured. The lungs had changes consistent with severe COPD. The cause of death was felt to be heart disease. The pathologist reported that blood was taken from the right pulmonary artery and a lithium level was performed. The blood was not sent for other toxicology. He reported that the body was fairly embalmed at the time of the autopsy. The pathologist told us that he reviewed the pathology literature related to lithium toxicity to keep himself updated on any new information that might be relevant to the autopsy. He reported that on autopsy he did not find results indicative of lithium or narcotic toxicity. The pathologist told us that he does not know how embalming quantitatively affects lithium levels. He did note that the lithium level was 0.2mmol/L, which was consistent with the patient's recent prior lithium levels of 0.3mmol/L on September 27, 2005, and 0.3mmol/L on August 16, 2005.

The complainant requested and received two autopsy reports. One was the preliminary report, which was signed on October 19, 2005, by the pathologist; the second one was the final autopsy report signed November 16, 2005. The preliminary report included the provisional anatomic diagnosis, and the final autopsy report included the final anatomic diagnoses.

Death Certificate: Because the complainant initially declined to have an autopsy performed, a death certificate was completed and signed by the MOD. It listed the causes of death as cardiac arrest, COPD, and CAD. After the autopsy was completed, the system's Decedent Affairs Clerk began to prepare a second death certificate which the MOD also signed. This certificate listed the causes of death as ischemic atherosclerotic heart disease and post myocardial infarction. After signing the second certificate, the

MOD decided that an addendum to the original death certificate was unnecessary because the post autopsy diagnoses were consistent with the diagnoses on the original death certificate. Consequently, the system's Decedent Affairs Clerk did not complete the process of issuing a second certificate. However, the complainant received copies of both death certificates, even though the second one was not complete, and she believed that the second certificate had been falsified.

Issue 5: Nursing Care

We did not find evidence that the patient's ADL care needs were neglected, that he was abused by nursing staff, or that he was inappropriately charged for laundry services.

ADL Care: The complainant alleged the patient was not assisted with eating and was not properly bathed, dressed, and toileted.

Staff interviews and medical record documentation indicate that the patient was independent with eating and received assistance with bathing and grooming as needed. The patient periodically refused to cooperate with his personal care and was resistant to personal hygiene attempts, choosing, for example, to remain in soiled clothes. The record indicates that nursing staff consistently tried to provide basic nursing and personal care to the patient. Facility policy M: 11-005-LM indicates that a patient's rights (for example, the right to refuse a bath) may be restricted on an individual basis only under special and limited circumstances if in the opinion of the physician and treatment team there is the likelihood of serious consequences from full exercise of the specific right.

Patient Abuse: The complainant alleged that the patient was abused by a nursing assistant (NA). Due to his cataracts, the patient had impaired vision. The complainant reported that a NA pushed the patient in his wheelchair and deliberately released him causing the patient to run into the wall. The NA told us that this did not occur, that the patient was blocking a doorway; then the NA asked the patient for permission to move him. The NA moved the patient toward the wall. The nurse manager did not witness the incident, but she also told us that from discussions with her staff, it appeared to her that the NA moved the patient out of the way and did not abuse the patient. The complainant reported this allegation to staff, and a police report was filed. The police investigation, done in November 2004, did not substantiate that the patient was abused; the police forwarded the case to Quality Management (QM). QM reviewed the case and also determined that there was not sufficient evidence to support the patient abuse allegation.

Laundry Services: We did not find that the patient was charged by nursing staff for laundry service.

The Nurse Manager told us that the patient was not charged for laundry services and that doing patients' laundry was not the responsibility of nursing staff. Laundry can be done

by families or by the system's laundry service. She also told us that a washing machine was available to the patients in the NHCU.

Theft of Personal Items: The complainant alleged that clothes, money, a ring, and a radio were stolen from the patient while he was in the NHCU. We did substantiate the patient lost clothing items. However, we could neither substantiate nor refute whether the clothes were stolen. Documentation shows VA police investigated the loss and could not substantiate that they were stolen. Documentation shows that the Manager of GEC addressed concerns related to the loss of clothing with the complainant and provided the complainant with the appropriate VA claim form to file for the missing clothes on September 27, 2004. Documentation shows that the system reimbursed the patient $584.50 for the clothing.

We also could not substantiate or refute that money was stolen from the patient. The VA police investigated the concerns related to missing money and could not substantiate that the money was stolen.

We could not substantiate that a ring and a radio were stolen from the patient. There were no police reports that addressed the loss of a ring or a radio. However, we were told by nursing staff that the patient told them that he sold the ring. Additionally, after the patient's death, a nursing employee inventoried the patient's belongings with his wife. The inventory list shows that a radio was taken home by his wife. We could not substantiate whether or not this was the radio which the patient's wife alleged had been stolen.

5. Conclusions

We concluded that lithium blood levels were monitored and that the PCP attempted to keep lithium blood levels low due to the patient's prior history of lithium toxicity. We also concluded that the patient's chronic pain was difficult to manage, but that his PCP attempted to utilize specialty consultation to assist in addressing management of the patient's pain and contributory underlying conditions.

We concluded that the PCP managed this medically complex patient within the realm of acceptable medical practice. The patient had multiple chronic psychiatric and medical conditions and required multiple medications. We also concluded that appropriate consults were placed when the patient required specialty care, including care for his cardiac condition and his cataracts.

We concluded that the complainant had the opportunity to communicate with the PCP and members of the treatment team. Telephone conversations between the complainant and the PCP and in-person conversations with nursing staff are documented in the medical record. Also, the record and case related documents indicate that the treatment

team and clinical managers were available and responsive to the complainant's concerns regarding her husband's care.

We concluded that the PCP requested neuropsychological consultation and an ethics advisory committee consultation regarding determination of the patient's capacity to make medical decisions. Despite intermittent non-adherence with consult referrals and medical treatment options recommended by his clinicians, the patient was deemed capable of making decisions regarding his medical care; the staff had an obligation to respect his wishes regarding his care.

We concluded that on the day that her husband died, the complainant was offered the opportunity to have an autopsy performed on his body. We did not substantiate an allegation that the death certificate was falsified. The causes of death before and after the autopsy were deemed to be cardiac related; therefore, the medical officer of the day did not perceive a need to file an amended death certificate.

We could not substantiate allegations that the patient's nursing care needs were neglected. We found that the facility properly initiated investigation of patient abuse allegations. The patient was reimbursed for his lost clothing. An inventory list signed by the complainant after the patient's death reportedly includes a radio that appears to be the one allegedly stolen from the patient.

6. Recommendations

We made no recommendations.

7. Comments

The VISN and Healthcare System Directors agreed with the report findings and conclusions. See Appendixes A (page 15) and B (page 16) for the Directors' comments.

(original signed by Dana Moore,
Deputy Assistant Inspector General
for Healthcare Inspections for:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 29, 2006

From: Director, VA New England Healthcare System

Subject: Healthcare Inspection - Quality Medical Management and Nursing Care, VA Boston Healthcare System, Boston, Massachusetts. Project number: 2006-00741-HI-0218

To: Assistant Inspector General for Healthcare Inspections

VISN 1 Network Office concurs with the findings of this report.

(original signed by:)

Jeannette A. Chirico-Post, MD

VISN 1 Network Director

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 26, 2006

From: Director, Boston Healthcare System

Subject: Healthcare Inspection - Quality of Medical Management and Nursing Care, VA Boston Healthcare System, Boston, Massachusetts. Project number: 2006-00741-HI-0218

To: Assistant Inspector General for Healthcare Inspections

VA Boston Healthcare System concurs with the findings of this report.

(original signed by:)
Michael M. Lawson

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Michael Shepherd, M.D. Telephone: 202-565-8496
Acknowledgments	Annette Acosta, RN, CNP Sunil Sen-Gupta, Ph.D.

Appendix D

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The Honorable John Kerry, U.S. Senate
The Honorable Stephen F. Lynch, U.S. House of Representatives

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