Administrative Closure
Alleged Mismanagement of Care and
Lack of Administrative Action
Robert J. Dole VA Medical Center (589A7/00)
Wichita, Kansas
MCI# 2012-03487-HL-0417

Purpose:

The VA Office of Inspector General Office of Healthcare Inspections received allegations regarding the quality of care at the Robert J. Dole VA Medical Center (facility) in Wichita, KS. Complainants stated the allegations were examples of facility and Veterans Integrated Service Network (VISN) 15 senior leaders' lack of action to correct deficiencies.

Background:

In June and July 2012, several complainants submitted allegations to the OIG Hotline Division regarding administrative and quality of care concerns at the facility. They alleged facility leaders were ineffective and did not implement corrective actions to improve patient care when necessary. They alleged VISN 15 leaders were aware of many of the cited facility problems, had done nothing to correct them, and directed facility staff to not report their concerns to the OIG.[i]

The allegations, summarized, include:

- Delay in patient transport to the Emergency Department (ED) from a private vehicle.
- Inadequate triage in the ED.
- Disregard of advance directives requests.
- Registered Nurses (RNs), as opposed to pharmacists, were routinely obtaining and dispensing medications after hours (when the pharmacy was closed).
- Lack of policy for scanning documents into the Electronic Health Record (EHR).
- Ineffective senior level facility leadership.
- Discouragement of reporting adverse events by the VISN.
- Delay in surgery due to lack of attending surgeon coverage.

We conducted an initial site visit July 31–August 3, 2012 and another on November 4–5, 2013. We interviewed the complainants, facility clinical and administrative staff, patients and their caregivers, and VISN and facility senior leaders.[ii] We reviewed medical and administrative records, quality management documents, and facility and VHA policies and procedures. Of note, between the visits, a new Associate Director of Patient Care/Nurse Executive, Quality Manager, and facility Director were appointed.

Patient transport to the ED from a private vehicle.

We substantiated that transport from a car in the facility's parking lot into the facility's second floor ED was inefficient and delayed in the case of an unconscious and apneic patient. However, despite the delay, we did not substantiate that the patient died as a result of this delay.

While we did not determine an unconscious and apneic patient driven to the facility died as a result of a delay getting him from the car to the ED,[iii] [iv] we found that facility staff did not know who was responsible to assist patients from vehicles and who was responsible for calling 911. We found the local relevant policy was unclear.[v] During our follow-up visit, we found that facility staff were revising local policies and employees were being retrained.[vi]

Inadequate patient triage in the ED

We substantiated the allegation that a patient who presented to the facility's ED with chest pain was not seen or triaged by an RN as required and that a check-in desk staff referred him to his Community-Based Outpatient Clinic (CBOC) primary care provider (PCP).

A patient reported that on the morning of March 27, 2012, he awoke with chest pain and thought he was having a "heart attack." A friend drove him to the local non-VA ED. The patient reported that after the local hospital staff assessed him, he was told that he had an irregular heartbeat and a muscle cramp in his chest and that he should report to his PCP. His friend then drove him the 81 miles to the facility's ED. We interviewed the patient and his friend, who stated that no one, other than a person at the desk, talked to them when at the facility's ED.[vii] According to the patient's EHR, the patient was next seen by an RN at the Hutchinson, KS, CBOC later that same day and the patient's PCP examined the patient, who was then transported by emergency medical services to a local, non-VA hospital.[viii]

During our initial site visit, we learned patients' first ED staff encounters were with ED clerical staff and not a triage RN. During our follow-up visit, we learned the facility had hired RNs to perform ED patient triage as required.[ix]

Disregard of patients' advance directives requests

We substantiated that providers did not follow Advance Directive (AD) and DNR protocols.

We reviewed the EHR of a patient identified by a complainant and found the patient had requested full code status, but that family members disagreed.[x] However, the patient's code status was changed to DNR after a family member was appointed to make the patient's health care decisions. The patient died in January, 2012.[xi]

During our initial site visit, we found factors that contributed to the facility's failure to honor the patient's requested code status included 1) the AD document was not scanned into the EHR, 2) providers' did not verify or update the AD during any admission to the facility, and 3) provisions to contact the facility's Ethics Committee or the Chief of Staff (COS) were not made when the family member's health care decisions were contradictory to the patient's wishes.[xii] During our follow-up visit, we found the facility implemented a new DNR policy[xiii] [xiv], and a new AD policy was pending Regional Counsel's review and approval.[xv] There are also standardized AD and DNR process training courses in VA's Talent Management System that staff are required to complete.[xvi] Additionally, staff now monitor AD form scanning.[xvii]

After-hours pharmacy availability

We substantiated allegations that nurses were routinely obtaining medications from the pharmacy after-hours, nurses were completing medication orders after-hours, there was a lack of pharmacist availability after-hours, and the local pharmacy policy had not been updated.

After-hours Access: Pharmacy hours are 7:00 a.m. to 8 p.m. Monday - Friday, and 7:00 a.m. to 3:30 p.m. Saturday and Sunday. At the time of our initial review, the nurses-on-duty (NODs) routinely retrieved medications from the pharmacy at least every other night.[xviii] Pharmacy staff subsequently increased Pyxis® machine stock levels of frequently ordered medication, and NODs now only need to access the pharmacy after-hours 4–5 times over a 2-week time period.[xix, xx]

Medication Review Process: At the time of our initial review, a pharmacist did not review after-hours medication orders until the following day.[xxi] Although facility leadership had approved to contract with a pharmacy service to provide after-hours pharmacy services, the contract had not been implemented. The facility implemented the contract in November 2012.[xxii]

Pharmacist Availability: At the time of our initial site visit, there was no after-hours pharmacy on-call list. Pharmacists were not required to answer or return calls. During our follow-up visit, facility leaders told us that the facility was implementing new pharmacy processes that include extended pharmacy coverage of 16 hours each day and mandatory after-hours call for pharmacy staff. Both of these initiatives are tentatively scheduled to be in place by December 2013.[xxiii]

Pharmacy Policy: At the time of our initial review, the pharmacy service had a policy that generally outlined after-hours services, such as how to contact a pharmacist and how to obtain medications from the pharmacy. However, facility staff stated they were not aware of the policy and the policy had not been updated to reflect current Joint Commission standards. During our follow-up visit, facility leadership told us they were revising the local pharmacy policy to incorporate new processes that were being implemented, such as the extended pharmacy hours and mandatory call for pharmacists.[xxiv]

Electronic Health Record (EHR) scanning

We substantiated the allegation that there was a lack of a clear policy for scanning documents into the EHRs.

At the time of our initial review, we found a large backlog of documents waiting to be scanned and no policy clearly defined EHR scanning processes or responsibilities as required by VHA policy.[xxv][xxvi] During our follow-up visit, we found the facility eliminated the backlog after hiring additional scanning staff and purchasing additional scanning machines.[xxvii] A local policy now clearly defines scanning process and there is a monitoring system.[xxviii]

Ineffective senior level facility leadership

We substantiated the allegation of ineffective leadership of prior facility management.

Multiple leadership and management changes occurred between our visits. A new Associate Director of Patient Care/Nurse Executive was appointed in September 2012, a new Quality Manager in August 2013, and a new facility Director in October 2013.

Discouragement of reporting adverse events by the VISN

We did not substantiate the allegation that the VISN discouraged adverse event reporting.

Delay in surgery due to lack of attending surgeon coverage

We substantiated the allegation that there was a delay in diagnosis and treatment of a patient with an acute abdomen,[1] and we substantiated that this patient was kept at the facility without timely surgical evaluation or intervention before ultimately being transferred to a community hospital for appropriate care. Finally, while we found that the facility's listed surgeon-on-call was unavailable, as alleged; we did not substantiate that that was the sole or even primary cause of delay in diagnosis and treatment. We found several factors for the delay in addition to the inability to reach the on-call surgeon. Most notably was an apparent lack of discernment of the necessity of promptly getting a surgeon involved in the patient's care, and from this lack of discernment, a lack of aggressiveness in pursuing alternative routes to obtain surgical consultation when it was clear that the listed on-call surgeon was unavailable.

Case Review: A patient presented to the facility's ED at approximately 9:45 p.m., on June 20, 2012, with complaints of abdominal pain, nausea, vomiting and diarrhea of several hours duration. He was seen by the ED physician at 10:22 p.m. The overall clinical picture, as determined by history, physical examination, laboratory studies, and radiographic studies, was that of an early small bowel obstruction.[2] Although not documented in the electronic health record, the ED physician attempted to obtain a surgery consult. The listed surgeon-on-call was unavailable, and the ED physician did not pursue the matter. At 1:55 a.m., June 21, the patient was transferred from the ED to a cardiac monitored inpatient bed.

The patient's condition worsened. He developed a clinical picture consistent with peritonitis[3] and an acute abdomen.[4] The nocturnist (night physician) on duty also attempted to obtain a surgery consult. She, too, found that the surgeon-on-call was unavailable and, like the ED physician, did not pursue the matter. Due to a rapid heart rate accompanied by a generally deteriorating overall condition, including elevated blood pressure and increasing abdominal pain, the patient was transferred to the Medical Intensive Care Unit (MICU) at 5:10 a.m. The Surgery Service was consulted, and the surgery resident evaluated the patient at 9:07 a.m., June 21. The surgery resident "recommend[ed] transfer to OSH [outside hospital] for further surgical evaluation as there are no staff surgeons available at the VA today." At 11:41 a.m., on June 21,

[1] "The acute abdomen may be defined generally as an intra-abdominal process causing severe pain and often requiring surgical intervention. It is a condition that requires a fairly immediate judgment or decision as to management." See http://www.ece.ncsu.edu/imaging/MedImg/SIMS/Module2/GE2_4.html (accessed 2/28/2014)
[2] In addition to the symptoms of abdominal pain, nausea, vomiting, and diarrhea, the patient's abdomen was diffusely tender, and he had an elevated white blood cell count, mildly elevated lipase and amylase, and dilated loops of small bowel on both plain film x-ray and CT scan.
[3] Inflammation of the lining of the abdomen.
[4] Tachycardia, sharp, cramping, severe abdominal pain with nausea, vomiting, and loose stools, with rebound tenderness and guarding on examination.

2012, the patient was transferred to Wesley Medical Center where he underwent multiple surgeries, included a resection of an ischemic small bowel.[5] On June 27, 2012, the patient was readmitted to the facility for continued care, and he presently receives care there.

Issues—Clinical Care: This case revealed several issues. There was an inability by both the ED physician and the nocturnist to locate the surgeon-on-call. It was later determined that the listed surgeon-on-call was not in Wichita and the schedule was inaccurate. However, either the ED physician or the nocturnist could have called the University of Kansas Medical School/Wichita surgery resident who was on rotation at the facility to activate the surgery chain-of-command or the Chief of Staff. Either could have initiated transfer out of the facility based upon their assessments. The early morning transfer to MICU indicates that the nocturnist understood how gravely ill the patient was. The patient's underlying disease process was clearly intra-abdominal, and therefore, it is perplexing as to why she did not, in the face of the inability to locate the surgeon-on-call, take other measures.

Issue—Quality Management: One peer reviewer (b)(3):38 U.S.C. 5705
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Current status: An OHI medical consultant followed up on this case. Since the time of the incident numerous steps have been taken to improve the accuracy of the surgeon-on-call schedule. The schedule is updated and validated both the day before call and the day of call. A back-up surgeon-on-call is now listed, and the Chief of the Surgery Service's telephone number is included on the call schedule. Likewise, the facility's senior nurse-on-duty has all facility contact information at his/her fingertips. At the time of this incident, only the Surgery Service secretary had access to the call schedule in order to make updates. This has been expanded to permit easier updating and accuracy of the call schedule. OHI's medical consultant was also informed by the Chief of Staff that this case and its management has been reviewed with the ED physician, the nocturnist, and the other physicians involved in the patient's care.

Disposition:

During our initial site visit, we substantiated several of the original allegations. Since that time, the facility has acquired new executive leadership and multiple process changes. During our follow-up site visit, we found that the new executive leadership was committed to making necessary changes and that facility staff had implemented multiple action plans to correct many

[5] Ischemic small bowel occurs when arteries to the intestines are narrowed or blocked, reducing blood flow. Decreased blood flow can cause pain and sudden loss of blood flow and is an emergency requiring immediate surgery. See http://www.mayoclinic.org/diseases-conditions/intestinal-ischemia/basics/definition/con-20023818 (Accessed 2/298/2014)
[6] VHA Directive 2010-025, June 3, 2010

of the issues we identified during our initial site visit. Because the facility completed appropriate actions and is also implementing ongoing process changes, I am administratively closing this case.

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