Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Discharge, Shelter Environment, and Staff Support Issues at the VA Greater Los Angeles Healthcare System Los Angeles, California

Report No. 06-03124-27 **November 22, 2006**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of this inspection was to determine the validity of allegations pertaining to discharge, shelter environment, and staff support issues at the VA Greater Los Angeles Healthcare System.

The complainant, a friend of the patient, alleged that:

- Clinicians prematurely discharged the patient home on July 11, 2006.
- Clinicians placed the patient in an unsanitary and unsafe transitional care facility (Exodus Lodge) on July 28, 2006.
- Social workers provided insufficient support and services.

We did not substantiate the allegation that the patient had been discharged prematurely. Medical record documentation shows that the patient was stable; had appropriate assessments; and received medication counseling, information about community services, and contact instructions. We determined that the patient was discharged appropriately.

We could not substantiate or refute that the environmental conditions in Exodus Lodge were unsanitary and unsafe at the time referred to by the complainant. During our unannounced inspection, Exodus Lodge appeared to be clean and adequately maintained. We did not observe unsafe conditions.

We did not substantiate the allegation that social workers provided insufficient support and services. We found that the inpatient unit social workers documented numerous interactions with the patient throughout his various hospitalizations, as well as meetings with the patient's girlfriend and family members. The social workers also made appropriate referrals to various agencies for continued needs after discharge.

We concluded that the patient was discharged appropriately, the environmental conditions at Exodus Lodge were acceptable, and that social workers provided sufficient support and services to the patient. We did not make any recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network 22

SUBJECT: Healthcare Inspection – Discharge, Shelter Environment, and Staff Support Issues at the VA Greater Los Angeles Healthcare System, Los Angeles, California

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding discharge, shelter environment, and staff support issues at the VA Greater Los Angeles Healthcare System (the healthcare system). The purpose of this inspection was to determine the validity of the allegations.

Background

The complainant, a friend of the patient, alleged that:

- Clinicians prematurely discharged the patient home on July 11, 2006.
- Clinicians placed the patient in an unsanitary and unsafe transitional care housing facility (Exodus Lodge) on July 28, 2006.
- Social workers provided insufficient support and services.

Exodus Lodge is a transitional housing facility located on the healthcare system's campus. It is under the administration of the Salvation Army. Exodus Lodge provides temporary housing and supervised care to discharged patients who do not require 24-hour nursing care. Patients placed at this facility must be medically stable and able to perform activities of daily living independently.

The healthcare system is part of Veterans Integrated Service Network (VISN) 22.

Scope and Methodology

We interviewed the complainant, the patient, and the patient's girlfriend to clarify the allegations. We reviewed letters from the complainant and the patient's girlfriend, the patient's medical records, local policies, and other pertinent documents. We visited the healthcare system on August 29, 2006, and interviewed clinicians. In addition, we conducted an unannounced inspection of Exodus Lodge, reviewed recent state and local inspection reports, and interviewed the Exodus Lodge manager.

We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Case History

The patient is a 65-year-old male with an extensive health history, including hypertension, elevated cholesterol, and chronic kidney failure. He has received treatment at the healthcare system for the past 6 years.

On May 16, 2006, the patient presented to his primary care physician (PCP), complaining of a lack of energy, fatigue, shortness of breath, and a non-productive cough. He also reported a 6-month history of decreased appetite and a 25-pound weight loss. Until May, the patient had been working full-time and living independently.

The PCP ordered a series of tests and procedures, including an imaging procedure that showed swollen lymph nodes and an enlarged spleen, suggestive of lymphoma (cancer of lymphatic system). On June 1, an oncologist evaluated the patient for possible malignancy. The patient reported drenching night sweats several times per week, fatigue, and an early feeling of being full after eating.

On June 2, clinicians admitted the patient to the healthcare system due to abnormal blood test results and treated him with medication and intravenous fluids. Clinicians ordered additional tests and procedures to evaluate the malignancy, including bone marrow and thyroid gland biopsies and specialty consultations. The patient was diagnosed with possible malignant lymphoma. He was discharged home on June 9, with a plan for a future admission to continue evaluation.

On June 13, the patient was admitted with high fever and chills. During this admission, the work-up for possible cancer continued, and a treatment plan was under development.

On June 26, the patient and his girlfriend agreed to participate in the Veterans Integrated Palliative (VIP) research study. The research study involves frequent interactions with a VIP nurse case manager and a social worker.

On June 28, the inpatient unit (the unit) social worker met with the patient to discuss the discharge plan. The patient consented for the social worker to speak with his daughter, who reportedly was supportive of the plan and willing to help the patient as needed.

On July 9, the attending physician (the attending) noted that the patient's fever and fatigue had been symptomatically treated with ibuprofen. The fever work-up did not reveal any infection, and the attending concluded the patient's fevers were secondary to his malignancy. The attending noted consideration of domiciliary care versus discharging the patient home, pending chemotherapy treatment.

On July 10, the unit social worker met with the patient and discussed the plan for him to return on an outpatient basis to receive chemotherapy. The social worker noted that the patient had a support system in place, including a daughter available to assist as needed. However, the patient expressed concerns about the travel distance from his home to the healthcare system and caring for himself at home after receiving chemotherapy. The patient's girlfriend also expressed anxiety regarding the patient's discharge home. A physician assistant performed a nursing home screening assessment and concluded that the patient did not require skilled nursing care. The social worker discussed the options of a community nursing home or VA domiciliary placement with the patient. The patient stated that he would prefer to go home.

On July 11, the medical intern indicated that the patient was without complaints and ready to go home. A clinical pharmacist met with the patient and provided discharge counseling on medication regimens. The unit social worker met with the patient and referred him to public transportation and senior nutrition programs in his home area. The patient, who was accompanied by his brother, was discharged home, and the plan was for continued cancer evaluation as an outpatient.

On July 13, the patient was admitted to a local community hospital. The patient stated that he was weak and unable to get up, eat, or drink. He reported having fever, chills, and night sweats and stated that he did not have anyone to assist him. The patient received intravenous fluids, antibiotics, and blood transfusions.

On July 18, the patient was transferred to the healthcare system for further care and initiation of chemotherapy. On July 25, at a family conference with the treatment team, plans were made to discharge the patient following his first dose of chemotherapy. The patient agreed to stay at a board and care (B&C) facility near the healthcare system during treatment due to renovations being completed on his apartment. The patient's girlfriend also agreed to the plan. The patient received his initial chemotherapy treatment on July 27, 2006, without complications. A clinician discharged the patient the following day. Because the room at the B&C facility was not yet available, the patient agreed to stay at Exodus Lodge temporarily. The patient arrived at Exodus Lodge on July 28, 2006. Less than 24 hours later, the patient left Exodus Lodge with his brother. On

July 31, the patient informed the unit social worker that he left Exodus Lodge over the weekend because he did not like staying there.

Issue 1: Premature Discharge

We did not substantiate the allegation that clinicians prematurely discharged the patient on July 11, 2006.

Medical record documentation shows that the patient was in stable condition. The agreed upon discharge plan was for the patient to receive chemotherapy treatment on an outpatient basis. The unit social worker stated that the patient had a support system in place, including a daughter available to assist as needed. The patient received appropriate assessments, medication counseling, and contact information. In addition, the VIP nurse case manager provided the patient with contact instructions for any questions or needs at any time. We determined that clinicians discharged the patient appropriately.

Issue 2: Unsanitary and Unsafe Environmental Conditions at Exodus Lodge

We could not substantiate or refute the allegation of unsanitary and unsafe environmental conditions at Exodus Lodge at the time referred to by the complainant.

The patient told us that Exodus Lodge was extremely dirty, hot, and that no one was available to assist him with changing his linens and obtaining ice and medications. He also stated that it was a place for drug addicts and homeless people, and he felt that no veteran should ever be placed in such a facility, especially someone who was vulnerable to infections like himself.

Our review of the recent state and local inspection reports of Exodus Lodge did not reveal environmental deficiencies. In addition, during our unannounced inspection of Exodus Lodge, the facility overall appeared clean, adequately maintained, and safe. The individual rooms appeared clean. Although most rooms had no air conditioning, large windows were open, and ventilation appeared adequate. The patient lounge at the end of the hall had a window air conditioner. An ice machine was present, and we were told that patients have access to ice at meal times. Although patients were not allowed to keep medications at the bedside, scheduled access to medications was available 5 times a day. For access at other times, patients must contact a staff member who will obtain the medication(s) from the locked medication room.

Issue 3: Social Workers Provided Insufficient Support and Services

We did not substantiate the allegation that social workers provided insufficient support and services to the patient and his family.

Medical record documentation shows active social worker involvement in the patient's treatment and discharge planning. We found several progress notes by social workers of their interactions with the patient, his girlfriend, and his family. We determined that social workers provided the necessary support services throughout the patient's various hospitalizations.

Conclusions

We concluded that the patient was discharged appropriately, the environmental conditions at Exodus Lodge were acceptable, and social workers provided sufficient support and services to the patient. We did not make any recommendations.

Comments

The VISN Director responded that he agreed with our findings. (See Appendix A, pages 6–7, for the full text of the response.) No corrective actions are necessary; we consider this matter closed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 31, 2006

From: Network Director (10N/22)

Subject: Hotline Case Number 2006-03124-HI-0417

To: Director, Los Angeles Regional Office of Healthcare Inspections

Thru: Director, Management Review Service (10B5)

1. A review by the Los Angeles Office of Healthcare Inspections (LAOHI) has been completed to determine the validity of allegations pertaining to discharge, shelter environment, and staff support issues at the VA Greater Los Angeles Healthcare System.

2. We agree with the LAOIH findings that concluded that the patient was discharged appropriately, the environmental conditions at Exodus Lodge were acceptable, and that social workers provided sufficient support and services to the patient.

3. In the complaint, a friend of the patient alleged that:

- Clinicians prematurely discharged the patient home on July 11, 2006.
- Clinicians placed the patient in an unsanitary and unsafe transitional care facility (Exodus Lodge) on July 28, 2006.
- Social Workers provided insufficient support and services.

4. The LAOHI did not substantiate the allegation that the patient had been discharged prematurely. Medical record documentation shows that the patient was stable; had appropriate assessments; and received medication counseling, information about community services, and contact instructions. It was determined that the patient was discharged appropriately.

5. It could not be substantiated or refuted that the environmental conditions in Exodus Lodge were unsanitary and unsafe at the time referred to by the complainant. During the unannounced inspection, Exodus Lodge appeared to be clean and adequately maintained. There were no unsafe conditions observed.

6. The allegation that social workers provided insufficient support and services could not be substantiated. The inpatient unit social workers documented numerous interactions with the patient throughout his various hospitalizations, as well as meetings with the patient's girlfriend and family members. The social workers also made appropriate referrals to various agencies for continued needs after discharge.

7. If you have any further questions regarding this issue, please contact Mrs. Teresa Osborn, RN, Quality Management Officer at (562) 826-5963.

(original signed by:)
Kenneth J. Clark, FACHE

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, RN, Director Los Angeles Office of Healthcare Inspections (213) 253-2677 ext. 4972
	Daisy Arugay Michelle Porter, RN Michael Shepherd, M.D.

Appendix C

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