



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues VA Loma Linda Healthcare System Loma Linda, California

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Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding several aspects of care and administration at the VA Loma Linda Healthcare System. The complainant wrote a letter to the OIG to request a review of the following allegations regarding the patient's care:

- The patient did not receive appropriate discharge instructions on August 10, 2007.
- The patient did not receive appropriate emergency room (ER) management during visits on August 18 and 21, specifically regarding:
 - Triage timeliness.
 - Fluid management and vital sign monitoring.
 - Specialty consultations.
 - Infection prevention.

We did not substantiate the allegations. We found documentation that discharge instructions were provided and discussed with the patient on August 10. The patient followed through on the instructions he was given.

Regarding ER management during the August 18 visit, we found that clinicians assessed the patient within 1 hour of arrival. In a patient who did not appear to be in acute distress, we found this to be appropriate. Nurses monitored the vital signs with adequate frequency for a stable patient. The physician appropriately requested a urology consult to check the patient's incision and drain sites. After the patient experienced a temporary loss of consciousness, the ER physician ordered fluids and requested a cardiology consult.

Clinicians monitored the patient's temperature, drain site, and white blood cell count for signs of infection and ordered blood cultures. On August 21, when the patient's temperature increased, they appropriately ordered antibiotics. We found the ER care provided to be timely and thorough.

Although this patient experienced a dramatic decline in his health on the evening of August 21, he gradually improved and was subsequently discharged. We concluded that his overall care was appropriate; therefore, we made no recommendations.



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

TO: Veterans Integrated Service Network 21 Director

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues, VA Loma Linda Healthcare System, Loma Linda, California

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding several aspects of care and administration at the VA Loma Linda Healthcare System (VALLHS), Loma Linda, CA. The complainant wrote a letter to the OIG to request a review of the allegations.

Background

The complainant made the following allegations regarding the patient's care:

- The patient did not receive appropriate discharge instructions on August 10, 2007.
- The patient did not receive appropriate emergency room (ER) management during visits on August 18 and 21, specifically regarding the following:
 - Triage timeliness.
 - Fluid management and vital sign monitoring.
 - Specialty consultations.
 - Infection prevention.

The VALLHS provides primary and tertiary health care services. It has 118 hospital beds, 108 long-term care beds, and five community based outpatient clinics. It is affiliated with Loma Linda University's School of Medicine. The VALLHS is part of Veterans Integrated Service Network (VISN) 22.

Scope and Methodology

We reviewed the patient's medical records and conducted interviews with the complainant and VALLHS staff. We conducted a site visit October 17–18, 2007.

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

Case Summary

On August 7, 2007, the patient, a 58-year-old male with a history of diabetes and hypertension, underwent a surgical procedure at the VALLHS to remove the prostate gland and surrounding lymph nodes due to prostate cancer. The radical prostatectomy procedure involved removal of the entire prostate gland and seminal vesicles through an abdominal incision. A Jackson-Pratt (JP) drain¹ was placed through the skin, sutured to the skin, and covered with a dressing. The margins of the cancer were subsequently found to be negative, and the cancer appeared confined to the prostate.

After surgery, the patient was transferred to a hospital unit with the JP drain and a urinary catheter in place. On the first post-operative day, a laboratory test indicated some urine leakage from the healing area, which the urologist told us was normal. The patient's hemoglobin level decreased slightly but appeared stable. The patient had a maximum temperature of 99.9 degrees Fahrenheit, and vital signs were stable.

On August 9, the JP drain output was over 200 milliliters (ml), and the urology team decided to leave it in place. The progress notes indicate that clinicians provided written discharge instructions to the patient advising him to call if he were to experience certain symptoms. In addition, he was given the dates for follow-up urology appointments. A clinical pharmacist documented that he reviewed the discharge medications with the patient, instructed him not to exceed a certain amount of pain medications per day, and told him to discontinue a medication used to relax the bladder 1 day prior to his follow-up urology clinic appointment. The patient was discharged to home on August 10.

On August 14, the patient returned to the VALLHS for his scheduled follow-up urology appointment. The notes indicate that the patient reported doing well. As instructed, he had been recording the output from the JP drain. The output had been between 100 and 150 ml per day. He reported that during the previous night, he had developed some leakage around the drain. The dressing was noted to be saturated with serous (clear) fluid. The patient denied leakage around the urinary catheter or at the surgical incision site. The urologist noted no redness around the JP drain site. The drain fluid was sent to the laboratory for analysis, and an abdominal x-ray was obtained to verify the position of the drain. Although a JP drain can be uncomfortable to have in place, if removed too early, urine may collect in the abdomen or pelvis. The urologist left the drain in place pending further healing and resolution of drainage.

¹ A Jackson-Pratt drain is a suction drain that is typically removed when the excess fluid has stopped draining from the body.

On August 18 at 8:30 a.m., the patient presented to the VALLHS ER complaining of a small amount of redness and of yellowish drainage around the JP drain site. His vital signs at approximately 9:20 a.m. were stable, and he had a normal temperature. An ER nurse noted that the JP drain was draining serous fluid. She noted firmness at the base of the drain, slightly cloudy drainage from the site and on the dressing, and a lack of redness or heat. The ER physician examined the patient, called for a urology consult, and asked the patient to wait in the waiting room.

The patient had reportedly not eaten since 4:00 p.m. the prior day because he thought he might have a procedure done in the ER related to the JP drain. He went to the cafeteria with his caretaker where he passed out for approximately 30 seconds. He was reportedly confused for less than a minute before returning to baseline mental status. Upon returning to the ER and reporting the incident, the patient was assessed by another ER nurse and kept on a gurney in the ER area. The nurse noted a small amount of drainage at the site and a small amount of redness.

The patient was again examined by the ER physician who noted minimal discharge, a minimal area of hardening, and no pus or signs of infection. She ordered several laboratory tests, including a complete blood count, a chemistry panel, a test for an increase in a cardiac enzyme that may indicate the presence of a heart attack, and a test to determine if blood is clotting. The patient's white blood cell count was 14,000 per millimeter cubed (mm³), which was mildly elevated (normal range is 4,000–10,000). An electrocardiogram (EKG) was obtained and showed a normal rhythm. Orthostatic blood pressure and pulse were checked and showed a 10 mm drop when moving from a lying down to a standing position, indicating borderline orthostasis.² The ER physician ordered 2 liters of normal saline intravenous fluid, because she thought he might have been dehydrated. The ER physician called for a cardiology consult. Vital signs at 3:15 p.m. were stable, and the patient had a normal temperature. The ER physician reported that although the patient did not appear to be ill or to have an infection, she obtained blood cultures pending evaluation of the drain site by the urologist.

According to the ER physician's note, the cardiology consultant felt that the patient's temporary loss of consciousness was probably vasovagal.³ The patient had no chest pain or shortness of breath, and the cardiac enzymes and the EKG were normal. We did not find a note from the cardiology consultant.

The urologist noted that the patient denied fevers, chills, nausea, or vomiting. He indicated that the JP drain site was clean with slightly cloudy fluid output and that there

² Orthostatic hypotension is defined by the American Academy of Neurology as either a 20 point decrease in systolic blood pressure or a 10 point decrease in diastolic blood pressure within 3 minutes of standing. It may be caused by dehydration.

³ Vasovagal syncope is the most common cause of fainting. It is triggered by a stimulus (such as dehydration, the sight of blood, or having a bowel movement) that results in a sudden, temporary drop in heart rate and blood pressure, possibly leading to loss of consciousness.

was no evidence of infection. The slightly increased white blood cell count was attributed to post-surgical physiologic stress reaction. The urologist recommended continuing the current care regimen with no acute surgical intervention or antibiotic treatment at that time. The patient was given a urology clinic appointment for August 23.

Because the patient had been seen in the ER over the weekend, urology arranged for the patient to be seen at the urology clinic on August 21, which was 2 days earlier than the scheduled appointment. The result of the blood culture from the ER was checked, and there was no bacterial growth. The surgical incision wound sutures were removed. The incision site appeared clean and intact. The drain fluid was slightly cloudy but reportedly, there was no pus. The JP drain was removed with minimal output noted. The site was reported to be clean with a minimal amount of mucus on the dressing.

That evening, the patient presented to the VALLHS ER with an elevated temperature (103.8 degrees Fahrenheit) and an elevated pulse rate. A complete blood cell count showed a mildly increased white blood cell count of 14,600 mm³, which was essentially unchanged from August 18, and a hemoglobin level that was stable. A coagulation profile was normal. A urinalysis showed 16 white blood cells per high powered field (normal range 0–5), and a urine culture was negative. A computerized tomography (CT) scan of the abdomen and pelvis were ordered to look for a possible abscess. Clinicians obtained blood cultures, administered intravenous fluid, started the antibiotic ciprofloxacin, and admitted the patient to the hospital.

The urology resident, who had also seen the patient earlier in the day at clinic, noted that the JP drain site had minimal blood-tinged drainage with some whitish material that was either pus or mucus. He started three antibiotics (Zosyn[®], vancomycin, and metronidazole). The next day, the patient underwent CT-guided fluid aspiration of the right pelvis, and 4 ml of slightly cloudy fluid was obtained, which was negative for bacteria. An ultrasound ordered to evaluate for a blood clot, as the possible source of the patient's fever was negative.

A chest x-ray obtained in the ER had been unremarkable. However, on the evening of August 22, the patient's respiratory status began to decline. His respiratory rate increased, his oxygen saturation level decreased, and his temperature remained elevated. His blood pressure was stable. A blood culture collected in the ER the prior evening showed bacteria. The patient was transferred to the intensive care unit (ICU) where he underwent a CT angiogram⁴ to determine if a blood clot was the source of his respiratory difficulty. The patient progressed to respiratory failure, requiring intubation and mechanical ventilation. While in the ICU, he received respiratory support and antibiotics. He developed acute kidney failure, requiring dialysis.

⁴ An angiogram is an x-ray test that uses a special dye and scope to visualize the blood flow in an artery or a vein.

The patient's respiratory and clinical status gradually improved. On September 24, he was able to breathe on his own. He was transferred out of the ICU and subsequently discharged to home.

Inspection Results

We did not substantiate the allegations. As noted in the case summary, we found documentation that discharge instructions were provided and discussed with the patient on August 10. The patient followed through on the instructions he was given.

Regarding ER management during the August 18 visit, we found that clinicians assessed the patient within 1 hour of arrival. In a patient who did not appear to be in acute distress, we found this to be appropriate. Nurses monitored the vital signs with adequate frequency for a stable patient. The physician appropriately requested a urology consult to check the patient's incision and drain sites. After the patient experienced a temporary loss of consciousness, the ER physician ordered fluids and requested a cardiology consult. We noted that documentation of the cardiology consult performed in the ER on August 18 was absent.

Clinicians monitored the patient's temperature, drain site, and white blood cell count for signs of infection and ordered blood cultures. On August 21, when the patient's temperature increased, they appropriately ordered antibiotics. We found the ER care provided to be timely and thorough.

Conclusions

Although this patient experienced a dramatic decline in his health during the evening of August 21, we concluded that the situation could not reasonably have been foreseen or prevented, and his overall care was appropriate. Therefore, we made no recommendations.

Comments

The VISN and VALLHS Directors concurred with our conclusions. (See Appendixes A and B, pages 6–7, for the full text of their comments.) We consider this case closed.

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 17, 2007

From: Director, VA Desert Pacific Network (10N22)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues, VA Loma Linda Healthcare System, Loma Linda, California**

To: Director, Los Angeles Regional Office of Healthcare Inspections (54LA)

Thru: Director, VHA Management Review Services (10B5)

I am concurring with the VA Loma Linda Healthcare System Director's response and consider this case closed.

(original signed by:)
Kenneth J. Clark, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 17, 2007

From: Director, VA Loma Linda Healthcare System (605/00)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues, VA Loma Linda Healthcare System, Loma Linda, California**

To: Director, Hotline Division, Office of the Inspector General (53E)

Thru: Network Director, VA Desert Pacific Healthcare Network (10N/22)

1. Upon receipt of your correspondence dated December 3, 2007, stating there were no findings related to Case No. 2007-03292-HL-0379, I am in agreement this case is closed.
2. If you have any questions or need additional information, please contact me at (909) 583-6150.

(original signed by:)
Dean R. Stordahl
Director

OIG Contact and Staff Acknowledgments

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| OIG Contact | Julie Watrous, RN Director, Los Angeles Office of Healthcare Inspections (213) 253-2677 ext. 4972 |
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Michael Shepherd, M.D.

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