



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Clinical and Administrative Issues
Ralph H. Johnson VA Medical Center
Charleston, South Carolina**

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Executive Summary

The purpose of the review was to determine whether the allegation that a registered nurse discontinued an intravenous line (IV) without authorization on an unstable patient had merit.

We substantiated that the nurse discontinued the IV, but the patient was asymptomatic, met discharge criteria, and had a valid discharge order. However, our review revealed that the nurse did not clarify the patient's condition before discharge, and the nurse and the physician did not communicate adequately on the patient's status despite the patient's developing pneumothorax, which is an accumulation of air in the space around the lung causing collapse of the lung; this was a known complication of the patient's procedure. We also found that staff did not follow policy related to orders as the patient never had a valid IV order. The complainant did not use the patient incident reporting (PIR) system, and the responsible nurse manager and Quality Manager were unaware of the incident.

We recommended that: (a) staff adhere to medical center policies as they relate to orders, (b) managers develop policy to standardize the hand-off communication process, and (c) staff is educated on the use of the PIR system for reporting real or potentially harmful patient related occurrences. The Veterans Integrated Service Network and Medical Center Directors agreed with our findings and recommendations and provided acceptable corrective action plans.



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

TO: Director, VA Southeast Healthcare Network (10N7)

SUBJECT: Healthcare Inspection – Clinical and Administrative Issues, Ralph H. Johnson VA Medical Center, Charleston, South Carolina

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation to determine the validity of an allegation regarding the performance of clinical duties on the ambulatory surgery unit at the Ralph H. Johnson VA Medical Center (the medical center) in Charleston, South Carolina. We also assessed the adequacy of hand-off communication and use of incident reporting in this case.

Background

The medical center is a tertiary care hospital that is part of Veterans Integrated Service Network (VISN) 7. The medical center has 98 operating hospital beds and provides medical, surgical, psychiatric, and long-term care services.

A complainant alleged that a registered nurse (RN) assigned to the ambulatory surgery unit discontinued an intravenous line (IV) on an unstable patient without a physician's authorization. The complainant reported that he did not report this incident to the nurse manager (NM), nor did he use the patient incident reporting (PIR) system, because management does not address issues brought to their attention regarding nursing care on this unit.

The ambulatory surgery unit provides nursing care to patients undergoing some surgical and invasive diagnostic procedures requiring moderate sedation (drug-induced depression of consciousness) on an outpatient basis. Moderate sedation requires that the patient have at least a peripheral intravenous (IV) line (a short catheter inserted through the skin into the vein) for medication administration. IVs are discontinued before patients are discharged home.

Medical center and service level policies related to the care of patients on this unit state:

- Physicians are responsible for entering pre-procedure, post-procedure, and discharge orders into the computerized patient record system (CPRS).
- Physicians are responsible for ordering all IVs and IV medications.
- RNs are responsible for the monitoring of patients before and after procedures, and for documenting patient-specific data on a standardized flow sheet (documentation tool used to record specified clinical factors monitored over time).
- When ordered by a physician, RNs are authorized to initiate IVs, and to maintain and discontinue IV lines per medical center protocol.
- Patients can be discharged when they meet specific discharge criteria, and when there is an order for discharge. The discharge criteria is based on a modified Aldrete score, which is a numerical scale used to assess a patient's consciousness, activity, airway, oxygen level, blood pressure, and heart rate.
- All employees are responsible for reporting actual or potentially harmful patient-related incidents using one of seven options for reporting.

Scope and Methodology

We visited the medical center June 28–29, 2006. During our visit, we interviewed RNs and NMs assigned to the ambulatory surgery unit and interventional radiology, patient advocates, and quality management (QM) staff. Prior to our visit, we interviewed the complainant. We reviewed the patient's medical record, medical center and service level policies, medical staff by-laws, and other applicable documents. We performed the inspection 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 underwent a computerized tomography (CT) guided lung biopsy, an invasive procedure requiring moderate sedation via an IV, on May 9, 2006, at 10:00 a.m. He returned to the ambulatory surgery unit for post-procedure monitoring with his IV in place. The patient's discharge was scheduled for 3:30 p.m. that afternoon. Per protocol, the patient underwent serial chest x-rays (CXRs) at 1, 2, and 4 hour intervals after his lung biopsy. Those CXR reports reflected the following:

- 11:35 a.m. - presence of a pneumothorax (PTX¹ - accumulation of air in the space around the lung causing collapse of the lung), which the interpreting radiologist discussed with the interventional physician.

¹ PTX is a known complication of CT guided lung biopsy.

- 12:27 p.m. – slight increase in the PTX, which was discussed with the interventional physician.
- 2:27 p.m. – PTX measuring 20–30 percent, which is a significant collapse of the lung requiring intervention.

Sometime after 2:00 p.m., the ambulatory surgery RN began preparing the patient for discharge and discontinued his IV. The interventional physician documented in his 2:58 p.m. note that the patient was asymptomatic, but would need to stay overnight and would likely need a chest tube, a decision he would make after the 4:00 p.m. CXR. He noted “an impression of enlarging PTX on the left” on the 4:02 p.m. CXR report. The patient returned to the radiology suite for the chest tube placement at 4:35 p.m. without an IV in place. The radiology nurse reinserted another IV prior to this procedure without difficulty. The patient was admitted to the hospital and discharged the following day in good condition after resolution of the PTX. Nursing documentation during and after the procedure indicates that the patient’s vital signs and oxygen levels were stable, and he did not have any pain.

Inspection Results

Issue 1: Discontinuation of the IV

We did not substantiate the allegation that the RN improperly discontinued an IV on an unstable patient without authorization. While we confirmed that the nurse discontinued the initial IV, documentation indicated that the patient was asymptomatic and met discharge criteria. In addition, the medical record contained a valid discharge order written earlier that day. Absent specific information and instructions to the contrary, we found the RN’s actions to be supported by policy. However, we believe that the RN did not exercise good clinical judgment as she did not clarify the patient’s condition before preparing him for discharge, even though she knew he was being followed for a possible PTX.

During the course of this review, we also found that the patient never had a valid IV order. The physician did not order the initial IV (pre-CT guided lung biopsy). He used an order set (a menu of select orders which allows for rapid order entry) for patients undergoing this procedure and failed to select the order for the IV. The radiology nurse, knowing the patient would require moderate sedation, initiated the patient’s peripheral IV (absent a valid order). Later, in preparation for the chest tube placement, another radiology nurse also initiated an IV without verifying the presence of an order in CPRS. While the staff provided the care the patient needed, they did not strictly adhere to policy. Orders are important because they reflect the treatment that was intended and authorized by a licensed medical provider. Failure to follow physician orders, or initiating treatment that was not ordered, could harm the patient.

Issue 2: Communication

Hand-off communication, defined as the transfer of patient information between providers, was inadequate. The only verbal communication between the RN and the physician regarding the patient's condition occurred at lunch time, when the RN called the interventional physician to ask about a diet for the patient. She stated the physician told her not to feed the patient because the patient needed another CXR; the physician would make a decision regarding the patient's care after reviewing the results. The physician, however, said he told the RN not to feed the patient because he might need to insert a chest tube (which would indicate to the RN that the patient had a significant PTX). We did not find any documentation by either the RN or the physician regarding the discussion of the patient's status. The physician and the RN recalled the content of the conversation differently, and we could not determine with certainty what information about the patient's status was actually exchanged.

The RN told us that she proceeded with her usual activities because she was unaware of the severity of the patient's PTX and the possibility that the patient might be admitted for overnight observation. She also told us that in her experience, patients often go home with small PTXs. She states that her scheduled tour of duty ended at 2:30 p.m., but she stayed over to assist the other ambulatory surgery nurse (the lone RN until 6:30 p.m.). She left sometime before 3:00 p.m. She told us that the patient had a discharge order for "May 9, 2006 @ 3:30 p.m.," entered by the physician at 9:12 a.m. that morning, and the patient had told the nurse that he wanted to be ready to go home when his wife arrived. Since the patient met discharge criteria and had a discharge order, she prepared him for discharge, discontinued the IV, and documented a discharge time of 3:00 p.m. The physician entered a progress note at 2:58 p.m. indicating the possibility of chest tube placement and overnight admission, and cancelled the discharge order at 3:08 p.m.

Policies and procedures are usually designed to provide general guidance on functions and practices in the work environment, and to standardize the way that work gets done. Because policies and procedures cannot cover every possible scenario or complication, strong communication to assure all providers are aware of the patient's status and plan is critical. In this case, the lack of communication between the providers, along with the timing of the discharge (at nursing shift change), resulted in a breakdown in continuity of care.

We also found that the standardized flow sheets used by the ambulatory surgery RNs could be improved. As currently written, the flow sheets are adequate tools to record vital information on patient status and recovery, yet they lack space for documentation of any narrative information on a patient's status. In this case, the patient's clinical status, as reflected on the flow sheet, showed that he was asymptomatic, stable, and at baseline for discharge. However, had the developing PTX been documented somewhere on the flow sheet for easy reference, this information may have prompted the RN to contact the physician before initiating activities necessary for the patient's discharge.

Issue 3: Patient Incident Reporting

We did not confirm the complainant's report that the NM does not address patient care issues brought to her attention. He stated that he has brought other performance issues to management's attention, and never received any feedback. QM staff confirmed that the complainant had previously reported instances of perceived staff performance issues relating to delivery of patient care. Management told us they address staff performance issues through the appropriate channels, and it would be inappropriate to discuss administrative actions taken with complainants. QM staff told us that if patient care or process issues were brought to their attention, improvement actions would typically be shared with the complainant. The NM told us that, in this case, the complainant did not tell her about the incident or his concerns. Neither the Risk Manager nor the Quality Manager knew about the allegation prior to our visit. The complainant told us that he knew there was a PIR system, but he chose not to use it because he did not think the nurse's performance would be addressed. Policy requires staff to report actual or potentially harmful incidents to the proper authorities.

Conclusion

We substantiated that the RN discontinued the IV; however, the patient did not appear to be unstable after his CT guided lung biopsy despite the presence of a PTX. He met discharge criteria as defined by policy, and a discharge order was present in the medical record. We found staff did not follow policy related to orders, and the nurse and the physician did not communicate adequately on the patient's status. The complainant did not use the PIR system to report problems that could potentially impact patients. The patient was not harmed as a result of this incident.

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that:

- a) Patient care providers adhere to medical center policies related to orders.
- b) Managers develop policies and procedures to standardize the hand-off communication process.
- c) Staff is educated on the use of the PIR system for reporting actual or potentially harmful patient related occurrences.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with our findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plans. Policies related to orders will be reviewed with the radiology physicians and nurses, and the Patient Care Manager will do chart audits to ensure compliance with policy. The medical center published a new policy on the hand-off communication

process and developed a mandatory educational course on the patient safety program for fiscal year 2007.

Assistant Inspector General Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 14, 2006

From: Acting Director, VA Southeast Healthcare Network (10N7)

Subject: **Draft Report** – Healthcare Inspection – Clinical and Administrative Issues, Ralph H. Johnson VA Medical Center, Charleston, South Carolina - Project Number: 2006-02181-HI-0367

To: Director, Management Review Service (10B5)

I concur with the report findings and the corrective actions identified in the attached facility response.

(original signed by:)

Thomas Cappello, MPH, FACHE

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 14, 2006

From: Director, Ralph H. Johnson VA Medical Center (534/00)

Subject: **Draft Report** – Healthcare Inspection – Clinical and Administrative Issues, Ralph H. Johnson VA Medical Center, Charleston, South Carolina - Project Number: 2006-02181-HI-0367

To:

I concur with the report findings and corrective actions identified in the attached facility response.

(original signed by:)

FLORENCE HUTCHISON, MD

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

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that:

- a) Patient care providers adhere to medical center policies related to orders.

Concur **Target Completion Date:** October 1, 2006

This issue was confined to Interventional Radiology. Policies related to orders will be reviewed in detail with all Radiology providers and Interventional Nurses. The Patient Care Manager of the Interventional Nurses will be tasked to audit random charts on Radiology cases which require moderate sedation to ensure policy compliance. Audits will begin October 2006 and reports will be forwarded to the Quality Manager each month through March 31, 2007 to ensure compliance. If compliance is not maintained, further action plans will be developed.

- b) Managers develop policies and procedures to standardize the hand-off communication process.

Concur **Target Completion Date:** Completed

A center policy, 11-06-16 "Communication of Patient Information-Hand Off Communication" was completed and published centerwide on September 7, 2006 (see attached²). This policy standardizes the hand-off communication process.

² Attachments are not included in this report.

c) Staff is educated on the use of the PIR system for reporting actual or potentially harmful patient related occurrences.

Concur **Target Completion Date:** March 31, 2006

A center policy, 00QM-05-03 "Patient Safety Program" was published December 15, 2005 (see attached). This policy delineates the process for reporting actual or potentially harmful patient related occurrences. A SYNQUEST educational course has been developed and in place for centerwide education (see attached). This program will be mandatory for all employees for FY 07.

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
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Acknowledgments	Susan Zarter, RN, Team Leader Jerome Herbers, MD
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