Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Case Review of a Patient with End-Stage Cancer John D. Dingell VA Medical Center Detroit, Michigan

Report No. 11-01194-224 **July 13, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations that facility staff did not respect a patient's treatment decision, misrepresented the family's wishes, and treated the patient and family disrespectfully. The complainant specifically alleged that:

- The patient's attending physician misrepresented the family's wishes and was unprofessional.
- Staff provided more than just comfort care to the patient prior to the patient's transfer from acute care to hospice care.
- Physicians delayed the patient's transfer to hospice care because they were unaware transfers were possible on a weekend.
- Nursing staff did not show compassion to the dying patient and the patient's family.

We did not substantiate that the patient's attending physician misrepresented the family's wishes and was unprofessional. The attending physician believed the patient desired treatment and therefore attempted to get another specialist's opinion on what was available for the patient.

We substantiated that staff did not provide comfort care to the patient prior to the patient's transfer from acute care to hospice care. Documentation showed that the team continued previous acute care orders after the patient requested only comfort care.

We substantiated that physicians delayed the patient's transfer to the hospice unit. A team member stated that the team chose not to transfer the patient over the weekend because they did not feel the transfer to hospice care was urgent.

We substantiated that the nursing staff did not show compassion to a dying patient and the patient's family. During our interviews, management reported that the family asked for assistance from a nurse and that the nurse did not provide assistance. Also, the hospice staff did not arrange to provide the family with privacy for bereavement.

We recommended that the Medical Center Director ensure that all clinical staff receive training in hospice and palliative care and that the facility follow hospice care guidelines to ensure all family members have adequate privacy for initial bereavement.

The VISN and Medical Center Directors concurred with our findings and recommendations and provided acceptable action plans. We will follow up until the planned actions are completed.

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

TO: Director, Veterans in Partnership (10N11)

SUBJECT: Healthcare Inspection – Case Review of a Patient with End-Stage Cancer, John D. Dingell VA Medical Center, Detroit, Michigan

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations regarding inappropriate treatment of a patient and lack of respect for the patient and family at the patient's end of life at the John D. Dingell Medical Center (the facility) in Detroit, MI. The purpose of the inspection was to determine if the allegations had merit.

Background

The facility is part of Veterans Integrated Service Network (VISN) 11 located in Detroit, MI. The facility provides a broad range of inpatient and outpatient health care services to a veteran population of approximately 330,994 in a primary service area that includes Wayne, Oakland, Macomb, and St. Clair counties.

The facility provides medical, surgical, mental health, geriatric, and rehabilitation services; a Homeless Veterans Program; and a Home-Based Primary Care Program. The medical center has 217 hospital beds, which includes a 109-bed Community Living Center where the hospice unit is located.

The goal of hospice and palliative care is to improve end-of-life care by enhancing the quality of life for the terminally ill and their loved ones. Hospice and palliative care maximizes comfort to enhance the quality of life remaining for patients. Hospice care strives to allow patients to die with dignity, pain-free.[1]

In November 2010, a complainant contacted OIG's Hotline Division with allegations that facility staff did not respect a patient's treatment decision, misrepresented the family's

[1] National Hospice and Palliative Care Organization, www.nhpco.org, accessed February 2, 2011.

wishes, and treated the patient and family disrespectfully. The complainant specifically alleged that:

- The patient's attending physician misrepresented the family's wishes and was unprofessional.
- Staff provided more than just comfort care to the patient prior to the patient's transfer from acute care to hospice care.
- Physicians delayed the patient's transfer to hospice care because they were unaware transfers were possible on a weekend.
- Nursing staff did not show compassion to the dying patient and the patient's family.

Scope and Methodology

We interviewed the complainant by telephone prior to the site visit on February 15–16, 2011. We interviewed managers, clinicians, and other employees with knowledge of the complaints. We reviewed the patient's medical records and pertinent policies and directives.

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

The patient was a male in his fifties with a history of coronary artery disease, hypertension, chronic kidney disease, and depression who received medical care at the facility for over 15 years. A non-VA hospital emergently treated the patient in early October 2010 for shortness of breath and chest discomfort. During their evaluation, physicians at the outside hospital diagnosed the patient with high-grade B cell lymphoma,[2] tumor lysis syndrome,[3] and acute kidney failure requiring short-term dialysis. At the patient's request, the physicians transferred the patient to the facility to initiate chemotherapy to treat the lymphoma.

On admission documentation, the patient's internal medicine physicians (team) noted that the patient still had significant kidney impairment. The team placed consults to two specialty services . One of the specialists determined that chemotherapy could not begin until the patient's kidney function improved. The team initiated treatment in an attempt to improve the patient's kidney function. The team ordered numerous laboratory tests to

[2] High-grade B cell lymphoma is a type of cancer involving cells of the immune system.
[3] Tumor lysis syndrome is a group of complications caused by the breakdown products of dying cancer cells and can include elevated levels of potassium, phosphate, uric acid, and calcium in the blood. Elevated uric acid in the blood can lead to acute kidney failure.

monitor the patient's response to treatment and continued to treat all other medical conditions. The patient's kidney function did not improve to a point where chemotherapy could be initiated.

On the 10th day, during the family meeting, the team discussed the patient's current medical conditions and a specialist's recommendations. The team recommended obtaining a second opinion on treatment options. The social worker documented that the patient's sister would contact the team concerning a second opinion. The patient was indecisive concerning the second opinion.

The patient's sister made an appointment with a non-VA cancer clinic but cancelled it because the patient was still an inpatient at the facility. During our interview, the complainant stated that the family wanted to talk to a facility specialist regarding treatment options, but the attending physician wanted to transfer the patient for the second opinion.

On the 11th day, a facility specialist discussed the patient's condition with the patient's sister explaining that chemotherapy was not an option because of the kidney disease, and recommended palliative radiation therapy[4] (RT) to treat the symptoms if needed.

On the 16th day, the palliative care physicians met with the patient and family. The patient and family wished to discuss possible treatment options with the radiation oncologist prior to making a decision on whether or not to treat the malignancy palliatively or admit the patient to the hospice unit.

Later that same day, a radiation oncologist evaluated the patient with the family present and recommended a trial of palliative RT. The patient and family agreed to this; however, when treatment started on the 18th day, the patient could not tolerate the procedure due to complications from the lymphoma.

On the evening of the 18th day, the patient became medically unstable, and the sister and patient requested comfort care only and transfer to the hospice unit. The team contacted a palliative care physician who recommended comfort care because the patient was not stable enough for transfer to the hospice unit. The team was to provide the patient with only comfort measures and symptom management and allow the patient's family to be at the bedside 24-hours a day. A palliative care physician was to re-evaluate the patient the next day.

On the morning of the 19th day, the team documented that the hospice unit could not accept a transfer until the 21st day; however, during our interview with a team member, a different palliative care physician contacted the team later that day and asked about transferring the patient to the hospice unit. The team member reported that the team did

[4] Radiation therapy is a treatment that uses high doses of radiation (x-rays) to kill cancerous cells and shrink tumors. Palliative radiation therapy is used to treat cancer symptoms and is not considered a cure for the disease.

not feel transferring the patient to the hospice unit at that time was urgent. However, documentation noted that the patient received care consistent with acute care needs despite orders and a request for comfort care only.

On the 21st day, the patient transferred to the hospice unit. Facility policy is for any seriously ill patient to transfer from one unit to another in a hospital bed. The staff transferred the patient in a wheelchair despite the patient's serious condition and inability to sit upright in a wheelchair without assistance. Staff confirmed that the assigned caregiver did not provide assistance when requested by the family.

The patient died later that night. The staff contacted the patient's family. Upon their arrival, staff did not provide privacy for bereavement. The complainant reported that when the sister requested information on donating the body to science, a staff member was unsure of the process, made an insensitive remark, and did not assist the family with the donation process.

Inspection Results

Issue 1: Misrepresented Family Wishes and Unprofessional Conduct

We did not substantiate that the patient's attending physician misrepresented the family's wishes and was unprofessional. The patient's attending physician did not agree with the specialist regarding treatment options. The attending physician believed that the patient desired pursuing treatment options and therefore attempted to get another opinion on options for the patient. The attending physician felt a second opinion was warranted and discussed obtaining a second opinion with the sister, who agreed with the request.

The sister, after speaking with a facility specialist, agreed with the treatment plan and no longer desired to pursue other treatment options.

Issue 2: Comfort Care

We substantiated that staff did not provide only comfort care to the patient prior to the patient's transfer from acute care to hospice care. Documentation noted that on the 18th day after admission, the patient requested hospice care. The patient desired only comfort care. However, the team drew blood, prescribed medications other than for pain and anxiety, and restricted the diet against family and patient wishes.

Issue 3: Delayed Hospice Unit Transfer

We substantiated that physicians delayed the patient's transfer to the hospice unit. The patient requested transfer to the hospice unit on the 18th day after admission to the facility. The transfer did not occur until the 21st day. Facility policy is to transfer a patient to the hospice unit when needed. On the 18th day, the hospice physicians did not transfer the patient because of medical instability. The hospice team does not transfer a

patient if they believe the patient may die within the next several hours to avoid additional stress on the patient.

A team member stated that the team chose not to transfer the patient because they did not feel the transfer to hospice care was urgent. The team felt staff could provide hospice care on the acute care unit. Per facility policy, the staff on the unit are to receive training from the palliative care consult team to provide comfort care to patients who are in need of hospice care. However, standing orders, blood tests, and restrictive diet orders continued after the patient and family asked for comfort care only. During our interviews, we found a palliative care physician was on-call and involved in the patient's care, determined that the patient was stable for transfer, and contacted the team on the 19th day to transfer the patient to the hospice unit.

Issue 4: Staff Compassion

We substantiated that the nursing staff did not show compassion to the dying patient and the patient's family. During our interviews, management reported that staff are required to transfer seriously ill patients from the acute care unit to the hospice unit in their hospital bed. The patient was seriously ill and unable to sit upright in a wheelchair. The staff placed the patient in a wheelchair while they changed the patient's bed. The family asked for assistance from a nurse to get the patient out of the wheelchair. The nurse did not provide assistance or request another staff member to provide assistance. Staff left the patient for over an hour in the wheelchair and then transferred the patient to the hospice unit in the wheelchair. Management reported that this staff member no longer works at the facility.

Staff are to provide privacy for the family to be with the patient on the unit after death. The hospice staff did not provide the family with privacy for bereavement.

The patient was on the hospice unit for less than 12 hours prior to death. The patient's sister asked the evening staff about donating the body to science. They were unaware of the donation process. In general, staff discusses arrangements for donations during the day shift and prior to the patient's death. After this incident, the facility initiated staff training on this process.

Conclusions

The patient entered the facility with a serious medical condition. The physicians involved in the case did not agree on treatment options. After the patient and family requested hospice care, the team was slow to act on their wishes. The transfer to the hospice unit did not follow facility policy. Staff failed to honor the dying patient's comfort care wishes. Staff did not provide compassionate care to the family during the initial bereavement period.

The facility provides hospice care outside of the hospice unit for patients that are imminently dying or waiting for transfer to the hospice unit. Education is required for staff outside the hospice unit to carry out this provision. All clinical staff should know what comfort care includes and excludes, as well as, be able to discuss this information with patients and families.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure all clinical staff receive training in hospice and palliative care.

Recommendation 2. We recommended that the Medical Center Director ensure staff follow hospice care guidelines to allow all family members to have adequate privacy for initial bereavement.

Comments

The VISN and Medical Center Directors concurred with our findings and recommendations and provided acceptable action plans (see Appendixes A and B, pages 7–10, for the full text of their comments). We will follow up until the planned actions are completed.

(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: June 24, 2011

From: Director, Veterans in Partnership (10N11)

Subject: **Healthcare Inspection – Case Review of a Patient with End-Stage Cancer, Detroit, Michigan**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, Management Review Service (10A4A4)

Please find attached response from the Detroit VAMC. If you have any questions, please contact Kelley Sermak, Acting QMO, at 734-222-4302.

Michael S. Finegan
Director, Veterans in Partnership (10N11)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 22, 2011

From: Director, John D. Dingell VA Medical Center (553/00)

Subject: **Healthcare Inspection – Case Review of a Patient with End-Stage Cancer, John D. Dingell VA Medical Center, Detroit, Michigan**

To: Director, Veterans in Partnership (10N11)

1. This is in response to the above subject OIG Case Review of a patient with end-stage cancer at the John D. Dingell VA Medical Center.

2. We agree with the recommendations and have identified clinical staff that will be trained in hospice and palliative care.

3. If you should have any questions, please contact Raghuram Matta, M.D., Deputy Chief of Staff, at 313 576-4341/3090.

(*original signed by*:)
Pamela J. Reeves, MD
Director, John D. Dingell VA Medical Center (553/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure all clinical staff receive training in hospice and palliative care.

Concur **Target Completion Date:** December 31, 2011

Facility's Response: Hospice Education Network (HEN) is a web-based End of Life training curriculum that allows access to any of 8 Hospice/End of Life modules anytime, and all clinical staff will be enrolled and tracked until completion. These courses are presented by nationally-known speakers throughout the country. The program is complete with administrative tools for documentation and reporting, is user friendly, and at the end of each module, there is an evaluation and certificate of completion. These modules may be accessed from the following website: http://hospiceonline.com/faq.html. In addition, Hospice/Palliative Unit Staff currently provide a weekly one hour interactive educational session held each Thursday to all clinical staff from MICU/SICU, Community Living Center, and the acute medical and surgical units. This is a face-to-face one hour weekly meeting with a total of 11 sessions that addresses various topics related to caring for hospice patients based on EPEC (Education on Palliative and End of Life Care). Finally, Palliative Care has a monthly session as part of the Medicine Service morning report schedule covering Hospice and Palliative Care issues, including the use of narcotic medications in pain management. These sessions are attended by hospitalists and rotating medical residents.

Status: A list of names is being developed from various disciplines, including MD, RN, LPN, PA, Ph.D.s, and Social Workers from all inpatient units that will be identified and informed by their quad member/supervisor that they must complete all 8 modules of the web-based HEN training.

Recommendation 2. We recommended that the Medical Center Director ensure that staff follow hospice care guidelines to allow all family members to have adequate privacy for initial bereavement.

Concur: **Target Completion Date:** August 31, 2011

Facility's Response: The Hospice & Palliative Care staff are developing a Standard Operating Procedure (SOP) to ensure as much privacy is afforded to the family of the dying patient as possible. The following information will be identified in the SOP for attempting to honor family requests for privacy at the end of life:

1. Staff will recognize when a patient has transitioned to a more active phase of dying and relay this information to the physician providers and nursing staff.
2. Staff will recognize the increased need for privacy for patients and family during the last hours of life and at the time of initial bereavement.
3. If space is available on the unit, either the patient or their roommate will be moved allowing the former patient to have a private room. In most instances, the roommate will be the one moved.
4. If a private room cannot be provided, appropriate measures will be taken to enhance privacy:
    a. Privacy curtains must be pulled between patients.
    b. Door closed, excessive noise/distractions (from TV or other sources) minimized.
    c. Additional chairs/seating will be provided for family/visitors.
5. If a private room cannot be provided, additional support and preparation will be provided to the roommate:
    a. Encourage out-of-room activities, providing patient with a comfortable alternative.
    b. Offer increased psychosocial support: social work or chaplain referral.

    Status: This SOP will be communicated by management to the appropriate staff on all shifts.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Cathleen King, RN, Project Leader Gayle Karamanos, PA, Team Leader Larry Ross, MS Robert Yang, MD, Medical Consultant Misti Kincaid, BS, Program Support Assistant

Appendix D

Report Distribution

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