



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Patient Abuse and Quality of Care Issues Louis Stokes VA Medical Center Cleveland, Ohio

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

TO: Director, VA Healthcare System of Ohio (10N10)

SUBJECT: Healthcare Inspection – Alleged Patient Abuse and Quality of Care Issues, Louis Stokes VA Medical Center, Cleveland, Ohio

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations of patient abuse and quality of care issues at the Louis Stokes VA Medical Center, Cleveland, OH. The purpose of the review was to determine whether the allegations had merit.

Background

The medical center is a tertiary care facility with two divisions—Wade Park and Brecksville—that provides a broad range of inpatient and outpatient health care services. It has 262 hospital beds, 160 community living center beds, and 225 domiciliary beds. The medical center is part of Veterans Integrated Service Network (VISN) 10.

According to the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), a ventral hernia typically occurs in the abdominal wall where a previous surgical incision was made. In this area, the abdominal muscles have weakened, resulting in a bulge or a tear. This can allow a loop of intestines or other abdominal contents to push into the sac, which could lead to potentially serious problems requiring emergency surgery.

Laparoscopic hernia repair is a technique to fix tears or openings in the abdominal wall using small incisions, laparoscopes (small telescopes inserted into the abdomen), and a patch (screen or mesh) to reinforce the abdominal wall. Although this operation is considered safe, complications during the operation may include adverse reactions to general anesthesia, bleeding, or injury to the intestines or other abdominal organs. Approximately 90,000 ventral hernia repairs are performed each year in the United States.¹

¹ SAGES website, <http://www.sages.org/publication/id/PI10/>, retrieved March 12, 2010.

The complainant contacted the OIG Hotline Division on February 2, 2010, to report that two Surgical Intensive Care Unit (SICU) nurses abused her husband during his extended hospitalization. She also alleged that her husband's lengthy hospitalization and subsequent death resulted from a surgical error during a hernia repair in the fall of 2009.

Scope and Methodology

We attempted to interview the complainant by phone on multiple occasions but were unable to make contact. We reviewed the patient's medical record and evaluated the medical center's quality of care reviews and patient advocate reports related to this case. We also interviewed the medical center's risk manager and patient advocate.

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

Case Summary

The patient was a male in his fifties with a primary medical history that included coronary artery disease, four vessel coronary artery bypass graft (CABG) in 2004, abdominal hernia repair with mesh in 2005, hypertension, gastroesophageal reflux disease, dyslipidemia,² and obesity. The patient was evaluated in clinic for laparoscopic hernia repair in August 2009 and was assigned a revised cardiac risk index (RCRI) score of "1" due to his history of ischemic heart disease. This RCRI score indicates that the patient was considered a low surgical risk. Clinicians completed a preoperative work-up and obtained needed clearances for surgery.

The patient was admitted to the medical center in late September 2009 (hospital day 1) for elective laparoscopic hernia repair. The general surgery history and physical note completed on admission stated that the patient had recurrent abdominal incisional hernias that were first noted after his CABG and repaired with mesh the following year. The patient stated that his hernias had recurred over the past year and had grown progressively larger. The patient reported occasional discomfort, but no pain, and indicated he wanted the hernias repaired because of his job.

The patient underwent surgery on hospital day 2 (HD2). A post-operative note completed at 11:08 p.m. noted "No acute events" during surgery. The surgeon described the patient's abdomen as "soft, distended, and appropriately tender," and noted hypoactive (reduced) bowel sounds throughout.

On HD3 a progress note, timed at 11:45 a.m., documented that the patient was "Doing well, mild [abdominal] distension, labs normal." However, the patient was transferred to the SICU later that evening for mild respiratory distress and low oxygen saturation.

² A condition with high blood levels of cholesterol and triglycerides.

On HD3, the surgeon documented that the patient “denies excessive pain, shortness of breath, or chest pain. Abdomen noted to be distended but soft, no bowel sounds. No evidence of pulmonary embolism. White blood count normal; afebrile [no fever] otherwise.”

On HD5, the surgeon documented his impression that the patient had a post-operative ileus (intestinal obstruction) and compromised respiratory effort secondary to pain and distension. He also documented that the patient’s white blood count was normal, he was afebrile (no fever), and he showed no clinical signs of pneumonia. Subsequent cardiac and pulmonary work-ups were normal.

On HD7, the patient exhibited signs and symptoms of an internal abdominal problem and was returned to the operating room (OR) for an exploratory laparotomy. Surgeons discovered and repaired a bowel perforation and resected part of the transverse colon. The patient was transferred to the surgical intensive care unit in critical condition with a diagnosis of sepsis.³

On HD8, surgeons spoke with the patient’s wife about complications from his first surgery and his current clinical condition. As a result of the sepsis, the patient required vasopressor drugs to maintain circulation and blood pressure, antibiotics for the infection, and continuous ventilator support. On HD9, the patient had a cardiac arrest but was successfully revived.

On HD12, the patient went to the OR for an abdominal washout. A small bowel resection, right hemicolectomy, and an ileostomy were performed to remove dead bowel tissue. He was sent out of the OR in guarded condition. The patient returned to the OR on HD37 for wound debridement.

Over the next several weeks, the patient remained critically ill with multi-system organ failure (MSOF) which required continued vasopressor treatment, ventilator support, and dialysis for kidney failure. In mid-November, clinical staff met with the patient’s wife and explained his condition and poor prognosis despite maximum support and treatment.

During December, clinicians continued to aggressively treat the patient’s MSOF, non-healing abdominal wound, and multiple recurrent infections. In spite of the aggressive care, the patient’s condition continued to decline. In mid-January, 2010, staff met with the patient’s family for 2 hours, answered their questions, and explained that the patient’s overall prognosis was guarded. Documentation reflected that the family verbalized understanding. The patient had continued to decline as evidenced by bleeding, profound hypotension resistive to vasopressors, recurrent infection, ongoing kidney dysfunction, and encephalopathy (brain dysfunction). The next day, the family decided to withdraw

³ A severe illness caused by overwhelming infection of the bloodstream caused by toxin-producing bacteria.

care. Morphine sulfate (pain medication) was administered for comfort, and the patient died with his family at bedside.

Inspection Results

Issue 1: Alleged Patient Abuse

We could not confirm or refute the allegation that one SICU nurse hit the patient in the chest two times, or that another SICU nurse choked the patient. We were unable to contact the complainant to get details of the alleged abuse to assist us in this investigation.

We found no evidence that these events were reported to the patient advocate, as alleged. The patient advocate and the risk manager (the patient advocate's supervisor) denied that family members complained that the patient had been abused while in the SICU. However, they did tell us that family members had complained about general nursing and personal care provided to the patient. The family also requested that certain nurses be assigned to the patient's care; however, there was not a similar request to exclude other SICU nurses from his care. The nurse manager apologized to the family for any nursing deficits they perceived, explained that she would speak with the staff about their concerns, and advised that she would make an effort to accommodate the staffing changes they requested.

Issue 2: Alleged Quality of Care Issues

We confirmed that the patient became septic after his bowel was perforated during hernia repair surgery in September 2009. We did not, however, substantiate the allegation implying poor quality of surgical care. Bowel perforation is a fairly infrequent, unfortunate, but known complication of laparoscopic hernia repair. VHA conducted a quality review of the case and took action as needed.

Typically, the clinical signs of a bowel perforation do not present immediately. Patients may become increasingly ill with symptoms which may include nausea, vomiting, fever, and pain over several days after the procedure. In this case, the patient did not experience nausea, vomiting, or non-surgical site pain. His white blood count was normal and he was afebrile for several days post-operatively. However, he did experience respiratory distress and tachycardia,⁴ prompting his transfer to the SICU.

The surgeon monitored and evaluated the patient for typical causes of post-operative respiratory distress which can include pulmonary embolism, pneumonia, cardiac dysfunction, and sepsis. The documentation indicates that because the patient did not initially display overt abdominal symptoms suggestive of perforation, was afebrile, and

⁴ Tachycardia is a rapid heartbeat.

had a normal white blood count, the initial focus of the surgeon's work-up was a possible pulmonary and cardiac etiology. In late September, the patient's condition further declined. The surgeon documented, "In the absence of cardiac and convincing lung pathology, his symptoms are more likely to result from mesh infection vs. intestinal leak/injury" and took the patient to the operating room for an exploratory laparotomy.

We concluded that reasonable actions were taken to identify the reason for the patient's deteriorating condition. After the perforated bowel was discovered, the patient received antibiotics to treat the infection and aggressive care relative to his MSOF. Unfortunately, sepsis can be hard to treat once it has invaded the body, and mortality rates are high, ranging from 28–50 percent.⁵

Conclusions

We could not confirm or refute the allegation of patient abuse. The complainant provided limited information which made it difficult to fully evaluate the issue. We found no evidence to support the allegation based on our review of patient advocate reports, medical records, and interviews with relevant staff.

We did not substantiate the allegation related to poor quality of care. While the patient's death did result from a perforated bowel during hernia repair surgery, this is an unfortunate but known potential complication of the procedure. When the perforated bowel and subsequent sepsis were discovered, clinical staff aggressively treated the patient's multiple and complex medical issues. The VISN and medical center Directors agreed with the report. We made no recommendations.

(original signed by:)
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⁵ *Crit Care Med* 2001, 29:1303–1310.

OIG Contact and Staff Acknowledgments

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Acknowledgments	Michael Shepherd, MD Susan Zarter

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