



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Poor Psychiatric Care and Delay in Diagnosis and Treatment Salem VA Medical Center Salem, Virginia

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Executive Summary

This review was initiated in response to a complainant's allegations of denial of care, inappropriate admission to a psychiatric unit, poor communication, and delay in diagnosis and treatment. The purpose of the inspection was to determine the validity of these allegations.

We found that the patient was not evaluated by the on-call psychiatrist on October 12, 2005, when he first presented to the medical center emergency room (ER) nor was he referred to an ER physician for medical clearance prior to his discharge. We concluded that the ER triage nurse inappropriately discharged the patient from the ER without a physician's clearance. We further concluded that the ER triage policy needs to specify that a physician's clearance is required prior to discharging a patient from the medical center ER.

We concluded that on October 13 the resident psychiatrist appropriately assessed the patient as requested by his wife, followed medical center policy for the treatment of patients considered to be a danger to self and others, and appropriately admitted the patient to the psychiatric unit for further evaluation and treatment.

We concluded that medical center clinicians communicated with the patient's wife and other family members about the patient's care. Clinicians informed family members of the need for admission to the acute psychiatry unit, transfer to the medical unit, treatment plan and rationale, and the patient's fall months later and subsequent transfer to the private hospital.

We concluded that the medical consultant managed the patient's medical needs while he was on the acute psychiatry unit and that the patient was transferred to the medical ward when he [the medical consultant] felt the transfer was clinically indicated.

We recommended that the Medical Center Director should (a) instruct the Mental Health Service Line Manager to ensure that all patients presenting to the ER for psychiatric care are seen by a physician prior to discharge and (b) ensure that clinical managers review and revise the ER triage policy to clarify that a physician's medical screening is required prior to discharging a patient from the medical center ER.



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

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

SUBJECT: Healthcare Inspection – Allegations of Poor Psychiatric Care and Delay in Diagnosis and Treatment, Salem VA Medical Center, Salem, Virginia

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) initiated an inspection in response to a complainant's allegations of denial of care, inappropriate admission to a psychiatric unit, poor communication, and delay in diagnosis and treatment. The purpose of this inspection was to determine the validity of these allegations.

Background

Located in Salem, Virginia, the Salem VA Medical Center (the medical center) provides tertiary care and a range of inpatient and outpatient health care services. The medical center is part of Veterans Integrated Service Network 6 and serves a veteran population of about 123,000 in a primary service area that includes 25 counties in southwestern Virginia. The medical center provides medical, surgical, and mental health services and maintains 110 acute care, 67 sub-acute care, 5 intermediate care, and 90 nursing home beds. The medical center maintains a 30-bed acute psychiatric locked unit for patients in need of involuntary admissions.

On January 30, 2006, the wife of a veteran wrote a letter to Congressman Bob Goodlatte on behalf of her deceased husband. She subsequently forwarded the letter to the VA OIG. She alleged that on October 12, 2005, she took her husband to the medical center emergency room (ER) following his discharge from a local hospital. She alleged that a medical center ER employee told her that her husband's condition was not an emergency and instructed her to bring him back the following day. When the patient and his wife returned to the ER the following day, he was admitted to a psychiatric unit. On January 8, 2006, following a fall at an extended care unit, the patient expired at a local hospital.

Scope and Methodology

We interviewed the patient's wife, daughter, and son to clarify issues and obtain relevant information pertinent to this case. OHI inspectors visited the medical center from May 17–18, 2006, and May 31–June 1, 2006. We interviewed senior managers and employees and reviewed pertinent medical center documents and the patient's medical records. We also toured the psychiatric unit where the patient was initially admitted.

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

Case Review

The patient was a 77-year-old retired policeman who had spent 30 years in the Navy. He was service-connected for degenerative arthritis, hypertensive vascular disease, and inguinal hernia. He had a medical history of diabetes, chronic renal failure, prostate cancer, and dementia. He was living with his wife of 43 years in Virginia and was independent in functioning, driving his car, and taking his own medicine.

The patient received his primary care, for the most part, from his private physician. On January 5, 2005, during a routine follow-up visit for his diabetes, his private primary care physician reported that, from talking with the patient's daughter, the patient was becoming increasingly confused, getting lost, not recognizing where he was, and not recognizing his wife. On July 21, 2005, the patient was again seen by his primary care physician for back pain. The physician noted on that visit that a nurse reported that the patient "has been eating wildly and a lot more than he used to." The physician's note stated that, "the patient's wife thought that the patient forgets that he had eaten and turns around and eats again."

On September 16, 2005, and on October 4, 2005, during outpatient follow-up visits, the patient's private physician noted increased confusion and that the patient was not taking his medication for his diabetes as he should have. His medications included Aciphex 20 milligrams (mg) a day; Humalog mix 75/25, 60 units in the morning and 80 units at supper; Celebrex 200mg, twice a day (bid) or as needed (prn); Aricept 10 mg at bedtime; Namenda 10 mg bid; Zocor 40 mg; lisiniprol 20 mg a day; and occasional Darvocet. At the October 4 visit, the wife reported that the patient had damaged two of his cars and that she was worried about his driving. The physician then asked the patient not to drive and told him to go to the medical center to have his diabetes further evaluated as well as his memory function.

On October 10, 2005, the patient staggered and fell at a local store. He was taken by ambulance to a local hospital where he was admitted. The admitting physician noted that the patient was admitted due to acute onset of dizziness. He also obtained a psychiatric consultation due to reported behavioral issues (such as wandering and progressive

memory loss). The evaluating psychiatrist's diagnosis included Alzheimer's disease, dementia with behavioral disturbances, and personality changes and delusions as a result of dementing illness. He recommended that the patient no longer drive a vehicle because of his poor abstraction and judgment and limited visual and spatial skills.

On October 12, 2005, the patient was discharged from the local hospital and, according to the patient's wife, she was told by the patient's physician to take the patient to the medical center for extended care. Shortly after his discharge from the local hospital, the patient and his wife drove to the medical center to pursue evaluation and treatment. The patient was triaged by an ER nurse who told the couple that the patient should return the following day for a psychiatric evaluation for long-term care placement.

The patient returned the following day and was admitted to a psychiatric unit. He was subsequently transferred to a medical unit, then to an extended care rehabilitation unit, and to a local hospital where he expired following a fall.

Inspection Results

Issue 1: Denial of Emergency Care on October 12, 2005

The complainant alleged that on October 12, 2005, the patient was denied admission to the medical center following his discharge from a local hospital.

The allegation was substantiated.

The patient's medical record shows that at approximately 5:26 p.m., on October 12, 2005, the patient and his wife presented to the medical center ER for evaluation and treatment. The patient was seen by the ER triage nurse, who took his vitals signs and documented that the patient and his wife denied any suicide or homicide ideations and voiced no other complaints. The triage nurse called the on-call psychiatrist and told her that the patient's wife was requesting long-term psychiatric care for the patient. The on-call psychiatry resident physician (resident psychiatrist) told us that because the ER triage nurse gave no information to indicate this was an emergent situation and because, as a new employee to the VA, she was not aware that all patients presenting to the ER were to be seen, she did not assess the patient that day. Instead, she told the triage nurse to inform the patient and his wife to return to the ER the following day for a psychiatric evaluation. The ER triage nurse noted that the patient's wife was upset that the patient was not assessed for admission that day, but the triage nurse did not consult with the ER physicians.

We interviewed the ER triage nurse's supervisor to determine whether the nurse had followed medical center policy. The ER nursing supervisor told us that the ER triage nurse should have referred the patient to the ER physician for medical clearance prior to discharging him home. However, the ER triage policy does not address the need for physician involvement in ER visits.

The patient was not evaluated by the on-call psychiatrist on October 12, 2005, when he first presented to the medical center ER, nor was he referred to an ER physician for medical clearance prior to his discharge. We concluded that the ER triage nurse inappropriately discharged the patient from the ER without a physician's clearance. We further concluded that the ER triage policy needs to specify that a physician's clearance is required prior to discharging a patient from the medical center ER.

Issue 2: Admission to the Psychiatry Unit

The complainant alleged that the patient was inappropriately admitted to a psychiatric unit.

The allegation was not substantiated.

On October 13, 2005, the patient and his wife presented to the ER as instructed by the ER nurse, requesting an evaluation for long-term psychiatric care. The patient was assessed in the ER by a resident psychiatrist and an ER social worker. The patient denied any problems and told the evaluating physician that he was unaware of why he was there. The patient's wife, however, reported that the patient had increasingly uncontrollable behavior, was becoming abusive towards her, and was becoming a safety risk. She reported incidents where the patient had wandered into the streets and exhibited increasingly violent behavior towards her. She reported that she was no longer able to care for him at home. The physician conducted a mental status examination and documented that the patient was unable to recall recent or significant past events and that he had a mild level of paranoia towards unfamiliar faces. The admitting physician notes also showed that "...Wife reports that he often threatens to kill me if I tell him what to do." The wife also told the resident psychiatrist that the patient had a substantial gun collection at home.

The evaluating physician concluded that the patient was a danger to himself and others due to his impulsive behavior and his direct verbal threats to his wife. He admitted the patient to the psychiatric unit. When the patient refused to be admitted, the attending physician initiated a Temporary Detainment Order (TDO).

Salem medical center policy memorandum dated January 7, 2002, *Detainment Commitment Procedures*, states that, "A TDO is used to hold a patient pending a commitment hearing for up to 72 hours, or 96 hours if a legal holiday falls on a Friday or Monday. This process may be used for either an inpatient or an outpatient who is unwilling to accept treatment, and in the judgment of a mental health professional, the patient is considered to be a danger to self and/or others, or unable to care for self due to a mental disorder."

We concluded that the resident psychiatrist appropriately assessed the patient as requested by his wife, followed medical center policy for the treatment of patients

considered to be a danger to self and others, and appropriately admitted the patient to the psychiatric unit for further evaluation and treatment.

Issue 3: Patient/Family Communication

The complainant alleged that she was not told that the patient was to be admitted to a psychiatric ward and that medical center employees did not communicate appropriately with family members.

Admission to the psychiatric unit

The allegation was not substantiated.

On October 13, 2005, the patient and his wife presented to the medical center ER and were interviewed by the ER triage nurse. The patient's wife told the nurse that the patient "wanders off the road" when driving his car and requested a psychiatric evaluation. She told the nurse that her husband had a diagnosis of dementia and Alzheimer's disease, and the nurse subsequently referred the patient to the ER psychiatrist for an evaluation.

The patient and his wife were interviewed by the ER resident psychiatrist and an ER social worker. When questioning the couple, the psychiatrist noted that the patient's wife was the primary historian due to the patient's severe dementia. The ER resident psychiatrist documented that the patient's wife reported noticing recent violent changes in her husband's behavior and that he [the patient] was a threat to her and everyone around her. The resident psychiatrist assessed the patient as being an imminent danger to himself and others due to his impulsive behavior and his direct verbal threats to his wife. The resident psychiatrist determined that the patient needed to be admitted.

The resident psychiatrist discussed the case with the attending psychiatrist, and the patient was involuntarily admitted to the sub-acute psychiatric unit for further evaluation and treatment. The patient refused admission, and security officers were called for assistance. A VA Police "Uniform Offense Report" (UOR#-05-10-13-1620) showed that the patient stated that, "...I am not staying here and you can't stop me." Security officers requested help from the patient's wife to assist in escorting the patient to the psychiatric unit. The patient's wife, accompanied by security officers, escorted the patient to the psychiatric unit.

The ER resident psychiatrist testified that he had talked extensively with the patient's wife about his [the patient's] admission to the psychiatric unit. He told her that the medical center did not have a dedicated unit for older patients with dementia needing acute psychiatric care and that her husband would be admitted to the locked acute psychiatric unit with other patients of various ages. He asserted that the patient's wife

verbalized understanding of what he had explained to her in detail about the psychiatric unit her husband was to be admitted to and consented to the patient's admission.

We concluded that the patient's wife was informed that her husband was being admitted to an acute psychiatry unit; she told OHI inspectors that she escorted her husband to the locked unit.

Poor communication with family members

The allegation was not substantiated.

The patient's medical records show that numerous staff members talked to the complainant during her husband's inpatient admission and after his death to address her concerns and answer her questions. The patient was admitted on a Thursday evening, and on the following Monday, October 17, 2005, a social worker contacted his wife. The social worker requested copies of the patient's medical record, conducted a psycho-social assessment, and discussed long-term care placement with her. On October 18, 2005, the attending physician met with the patient's wife to discuss his treatment and request for the patient's living will.

On October 20, 2005, the patient advocate received a call from a medical ward nurse who told her that the patient's family was requesting to speak with medical center managers about the care the patient received while on the acute psychiatric unit. The patient advocate went to the ward and spoke with the patient's wife and her son regarding their concerns; the patient advocate referred the issues to the attention of clinical managers for their review.

On October 27, 2005, the Chief of the Mental Health Service Line, the medical ward physician, and a physician assistant met with the patient's wife to discuss her concerns regarding her perceptions of the treatment her husband received on the acute psychiatry unit.

In January 2006, after the patient expired at a local hospital, the medical center Chief of Staff spoke with the complainant to discuss the care provided to her husband at the medical center. The complainant requested that a meeting be arranged so that she and her family could express their concerns directly with medical center management and with other clinical managers involved in the patient's care. On February 1, 2006, a meeting was arranged for family members to meet with the medical center Director, Chief of Staff, physicians involved with the patient's care, and the patient advocate. Prior to that meeting, the complainant called and canceled the meeting because her son was unable to attend. The complainant stated that she would be interested in scheduling another meeting and that she would call back when all of her family members could attend. As of our inspection, the meeting had not been rescheduled.

We concluded that medical center clinicians communicated with the patient's wife and other family members about the patient's care. Clinicians informed family members of the need for admission to the acute psychiatry unit, transfer to the medical unit, treatment plan and rationale, the patient's fall months later, and the subsequent transfer to the private hospital.

Issue 4: Care Provided to the Patient in the Psychiatric Unit

The complainant alleged that the patient received poor psychiatric care, was inappropriately restrained, and was given the wrong medication.

The allegation was not substantiated.

On October 13, 2005, the patient was admitted to the acute psychiatric unit; shortly after his admission, he was evaluated by a resident psychiatrist. The resident psychiatrist documented that the patient was highly agitated toward nursing employees and that they were concerned about their safety and the safety of other patients. Therefore, the resident psychiatrist placed the patient on behavioral observation status and ordered restraints to control his behavior. The resident psychiatrist also ordered haloperidol injections as needed for acute agitation.

On October 14, 2005, the patient was evaluated by the attending psychiatrist. The psychiatrist reviewed the patient's medical record, interviewed the patient, and discussed the case with the rotating resident psychiatrist. The psychiatrist diagnosed the patient as suffering from dementia, hypertension, prostatic cancer, spinal stenosis, and renal failure and requested the patient's medical records from his private physicians. He also ordered a medical consultation for evaluation of the patient's renal dysfunction and other chronic medical issues.

The patient's medical record shows that he was seen by providers from Internal Medicine during the weekend of October 15–16, 2005, and on a daily basis until his transfer to the medical unit.

On October 17, 2005, the patient suffered a fall with no apparent injury. He was assessed that day by the attending physician, who noted that the patient had markedly improved from a behavioral standpoint. He noted that the patient was less aggressive and no longer guarded and suspicious. He also noted that the patient would continue to benefit from remaining on behavioral observation status (BOS), primarily as a fall precaution.

On October 18, 2005, the patient was again seen by the attending physician. The attending physician had received the patient's medical records from his private physicians, including copies of neurology, oncology, and urology evaluations, and records from his private primary care physician. The attending physician met with the patient's wife, reviewed the patient's psychiatric and medical status with her, and

discussed the rationale, benefits, and risks of the medication [haloperidol] he had prescribed. He also referred the patient for transfer to a dementia unit with possible long-term care placement in the community.

On October 19, 2005, the patient was seen by a renal consultant. On October 20, 2005, a medical consultant assessed the patient and determined that the patient needed to be transferred to a medical ward for closer supervision of his medical problems. Nursing employees notified the patient's wife that they were in the process of transferring the patient to the medical ward.

We concluded that the medical consultant properly managed the patient's medical care on the psychiatry unit and, when the patient's clinical picture changed, transferred the patient to the medical ward for intravenous (IV) hydration and closer supervision of his medical needs.

Issue 5: Denial of Hospital Visitation on the Acute Psychiatric Unit

The complainant alleged that she was not allowed to visit her husband on the psychiatric unit.

The allegation was partially substantiated.

While we found that the patient's wife was denied visitation rights when her husband was first admitted to the acute psychiatric unit, we did not substantiate that this was inappropriate.

Psychiatric inpatients are placed on BOS based on their level of severity and risk. Level 1 means that an employee must remain within arm's length of the patient, level 2 means that an employee must remain in the same room as a patient, and level 3 means that an employee is required to observe the patient at 15-minute intervals.

On admission to the acute psychiatric unit, the patient was placed on "behavioral observation status (BOS) level 3." A BOS level 3 requires observation by a nursing employee every 15 minutes. The ER resident psychiatrist ordered a BOS level 3 because the patient was agitated and a fall risk. Medical center policy memorandum dated February 15, 2002, *Privileges and Restriction of Patients (Mental Health Service Line)* states that, "Patients on Suicidal Observation Status (SOS) or Behavioral Observation Status (BOS) levels are not allowed to receive visitors." Nursing employees on the unit acknowledged that psychiatric inpatients on a behavioral observation status are not allowed visitors except when authorized by the attending physician.

On October 17, 2005, the social worker called the patient's wife and told her that her husband would remain on BOS level 3 as a fall precaution but that she was now able to visit with him.

We concluded that family members were not allowed to visit the patient on the acute psychiatric unit while he was on a BOS level 3 for his aggressive behavior. However, this is consistent with medical center policy. Because the patient was cognitively impaired with bouts of aggressive behavior, clinicians determined that family visitations would not be beneficial while the patient was on a BOS level 3. When his agitation declined, (although he remained on BOS level 3), family members were told that they could visit with him.

Issue 6: Delay of Medical Treatment

The complainant alleged that the patient was denied transfer to a medical ward because a medical care bed was not available.

The allegation was not substantiated.

On October 14, 2005, the day following the patient's admission, the inpatient psychiatric attending physician ordered a medical consultation to assess the patient's medical needs. The medical consultation was completed the following day.

On October 18, 2005, the psychiatric attending physician met with the patient's wife to discuss the patient's course of treatment. He told her that he had obtained a medical consultation shortly after the patient's admission. The medical consultant did not believe that a transfer to the medical ward was clinically indicated and said that he would continue to monitor the patient's medical condition while he was on the acute psychiatric unit.

We concluded that the medical consultant managed the patient's medical needs while he was on the acute psychiatry unit and that the patient was transferred to the medical ward when he [the medical consultant] felt the transfer was clinically indicated.

Issue 7: Delay of Transfer for an Emergency Condition

The complainant alleged that there was a delay in the patient receiving timely medical care following a fall.

The allegation was not substantiated.

On December 30, 2005, at 6:05 p.m., the patient, while on high risk fall precautions, suffered a fall while attempting to get out of his wheelchair unassisted. The patient complained of pain over his left hip, and at 6:30 p.m., he was transported to the ER. The ER physician ordered an x-ray to determine the extent of the patient's injury. At 7:30 p.m., the patient was transported by stretcher to the radiology department for his x-ray and was returned to the ER at 7:45 p.m. The x-ray confirmed a left femoral neck fracture. Because the medical center did not have an orthopedic surgeon immediately

available to see the patient, the ER physician made arrangements to transfer the patient to a private hospital. The ER physician contacted the patient's wife, and she consented to the transfer. At 10:00 p.m., the patient was transferred to a local hospital for further care of his fracture.

We concluded that the patient received appropriate care after his fall and that his transfer to a private hospital for orthopedic care was timely.

Recommendation

The Medical Center Director should:

- a. Instruct the Mental Health Service Line Manager to ensure that all patients presenting to the ER for psychiatric care are seen by a physician prior to discharge.
- b. Ensure that clinical managers review and revise the ER triage policy to clarify that a medical screening by a physician is required prior to discharging a patient from the medical center ER.

Medical Center Director Comments

The VISN Director and Medical Center Director have concurred with the conclusions of this inspection report and have taken actions to implement the recommendations in this report.

Assistant Inspector General Comments

The Assistant Inspector General for Healthcare Inspections agrees with the actions taken by the VISN and Medical Center Directors to the issues raised in this report. We will follow up on planned actions until they are complete.

(original signed by:)

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

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 16, 2006

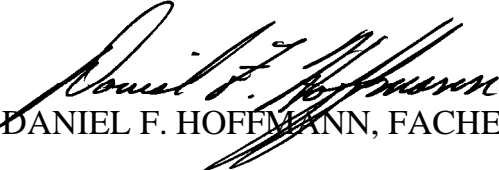
From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Alleged Poor Psychiatric Care and Delay in Diagnosis and Treatment, VA Medical Center, Salem, Virginia**

To: Director, Washington, DC Region Office, Office of Healthcare Inspections

I reviewed the captioned hotline draft report and concur with the findings and recommendations.

Thank you for your review.


DANIEL F. HOFFMANN, FACHE

**Department of
Veterans Affairs**

Memorandum

Date: August 7, 2006

From: Interim Director (658/00), Salem VA Medical Center

Subject: Alleged Poor Psychiatric Care and Delay in Diagnosis and Treatment, Salem VA Medical Center, Salem, Virginia

To: Director, Health Care Inspections, Washington, D.C. Region Office

Response to Recommendation

1. I have received your draft report regarding the Alleged Poor Psychiatric Care and Delay in Diagnosis and Treatment, VA Medical Center, Salem, Virginia.

2. Our response to your recommendation is as follows:

a. Recommendation (a): The Medical Center Director should instruct the Mental Health Service Line Manager to ensure that all patients presenting to the ER for psychiatric care are seen by a physician prior to discharge.

Response: The Chief, Mental Health Service Line, at the Salem VAMC has informed all residents and attending staff providers that all patients presenting to the emergency room for care are to be seen and assessed, with notes documented in the medical record, prior to discharge from the emergency room. This communication has been re-enforced recently so that all providers are aware of this expected process.

b. Recommendation (b): The Medical Center Director should ensure that clinical managers review and revise the ER triage policy to clarify that a physician medical screening is required prior to discharging a patient from the VAMC ER.

Response: All staff, both nursing and medical staff, have received education regarding the necessity of medical

screening by a provider prior to discharge from the emergency department. This education included facts surrounding phone messages by residents or attending providers on call, as well as, communication with providers in the emergency room regarding patient assessment prior to disposition. This education is documented in the educational records of all emergency room staff members and has been reinforced since the initial education was completed. This is now also a part of the orientation of new emergency room staff. The triage policy has been revised to include the necessity of the documentation of medical screening by a medical staff provider prior to discharge from the emergency department.

3. I trust you will find our response helpful to you in finalizing your report. Thank you for your assistance in this matter.

(original signed by:)

CAROLYN L. ADAMS

OIG Contact and Staff Acknowledgments

OIG Contact	Nelson Miranda, Director Healthcare Inspections Region Office, Washington, DC 202 565-8181
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