



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 13-01956-37

Healthcare Inspection

Quality of Care Issues San Juan VA Medical Center San Juan, Puerto Rico

December 30, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to review allegations from a confidential complainant about quality of care issues, inadequate discharge planning, and lapses in communication at the San Juan VA Medical Center (the facility), in San Juan, Puerto Rico.

We substantiated the allegations that the medical condition leading to the patient's acute delirium was not addressed, that physicians failed to diagnose the patient's urinary tract infection and sepsis, and that the patient was not medically stable when he left the facility.

We substantiated the allegation that the patient suffered a significant weight loss while he was in the hospital, and determined that the patient's nutritional treatment plan was inadequate. We substantiated the allegation that the patient's sutures from the hernia surgery were not removed for 7 weeks; however, this did not cause the patient harm.

We substantiated the allegation that the patient fell once, but we could not substantiate the allegation that the staff treated the patient roughly, or that he fell a second time. We substantiated the allegation that family members did not receive adequate information regarding the patient's condition. We substantiated the allegation that no attempts were made by staff to arrange for appropriate follow-up care with providers at the Arizona VA facility.

We determined that accurate skin assessments were not performed, and that actions taken to prevent and/or treat pressure ulcers were inadequate.

We recommended that thorough nutritional assessments are completed (including weights), processes be strengthened to ensure nursing staff perform accurate daily skin inspections, and discharge planning processes are appropriate for the patient's condition. We also recommended that the informed consent process complies with VHA requirements, and that the facility director consults with Regional Counsel regarding possible disclosure of failure to diagnose urinary tract infection and prevent and treat pressure ulcers.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 14-17 for the Directors' comments.) We will follow up on the planned actions until they are completed. We consider recommendation 5 closed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to review allegations from a confidential complainant about quality of care issues, inadequate discharge planning, and lapses in communication at the San Juan VA Medical Center (the facility), in San Juan, Puerto Rico. The purpose of the review was to determine whether the allegations had merit.

Background

Facility

The facility, part of the VA Caribbean Healthcare System (the system), is a teaching hospital that provides emergency, medical, surgical, physical medicine and rehabilitation, psychiatric, and long-term care services. The system is a part of Veterans Integrated Service Network (VISN) 8 and has a total of 238 acute care beds and 37 intensive care beds.

Chronic Liver Disease/Cirrhosis

Chronic liver disease¹ (CLD) refers to the gradual destruction of liver tissue over time and has several causes, including cirrhosis of the liver. Cirrhosis is a condition in which the liver slowly deteriorates and malfunctions due to chronic injury. Scar tissue replaces healthy liver tissue, partially blocking blood flow through the liver. Scarring also impairs the liver's ability to remove toxins from the blood, process nutrients, and make proteins essential for regulating blood clotting.

Symptoms of cirrhosis vary, depending on severity of the condition, and include weakness, fatigue, loss of appetite, nausea, vomiting, weight loss, abdominal pain, ascites,² jaundice,³ and the presence of spiderlike blood vessels on the skin, among others.

Prognostic scores are calculated for patients with cirrhosis to estimate the probability of death within a given time interval and assess the patient's capacity to withstand surgical or other aggressive therapeutic interventions. The Child-Pugh classification system is commonly used for this purpose, and includes three categories: Class A is well-compensated disease; Class B is disease with significant functional compromise; and Class C is decompensated liver disease. Patients with class C disease have a 50 percent survival rate of 1 year. Patients with class A or B disease have a 70-80 percent survival rate of 5 years.

¹ A chronic disease or condition is one that last three months or longer.

² Abdominal ascites is the accumulation of fluid in the abdomen.

³ Jaundice is a yellowing discoloration of the skin.

Treatment for cirrhosis depends on the cause of the disease and whether complications are present. The goals of treatment are to slow the progression of scar tissue in the liver and prevent or treat disease complications. Cirrhosis is a progressive disease and damage sustained to the liver is irreversible. With proper nutrition, early intervention, avoidance of toxins (such as alcohol), vitamin supplementation, and management of cirrhosis complications, further liver damage can often be delayed or stopped. In severe cases of cirrhosis, liver transplant may be considered.

Malnutrition

Malnutrition is defined as the result of inadequate food and nutrient intake or inadequate absorption of nutrients. “Malnutrition is a well-known complication of advanced liver disease and is associated with detrimental consequences if left untreated.”⁴ Treatment is focused on maintaining adequate protein and caloric intake and correcting nutrient deficiencies. When oral intake is insufficient, early implementation of enteral tube feedings⁵ should be considered. Malnutrition is a potentially reversible condition that, when identified and treated appropriately, can lead to improved outcomes.

Since there is no single parameter that is definitive for adult malnutrition, the Academy of Nutrition and Dietetics recommends the identification of two or more of the following six characteristics for the diagnosis of malnutrition: insufficient energy intake (calorie count), weight loss, loss of muscle mass, loss of subcutaneous fat, localized or generalized fluid accumulation that may sometimes mask weight loss, and diminished functional status as measured by hand grip strength. In addition, tracking food and nutrient intake may be used as evidence of insufficient calories. The nutritional status of patients with liver disease should be assessed to identify those at risk of developing preventable complications. “Initiating nutritional therapy can reduce the risk of complications and improve the overall mortality rate.”⁶

Acute Delirium

Acute delirium is a sudden disturbance in a person’s mental abilities that results in a decreased awareness of one’s environment and a confused thinking process. It is associated with negative consequences, including prolonged hospitalization, functional decline, increased use of restraints, and increased mortality. “Delirium affects as many as 25-60 percent of hospitalized adults, yet is often unrecognized by clinicians.”⁷

⁴ Henkel Anne S., Buchman Alan L.; Nutritional Support in Patients with Chronic Liver Disease. Nature Clinical Practice Gastroenterology & Hepatology, January 2006.

⁵ Enteral feedings are nutritionally complete liquids delivered directly into the gastrointestinal tract through a tube.

⁶ Henkel Anne S., Buchman Alan L.; Nutritional Support in Patients with Chronic Liver Disease. Nature Clinical Practice Gastroenterology & Hepatology, January 2006.

⁷ Lehman Cheryl, Confusion in Older Adults: Determining the Difference Between Dementia and Delirium. Gerontology Update ARN Network, December 2007.

Predisposing risk factors for acute delirium include severe illness, multiple co-morbidities, alcoholism, older age, and dementia, among others. Evidence based research data indicate that some precipitating risk factors for acute delirium include acute illness, surgery, dehydration, infection, electrolyte imbalance, and urinary retention.⁸ Furthermore, “The presence of acute delirium warrants prompt intervention to identify and treat underlying causes and provide supportive care.”⁹

Primary signs and symptoms of acute delirium include an inability to stay focused, poor thinking skills (cognitive impairment), and behavioral changes such as hallucinations,¹⁰ restlessness, agitation, depression, and disturbed sleep habits. The onset of acute delirium is usually sudden, often within hours or a few days; however, is often unrecognized and undocumented by clinicians. Therefore, patients at risk for acute delirium should be assessed frequently to facilitate prompt identification and management of acute delirium and underlying causes.

Pressure Ulcers

Pressure ulcers, also known as decubitus ulcers or bedsores, are localized injuries to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. The most common sites are the sacrum, coccyx, heels, or the hips, but other sites such as the elbows, knees, ankles, or the back of the cranium can be affected.

Pressure ulcers most commonly develop in persons who are confined to bed or wheelchairs. Other factors that can increase the risk of pressure ulcer development include malnutrition and skin wetness caused by sweating or incontinence.

Although often prevented and treatable if detected early, pressure ulcers can be very difficult to prevent in critically ill patients. Primary prevention is to redistribute pressure by turning the patient regularly. In addition to turning and re-positioning the patient, having an adequate protein intake and keeping the skin free from exposure to urine and stool is very important. A widely used tool for documentation of skin condition is the Braden Scale, a clinically reliable tool that scores and predicts an individual’s level of risk for developing pressure ulcers.

The complainant contacted the OIG in December 2012 with the following allegations:

- The medical condition leading to the veteran’s acute delirium was not addressed.
- The veteran was not medically stable when he left the facility via a commercial flight, and required admission to another VA facility immediately upon arrival.

⁸ Christine M. Waszynski, General Assessment Series, The Confusion Assessment Method (CAM), No.13, revised 2012.

⁹ Ibid.

¹⁰ Hallucinations are auditory, visual, or tactile sensations that appear real but do not exist.

- The veteran lost 100 pounds (lbs.) while in the hospital. He was too weak to eat and did not receive assistance with meals.
- The veteran's sutures placed after the hernia surgery had not been removed after seven weeks.
- The veteran fell twice, and complained of being treated roughly by staff.
- The facility did not consistently communicate changes in the patient's condition to the family.
- The veteran received minimal care during the last two weeks of his hospitalization.
- The facility did not arrange follow up care for the patient prior to discharge.

Scope and Methodology

We interviewed the complainant prior to conducting a site visit on May 7–9, 2013. During our site visit, we interviewed physicians, registered dietitians, social workers, and registered nurses. We reviewed current pertinent literature, electronic health record (EHR) documentation, VHA directives, system policies and procedures, and quality management data.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient is a male in his early forties who relocated from Arizona to Puerto Rico in December 2011. His chronic medical conditions include alcohol-related CLD and cirrhosis, umbilical hernia, and major depressive and bipolar disorders.

Between December 2011 and August 2012, the patient had a brief inpatient stay and frequent outpatient visits for decompensated CLD. He required diagnostic and therapeutic paracentesis¹¹ at least monthly from February 2012 through August 2012 for refractory ascites.¹²

In early September 2012, the patient presented to the ED complaining of tense ascites,¹³ abdominal pain, and vomiting. A surgeon admitted him for emergent laparoscopic¹⁴ repair of an incarcerated umbilical hernia.¹⁵ The EHR reflected that the patient's Child-Pugh score was Class B (disease with significant functional compromise). The surgeon advised the patient that he was at high risk for postoperative complications because of his advanced liver disease. During surgery, the surgeon identified and removed a section of necrotic bowel¹⁶ and repaired the hernia. The patient subsequently had a prolonged hospital course with multiple complications summarized below.

During the hospitalization, the patient lost a significant amount of weight. Outpatient records showed he weighed 165 lbs. in August 2012. Nurses weighed the patient four times during the hospitalization: 213.9 lbs. on post-operative day (POD) 5, 227.4 lbs. on POD 24, 209.8 lbs. on POD 35, and 113 lbs. on POD 50. Nutritionists monitored the patient and made recommendations to the care team throughout his stay.

The patient had frequent skin assessments throughout his hospital stay. A nurse recorded a Stage I left heel pressure ulcer on POD 24. A note on POD 25 documented redness on the sacrum. Nurses recorded a 1x1cm laceration of the sacrum on POD 43 and POD 49. The final assessment on the day of discharge documented a rash in the gluteal (buttock) area and that the left heel ulcer had healed.

Following surgery, the patient remained in the surgical intensive care unit (SICU) for 24 days. During this time, he received aggressive life support measures including

¹¹ Paracentesis is performed by inserting a needle into the peritoneal space between the abdominal cavity and the abdominal wall that is created by accumulated fluid. Diagnostic paracentesis refers to the removal of a small quantity of fluid for testing. Therapeutic paracentesis refers to the removal of a large quantity of fluid to reduce abdominal pressure.

¹² Refractory ascites is an accumulation of fluid in the peritoneal space that is unresponsive to medication.

¹³ Tense ascites is an accumulation of fluid in the abdomen that is significant enough to cause pressure on organs and difficulty breathing.

¹⁴ Laparoscopic surgery is performed through small incisions with the aid of a camera.

¹⁵ An umbilical hernia is the protrusion of intestines through the abdominal wall. An incarcerated hernia occurs when the protruded intestines is trapped which can lead to compromised blood supply and tissue death.

¹⁶ Necrotic bowel is non-viable intestinal tissue, in this case, from lack of blood supply to the area.

mechanical ventilation,¹⁷ antibiotics, intermittent intravenous drugs for low blood pressure, and nasogastric (NG) tube feedings for nutritional support. The SICU care team also implemented measures to help prevent skin breakdown and ventilator associated pneumonia.

While in the SICU, the patient had refractory ascites requiring paracentesis five times. Despite the care team's prevention measures, he developed ventilator associated pneumonia, necessitating treatment with antibiotics. Attempts to wean the patient from the ventilator were unsuccessful, so surgeons placed a tracheostomy tube¹⁸ for long-term respiratory support.

On POD 24, the patient transferred to the respiratory care unit. While there, doctors successfully weaned him from the ventilator after a total of 33 days of mechanical support. He developed further complications, including an episode of acute delirium secondary to sepsis,¹⁹ a seizure, and cellulitis (skin infection). He required paracentesis an additional nine times.

On POD 39, the patient moved to a general medical unit. The next day staff removed his indwelling bladder catheter and submitted urine for analysis. The urinalysis results were suggestive of, but not definitive for, a urinary tract infection (UTI). A consultant noted these findings on POD 41, and recommended a culture and antibiotic adjustments if indicated; however, the internal medicine team did not order a culture or change antibiotics. The antibiotics were discontinued on POD 46.

On POD 44, the nursing staff documented that the patient was confused, uncooperative, incoherent and needed restraints to prevent self-harm. Nursing notes indicated the patient remained confused and combative, had visual hallucinations, and required intermittent restraints during the remainder of his hospitalization. They also noted the patient was unable to stand, perform self-care, or feed himself.

Physicians' notes during this episode of acute delirium indicated they were initially aware of nursing notes documenting the patient's symptoms and restraints. On POD 44, a psychiatry consultant recommended the internal medicine physicians evaluate for a medical cause of acute delirium. On POD 49, the psychiatrist recommended delaying discharge plans until the acute delirium was completely resolved. The same day an internal medicine physician wrote, "will follow ammonia and TSH [thyroid stimulating hormone] levels and if no abnormal values found that may be contributing to on-off altered mental status, then will proceed with discharge from medical service tomorrow."

A physician wrote discharge orders on POD 50; however, the patient remained on the general medicine unit for another five days until travel arrangements were completed. On POD 52, despite nursing notes to the contrary, both the psychiatry and internal

¹⁷ Mechanical ventilation is the use of a machine to assist or replace an individual's spontaneous breathing.

¹⁸ A tracheostomy tube is inserted through the front of the neck directly into the windpipe.

¹⁹ Sepsis is a life-threatening condition caused by severe infection.

medicine physicians recorded that the patient was stable and without symptoms of acute delirium.

The patient left the facility 54 days after surgery. A social worker advised the patient's family to arrange for acute inpatient rehabilitation after arrival home. The patient required ambulance transport to the airport. His family accompanied him on the commercial flight back to Arizona. Immediately on arrival, the family drove him to the local VA facility ED.

Sixteen hours after leaving the San Juan VA, the patient required admission to the SICU for sepsis due to UTI, acute renal failure from dehydration, and acute delirium. He weighed 117.5 lbs. Admission notes documented a recent dramatic weight loss and cachectic²⁰ appearance. His admission skin assessment revealed multiple Stage I and II pressure ulcers on the left heel, right ankle, both elbows (8x8 cm and 3x3 cm), and both knees (11x11 cm and 4x4 cm); a Stage II sacral ulcer measured 8x2 cm. He remained hospitalized for 27 days before he was transferred to an acute inpatient rehabilitation unit and eventually discharged to a Veteran's State Home.

Inspection Results

Issue 1: Quality of Care Issues

Inadequate Treatment for Acute Delirium

We substantiated the allegation that the medical condition leading to the patient's acute delirium was not addressed. Specifically, the patient's acute delirium secondary to a severe UTI went unrecognized and untreated. We also substantiated the allegation that the patient was not medically stable when he left the facility via a commercial flight, and required admission to another VA facility immediately upon arrival.

On POD 41, a consultant recommended that providers obtain a urine culture to evaluate for a possible UTI and adjust antibiotics if indicated; however, no urine culture was obtained. By POD 44, the patient developed symptoms of acute delirium including confusion, hallucinations, and agitation. He was seen by Psychiatry Services, who recommended evaluation for underlying medical causes for delirium. The patient remained intermittently agitated, often requiring the use of restraints to prevent self-harm during the remainder of his hospital stay. The EHR did not reflect that measures were taken to identify infection as an underlying medical cause for the patient's acute delirium.

On POD 53, the attending physician indicated that, "From internal medicine viewpoint, patient is medically stable and able to travel to Arizona with his family. Also, as per last psychiatric evaluation, there is no actual contraindication for traveling back with his

²⁰ Cachectic appearance refers to generalized emaciation including muscle loss, fatigue, and weakness usually occurring in association with cancer or a chronic disease.

family as his acute symptoms are resolved and patient [sic] is not in delirium. Patient and relatives were oriented and are aware of these findings.” Although the patient was cleared for discharge, other EHR entries by nursing staff reflected that the patient was intermittently confused and required restraints due to hallucinations.

The patient left the facility early in the morning of October 31 for a commercial flight to Arizona. Immediately upon arrival, his family took him to the local VA facility, where he was admitted to the intensive care unit with sepsis secondary to a UTI, acute delirium, and acute renal failure secondary to dehydration.

We determined that physicians did not acknowledge nursing documentation of the patient’s acute symptoms including agitation, confusion, and hallucinations. We also determined that physicians failed to adequately assess for underlying causes of acute delirium and failed to diagnose the patient’s UTI and sepsis. We determined that the patient was not medically stable at the time he left the facility.

Lack of Nutritional Support

We substantiated the allegation that the patient lost a significant amount of weight while he was in the hospital. We could not substantiate the allegation that he was too weak to eat and no one assisted him.

VHA policy²¹ requires that a nutritional assessment be conducted that includes evaluation of nutrition intake, hydration status, recent weight, and weight history, followed by the implementation of a nutrition care plan.

Local clinical practice guidelines for the prevention and treatment of pressure ulcers requires that the patient’s nutritional status be monitored, including assessment of the patient’s intake and output, weight on admission and weekly thereafter, and calorie counts. In addition, local protocol for patients receiving enteral nutrition requires weekly weights on patients receiving enteral tube feedings.

All three clinical dietitians we interviewed acknowledged that the commonly accepted practice of calculating caloric intake for patients receiving nutrition through tube feedings was not done for this patient.

The EHR indicated that the patient was on tube feedings from POD 3–23 and from POD 26–34, followed by a pureed diet. We found that nursing intake and output documentation and progress notes from members of the interdisciplinary team reflected percentage of food ingested, and/or a description of patient’s appetite, but no documentation of actual caloric intake.

While the patient was in the SICU receiving enteral nutrition, daily weights were documented in the progress notes; however, they were not current or accurate. Instead, the same two weights, one obtained in August 2012 (165 lbs.) and one

²¹ VHA Handbook 1109.02, Clinical Nutrition Management, February 14, 2012.

obtained after six days in the hospital (213 lbs.), were repeatedly included in the physician and nursing staff notes, were clearly contradictory, and according to the date and time stamps, were not current.

EHR notes also indicated that when the patient was transferred to the general medical unit and was still receiving enteral nutrition, his weight was recorded only 2 of the 16 days he was there, with no documentation of his weight for 11 consecutive days.

When comparing the patient's initial weight of 213.19 lbs. with the weight of 113 lbs. obtained 4 days prior to discharge, it was clear that the patient lost a significant amount of weight during 55 days of hospitalization. His weight of 117.5 lbs. at the Arizona VA facility correlates with the last recorded weight at the facility prior to discharge.

The family told us that the staff did not assist the patient with meals; however, EHR documentation reflects that the patient was assisted with meals.

We determined that the patient was not weighed as required by local policy. We also determined that the patient's nutritional treatment plan was inadequate. It was based on inaccurate weights and incomplete assessments of nutritional intake.

Surgical Wound Care

We substantiated the allegation that the patient's sutures from the hernia surgery were not removed until 7 weeks after surgery. They were removed the day before he was discharged; however, we found that the delay was medically justified.

A provider's note in the EHR on the POD day 13 stated, "Staples will be kept in place longer due to his large abdomen," which justified the need to keep the sutures in place. Although documentation indicated that the sutures were in place for 45 days post-surgery, it did not cause any harm. The sutures were necessary to prevent the wound from not closing properly due to the patient's ascites.

Inadequate Management of Patient's Fall

We substantiated the allegation that the patient fell once, but could not substantiate the allegation that the patient was treated roughly, or that he fell a second time.

Local policy defines falls as a loss of upright position that results in landing on the floor, or a sudden, uncontrolled, downward displacement of the body to the floor. The policy requires that a fall risk assessment be done on admission and with changes in the patient's mental or physical condition, or a change in the treatment plan.

The patient was identified by the nursing staff as high risk for falls, and fall risk assessments were documented as required. EHR notes indicated that the patient had a fall, and the nursing staff initially helped him to slide down to the floor and then placed him back on the bed. The patient was evaluated by a physician after the fall, who indicated no evidence of trauma. We found no documentation in the EHR of a second fall.

Lack of Communication with the Family

We substantiated the allegation that family members did not receive adequate information regarding the patient's condition for several weeks.

The complainant told us that the patient's medical team kept the family informed of the patient's condition and treatment while they were with the patient during the first week in the SICU. However, after they returned home, they had difficulty obtaining timely updates on the patient's condition.

The EHR indicated that providers attempted and/or spoke to the patient's relatives frequently while the patient was in the SICU. We determined that there was a decrease in communication with the patient's relatives regarding changes in the patient's condition and treatment plans after he was transferred out of the SICU.

Minimal Care Prior to Discharge

We could not substantiate the allegation that the patient received minimal care for the last 2 weeks prior to his discharge on October 27, 2012.

The complainant stated to us that when the patient's family was there with the patient during the last 2 weeks of his hospitalization, the staff expected them to assist the patient with his basic activities of daily living such as feeding, bathing, and getting him out of bed. They also said that the patient was very weak, confused, and unable to do things by himself, which caused them concern. However, the EHR reflected that routine care was provided by the nursing staff.

Issue 2: Lack of Adequate Discharge Planning

We substantiated the allegation that no attempts were made by staff to arrange for appropriate follow-up care or coordinate care with providers at the Arizona VA facility.

VHA policy ²² requires that transfers be coordinated into and out of its medical facilities under circumstances that provide maximum safety for patients. In addition, local policy requires that the attending physician is responsible for determining the necessity for transfer and transportation requirements for the specific medical needs.

The EHR indicated that on discharge, providers identified medical and mental health follow up needs, and recommended inpatient rehabilitation. However, no arrangements were made for inter-facility transfer to the Arizona rehabilitation facility, and there was no communication with the Arizona facility regarding the patient's need for ongoing inpatient care. Instead, family members were instructed to contact acute rehabilitation, mental health, gastroenterology, and speech and swallowing services at the Arizona VA facility to arrange further care when they arrived home.

²² VHA Directive 2007-015, Inter-Facility Transfer Policy, May 2007.

Local policy requires that the patient's discharge needs be identified upon admission and until discharge or transfer, and that the interdisciplinary team assures continuity of care by performing appropriate referrals to VA or community agencies. Local policy also requires that discharge orders should be completed 24–72 hours prior to the approximate discharge date.

The patient remained at the facility for 4 days after he was formally discharged. While the EHR reflected that physicians saw the patient between the time he was discharged and actually left the facility, the discharge orders were written 4 days prior to actual discharge and were not re-evaluated for appropriateness.

We determined that the discharge planning process was inadequate given the patient's condition and his need for ongoing treatment and services.

We determined that the attending physician failed to provide appropriate oversight for coordination of required services based on patient's medical, mental health, and rehabilitation needs, and that discharge orders were not timely or appropriate for the patient's condition.

Issue 3: Other Findings

In the course of our review, we also found the following conditions.

Inadequate Actions for Prevention of Pressure Ulcers

We found that actions taken to prevent and/or treat pressure ulcers were inadequate.

Local policy requires that nursing staff perform skin inspections and obtain a Braden Scale score for all patients upon admission, discharge, transfer, or change in patient's condition; and that a skin assessment be documented within 24 hours of admission and daily thereafter.

We found that the nursing skin assessment documentation reflected significant discrepancies concerning the patient's actual condition. Although a daily skin assessment was documented on 53 of the 55 days of the patient's hospitalization, the documentation was contradictory and inconsistent. The skin assessment at discharge documented only a rash in the gluteal area and a healed left heel ulcer. The admission skin assessment at the Arizona VA facility revealed multiple stage I and II pressure ulcers on the left heel, right ankle, both elbows (8x8 cm and 3x3 cm), and both knees (11x11 cm and 4x4 cm); and a stage II sacral ulcer that measured 8x2 cm.

We determined that accurate skin assessments were not performed, and multiple existing pressure ulcers were not identified or treated.

Inadequate Informed Consents

We found a lack of documentation of notification of the patient and/or family regarding changes in the patient's treatment plan.

VHA policy²³ requires that the practitioner performing a procedure be identified, as well as any other practitioner responsible for supervision. In addition, VHA requires that if a different practitioner is substituted for the practitioner responsible for conducting the procedure, his/her name and signature must be added to the consent form, or a progress note must be placed in the patient's EHR to indicate all changes to the treatment plan, as well as patient agreement.

We noted that providers other than those listed on the informed consent performed procedures two different times. While the change in the provider performing the procedure was documented in the EHR, there was no documentation that the change was discussed with the patient and/or family. This is a repeat finding from a previous Hotline at this facility (*Alleged Quality of Care and Responsiveness Issues, VA Caribbean Healthcare System, San Juan, Puerto Rico Report # 11-03896-209 June 22, 2012.*)

Conclusions

We substantiated the allegation that the medical condition leading to the patient's acute delirium was not addressed. We determined that the physicians failed to diagnose the patient's UTI and sepsis. We also substantiated the allegation that the patient was not medically stable when he left the facility, and required admission to another VA facility immediately upon arrival home.

We substantiated the allegation that the patient lost a significant amount of weight while he was in the hospital. We could not confirm the allegation that he was too weak to eat and no one assisted him. We determined that the patient's nutritional treatment plan was inadequate, and was based on inaccurate weights and incomplete assessments of nutritional intake.

We substantiated the allegation that the patient's sutures from the hernia surgery were not removed for 7 weeks, until the day before he was discharged. However, this did not cause the patient harm and may have been medically necessary to prevent further complications.

We substantiated the allegation that the patient fell once, but we could not confirm the allegation that the staff treated the patient roughly, or that he fell a second time.

We substantiated the allegation that family members did not receive adequate information regarding the patient's condition for several weeks. We could not

²³ VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, August 14, 2009.

substantiate the allegation that the patient received minimal care the last two weeks of his hospitalization.

We substantiated the allegation that no attempts were made by staff to arrange for appropriate follow-up care with providers at the Arizona VA facility. We determined that the discharge planning process was inadequate. The attending physician failed to provide appropriate oversight for coordination of required services, and providers failed to communicate on-going care needs to the Arizona facility. We determined that discharge orders were written more than 72 hours prior to actual discharge, and were not re-assessed for appropriateness.

We determined accurate skin assessments were not performed, and that actions taken to prevent and/or treat pressure ulcers were inadequate.

We found a lack of documentation of the patient and/or family notification regarding changes in the patient's treatment plan.

Recommendations

1. We recommended that the System Director ensures that thorough nutritional assessments are completed (including weights), plans are implemented, and patient progress is continually monitored.
2. We recommended that the System Director ensures that processes be strengthened to ensure that nursing staff perform and document accurate daily skin inspections for all hospitalized patients identified as being at risk for pressure ulcers, and that compliance is monitored.
3. We recommended that the System Director implement measures to ensure that discharge planning processes are appropriate for the patient's condition, discharge orders comply with local policy, and that compliance is monitored.
4. We recommended that the System Director implement measures to ensure that the informed consent process complies with VHA requirements.
5. We recommended that the System Director consult with Regional Counsel regarding possible disclosure to the patient and family of failure to diagnose urinary tract infection with sepsis, and failure to prevent and treat pressure ulcers.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 3, 2013

From: Director, VA Sunshine Healthcare Network (10N8)

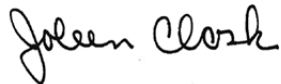
Subject: **Healthcare Inspection – Quality of Care Issues, San Juan VA
Medical Center, San Juan, PR**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10AR MRS OIG
Hotline)

I have reviewed and concur with the Healthcare Inspection on Quality of Care issues performed by the Office of Inspector General.

Corrective action plans have been established with planned completion dates, as detailed in the attached report.



Joleen Clark, MBA, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 3, 2013

From: Director, VA Caribbean Healthcare System (672/00)

Subject: **Healthcare Inspection – Quality of Care Issues, San Juan VA
Medical Center, San Juan, PR**

To: Director, VA Sunshine Healthcare Network (10N8)

Enclosed you will find the VA Caribbean Healthcare System's response to the Healthcare Inspection on Quality of Care issues performed by the Office of Inspector General.



DeWayne Hamlin

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensures that thorough nutritional assessments are completed (including weights), plans are implemented, and patient progress is continually monitored.

Concur

Target date for completion: January 31, 2014

Facility response: VACHS recognizes the need to strengthen compliance with facility policy of weighing patients at time of admission, transfer or by doctors' orders. Nutritional assessments were completed in required timeframe however there is a need to improve on patients' nutritional progression, including caloric count where clinically indicated. Current policies are being evaluated to ensure there are no gaps in our nutritional assessment including weights and that plans are implemented and patients' progress is continuously monitored. Quality monitoring of nutritional assessments commenced on November 15, 2013, and will continue until improvement is sustained with reviews indicating 90 percent compliance.

Recommendation 2. We recommended that the System Director ensures that processes be strengthened to ensure that nursing staff perform and document accurate daily skin inspections for all hospitalized patients identified as being at risk for pressure ulcers, and that compliance is monitored.

Concur

Target date for completion: March 31, 2014

Facility response: An action plan to improve nursing documentation of Braden Scale assessments is underway and includes direct observation, record audits and staff interviews for perception of barriers. Based on these findings, education and training will be provided to the nursing staff and skin care champions by the end of December 2013. Monthly auditing will continue until documentation confirms compliance at 90 percent or greater.

Recommendation 3. We recommended that the System Director implements measures to ensure that discharge planning processes are appropriate for the patient's condition, discharge orders comply with local policy, and that compliance is monitored.

Concur

Target date for completion: March 30, 2014.

Facility response: A system redesign project was conducted and the VACHS is allocating additional resources needed to strengthen this process. The recently created Patient Flow Committee and the Social Work Service will monitor the process until at least 90 percent compliance is sustained.

Recommendation 4. We recommended that the System Director implements measures to ensure that the informed consent process complies with VHA requirements.

Concur

Target date for completion: January 31, 2014

Facility response: VACHS has initiated a monitor to review informed consents and to include inpatient procedures performed at bedside as appropriate. Our Medicine Service Section Chiefs reinforced with our residents that the informed consent could be obtained by anyone who was on the treatment team. If the person obtaining the consent was not performing the procedure, then the resident needed to document in a progress note that the patient had been notified and agreed to the change in provider. To monitor compliance QMS (Quality Management Service) started reviewing inpatient procedures performed and documentation of the procedures within the Medicine Service on a monthly basis until at least 90 percent compliance with the informed consent policy is sustained.

Recommendation 5. We recommended that the System Director consult with Regional Counsel regarding possible disclosure to the patient and family of failure to diagnose urinary tract infection with sepsis, and failure to prevent and treat pressure ulcers.

Concur

Target date for completion: November 8, 2013

Facility response: A consultation with Regional Counsel was completed and a disclosure was made to the patient and family.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Alice Morales-Rullan, MSN, Team Leader Monika Gottlieb, MD Karen McGoff-Yost, LCSW Carol Torczon, ACNP Jackelinne Melendez, MPA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Sunshine Healthcare Network (10N08)
Director, VA Caribbean Healthcare System (672/00)

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
Senate Committee on Homeland Security and Governmental Affairs
Related Agencies
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
Resident Commissioner for the Commonwealth of Puerto Rico: Pedro Pierluisi
Delegate to Congress from the U.S. Virgin Islands: Donna M. Christian-Christensen

This report is available on our web site at www.va.gov/oig