Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04491-394

Healthcare Inspection

Communication and Quality of Care Concerns
VA Black Hills Health Care System
Fort Meade, South Dakota

July 8, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review in response to correspondence from former Senator Tim Johnson in which a complainant alleged a lapse in communication with a patient's family and that the same patient was provided poor quality of care at the VA Black Hills Health Care System (system), Fort Meade, SD.

The complainant alleged that in fall 2013, a patient was inappropriately discharged from the system where he was admitted for 24-hour observation one morning, sent home that same evening, then admitted with a stroke to a non-VA community hospital the next day.

The complainant also alleged that system staff failed to notify the patient's wife when, in spring 2014, while the patient was recovering from surgery at the system's Community Living Center, his condition worsened, and after being assessed in the system Emergency Department, he was transferred to a non-VA community hospital.

While in the non-VA community hospital, staff found an abscess under a drain tube. The complainant alleged that system staff failed to act on the patient's complaint of an odor arising from a drain tube and failed to clean the area around the site.

While we substantiated that the patient was discharged from the system in fall 2013 and admitted to a non-VA community hospital with multiple medical problems the following day, we did not find that the patient's discharge from the system was inappropriate.

We substantiated that in spring 2014, system staff documented appropriate family notification when the patient was transferred from the Community Living Center to the Emergency Department. However, we did not find documentation that the patient's family was notified as required when he was transferred from the Emergency Department to a different facility.

We did not substantiate quality of care concerns related to the presence of an abscess and the failure of system staff to clean the area around his drain tube despite the presence of an odor. We found nursing staff documentation of daily assessments of the tube insertion site and subsequent wound care.

We recommended that the System Director strengthen processes to ensure families or caregivers are notified when patients are transferred to new locations of care.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 7–9 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 a review in response to correspondence from former Senator Tim Johnson in which a complainant alleged a lapse in communication with a patient's family and that the same patient was provided poor quality of care at the VA Black Hills Health Care System (system), Fort Meade, SD. The purpose of this review was to determine if the allegations had merit.

Background

The system is part of Veterans Integrated Service Network (VISN) 23 and has divisions at Fort Meade and Hot Springs, SD. The system provides primary and secondary medical and surgical care, residential rehabilitation treatment program services, extended nursing home care, and tertiary psychiatric inpatient care. The Fort Meade division has an Emergency Department (ED), medical/surgical beds, a Medical/Surgical Intensive Care Unit, mental health beds, and two Community Living Centers (CLCs). The Hot Springs division provides inpatient acute medical and CLC patient services and has an Urgent Care Center (UCC) that is open 24 hours a day, 7 days a week. The division does not provide surgical care.

Allegations

A letter was submitted to former Senator Johnson (and concurrently to the OIG) by a complainant alleging system failure to communicate with a patient's family and provide quality care to the patient.

The complainant alleged that a patient was inappropriately discharged from the system in fall 2013. Specifically, the complainant reported that the patient had been admitted for 24-hour observation one morning but sent home the same evening and was subsequently admitted with a stroke to a non-VA community hospital the next day.

Further, in spring 2014, while the patient was recovering from surgery in the system's CLC, his condition deteriorated, and he was transferred to a non-VA community hospital. The complainant alleged that (1) system staff failed to notify the patient's wife of the transfer—instead, the patient's roommate contacted her; (2) system staff failed to act on the patient's complaints of an odor arising from a drain tube under which the non-VA community hospital identified an abscess; and, (3) system staff failed to clean the area around the patient's drain tube despite the presence of an odor.

Scope and Methodology

We reviewed the system's processes related to the provision of care for the single patient identified in the allegation for the period from fall 2013 to spring 2014.

We reviewed relevant Veterans Health Administration (VHA) policies, the patient's electronic health record (EHR), and the patient's non-VA medical records.

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

In fall 2013, the patient presented to the system's ED with complaints of a change in mental status. He was in his mid-60s with a medical history of diabetes mellitus,[1] benign prostatic hyperplasia,[2] Barrett's esophagus,[3] high blood pressure, and chronic kidney disease; he had been receiving his primary care through the system for more than 10 years.

A computed tomography (CT) scan of the head was ordered and reviewed by the ED physician who, according to the EHR, determined the CT scan did not identify acute pathology, documented a normal neurological exam, and admitted the patient for a 23-hour medical observation stay.[4] Blood tests and a urinalysis demonstrated a mild increase in the patient's creatinine[5] but were otherwise unremarkable. The patient was discharged the following day. While the provider's discharge note does not document a neurological exam, a nursing note on the day of discharge indicated that the patient was oriented and appropriately responsive.

The patient's wife contacted emergency medical service (EMS) the next day, stating that the patient was unresponsive. EMS transported the patient to a non-VA community hospital, where he was admitted to the intensive care unit. Outside records indicated that his white blood cell count was elevated at 18,000 cells per cubic millimeter of blood (normal range 4,500–10,000; elevated counts can be indicative of infection), and his chest x-ray and blood tests were consistent with congestive heart failure. Admitting physicians suspected that the patient had systemic inflammatory response syndrome[6] caused by an infection of the urinary tract. The non-VA community hospital records did not support the diagnosis of a stroke as alleged by the complainant; rather, the patient's unresponsiveness was attributed to a severe infection and resolved with treatment of the infection.

In early spring 2014, the patient was admitted to a non-VA community hospital where he underwent resection of a mass extending from the stomach into the duodenum. The patient subsequently developed a small leak at the duodenal closure and, 3 days later, underwent re-exploration and placement of a T tube.[7] The patient also developed a

[1] Diabetes mellitus is a disease that affects how the body uses blood glucose (commonly called blood sugar) which is an important source of energy for the cells that make up the muscles and tissues.
[2] Benign prostatic hyperplasia is the noncancerous enlargement of the prostate gland in men.
[3] Barrett's esophagus occurs when the lining of the esophagus becomes damaged by stomach acid and becomes similar to the lining of the stomach.
[4] Medical observation stays are generally 23 hours or less and used to assist providers in determining if a patient needs to be admitted as an inpatient or can be discharged.
[5] Creatinine is a by-product of normal muscle contraction; creatinine levels may be used with results of other tests to evaluate kidney function.
[6] A systemic inflammatory response syndrome, also known as SIRS, can signal the presence of a serious underlying condition, including infection.
[7] A T-tube is a tubular device shaped like a "T" that is inserted through the skin into a cavity or wound to allow drainage and decompression.

duodenal cutaneous fistula (an abnormal passage between the intestines and the skin), which was expected to heal without further surgical intervention. Both the leak and the fistula are recognized complications of the patient's original procedure.

Following the hospitalization, the patient was admitted to the system's CLC for rehabilitation. During the patient's admission to the CLC, the patient received appropriate and timely care for symptoms related to a potential abscess and leak at the T tube site as discussed below.

While in the CLC, the patient developed nausea and vomiting. The Medical Officer of the Day (MOD) evaluated him and ordered a CT of the abdomen and pelvis, chest x-ray, electrocardiogram,[8] and several blood tests. He was transferred to the inpatient surgical ward. The CT demonstrated an abscess next to the duodenal stump thought to be suspicious for stump dehiscence (rupture of the suture line at the site of surgery). However, the patient had a normal white count and no fever, and the patient's EHR indicated clinical improvement. A subsequent T tube study showed no duodenal leak. Within 2 days of the transfer, the patient was tolerating clear liquids, was afebrile (no fever), had no complaints of abdominal pain, and had a normal white blood cell count (indicative of a lack of infection). He returned to the CLC the following day.

Upon arrival to the CLC, the patient's T tube was noted to be draining brownish, green material. Between CLC day 1 through 4, nursing notes documented continued drainage but noted the patient was afebrile and generally doing well. Nursing skin care notes reflect daily assessment and cleaning of the insertion site for both tubes. On CLC day 3, a nursing note described "bile colored odorous fluid" but that the patient was otherwise stable. On CLC day 5, the patient developed fever and left hip pain. Later that day, he became increasingly somnolent. CLC nursing staff called the MOD, and the patient was transferred to the ED where the MOD found the patient to be lethargic and barely responsive with fever greater than 102 degrees Fahrenheit. He discussed the case with the attending surgeon. Because of the high risk for sepsis and intra-abdominal abscess, the MOD transferred the patient from the ED to a community tertiary care hospital. Although the MOD did not document that he discussed the transfer to the community hospital with the patient's wife, one of the CLC nurses documented a call to the spouse notifying the wife that the patient had been taken to the system's ED for evaluation. At the non-VA community hospital, the patient was diagnosed with an intra-abdominal abscess. The non-VA community hospital physician placed a right upper quadrant drain with resolution of the abscess formation.

[8] An electrocardiogram (EKG) is a test used to assess the problems with the electrical activity of the heart.

Inspection Results

Issue 1: Alleged Inappropriate Discharge from the System

Quality of Care Concern

While we substantiated that the patient was discharged from the system and admitted to a non-VA community hospital with multiple medical problems the following day, we did not find that the patient's discharge from the system was inappropriate. The patient had previously received evaluations for a potential intra-abdominal abscess. The system monitored his white count and clinical status and ordered follow-up studies. Tests that were noted to be abnormal at the non-VA community hospital were recorded as normal prior to the patient's discharge from the system, and according to the patient's admission history and physical at the non-VA community hospital, the patient's mental status did not decline until after discharge from the system.

Issue 2: Alleged Poor Post-Operative Care at the CLC Following Resection of an Intestinal Tumor

Communication with Family

VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007[9], states that the facility (system) director is responsible for ensuring that "efforts are made to keep the family and other caregivers informed regarding transfer plans…." We found that system staff documented appropriate family notification when the patient was transferred from the Community Living Center to the Emergency Department. However, we did not find documentation that the patient's family was notified as required when he was transferred from the Emergency Department to a different facility.

Quality of Care Concerns

We did not substantiate quality of care concerns related to the presence of an abscess and the failure of staff to clean the area around the drain tube despite the presence of an odor. We found nursing staff documentation of daily assessments of the tube insertion site and subsequent wound care. Nursing notes record the presence of drainage from the patient's T tube and specific characteristics of the drainage, including odor, as well as evidence of the patient being assessed for infection, and notification of the provider when the patient's status deteriorated.

Conclusions

While we substantiated that the patient was discharged from the system in fall 2013 and admitted to a non-VA community hospital with multiple medical problems

[9] This Directive expired May 31, 2012 and has not yet been updated.

the following day, we did not find that the patient's discharge from the system was inappropriate.

Our review of the patient's EHR revealed a failure to adequately communicate with family when the patient was transferred from the system to a non-VA community hospital in spring 2014. We found documentation that family was notified when the patient was transferred from the Community Living Center to the ED but did not find documentation that the family was notified of his transfer from the system's ED to a different facility.

We did not substantiate quality of care concerns related to the patient's post-operative care in the CLC.

Recommendation

1. We recommended that the System Director strengthen processes to ensure families or caregivers are notified when patients are transferred to new locations of care.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 23, 2015

From: Acting Director, VA Midwest Health Care Network (10N23)

Subj: Healthcare Inspection—Communication and Quality of Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed and concur with the attached VHA submission from VA Black Hills Health Care System, Ft. Meade, South Dakota.

2. If you have any questions, you may contact the Acting Director at VA Black Hills Health Care System at (605) 347-2511 Extension 7170.

Steven C. Julius, M.D.

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: March 19, 2015

From: Acting Director, VA Black Hills Health Care System (568/00)

Subj: Healthcare Inspection—Communication and Quality of Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota

To: Director, VA Midwest Health Care Network (10N23)

1. Attached please find the VA BHHCS response.
2. If you have any concerns, you may contact the Acting Director at the VA Black Hills Health Care System at (605) 347-2511 Extension 7170.

(original signed by:)

Name: Jo-Ann Ginsberg, RN, MS
Title: Acting Director VA Black Hills Health Care System

Comments to OIG's Report

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

OIG Recommendation

Recommendation 1. We recommended that the System Director strengthen processes to ensure families or caregivers are notified when patients are transferred to new locations of care.

Concur

Target date for completion: June 30, 2015

Facility response: The VA BHHCS will develop a standardized process to ensure compliance with VA BHHCS Inter-Facility Acute Transfer Policy (COS-22) dated February 28, 2013.

Appendix C

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Susan Tostenrude, MS, Team Leader Andrea Buck, MD, JD Sami O'Neill, MA

Appendix D

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