Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues
Central Arkansas Veterans Healthcare System
Little Rock, Arkansas

Report No. 09-02397-48

December 11, 2009

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The purpose of this review was to determine the validity of allegations regarding the quality of care provided to a patient in the emergency department (ED) at the Central Arkansas Veterans Health Care System, Little Rock, AR.

We did not substantiate that the patient was inadequately diagnosed or treated for severe abdominal pain. We found that clinicians appropriately treated the patient's pain and ordered the correct treatments based on laboratory and imaging tests. We did not substantiate that the patient was placed in a locked room where no one checked on him for over 6 hours. After discharge the patient was allowed to sleep in an unoccupied bed adjacent to the ED because he had no transportation until the next morning. Staff checked on him several times during the night. We could not substantiate or refute that someone told the patient's wife the patient was discharged but they did not know where he was located. To reinforce the importance of effective communication with family members, the system Director issued a memorandum while we were onsite.

The VISN and Management agreed with our findings. We made no recommendations.

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

TO: Director, South Central VA Health Care Network (10N16)

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, conducted an inspection to determine the validity of allegations regarding the quality of care provided to a patient at the Central Arkansas Veterans Health Care System, Little Rock, AR.

Background

The Central Arkansas Veterans Health Care System (system) provides primary, tertiary, and long-term care to about 170,000 veterans throughout 46 counties in Arkansas. The system has 294 hospital beds and 177 community living center beds and is affiliated with the University of Arkansas for Medical Sciences. The system is part of Veterans Integrated Service Network (VISN) 16.

We reviewed allegations from a patient and his wife that during a May 2–3, 2009, visit emergency department (ED) staff:

- Did not adequately diagnose or treat his severe abdominal pain.
- Placed him in a locked, unmonitored room for 6 hours following discharge.
- Did not know his whereabouts after discharge when he remained in the ED awaiting a ride home.

Scope and Methodology

We interviewed the complainant by phone. We conducted a site visit on June 22–23, 2009, and interviewed administrators, physicians, nurses, a social worker and a patient advocate who were knowledgeable about the patient's care. We reviewed

the patient's VA and private hospital medical records, relevant medical center policies and procedures, and patient advocate data. We also conducted an environment of care inspection of the ED.

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

Case Summary

The patient was treated in a private hospital ED on May 2, 2009, for epigastric pain and sharp lower chest pain radiating to the back. The patient initially rated the intensity of his pain to be 10 (on a scale of 0 to 10), but rated his pain 7 after he received an intravenous medication. The electrocardiogram and laboratory tests, including pancreatic enzymes and cardiac biomarkers, were normal. Radiological studies of the abdomen revealed dilated loops in the right upper quadrant with no air fluid levels. The patient was stabilized and transferred to the system via ambulance at approximately 3:45 p.m. for further evaluation of a "probable small bowel obstruction."

On admission to the system ED, the patient stated that his pain was constant and his pain level 7/10. The medical record noted the patient's history of asymptomatic gallstones incidentally discovered by abdominal ultrasonography in January 2008. Vital signs were: temperature 97.5, pulse 66, respirations 18, and blood pressure 151/81.

After receiving morphine 4 mg IV, the patient reported that his pain had decreased to 4/10. Physical examination findings included a soft, non-distended abdomen, with positive bowel sounds, overall diffuse tenderness, no rebound, and no bruits. Additional diagnostic tests included computed tomography (CT) of the abdomen and pelvis with contrast. CT findings were "unremarkable with no acute inflammatory process in the abdomen or pelvis." The patient was given additional medication and his pain level decreased to 2/10.

At 10:00 p.m., the patient was discharged with a diagnosis of gastritis. He was instructed to take esomeprazole twice daily until the pain improved and to follow up with his primary care provider (PCP). The discharge instructions also noted that if the patient's symptoms did not improve, the PCP might need to order esophagogastroduodenoscopy.[1]

A social worker noted that the patient was unable to reach his wife to notify her of his discharge from the ED, and he had no transportation home. Staff decided to allow the patient to sleep in an unoccupied ED room until his family could pick him up. His brother picked the patient up at approximately 10:00 a.m. the following morning.

[1] Esophagogastroduodenoscopy is an endoscopic examination of the esophagus, stomach, and duodenum.

On May 7, 2009, the patient returned to the system ED and was diagnosed with acute cholecystitis. He underwent laparoscopic cholecystectomy on May 8, was discharged home on May 9, and had an uneventful recovery.

Inspection Results

Issue 1: Diagnosis and Treatment

We did not substantiate that the patient was inadequately diagnosed or treated for severe abdominal pain.

The patient presented to a private hospital ED on May 2, 2009, at approximately 12:00 p.m. with complaints of abdominal and chest pain. Following initial evaluation, he was transferred via ambulance to the system ED with a presumed diagnosis of small bowel obstruction.

On arrival the patient was examined, given appropriate medications for pain and sent to radiology for CT scans of the abdomen and pelvis. At 10:00 p.m., the ED physician discussed the negative CT findings with the patient and discharged him home, allowing him to sleep in an unoccupied room until a family member could pick him up the next morning.

Issue 2: Post Discharge Treatment

We did not substantiate that the patient was placed in a locked room where no one checked on him for over 6 hours. Because he had been discharged from the ED, formal monitoring was not continued.

The patient was discharged but did not have a ride home until the next morning. A nurse and social worker arranged for the patient to spend the night in a fully equipped ED private patient room. The nurse recalled going into the room to check on the patient several times between midnight and 6:00 a.m. Each time the patient was asleep and the room was unlocked.

Issue 3: Family Communication

We could not substantiate or refute the allegation that someone told the patient's wife the patient was discharged but they did not know where he was.

Clinical staff were aware that the patient was sleeping in an unused private room in the ED. Clerical staff have been instructed to transfer calls to clinical staff as appropriate. To reinforce the importance of effective communication between the staff and patients and family members, the system Director issued a memorandum while we were onsite. The memorandum states "if a family member contacts administrative or clerical

personnel regarding their loved one, and voices anxiety or continued concern (for example, unexpected disposition), the call should be forwarded directly to an ED nurse or physician who is a part of the clinical care team for further discussion."

Conclusions

Because we did not substantiate any of the allegations in this hotline, we made no recommendations.

Comments

The VISN and system Directors concurred with the inspection results (see Appendixes A and B, pages 5–6 for the full text of their comments).

(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: August 17, 2009

From: Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas**

To: Assistant Inspector General for Healthcare Inspections

I have reviewed and concur with the inspection results and conclusions. If you have any questions, please contact Mary Jones at 601-364-7871.

(original signed by:)

George H. Gray, Jr.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 17, 2009

From: Director, Central Arkansas Veterans Healthcare System (598/00)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas**

To: Assistant Inspector General for Healthcare Inspections

Thru: Director, South Central VA Health Care Network (10N16)

I would like to take this opportunity to commend the OIG Healthcare Inspection Team for both their thoroughness and professionalism. I concur with the inspection results and conclusions.

(original signed by:)
MICHAEL R. WINN

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia Solana Director, Denver Office of Healthcare Inspections (303) 270-6500
Acknowledgments	Cheryl Walker Laura Dulcie

Appendix D

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