DR 2010-417

Appeal-claim denied 10/16/09

Department of Veterans Affairs
Office of Inspector General
Office of Healthcare Inspections
MCI#2009-01813-HL-0897/HI-0001
August 27, 2009 updated October 5

On July 31, 2009, the VA Office of Inspector General Hotline Division received an e-mail from [(b)(3):5 U.S.C. App 3 (IG Act);] concerning patient care on the nursing home care unit at the New Jersey Healthcare System, Lyons Campus. The complainant alleged that patients died because of employee misconduct and/or negligence. However, she did not provide any patient names. On August 3, Hotline staff e-mailed the complainant and requested the full names and last four digits of the patients' social security numbers she referred to in her e-mail.

The complainant did not respond to the Hotline e-mail request. On August 5 OIG investigators interviewed the complainant at her residence. The complainant provided the names of 7 patients whose deaths she believed were preventable. However, she told the investigators she was too busy to talk with them but that she would provide Hotline with patient identifiers by August 14.

On August 15, because the complainant did not provide additional information to hotline, OIG investigators again interviewed her at her residence. However, she was only able to provide limited information on the 7 patients. She did not have the SSNs for any of the patients, had only the last name for 2 patients, and date of death for 3 patients. Despite the limited information, an OHI physician and registered nurse, using CAPRI, believe they correctly identified 6 of the 7 patients. A patient with the same last name as the complainant's seventh patient , a Viet Nam era veteran, was identified, but this patient's clinical characteristics did not match the complainant description.

Following is the review of the seven patients treated at the New Jersey Healthcare System, East Orange and Lyons campuses

1. [(b)(3):38 U.S.C. 5701. (b)(6):]. Patient died July 18, 2009. He allegedly "needed a tracheostomy that he didn't received while at VAMC Lyons." CAPRI review revealed [(b)(3):38 U.S.C. 5701 (b)(6):] [(b)(3):38 U.S.C. 5701.(b)(6):]. Pulmonary function tests (PFTs) in September 2008 revealed "severe reduction in pulmonary function."

   Transferred from Lyons to East Orange, where on July 16 a pulmonary consultant wrote, "end-stage COPD at baseline, would re-address end-of-life issues with pt and family." No mention of tracheostomy.

   Transferred back to Lyons July 17. Physician assistant wrote, "...this patient would probably benefit from a trach..." In the Physician Long Term Care Note entered by [(b)(6):] [(b)(6):] the Assessment and plan states, "follow up with pulmonologist to evaluate for

10-11-

Transferred back to Lyons July 17. Physician assistant wrote, "...this patient would probably benefit from a trach..." In the Physician Long Term Care Note entered by [redacted] the Assessment and plan states, "follow up with pulmonologist to evaluate for alternative treatment, eg trach to see if trach can help in this severe lung parenchyma disease nurse frequent monitor q30min to make sure that he is on O2 and pulse Ox is optimal."

Conclusion: Tracheostomy was described by a physician assistant as probably beneficial, but the attending physician referred to it only as a possible option. A pulmonary consultant who saw the patient two days before his death made no mention of a tracheostomy. It is very unlikely that a tracheostomy would have been of any benefit to this patient.

2. [redacted] This is a patient who "died approximately ten to twelve years ago because he needed a tracheotomy at VAMC Lyons and there was no doctor available to perform the procedure." CAPRI review shows a [redacted] who died 7/17/2000 and for whom there are only two outpatient notes, no consults or inpatient notes, and no mention of lung disease.

CAPRI review also revealed [redacted] who died 10/19/1987. No progress notes or problem lists are present in CAPRI. Limited x-ray data include an abnormal abdominal CT scan (Aug 1986: kidney mass).

Conclusion: We found no patient with a condition consistent with the allegation; electronic medical records are very limited for patients treated in the 1980s.

3. [redacted] patient who "was found dead in his room at 6AM one morning after it appeared he bad been ignored by staff because they thought of him as a "troublemaker" reporting perceived misconduct." CAPRI review reveals [redacted] who died 8/27/2005. The discharge diagnosis at the time of [redacted]'s death was "advanced chronic obstruetive pulmonary disease [COPD] with chronic respiratory failure." On 8/17/2005 a physician wrote, "do not intubate and do not resuscitate [DNR] orders are active." The last progress note prior to the patient's death was entered on 8/24/2005.

Conclusion: We are unable to substantiate or refute that the staff neglected this patient, but note that no resuscitative efforts would have been instituted because of his DNR status.

4. [b;(3;38 U.S.C. 5701] No specific allegation was made, but it was implied that the patient had been neglected. Electronic medical records revealed that [b;(3;38 U.S.C. 5701] was treated at Lyons VAMC for severe COPD and chronic pain. He was found unresponsive at approx. 4:00 am on August 9, 2001. Resuscitative efforts (including intubation & defibrillation) were unsuccessful. The patient had medications ordered to be administered every six hours. A note by a physician assistant on August 6 states " pt still c/o back pain which is helped with Percocet." CAPRI and CPRS documentation is inadequate to show actual medication administration. However, nursing documentation reveals that patient assessment and monitoring was occurring 2-3 times daily on August 7-8.

   Conclusion: No evidence of poor quality of care was identified.

5. [b;(3;38 U.S.C. 5701], a patient who "may have died because he was left unattended." CAPRI review reveals [b;(3;38 U.S.C. 5701] who died 11/12/2005. [b;(3;38 U.S.C.] was a paraplegic (following a fall) and also had bipolar and schizo-affective disorders, and congestive heart failure. Autopsy revealed "aspiration of gastric contents with congestive heart failure."

   Conclusion: No evidence of poor quality of care was identified.

6. [b;(3;38 U.S.C. 5701] a patient on the psychiatric unit who had reportedly accused a VAMC employee of physical abuse. No specific quality of care allegation was made. CAPRI review found [b;(3;38 U.S.C. 5701], a patient with dementia and congestive heart failure who had a tracheostomy, was bed-bound, and was receiving nutrition by gastric tube. He was transferred to East Orange on March 7, 2003, with profound dehydration. He died March 22, 2003.

   Conclusion: This patient's profound dehydration raises the question of whether he was receiving adequate water through his gastric tube. Assessment of this aspect of care would require review of nursing documentation not available in CAPRI or CPRS. Extensive attempts to recover archived paper records were unsuccessful in retrieving records covering March 2003.

7. [b;(3;38 U.S.C. 5701], patient who allegedly committed suicide while an inpatient. CAPRI review revealed no patients with this or similar name. [b;(3;38 U.S.C. 5701] born in 1945, died 1/14/1993; however, this patient was not treated as an inpatient and had no psychiatric diagnosis.

   Conclusion: No evidence of poor quality of care was identified.

Patricia Christ, RN
Jerome Herbers, MD