Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Post-Operative Care Case Review at the VA Central Iowa Health Care System's Knoxville Division Knoxville, Iowa

Report No. 09-02986-31 **November 30, 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

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Executive Summary

At the request of Senator Charles E. Grassley, the VA Office of Inspector General, Office of Healthcare Inspections reviewed allegations regarding the lack of post-operative care resulting in a patient's death at the Knoxville Division of the VA Central Iowa Health Care System. The purpose of the inspection was to determine the validity of the allegations.

A complainant specifically alleged the following:

- Laboratory tests ordered by the patient's case manager were never performed.
- The patient was denied water by nursing staff resulting in dehydration.
- There were inaccuracies in the patient's autopsy report.

We concluded that the laboratory studies ordered during the course of his admission were performed. In addition, although the patient complained of dehydration, he received oral fluids regularly with meals and during hydration rounds on every shift. Finally, the autopsy report, completed at University of Iowa Hospital, did have some documented inaccuracies; however, the information did not impact the care provided or patient outcomes. We made no recommendations.

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

TO: Director, VA Midwest Health Care Network (10N23)

SUBJECT: Healthcare Inspection – Post-Operative Care Case Review at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa

Purpose

At the request of Senator Charles E. Grassley, the VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding the lack of post-operative care resulting in a patient's death at the Knoxville Division (KD) of the VA Central Iowa Health Care System (system). The purpose of the inspection was to determine the validity of the allegations.

Background

The system consists of two divisions, located in Des Moines and Knoxville, Iowa. The Des Moines Division (DMD) provides primary care, medical, surgical, psychiatric, substance abuse, and home care services. KD provides rehabilitation, mental health, and community living center care and is a referral center for acute and long-term mental health patients. The system is academically affiliated with University of Iowa's Carver College of Medicine; Des Moines Area Medical Education Consortium, Incorporated; and Des Moines University.

A complainant specifically alleged the following:

- Laboratory tests ordered by the patient's case manager[1] were never performed.
- The patient was denied water by nursing staff resulting in dehydration.
- There were inaccuracies in the patient's autopsy report.

[1] The complainant referred to the primary care provider as the case manager.

Scope and Methodology

The inspection included interviews with the complainant, system leaders, the primary care provider (PCP), nurse manager, and rehabilitation and nursing staff involved in the case. We conducted a detailed review of the patient's medical records, relevant policies and procedures, and other pertinent case related documents. We conducted a site visit on September 30–October 2, 2009.

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

Case Summary

This 61 year-old patient had a history of hypertension, colon cancer with resection in 2001, obstructive sleep apnea, depression and anxiety, hypothyroidism, and morbid obesity.

In mid-April 2009, the patient sustained a right tibial plateau fracture (lower leg) after a fall on wet pavement. He underwent an open reduction internal fixation at DMD 2 days later and was discharged to the KD Rehabilitation Unit on postoperative day (POD) 6. He was admitted to KD in good condition with instructions to be non-weight bearing for 3 months and to receive physical therapy twice a day (passive range of motion to 90 degrees). The patient had no pain on admission, was eating and drinking without problems, and was independent in a wheelchair.

On POD 8, during the interdisciplinary team meeting with the patient, nursing, PCP, therapists, and social worker, the patient insisted on going home alone for the weekend. The patient was very active socially, not likely to remain at home, and his non-weight bearing status would be difficult to maintain. Special equipment was ordered for home use, and he was advised to stay in rehabilitation until the equipment was available. The patient understood that if he left KD he would go "against medical advice" (AMA). He was advised to stay 2 weeks or until equipment arrived.

On POD 9, the patient left AMA and was given an irregular discharge. Two days later he returned to KD and nursing staff found him in his former bed. Staff notified the PCP and he was readmitted to KD. Although he stated he continued to use the immobilizer and was non-weight bearing, he admitted to falling at home. When the immobilizer was removed, the dressing on the wound was saturated with dry blood and had a foul odor. Documentation revealed the patient had no dressing changes during his AMA absence from KD.

When notified of the patient's return, the PCP suggested the medical officer on duty (MOD) order laboratory studies; however, the MOD assessed the patient and decided not

to order the studies. The following day, the PCP became aware the laboratory studies had not been ordered and initiated orders for a complete blood count, urinalysis, and a comprehensive metabolic panel which were performed and received on POD 13. The patient's surgical wound and staples were intact with moderate drainage and he had no fever. A nutritional assessment indicated the patient's hydration status was normal; however, he was mildly compromised due to the need for healing of the tibial fracture and his obesity. Later that day, the patient saw the PCP in the hallway and complained of a sore throat, congestion, and coughing. He was treated with Cepacol® and Robitussin®, and a sputum culture was obtained. During the night, the patient asked for water when the nursing assistant (NA) was obtaining vital signs and culture samples from other patients.

On the morning of POD 14, the patient complained of being dehydrated and having a sore throat. The medical record review reflected the patient was receiving fluids with meals and was provided with additional pitchers of water by the nurse manager. He refused lunch and supper, but consumed two pitchers of water during the day and 100 percent of fluids and snacks that evening. That night he complained of being hot, he had a temperature of 97.6 degrees Fahrenheit (°F), his wound was intact with slight redness, warm to touch, and had a small amount of bloody drainage.

On POD 15, the patient refused occupational therapy and consumed 75 percent of breakfast and fluids. At 8:30 a.m., his vital signs were: temperature 96.6 °F, pulse 93 beats per minute, respirations 22 breaths per minute, blood pressure 67/47 millimeters of mercury (mm/hg), and oxygen saturation (blood oxygen level) of 77 percent. The patient was started on two liters of oxygen by nasal cannula and his oxygen saturation level increased to 95 percent. The sputum culture which had been taken on September 28 indicated pneumonia. Ceftriaxone (a broad spectrum antibiotic) was administered intravenously and Azithromycin (antibiotic used to treat infections including pneumonia) was administered orally. The nursing staff obtained a wound culture from his surgical site which was later identified as staphylococcus (a type of bacteria) infection.

Later that morning, an ambulance was called to transfer the patient to the DMD emergency room; however, the transfer to DMD was canceled due to a decline in the patient's oxygen saturation level despite receiving 100 percent oxygen via non-re-breather mask. At 10:20 a.m., the patient was transferred to the Knoxville Community Hospital for respiratory stabilization.

At 6:48 p.m., the patient was transferred to the Iowa City VA Medical Center (ICVAMC) and admitted directly to the Medical Intensive Care Unit. His vital signs were pulse 100-120, blood pressure 120/70 mm/hg, and oxygen saturation 92 percent. At 9:00 p.m., the patient became hypoxic (low blood oxygen level), hypotensive (low blood pressure), and unresponsive. The patient was intubated (breathing tube inserted) with improvement, but showed signs of sepsis (presence of infection throughout tissues and

bloodstream) with multi-system failure. At 11:28 p.m., the pulmonary consultant determined the patient was in septic shock,[2] acute renal failure, and rapidly deteriorating.

On POD 16, at 10:30 a.m., the patient was transferred to the University of Iowa Hospital (UIH) where he expired at 2:50 p.m. The autopsy completed at UIH the following day revealed sepsis due to acute pneumonia of the right lung as the cause of death.

Inspection Results

Issue 1: Laboratory Studies Ordered Never Performed

The allegation that laboratory studies were ordered by the PCP and never performed was not substantiated.

The patient left the facility AMA for 2 days. Upon his return, the PCP suggested the MOD order laboratory studies; however, the MOD assessed the patient and decided not to order the studies. The following day the PCP became aware the laboratory studies had not been ordered and initiated the orders. Blood and urine samples were obtained the following morning with results received later that day.

Issue 2: Patient Denied Water

The allegation that the patient was denied water by nursing staff was not substantiated.

On POD 13, a nutritional assessment indicated the patient's hydration status was normal. However, he was mildly compromised due to the need for healing of the tibial fracture and given his obesity.

During the night, the patient asked for water when the NA was obtaining vital signs and culture samples from other patients. The NA told us a cup of water was given to the patient from a sink in his room and a pitcher of ice water was provided 1.5 hours later. In addition, medical record reviews and interviews with the nurse manager and nursing staff reflected hydration rounds were made on every shift.

Issue 3: Inaccuracies in Autopsy Report

The allegation of inaccuracies in the patient's autopsy report was substantiated; however, during our site visit, staff interviews, and documentation reviews, we could not determine how the inaccurate information in UIH's autopsy report was obtained.

The UIH autopsy report indicated the patient had been absent AMA for 1 week; however, the patient had been gone for 2 days. The autopsy report also indicated the patient had been transferred to the DMD on POD 15, prior to his death. Actually, the patient went to the Knoxville Community Hospital, where he was stabilized in the Emergency Room.

[2] A condition of the blood, characterized by increasingly high levels of bacteria in the circulatory system.

He was later transported to the ICVAMC where he was intubated due to his compromised respiratory status. Finally, the patient was transferred to the UIH due to renal and respiratory failure and the need for hemodialysis.[3] The patient passed away on POD 16. The autopsy was completed at UIH the following day and revealed sepsis due to acute pneumonia of the right lung as the cause of death.

We determined that the inaccurate information in the autopsy report had no impact on the care provided or patient outcomes.

Conclusions and Comments

We concluded that the laboratory studies ordered during the course of his admission were performed. In addition, although the patient complained of dehydration, he received oral fluids regularly with meals and during hydration rounds on every shift. Finally, the autopsy report completed at UIH did have some documented inaccuracies; however, the information did not impact the care provided or patient outcomes. We made no recommendations and plan no further actions.

The VISN and System Directors concurred with our findings (see pages 6 and 7).

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

[3] A medical treatment used to remove waste materials from the blood of patients lacking renal function.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 3, 2009

From: Acting Director, VA Midwest Health Care Network (10N23)

Subject: **Healthcare Inspection – Post-Operative Care Case Review at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa**

To: Director, Dallas Office of Healthcare Inspections (54DA)

I concur with the report and suggested correction requested by the Director, VA Central Iowa Health Care System.

Cynthia Breyfogle

CYNTHIA BREYFOGLE, FACHE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 3, 2009

From: Director, VA Central Iowa Health Care System (636A6/00)

Subject: **Healthcare Inspection – Post-Operative Care Case Review at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa**

To: Director, VA Midwest Health Care Network (10N23)

It is requested that this report reflects who performed the autopsy and that the autopsy and the report were not completed by VA staff. With that clarification, I concur with the report.

DC Cooper

DONALD C. COOPER

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Linda DeLong, Director Dallas Office of Healthcare Inspections 214-253-3331
Acknowledgments	Marilyn Walls, Team Leader Wilma I. Reyes Laura Dulcie George Wesley, MD

Appendix D

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