Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Oversight Review of Quality of Care Issues
Edward Hines, Jr. VA Hospital
Hines, Illinois

Report No. 11-03921-63

January 5, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

At the request of Congressman Peter Roskam's office, the VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection and oversight review to determine the validity of allegations regarding the quality of care received by a patient at the Edward Hines, Jr. VA Hospital. A complainant made the following allegations regarding the patient's care:

- The patient did not receive assistance with his activities of daily living (ADL) while on the Respite Care unit or during a subsequent inpatient admission.
- The patient did not receive rehabilitative therapy treatments as ordered on the Respite Care unit or during a subsequent inpatient admission.
- The patient was seen by three different physicians during an Emergency Department (ED) evaluation and the care was not coordinated.
- The patient had an indwelling urinary Foley catheter placed in order to keep him from trying to get out of bed during the night.
- The patient was discharged from his inpatient admission without medication reconciliation and follow-up instructions.

We did not substantiate the allegations that the patient did not receive help with his ADLs or receive ordered rehabilitative treatments during his respite care admission.

We substantiated that the patient was seen by two staff physicians and a resident physician during his 5-hour stay in the ED. We did not substantiate that the physicians did not communicate or coordinate care for the patient.

We substantiated the allegation that the patient did not receive rehabilitative treatments during his inpatient stay and while acutely ill; however, he did not meet the criteria for an intervention. We did not substantiate the allegations that he was not assisted with ADLs, that he had a Foley catheter inserted, or that discharge instructions and medication reconciliation were not provided.

We made no recommendations.

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

TO: Veterans Integrated Service Network Director 12

SUBJECT: Healthcare Review – Quality of Care Issues, Edward Hines, Jr. VA Hospital, Hines, Illinois

Purpose

At the request of Congressman Peter Roskam's office, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection and oversight review to determine the validity of allegations regarding the quality of care received by a patient at the Edward Hines, Jr. VA Hospital (the facility). The allegations pertained to two episodes of care at the facility: a Respite Care Program admission and an evaluation in the facility's Emergency Department (ED) with subsequent admission to an inpatient unit.

Background

The facility is part of Veterans Integrated Service Network (VISN) 12, and offers primary, extended and specialty care and serves as a tertiary care referral center for VISN 12. Specialized clinical programs include spinal cord injury, neurosurgery, blind rehabilitation, radiation therapy, and cardiovascular surgery. The facility operates 471 beds and 6 community based outpatient clinics. The facility provides care to over 54,000 veterans, primarily from Cook, DuPage, and Will counties.

The facility's level 3 ED is staffed 24 hours a day by 3 attending physicians, 1 resident and 8-10 registered nurses, and receives over 21,000 patient visits per year.

The facility has a 210-bed Community Living Center that provides respite care for veterans. This allows the caregivers a "break" by taking over the veteran's care for a limited time, up to 30 days in a calendar year.

Home Based Primary Care (HBPC) services are also available through the facility. This program provides comprehensive, interdisciplinary, primary care in the homes of veterans with complex medical, social, or behavioral conditions for whom routine clinic-based care is difficult.

In August 2011, OIG received a complaint regarding a patient's inpatient care. The complaint included a copy of a letter dated early July 2011. In the letter, a complainant made the following allegations regarding the quality of care a patient received in March 2011 at the Respite Care unit, and during an inpatient admission in June 2011:

- The patient did not receive assistance with his activities of daily living (ADL) while on the Respite Care unit or during a subsequent inpatient admission.
- The patient did not receive rehabilitative therapy treatments as ordered on the Respite Care unit or during a subsequent inpatient admission.
- The patient was seen by three different physicians during an ED evaluation and the care was not coordinated.
- The patient had an indwelling urinary Foley catheter placed during his inpatient admission in order to keep him from trying to get out of bed during the night.
- The patient was discharged from his inpatient admission without medication reconciliation and follow-up instructions.

The complainant mailed the letter in early July. The facility stated they had no record of receiving the letter. The facility first became aware of the allegations when we notified them of our inspection and provided them with a copy of the letter in August. After receipt of a copy of our letter, the facility conducted a thorough review of the allegations and forwarded their report to the VA OIG, Office of Healthcare Inspections.

Scope and Methodology

We reviewed the facility's report and conducted interviews with the complainant and members of the facility's investigative team. We reviewed the patient's medical record and pertinent policies and procedures associated with the Respite Care and inpatient units.

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

This patient was a man in his 90s, with a history of prostate cancer, cerebrovascular accident,[1] hypertension, coronary artery disease, dementia and long-term anticoagulation therapy. The patient resides with a family member and attends Adult Day Care 5 days a week. The outpatient clinic provides the patient's primary care and he receives additional nursing support through his enrollment in HBPC.

In early March 2011, the facility admitted the patient to the Respite Care Program. He required assistance with ADLs, transferring, and ambulating. The plan of care was to monitor the patient's response to anticoagulation therapy, provide supportive care, and improve ambulation and ADLs with physical and occupational therapy services. Nursing staff discussed the frequency and goals of rehabilitative services with the patient's family at the time of admission. Documentation did not reveal that the family verbalized any concerns or complaints during his stay. The patient was discharged home after 2 weeks.

In late June 2011, the patient developed a fever and diarrhea. The patient's family contacted the Elgin VA Community Based Outpatient Clinic and was instructed to take the patient to the facility's ED. While in the ED, the patient was given intravenous (IV) fluids and evaluated with laboratory and x-ray diagnostic studies. An ED physician recommended admission to the hospital for a possible urinary tract infection. The patient was admitted to the inpatient medical unit after about 5 hours in the ED.

After the patient was admitted to the medical unit, the admitting physician called the patient's family and discussed the patient' diagnosis and treatment plan. Later that day, the urine test results became available and did not indicate an infection. The admitting physician subsequently ordered a chest x-ray. This revealed evidence of pneumonia, and the physician started IV antibiotic drugs.

The following day, the physician called the patient's family to explain the new diagnosis of pneumonia and plans for probable discharge 2 days later. On the third hospital day, the physician again called the patient's family to report that the patient continued to improve and he planned to discharge him the following day. Later that night, the patient vomited coffee ground emesis.[2] The on-call physician evaluated the patient, and noted that he was hemodynamically stable. The physician ordered monitoring labs and started an IV proton-pump inhibitor drug. [3]

The next morning, the physician called the patient's family to review the overnight events and plans for the patient to remain in the hospital for at least 1 more day of monitoring.

[1] Cerebrovascular accident is the rapidly developing loss of brain function(s) due to disturbance in the blood supply to the brain.
[2] Coffee-ground emesis refers to emesis (vomit) mixed with dark blood.
[3] Proton-pump inhibitor drugs produce long-lasting reduction of stomach acid.

On the fifth hospital day, the patient had again improved. The physician recommended discharge with an additional 10 days of oral antibiotic and oral proton-pump inhibitor drugs. He called the patient's family to review the discharge plans and new medications. The patient's family took him home later that day, after receiving oral and printed discharge instructions.

The next business day (2 days later), the HBPC nurse, contacted the patient' family via telephone for post-discharge follow-up care. Documentation of the call states that the family verbalized understanding the discharge medications and the need for follow-up care within 30 days. The patient had a HBPC nurse visit 1 week after discharge.

Review Results

Issue 1: Quality of Care on the Respite Care Unit

We did not substantiate the allegations that the patient did not receive help with his ADLs or receive the ordered rehabilitative treatments.

According to our inspection of medical record documentation, interviews with staff, and review of the facility's report, the patient received ADLs on a daily basis. We reviewed the available ADL documentation. It indicates the patient received assistance with bathing, dressing, and feeding. Shaving may not have occurred on a daily basis depending upon conflicts with the patient's schedule.

Rehabilitative therapy was included in the patient's treatment plan. Upon admission to the Respite Care Program, a consultation with a Physical Medicine and Rehabilitation Service was ordered. Physical Therapy evaluated the patient and recommended kinesiotherapy. Kinesiotherapy is prescribed to treat patients with general deconditioning who do not have the endurance to participate in the more challenging physical therapy sessions. The patient received four of eight scheduled treatments. Of the four missed sessions, two were due to conflicting medical appointments and two were missed because the patient refused to go.

The patient was also seen and evaluated by Occupational Therapy and participated in four sessions during his respite care stay. A feeding evaluation was performed and it was found that the patient needed supervision, but did not require assistive devices for meals.

Issue 2: Quality of Emergency Department Care

We substantiated that the patient was seen by two staff physicians and a resident during his 5-hour stay in the ED, for a total of three physicians; but we did not substantiate that the physicians did not communicate or coordinate care for the patient. We reviewed the medical record, interviewed facility department directors, and reviewed the facility's findings and supporting documentation.

The patient arrived in the ED at 11:45 a.m. The first tour of duty for physician coverage in the ED ends at 12:30 p.m. There is a note in the electronic medical record documenting hand-off communication between the physician ending this tour of duty and the physician covering the afternoon tour.

Staff described the standard procedure for physician hand-off as an in-person discussion of each patient chart. Nursing documentation of the ED care indicates there were hourly patient assessments.

Issue 3: Quality of Inpatient Hospital Care

We substantiated the allegation that the patient did not receive rehabilitative treatments; however, he did not meet the criteria for the intervention. He was acutely ill at the time. We did not substantiate the allegations that he was not assisted with ADLs, that he had a urinary Foley catheter inserted, or that discharge instructions and medication reconciliation were not provided.

The patient's functional status was assessed in the ED and again upon admission to the inpatient unit. The documented assessments did not identify new functional problems that would trigger a consultation for rehabilitative therapies.

According to our inspection of medical record documentation, staff interviews, and review of the facility's report, the patient received ADLs on a daily basis. Nursing documentation indicated that there were regular patient checks that addressed the patient's personal hygiene. The patient was not shaved because an electric shaver was not available as required for patients on anticoagulation therapy.

Medical record documentation indicated that the patient had an external urinary catheter throughout his hospital stay, rather than an indwelling urinary Foley catheter. An external catheter does not restrict movement and is a non-invasive mechanism to control incontinence and assist in precisely measuring urinary output.

The medical record documents that a nurse gave a copy of templated discharge instructions to the patient and patient's family. This standard discharge template records medications and future follow-up appointments. It noted the medication changes made during the patient's inpatient admission.

Our review of the patient's medical records indicated that the family received both verbal and written medication reconciliation by the pharmacist at the outpatient pharmacy window. During our interview, the complainant recalled this education session and agreed that medication reconciliation and education had been provided.

According to the patient's family, they received a discharge instruction printout, but there were no specific instructions regarding when to schedule a follow-up appointment. The

family called the HBPC nurse 2 days later and learned that no appointment was necessary as the patient has regular home nurse visits.

Conclusions

We found the facility's review of the allegations was thorough. We concur with their findings that there were no quality of care concerns during the patient's Respite Care unit stay, the ED evaluation, and the inpatient hospitalization. Our inspection of medical records, facility policy and procedure, and interviews support the conclusions.

Nursing personnel on the Respite Care unit attended to the hygienic needs of the patient. The unit managers provided opportunities for the patient and his family to express their concerns. After the facility investigated the allegations, the patient had another admission to the Respite Care Program. Both the patient and family were satisfied with his progress and care he received during this subsequent stay.

We found that the care provided in the ED included appropriate interventions and assessments. The inter-provider communication and coordination of care followed the facility policy. The physicians' face-to-face handoff with active review of the medical record demonstrates an effective communication process.

We found that the medical care provided during the patient's June 2011 hospitalization was appropriate and included attention to his hygiene and functional needs. We found that the physician's daily communication with the family is a model of patient-centered care.

Recommendations

We made no recommendations.

Comments

The VISN and Facility Directors agreed with the findings and recommendations (see Appendixes A and B, pages 8–9, for the full text of their comments).

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 13, 2011

From: Director, VA Great Lakes Health Care System (10N12)

Subject: **Healthcare Inspection – Quality of Care Issues, Edward Hines, Jr. VA Hospital, Hines, Illinois**

To: Chicago Regional Director, Office of Healthcare Inspections, VA Office of Inspector General

I have reviewed the document and concur with the recommendations. No corrective action plans are required.

Jeffrey A. Murawsky, M.D.

Appendix A

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 8, 2011

From: Director, Edward Hines, Jr. VA Hospital (578/00)

Subject: **Healthcare Inspection – Edward Hines, Jr. VA Hospital, Hines, Illinois**

To: Director, VA Great Lakes Health Care System (10N12)

I have reviewed the document and concur with the recommendations. No corrective action plans are required.

(original signed by:)

Sharon Helman

Appendix B

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	Verena Briley-Hudson, ARNP, MN, Project Leader JoDean Marquez, RN, Team Leader Debra Boyd-Seale, Ph.D. Monika Gottlieb, MD Judy Brown, Program Support Assistant

Appendix C

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