Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Surgical Care Case Review
John L. McClellan Memorial Veterans Hospital
Little Rock, Arkansas

Report No. 09-01468-208 **August 31, 2009**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The purpose of this review was to determine the validity of allegations of poor care associated with a patient's death at the John L. McClellan Memorial Veterans Hospital, a hospital of the Central Arkansas Veterans Healthcare System in Little Rock, Arkansas. Specifically, the complainant alleged the patient did not have an appropriate medical evaluation prior to colon surgery, post-operative lack of oxygen nearly caused the patient's death, and medical treatment in the emergency department (ED) was inadequate for one identified patient.

The allegation that the patient did not receive appropriate medical care and evaluation prior to colon surgery was not substantiated. The patient had a chronic cardiac condition and was examined pre-operatively by a cardiologist. The cardiologist judged the patient to be "at low to intermediate but acceptable risk for peri-operative cardiovascular events."

The allegation that the patient was oxygen-deprived while in the Surgical Intensive Care unit (SICU) was not substantiated. Flow charts for hourly oxygen saturation monitoring in the SICU revealed adequate levels of oxygenation.

Additionally, the allegation that the patient received inadequate medical treatment in the ED was not substantiated. Shortly after arriving at the ED, the patient collapsed in the waiting room and ED staff provided immediate cardiac life support.

Allegations of poor care associated with a patient's death were not substantiated. We made no recommendations and plan no further actions. The VISN and Central Arkansas Healthcare System Directors concurred with our findings.

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

TO: Director, South Central VA Health Care Network (10N16)

SUBJECT: Healthcare Inspection – Surgical Care Case Review, John L. McClellan Memorial Veterans Hospital, Little Rock, Arkansas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), reviewed allegations of poor care associated with a patient's death at the John L. McClellan Memorial Veterans Hospital, Little Rock, Arkansas.

Background

The Central Arkansas Veterans Healthcare System has two hospitals, the John L. McClellan Memorial Veterans Hospital in Little Rock and the Eugene J. Towbin Healthcare Center in North Little Rock. The John L. McClellan Memorial Veterans Hospital (referred to in this report as Little Rock) is a tertiary care facility that provides a broad range of inpatient and outpatient health care services for veterans throughout 46 counties in Arkansas. The patient's son questioned the care leading up to and following colon surgery at Little Rock, alleging that:

- The patient did not have an appropriate medical evaluation prior to colon surgery.
- Post-operative lack of oxygen nearly caused the patient's death.
- Medical treatment in the emergency department (ED) was inadequate.

Scope and Methodology

On May 28, 2009, OHI inspectors interviewed the patient's son to obtain additional information and clarify issues pertinent to the complaints. On June 2–4, inspectors conducted an onsite inspection and interviewed Little Rock senior managers, physicians, nurses, and other employees knowledgeable about the patient's care. Medical records, Little Rock policies and procedures, and other pertinent documents were reviewed, focusing on the last 6 months of care provided for the patient.

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

Case Summary

This elderly patient had a history of hypertension, coronary artery disease, aortic stenosis (narrowing of the aortic valve opening), and abdominal aortic aneurysm, and had undergone coronary artery bypass graft surgery in 2002. In June 2008, the patient underwent colonoscopy after stool tests revealed occult blood. A polyp was removed from the cecum (part of the colon at its junction with the small intestine) and found to have "focal areas suspicious for invasive adenocarcinoma" (a cancer that originates in glandular tissue). The patient's primary care provider consulted general surgery and ordered computed tomography of the abdomen and pelvis. A surgeon assessed the patient 3 weeks later, recommended removal of part of the colon, and referred the patient to cardiology for pre-operative evaluation. Cardiology had followed the patient for several years, documenting echocardiographic progression of aortic stenosis from May 2006 to May 2008. On July 23, 2008, a cardiologist judged the patient to be "at low to intermediate but acceptable risk for peri-op cardiovascular events" and advised, "no further evaluation or intervention is needed at this time…."

The patient underwent laparoscopic right hemicolectomy (surgical removal of the right side of the colon) on August 21, 2008, followed by admission to the surgical intensive care unit (SICU). On the evening of August 22, the patient had nausea, vomiting, and atrial fibrillation (irregular heart rhythm often associated with a rapid heart rate). The atrial fibrillation resolved after treatment with medication. Cardiology recommended cardiac catheterization (a medical procedure used to diagnosis and treat certain heart conditions), but this procedure was delayed because the patient had transient gastrointestinal bleeding. Cardiac catheterization performed August 29 revealed occluded grafts, significant stenosis of native vessels, and severe aortic stenosis. On the following day, a cardio-thoracic surgeon recommended that the patient recover from the colon surgery prior to consideration of possible cardiac surgery for aortic valve replacement and additional coronary artery bypass.

A cardio-thoracic surgery appointment was scheduled for 2 weeks after discharge, but the patient called and cancelled the appointment 2 days before the appointment date. A nurse practitioner in the cardio-thoracic clinic documented a call confirming that the patient did not want cardiac surgery. This provider instructed the patient to go to the ED or call the cardiology clinic should any cardiac symptoms occur.

On January 3, 2009, the patient was treated for bronchitis in the ED. On January 10, the patient spoke to the telephone triage nurse, complaining of dizziness and sweating, and was advised to seek emergency care. After arriving at the ED and checking in with the clerk, the patient collapsed in the waiting room. ED staff provided immediate cardiac life support and the patient was admitted to the hospital. The patient's spouse requested that interventions be limited to continued respiratory support and comfort care, and the patient died on the morning following admission.

Inspection Results

Issue 1: Evaluation Prior to Colon Surgery and Possible Cardiac Surgery

We did not substantiate that the patient did not receive appropriate medical care and evaluation prior to colon surgery. The patient had a chronic cardiac condition and was examined pre-operatively by a cardiologist. After surgery, the patient suffered a cardiac event and was evaluated by a cardio-thoracic surgeon. The surgeon recommended that the patient's options for possible cardiac surgery be reconsidered 2 weeks after discharge. The appointment was scheduled, but the patient cancelled the appointment.

Issue 2: Post-Operative Oxygen Delivery

We did not substantiate that the patient was oxygen-deprived while in the SICU. We reviewed the flow charts for hourly oxygen saturation monitoring during the patient's 9 day admission to the SICU. Documentation revealed adequate levels of oxygenation.

Issue 3: Medical Treatment in the Emergency Department

We did not substantiate that the patient received inadequate medical treatment in the ED. Shortly after arriving at the ED, the patient collapsed in the waiting room and ED staff provided immediate cardiac life support. We reviewed the ED policies and decision tree used by the admitting clerk, who followed all guidelines.

Conclusions

Allegations of poor care associated with a patient's death were not substantiated. We made no recommendations and plan no further actions. The VISN and Central Arkansas Veterans Healthcare System Directors concurred with our findings.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 3, 2009

From: Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Surgical Care Case Review, John L. McClellan Memorial Veterans Hospital, Little Rock, AR**

To: Assistant inspector General for Healthcare Inspections

I have reviewed the report and concur with the inspection results and conclusions.

(original signed by:)

George H. Gray, Jr.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 3, 2009

From: Director, Central Arkansas VA Veterans Healthcare System (598/00)

Subject: **Healthcare Inspection – Surgical Care Case Review, John L. McClellan Memorial Veterans Hospital, Little Rock, AR**

To: Assistant Inspector General for Healthcare Inspections

Thru: Director, South Central VA Health Care Network (10N16)

I would like to take this opportunity to commend the OIG Healthcare Inspection Team for both their thoroughness and professionalism. I concur with the inspection results and conclusions.

(original signed by:)
MICHAEL R. WINN

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Cathleen King Dallas Office of Healthcare Inspections (214) 253-3333
Acknowledgments	Wilma Reyes Barry Simon Jerome Herbers, M.D.

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VISN 16 (10N16)
Director, John L. McClellan Memorial Veterans Hospital (598/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Blanche L. Lincoln, Mark L. Pryor
U.S. House of Representatives: Marion Berry, John Boozman, Mike Ross, Vic Snyder

This report is available at http://www.va.gov/oig/publications/reports-list.asp.