Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03178-70

Healthcare Inspection
Alleged Lapses in Communication and Poor Quality of Care
Charlie Norwood VA Medical Center
Augusta, Georgia

February 12, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the Charlie Norwood VA Medical Center in Augusta, GA. in response to allegations received through the OIG's Hotline Division and from Congressman Doug Collins' office of poor patient care, lapses in communication between facility staff and the patient's family, inadequate physician/nurse staffing, loss of the patient's personal property, and failure to provide medical information to another facility.

We substantiated that the patient developed pressure ulcers on his sacrum and coccyx after admission to the hospital and that documentation of care rendered to prevent ulcers was inconsistent. Since the facility is in the process of improving the prevention of pressure ulcer program and progress will be monitored through the Combined Assessment Program review follow-up, we made no recommendations concerning this allegation.

We substantiated that facility staff and physicians failed to effectively communicate with the patient's family regarding the patient's condition and treatment needs. We substantiated that facility staff did not securely safeguard the patient's personal belongings during the patient's hospitalization.

We did not substantiate the allegation that staff members expressed concern regarding inadequate nurse staffing levels. We found that nurse staffing levels in the intensive care unit met or exceeded target levels. We addressed the physician staffing levels in the context of resident physician communications with the family.

We did not substantiate the allegation that the facility did not provide the private rehabilitation center with current patient health records.

We recommended that the Facility Director (1) ensure that patient information is shared with patients, families, and significant others in an appropriate manner that protects patient privacy, and (2) ensure that processes be strengthened for inventory, documentation, storage, and retrieval of patient belongings, and that compliance is monitored.

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 9–12 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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 in response to allegations received by the OIG's Hotline Division and from Congressman Doug Collins' office of poor patient care, lapses in communication between facility staff and the patient's family, inadequate physician/nurse staffing, and loss of the patient's personal property at the Charlie Norwood VA Medical Center (the facility) in Augusta, GA. The purpose of this inspection was to determine whether the allegations had merit.

Background

The facility is part of a two-division system in Veterans Integrated Service Network (VISN) 7, and is located in Augusta, GA. The facility has 278 acute inpatient beds, 60 domiciliary beds, and 132 community living center beds. Medicine, surgery, mental health, rehabilitation, and spinal cord injury services are provided at a downtown campus, and mental health and long term care are provided at an uptown campus.

Pressure Ulcers

Pressure ulcers, also known as decubiti 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 at which pressure ulcers occur are the sacrum, coccyx, heels, and hips, but other sites such as the elbows, knees, ankles, or the back of the head also may 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, poor nutritional intake, and skin wetness caused by sweating or incontinence, and virtually any overall catabolic (body-wasting) state.

Although often prevented and treatable if detected early, pressure ulcers can be difficult to prevent and even more difficult to treat in critically ill patients. Primary prevention measures consist of attempting 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 feces is critical. A clinically reliable tool for documentation of skin condition is the Braden Scale[1] that is widely used to score and predict an individual's level of risk for developing pressure ulcers. When present, pressure ulcers are categorized in stages by degree of severity as follows:

- Stage I: the skin appears reddened and does not blanch (loss of color when slight pressure is briefly applied).
- Stage II: the skin breaks open, wears away, or forms an ulcer, which is usually tender and painful. The sore extends into deeper layers of the skin.

[1] The Braden Scale assesses a patient's risk of developing a pressure ulcer by examining six criteria. http://www.nlm.nih.gov/research/umls/sourcereleasedocs/2009AA/LNC_BRADEN/ accessed September 26, 2013.

- Stage III: the sore extends into the tissue beneath the skin, forming a small crater; fat may show in the sore, but not muscle, tendon, or bone.
- Stage IV: the pressure sore is very deep, reaching into muscle and bone; damage to deeper tissues, tendons, and joints may occur.
- Unstageable: the base of the sore is covered by a thick layer of other tissue and pus so that the depth and stage is undeterminable.

Allegations

The OIG's Hotline Division received the following allegations in May and August 2013:

- A patient received poor care during hospitalization and as a result, acquired a Stage III pressure ulcer on his sacrum and coccyx.
- Nursing staff were rude, and reported inaccurate and inconsistent information to the family regarding the patient's health status.
- Physicians did not return phone calls to the family, and did not consistently communicate changes in the patient's condition to the family.
- Facility staff members expressed concerns to the patient's family regarding physician staffing levels (coverage) in the context of alleged difficulty in communicating with house staff (physicians-in-training).
- Facility staff members expressed their concerns to the patient's family regarding inadequate nurse staffing levels.
- Facility staff members mishandled and lost the patient's personal belongings and valuables.
- The facility did not provide current health records prior to transferring the patient to a private rehabilitation center.

Scope and Methodology

We conducted a site visit during the week of August 12, 2013. We interviewed facility leadership, clinical providers, facility managers, and other employees with direct knowledge of the patient's care. We reviewed the patient's electronic health record (EHR) documentation, Patient Advocate Tracking System reports, VHA and facility policies, peer reviews, staff competency and training folders, staffing methodology statistics, and other documents pertinent to the allegations.

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 was a male veteran in his late sixties with multiple medical conditions, including: chronic heart failure, chronic kidney disease, coronary artery disease, peripheral vascular disease, diabetes-type II, diabetic neuropathy, and diabetic foot ulcers. He had had a previous right below-the-knee amputation in December 2009, and a cerebral vascular accident in 2012.

The patient had long-standing circulation problems in his left leg. Numerous interventions from December 2012 to April 2013 were unsuccessful in preserving the integrity of the patient's left foot. When the patient returned to the facility for follow-up assessments of his left leg and foot condition in April 2013, he was diagnosed with a plantar ulcer[2] with necrosis (dead tissue) and suspected sepsis,[3] and was admitted to an inpatient medical unit at the facility. Admission nursing notes documenting a skin assessment do not include a reference to breakdown in the sacrum or coccyx area and indicated that the patient was not at high risk for developing pressure ulcers.

On hospital day (HD) 2, the patient had a guillotine amputation[4] of the left foot and ankle, the first of a two-part limb amputation. The patient's EHR reflected that directly following this procedure, the patient was transferred back to the medical unit. On HD 10, the patient had a below the knee amputation of the left leg, and was transferred to the intensive care unit (ICU). He remained in the ICU for 2 days.

On HD 12, the patient was transferred back to the same medical unit in stable condition. On HD 13, the patient was moved to the ICU because of low urinary output and recurring episodes of low blood pressure. It was determined that the patient needed hemodialysis[5]. On HD 14, the patient was intubated[6] and placed on a ventilator due to acute respiratory distress. Hemodialysis was performed daily for 2 days.

Attempts to wean the patient from the ventilator were successful, and on HD 18, the patient was removed from the ventilator. On HD 20, the patient was transferred from the ICU back to the medical unit from which he had been transferred.

On HD 22, while still on the medical unit, the patient's respiratory condition once again began to deteriorate. The patient was intubated, transported to the ICU, and placed back on a ventilator. On HD 24, the patient underwent bilateral thoracenteses (removal of excess fluid from the chest cavity). On HD 25, a percutaneous endoscopic gastrostomy[7] tube was placed for nutritional support.

[2] A plantar ulcer is a deep ulcer on the sole of the foot often resulting from repeated injury because of lack of sensation.
[3] Sepsis is a potentially life-threatening blood infection.
[4] Guillotine amputation is an emergency removal of a limb, with the surgical site left open.
[5] Hemodialysis is a process that uses a man-made membrane (dialyzer) to remove wastes from the blood, restore the proper balance of electrolytes in the blood, and eliminate extra fluid from the body.
[6] Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway.
[7] A percutaneous endoscopic gastrostomy tube is a feeding tube placed into the stomach through the abdominal wall.

On HD 35, a wound care specialist was consulted. Documentation in the EHR reflected that the patient had an "unstageable" pressure ulcer on the sacrum/coccyx, and that the wound was covered with black eschar.[8] Specific orders for repositioning the patient, dressing changes, and wound care were given. On HD 36, a critical care surgeon documented that the patient's sacral pressure ulcer might need surgical debridement. On HD 38, the patient was seen by a plastic surgeon, who felt that the patient was not a candidate for surgical intervention at that time.

Attempts to wean the patient from the ventilator were unsuccessful and on HD 42, the patient had a tracheostomy[9] tube inserted for long term airway management. By HD 73, the patient was successfully weaned from the ventilator.

On HD 80, the patient was transferred by ambulance to a private rehabilitation center in Alabama.

Inspection Results

Issue 1: Poor Patient Care

We substantiated that the patient developed a stage III-IV pressure ulcer, later deemed unstageable, on his sacrum and coccyx while hospitalized at the facility.

We reviewed EHR documentation of the patient's skin condition and actions taken to prevent and/or heal pressure ulcers. We found that a template note was used on the medical unit, and documentation of the presence and severity of pressure ulcers and actions taken to prevent and treat the patient's pressure ulcers was inconsistent, making it difficult to ascertain when and where the pressure ulcers developed and what was done for the patient in this regard. The patient's EHR reflected skin breakdown only on the patient's foot upon admission with documentation of an ulcer in the sacrum and coccyx area later during his hospitalization.

Issue 2: Ineffective Communication

Family Communication. We substantiated that staff and physicians provided neither accurate nor sufficient information about the patient to the patient's family.

VHA policy[10] states that staff may disclose individually identifiable information including health information to next-of-kin, family members, and others with a significant relationship to the individual to whom the information pertains, without authorization, when in the best interests of the individual. The disclosure must be limited to information directly relevant to the requestor's involvement with the individual's health care.

[8] Eschar is considered nonviable, dark, crusty, dead tissue.
[9] A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is usually placed through this opening to provide an airway and remove secretions from the lungs.
[10] VHA Handbook1605.1, Privacy and Release of Information, May 17, 2006.

Members of the patient's family stated that they were given incorrect information about whether or not the patient had undergone a thoracentesis. We interviewed a staff member that recalled talking to the patient's family and inadvertently giving them erroneous information regarding a thoracentesis procedure the patient had recently undergone.

The family also stated that they were not notified, as requested, if the patient was transferred from one hospital location to another or needed new treatments. When the patient required hemodialysis, the EHR reflected that the attending physician made multiple unsuccessful attempts to reach the patient's family to discuss the patient's condition and to obtain consent for the hemodialysis. As previous conversations were understood by the patient's physician to mean that the family wished for all treatment to be continued, informed consent was obtained from the patient and hemodialysis was initiated.

When the patient was transferred from ICU to the medical unit on HD 12, nursing documentation indicated that the attending physician was made aware of the family's standing request to be contacted for any changes in the patient's condition or when transferring the patient to another unit. We found no evidence that the family was contacted prior to moving the patient to the medical unit on HD 12.

We did not substantiate the allegation that facility staff members expressed concerns to the patient's family regarding physician staffing levels and physicians not returning their phone calls.

A staff member recalled asking the weekend on-call resident assigned to the patient to contact the patient's family as had been requested, and provided the resident with the contact information. When the staff member asked the resident later in the day if he had contacted the family, he said he had not. The staff member did not take further action, such as contacting the patient's attending physician. We were told that when management became aware of the family's frustration in regard to the frequency and accuracy of communications by the facility, a nurse practitioner in Surgical Services was designated as the contact person for the family, and attempted to keep them apprised of the patient's condition.

Nursing and physician staff described widely varying approaches used when discussing a patient's condition over the phone. Some staff members we interviewed expressed frustration with the lack of consistency between staff regarding processes for release of information about inpatients. Facility leadership told us that they did not have a facility-wide process in place for release of patient information in a secure manner until just prior to our visit. They presented a policy for secure sharing of patient information to us while we were on site.

Rude Staff. We did not substantiate the allegation that staff nurses were rude to the family members during the patient's hospitalization. Review of patient advocate reports for the first 3 quarters of FY 2013 did not reveal any complaints of ICU staff rudeness.

Issue 3: Staffing

We did not substantiate the allegation that facility staff members expressed concern to the patient's family regarding inadequate nurse staffing levels.

The staff we interviewed did not recall discussing staffing levels with the patient's family. Furthermore, none of the nursing staff felt that staffing was inadequate. We evaluated staffing levels in the ICU for the 6 months prior to our inspection visit and found that recommended staffing levels were consistently maintained and the methodology used was consistent with VHA guidelines. Additionally, a recent evaluation of nurse staffing on three inpatient units done as a part of the Combined Assessment Program (CAP) Review of the facility (*Combined Assessment Program Review of the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 13-01972-284, August 19, 2013) showed that staffing levels met or exceeded targets.

Issue 4: Loss of Personal Property

We substantiated that facility staff failed to properly document, track, and protect the patient's personal belongings, resulting in loss of some of the patient's clothing, personal items, a wallet, and the temporary loss of the patient's motorized wheelchair.

Local policy requires that Health Administrative Service (HAS) inventory and secure non-ambulatory patients' belongings. Belongings are to be listed, labeled, and placed in an envelope. A receipt is placed on the patient chart, and the patient's belongings are stored in a secure area. If HAS staff is not available, nursing staff are to perform these functions. EHR documentation by nursing staff regarding the patient's personal belongings is summarized in Table 1.

HD #	Unit Transferred From/To	Documentation of the Disposition of the Patient's Personal Belongings
Admission	Admitted to medical unit	1 red motorized wheelchair (placed in cast room), 1 short sleeve green shirt, 1 pair of blue jean shorts, 1 pair black orthopedic shoes, 1 black cell phone, $53.95 cash, and 1 red credit card
10	Medical unit to surgery to ICU	No documentation in the EHR regarding disposition of the patient's personal property
12	ICU to medical unit	EHR documentation in the transfer summary from ICU to the medical unit indicated "none" for disposition of patient belongings
13	Medical unit to ICU	EHR documentation stated that "vet received from unit with no valuables or clothing." Another note stated "clothing room" for disposition of patient belongings. A third note stated that "no personal belongings arrived with pt [patient] from 4A"
20	ICU to medical unit	No documentation in the EHR regarding disposition of the patient's personal belongings

22	Medical unit to ICU	EHR documentation indicated that there were, "no personal effects noted" for the patient
80	Discharged from the ICU to private rehabilitation center	EHR documentation included: 1 prosthetic limb with shoe (black), 1 aluminum cane (copper brown), 2 cell phones, 1 charge card, 1 pair black frame glasses, 1 black ortho shoe, 1 beige stump sock, 1 pair jean shorts, 1 brown belt, 1 green pullover shirt (short sleeve), 1 pair underwear, 1 Bluetooth, 8 quarters, 2 nickels, 1 dime, and no wallet among the things brought to the ICU. A nursing discharge summary, written later the same day, stated that the patient has no specialty equipment to be returned to him.

Table 1. Documentation of the Disposition of Patient Belongings

The facility was not aware that the patient's motorized wheelchair had been misplaced until we brought it to their attention. At the time of our visit, the wheelchair was located in a storage room on one of the medical units. The facility agreed to have the wheelchair delivered to an address provided by the patient's son.

Facility staff gave contradictory information regarding the process for inventory, tracking, and management of the patient's personal belongings. Documentation of the disposition of the patient's personal belongings in the EHR was inconsistent. Some staff members used a template note for documentation of disposition of personal belongings, while others made an entry into nursing transfer notes. A consistent process to account for clothing items stored in the facility "clothing room" was not in place. Additionally, we noted that while there was a process for inventorying, documenting, labeling, and storing personal property, including money, jewelry, and other valuables, staff was confused as to which staff was responsible for carrying out the process.

Issue 5: Transfer of Patient Information

We did not substantiate that the facility failed to provide current health records to the private rehabilitation center where the patient was transferred upon discharge.

Facility staff members involved with the patient's transfer stated they faxed the last three days of the patient's hospitalization records to the center and provided copies to the patient on the day of transfer. They stated they were in contact by phone with the rehabilitation center's transfer coordinator. We made multiple attempts to reach the rehabilitation center's admissions coordinator and director, but neither responded to our requests for information. While we were on site, the facility's risk manager contacted the rehabilitation center and requested copies of the health records sent by the facility to verify what information was provided. The rehabilitation center did not respond to follow-up phone calls or emails, and did not provide the requested documents.

Conclusions

We substantiated the allegation that the patient developed stage III-IV pressure ulcers on his sacrum and coccyx during his hospitalization.

Documentation of measures taken to prevent and/or treat pressure ulcers was inadequate. While we were onsite, the facility provided documentation about recent actions taken to improve the pressure ulcer prevention and monitoring program. These actions were in response to findings and recommendations from a recent CAP visit. Since the facility is in the process of improving this program, and progress will be monitored through CAP follow-up processes, we made no recommendations in this area.

We substantiated that facility staff and physicians failed to effectively communicate with the patient's family regarding the patient's condition and treatment needs.

We did not substantiate that staff members were rude or that they expressed concern regarding inadequate staffing levels. We found that staffing levels in the ICU met or exceeded target levels.

We substantiated that facility staff did not securely safeguard or retrieve the patient's personal belongings during the patient's hospitalization.

We did not substantiate the allegation that the facility did not provide the private rehabilitation center with current patient health records. The facility provided the last three days of hospitalization records to the admissions coordinator at the receiving facility, and was in contact with the rehabilitation center's transfer coordinator during the discharge process.

Recommendations

1. We recommended that the Facility Director ensure that a process is in place to assure that patient information is shared with patients, families, and significant others in an appropriate manner that protects patient privacy.

2. We recommended that the Facility Director ensure that processes be strengthened for inventory, documentation, storage, and retrieval of patient belongings, and that compliance is monitored.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 22, 2014

From: Director, Veterans Integrated Service Network (10N7)

Subject: **Draft Report -** Healthcare Inspection - Alleged Lapses in Communication and Poor Quality of Care, Charlie Norwood VA Medical Center, Augusta, GA

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

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

1. I have reviewed the draft report and concur with Augusta's actions for improvement. The VISN will monitor and ensure improvements are implemented and sustained.

2. If you have any questions please contact Robin Hindsman, VISN 7 QMO at 678-924-5723.

(original signed by:)

Charles E. Sepich, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 10, 2014

From: Facility Director, Charlie Norwood VAMC (509/00)

Subject: **Draft Report—** Healthcare Inspection - Alleged Lapses in Communication and Poor Quality of Care Concerns, Charlie Norwood VA Medical Center, Augusta, GA

To: Director, VA Southeast Network (10N7)

1. I have reviewed the draft report and concur with the report's recommendations.

2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations. If you have any questions, please contact Kimberlie Denmark, RN, Chief, Quality Management Service, at 706-733-0188, extension 2447.

Robert. U. Hamilton, MHA, FACHE

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 Facility Director ensure that a process is in place to assure that patient information is shared with patients, families, and significant others in an appropriate manner that protects patient privacy.

Concur

Target date for completion: March 31, 2014

Facility response:

- The facility developed a policy entitled "Pass Code for Sharing of Patient Information" (Medical Center Policy Memorandum No. 116-13-07, dated 8/6/13) which provides the staff with a process for sharing patient information with patients, families and significant others without violating the patient's privacy rights.

- The policy was approved through facility committees and forwarded to service chiefs for staff education.

- The facility is rolling out a new patient centered care initiative in February 2014. The emphasis of this initiative will be communication between caregivers and patients/families. Facility leadership will focus on the engagement of staff with patients and families throughout the facility.

Recommendation 2. We recommended that the Facility Director ensure that processes be strengthened for inventory, documentation, storage, and retrieval of patient belongings, and that compliance is monitored.

Concur

Target date for completion: February 28, 2014

Facility response:

- Health Administration Services (HAS) has reviewed and revised the standard operating procedure, Ward Administration/Admissions/SCIU Receipt and Disposition of Patient Effects and Valuables, to ensure patient's effects and valuables are secured and returned to the patient.

- Medical Center Policy Memorandum No. 116-12, Patient Clothing, Effects and Valuables, was reviewed to reflect consistency with the revised standard operating procedure and revisions to be approved through facility committee.

- Staff will be re-educated on the standard operating procedure and medical center policy memorandum.

- Reviews of admissions/discharges will be conducted to monitor compliance with the established policy and procedure for the receipt and disposition of patient effects and valuables.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Darlene Conde-Nadeau, MSN, ARNP, Team Leader Carol Torczon, MSN, ACNP Dr. George Wesley, M.D. Jackelinne Melendez, Program Support Assistant

Appendix D

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