Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues
VA Medical Center
Atlanta, Georgia

Report No. 06-03742-142 **June 6, 2007**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The purpose of the review was to investigate allegations made by a complainant regarding patient care, communications, and cleanliness at the medical center. The complainant alleged that: (1) the patient did not receive timely diagnostic tests; (2) nothing was done to improve or stabilize the patient's condition; (3) the patient went without food and water for extended periods; (4) providers did not discuss results of tests or the patient's condition with the patient or his family; (5) sanitary conditions in the medical center were "horrific"; and (6) staff were impolite and uncooperative in responding to the complainant's issues. The complainant further alleged that after presenting these concerns to the acting medical center director, the patient was discharged abruptly, in an unstable condition, without discharge instructions.

We found that the patient received timely diagnostic tests and determined that appropriate care and treatment was provided to improve and stabilize the patient's condition during hospitalization. While we determined that the patient did not receive anything to eat or drink for long periods, we did not substantiate the implied inappropriateness because the patient had been intermittently placed on NPO (Nothing per Oral/Nothing per Mouth) status to undergo testing. We could not confirm or refute poor communication between providers and the patient, or providers and members of the patient's family. Additionally, we could not determine the degree of medical center cleanliness at the time of the patient's hospitalization. We did not substantiate that medical center staff members were impolite and uncooperative during attempts to discuss the family's concerns or that the patient was discharged abruptly because of family complaints to managers regarding the patient's care.

When we subsequently contacted the patient at his home, he indicated satisfaction with the care received and in retrospect, he and his family would not make the same complaints. Based on these findings, we did not make any recommendations. The acting medical center director concurred with our report findings.

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

TO: Director, VA Medical Center, Atlanta, Georgia (508/00)

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues, VA Medical Center, Atlanta, Georgia

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations of poor patient care at the Atlanta VA Medical Center (the medical center).

Background

The medical center is a tertiary care hospital that is part of Veterans Integrated Service Network (VISN) 7. The medical center provides primary and specialized outpatient health care, extended care, and acute inpatient medical, surgical, intermediate, and psychiatric care services.

The complainant alleged that her father-in-law received poor care during his 5-day hospitalization. She alleged that:

- The patient did not receive timely diagnostic tests.
- The patient went without food and water for extended periods.
- Providers did not discuss results of tests or the patient's condition with the patient or his family.
- Staff were impolite and uncooperative in responding to the complainant's issues.
- Nothing was done to improve or stabilize the patient's condition.
- Sanitary conditions in the medical center were "horrific."

The complainant further alleged that after presenting these concerns to the acting medical center director, the patient was discharged abruptly, in an unstable condition, without discharge instructions.

Scope and Methodology

We reviewed the patient's medical record, medical center and national policies, patient safety and environmental management records, and other applicable documents. We reviewed information from the patient advocate database. We contacted responsible medical center staff to determine if they were aware of the complaint and to identify actions taken as a result, and we spoke with the acting medical center director about his verbal exchange with the complainant. We reviewed documentation provided by the medical center to the VISN and the Veterans Health Administration (VHA) related to these complaints. We contacted the patient to discuss the specific issues outlined in the complaint and to inquire about his current health status.

This review was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case Summary

The 58-year-old patient was evaluated by a private sector physician on September 9, 2006, for a 3-week history of neurological symptoms. The physician diagnosed Bell's palsy and, since the patient did not have healthcare insurance, suggested obtaining additional medical care at the medical center. The patient, who had not received previous care at any VA facility, presented to the medical center emergency room 2 days later and was admitted for evaluation and testing. At the time of admission on September 11, the patient was alert and oriented to person, place, and time. The patient underwent a series of diagnostic laboratory and radiology tests over the course of his hospitalization and was subsequently diagnosed with a subacute ischemic cardiovascular accident (stroke). The patient was discharged in stable condition on September 15 with plans for continued neurology follow-up and monitoring by primary care.

Inspection Results

At the time of our contact with the patient, he requested that we not pursue this complaint any further and that we not contact the complainant, his daughter-in-law. The patient speculated that the concerns voiced by the complainant were possibly due to the emotional impact of the medical events and that, retrospectively, he would not share the same complaints at this time. We determined that the patient received appropriate care.

Diagnostic Tests. We did not substantiate the allegation that the patient did not receive timely diagnostic tests. On September 11, the provider ordered computed tomography (CT) exams, an ultrasound Doppler examination of the carotid arteries, and a chest x-ray. On September 12, the provider ordered a magnetic resonance imaging (MRI) exam of the head and a magnetic resonance angiography (MRA) exam to evaluate cerebral circulation. All of these tests were completed within 2 days of the request. A

transesophogeal echocardiogram (TEE)[1] was ordered by the provider on September 11 and the patient was placed in an overbook status (if cancellation occurs) on September 14; the test was completed on September 15. In addition, the provider ordered several diagnostic laboratory tests, including a complete blood count (CBC), partial thromboplastin time (PTT),[2] urinalysis, and other routine tests to evaluate the patient's health status. We found completion of all requested diagnostic tests within reasonable timeframes.

Nutrition. We did substantiate that the patient did not receive anything to eat or drink for long periods during his hospitalization. However, this was appropriate because the patient had been intermittently placed on NPO (Nothing per Oral/Nothing per Mouth) status to undergo testing. The complainant alleged that the patient did not receive food or water for a 10-hour period on September 14 and, on September 15, had not received food or water since the family's visit the previous day. We found documentation that, on September 14, the patient was NPO starting at 8:41 a.m. so he could be in an overbook status for a TEE later that day; the NPO continued through the lunchtime meal on September 14. The NPO status was continued until it was determined that the test could not be completed and staff ordered a late tray at 4:46 p.m. Medical record documentation indicates that the patient ate 75 percent of his dinnertime meal.

The patient was again on NPO status beginning at 12:00 a.m. on September 15 with the TEE performed at 1:25 p.m. The patient returned to his hospital room at 3:15 p.m. and the NPO status continued until 3:30 p.m. to allow for interpretation of the results and to assure no further testing was required. The patient inquired about his discharge plans upon return to his hospital room after completion of the TEE, and the nursing staff notified the provider of the patient's desire to go home. We did not find documentation that the patient requested a meal or that a late tray was ordered for this date. The discharge order was written at 5:25 p.m., and the patient was discharged at 6:45 p.m.

Communication. We could not confirm or refute the allegation of poor communication between providers and the patient, or providers and members of the patient's family. We did not find clear documentation of discussions with the patient or family except for the discharge instructions. However, during our interview, the patient did not voice concerns regarding poor communication by his medical providers at the time of his hospitalization.

We did not substantiate the allegation that medical center staff, including the "hospital administrator," were impolite and uncooperative during attempts to discuss the family's concerns at the time of the patient's hospitalization. In response to the letter of complaint to the OIG, a copy of which the complainant had also sent to the medical center, the acting director contacted the complainant by phone on September 29 to determine the patient's current condition. Immediately after he introduced himself, the complainant

[1] The test is used to detect clots inside the left atrium of the heart for patients who have had a stroke.
[2] A test that measures clotting time in plasma (the liquid portion of blood).

realized that the acting director, who speaks with a distinct accent, was not the person she had voiced concerns to. The remainder of the phone conversations focused on the patient's health status. We also found that the patient advocate did not have any record that the complainant or patient voiced any concerns about staff courtesy.

Condition Improvement/Stabilization. We did not substantiate the allegation that nothing was done to improve or stabilize the patient's condition. Please see the above section regarding diagnostic testing for his stroke. The medical record documents that the patient was not experiencing an acute or imminent stroke on presentation to the medical center, but was found to have suffered a recent (subacute) stroke. We found that the patient was started on therapeutic dosages of aspirin (helps prevent the recurrence of a stroke) and a statin drug (used to reduce cholesterol). Additionally, the discharge summary documents almost complete resolution of stroke symptoms at the time of discharge.

Cleanliness. We could not determine the medical center's degree of cleanliness at the time of the patient's hospitalization in September 2006. However, for the period May through October 2006, we did not identify any complaints to the patient advocate related to cleanliness or safety on the patient's hospital unit. Additionally, the medical center has been recognized for ongoing efforts in cleanliness, including performance at or above the standard during 2005 and 2006 Annual Workplace Evaluations and during the 2006 OIG *Combined Assessment Program Review of the Atlanta VA Medical Center*, Report No. 06-01571-231, issued September 29, 2006.

Discharge Planning. We did not substantiate the allegation that the patient was discharged abruptly because a family member complained to managers about his care. The patient was undergoing diagnostic testing for his stroke throughout his hospitalization. A September 15 progress note, timed at 11:57 a.m., states "TEE: today, according to results may discharge pt [patient] today with f/u [follow up] with neurology as outpt [outpatient]." The discharge occurred at 5:25 p.m., a few hours after completion of the final diagnostic test (the TEE) on September 15. The discharge instructions provided clear information on the patient's diagnosis, medication regimen, and the plan for continued outpatient follow-up with neurology providers.

In our conversation with the patient, he reported feeling well and stated that he was returning to work on a part-time basis. Medical record documentation reflects appropriate arrangement of outpatient follow-up care with a VA primary care provider and neurologist.

Conclusion

We found that the patient received appropriate and timely medical care. We did not substantiate the quality of care allegations. We could not confirm or refute the allegation regarding poor communication and unit cleanliness at the time of hospitalization. The patient indicated that he was satisfied with the care he had received, and in retrospect, he

told us he thought the complainant's concerns may have been due to the emotional impact of medical events at the time of hospitalization. Based on these findings, we did not make any recommendations. The medical center director concurred with our findings. We consider the issue closed.

JOHN D. DAIGH, JR., M.D.
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Healthcare Inspections

Appendix A

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates Director, Atlanta Office of Healthcare Inspections (404) 929-5962
Acknowledgments	Toni Woodard, Healthcare Inspector Michael Shepherd, M.D.

Appendix B

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