



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Violation of Patient Rights Carl Vinson VA Medical Center Dublin, Georgia

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoiqhotline@va.gov
(Hotline Information: <http://www.va.gov/oig/hotline/default.asp>)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations that a patient's rights were violated at the Carl Vinson VA Medical Center (the facility); that the patient's Durable Power of Attorney for Health Care (DPAHC) may not have been valid; and that facility leaders were not responsive to staff and family concerns about this case.

We did not substantiate that a patient with dementia, who was deemed to have decision making capacity regarding where he wanted to live, was held against his will for an extended period of time. The Interdisciplinary Treatment (IDT) team made efforts to address the complicated medical, ethical, and legal considerations that delayed the patient's discharge to a Florida assisted care facility. While these actions were underway, the patient continued to reside on a secure CLC unit where he knew other patients and staff, understood the day-to-day routine, and received care in a safe environment.

We could neither confirm nor refute the validity of the patient's DPAHC. Due to a lack of medical record documentation, a Regional Counsel attorney was unable to determine whether the document was legally executed. However, during most of the patient's nearly 3-year stay at the facility, the son was the patient's health care agent—a designation that providers and other family members did not question.

We confirmed that facility leaders did not appear to respond to clinicians' requests for assistance in resolving this case or document their responses to family concerns. We discussed these issues with facility leadership and were assured that complicated cases will continue to be discussed at the daily executive clinical meeting that includes the Service chiefs and the Chief of Staff. Further, facility leaders reported that they routinely have discussions with families over the telephone but also acknowledged the need to document follow-up of controlled correspondence.

We made no recommendations.



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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection–Alleged Violation of Patient Rights, Carl Vinson VA Medical Center, Dublin, Georgia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed an allegation of violation of patient rights at the Carl Vinson VA Medical Center (facility) in Dublin, GA. The purpose of the review was to determine whether the allegations had merit.

Background

The facility is designated as a Veterans Rural Access Hospital. It is located in Dublin, GA, and operates 34 acute care beds, 161 community living center (CLC) beds, and 145 domiciliary beds. Outpatient care is also provided at four community based outpatient clinics (CBOCs) in Albany, Macon, Brunswick, and Perry, GA. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 125,000 throughout 52 counties in Georgia.

According to the Veterans Health Administration (VHA) National Ethics Committee, clinicians have both an ethical and legal obligation to ensure that patients are informed about and allowed to participate in choices regarding their own health care. Respect for autonomy requires acknowledgment of an individual’s right to have opinions, to make choices, and to take actions based on personal goals and values.¹

Decision-making capacity is defined as the ability “to understand and appreciate the nature and consequences of health decisions and to formulate and communicate decisions concerning health care.” Although decision-making capacity and competency both describe patients’ ability to make decisions, they are *not* synonymous. Whereas competency is determined by a court of law, decision-making capacity is assessed by

¹ National Center for Ethics in Health Care, Veterans Health Administration, Department of Veterans Affairs, *Ten Myths About Decision-Making Capacity*, NEC_Report_20020201_Ten Myths_about_DMC.pdf

clinicians as an everyday part of clinical care.² When patients lack decision-making capacity for health care decisions, someone else must make decisions for them. Patients can choose, via a durable power-of-attorney for health care (DPAHC), the specific person (the “agent”) they wish to make health care decisions on their behalf in the event that they lose decision-making capacity in the future.

In March 2012, a complainant alleged that a patient, who was deemed to have decision-making capacity related to where he wanted to live and to accept or reject treatment, was held against his will for an extended period of time. The complainant also questioned the validity of the DPAHC and alleged that facility leaders did not respond to clinicians’ requests for assistance in this case.

Scope and Methodology

We conducted a site visit May 9–10, 2012. Prior to our site visit, we reviewed facility and VHA policies, directives, and handbooks; the patient’s electronic health record (EHR); correspondence between the patient’s family and facility managers; and quality management documents. While on site, we interviewed the facility Director, the Chief of Geriatrics and Extended Care, the patient’s interdisciplinary treatment team (IDT) members, Ethics Committee members, and other clinical and administrative staff knowledgeable about the issues. In addition, we interviewed the Chief of Staff (COS) and the regional counsel representative.

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.

² National Center for Ethics in Health Care, Veterans Health Administration, Department of Veterans Affairs, *Ten Myths About Decision-Making Capacity*, NEC_Report_20020201_Ten Myths_about_DMC.pdf

Case Summary

The patient was a widowed man in his nineties who had a medical history significant for hypotension (low blood pressure), Parkinson's disease, and benign prostatic hypertrophy (BPH-enlargement of the prostate gland). He was diagnosed with Alzheimer's-type dementia (a progressive brain disease that affects memory, thinking, and behavior) in 2007. At the time, he had been living alone in Florida and his daughters would check on him weekly. While the EHR is somewhat vague, it appears that sometime between February and September 2008, family members discovered that the patient showed evidence of possibly impaired judgment, specifically, he had no food in his house, had given away furniture and dishes, and had dismantled the stove hood and removed tiles and carpet from his home.

After this discovery, the patient went to live with his daughters for a short time. As the siblings had agreed that each would care for their father on a rotational basis, the patient moved to Georgia to live with his son and daughter-in-law in December 2008. The patient reportedly became increasingly argumentative, was flushing food and small objects down the toilet, and began wandering away from his son's home. To prevent the wandering, the patient's son erected a fence; however, the patient dismantled it. At one point, the patient was picked up by local police and had to be returned to his son's home; at another time, the patient stepped in front of a car in an attempt to get it to stop. While the patient was not harmed in either of these episodes, his behavior prompted the family to seek assistance.

In late December, the patient was admitted for 15 days to a private-sector psychiatric facility with a diagnosis of altered mental status and cognitive³ decline. During his hospitalization, he participated in individual and group therapies. He was continued on donepezil (to treat dementia) and carbidopa (used to treat Parkinson symptoms such as muscle stiffness, tremor, and difficulty with movement). His provider also prescribed citalopram for depression and anxiety, and memantine to improve his cognitive function. During hospitalization, the patient showed improvement in mood. His intermittent confusion and irritability gradually resolved. Upon discharge, the patient was alert and oriented to person and generally to time and place. His mood was reported as "fairly good" and his affect was mildly constricted; however, his judgment and insight remained impaired. He was discharged to a supervised personal care home in January 2009.

In early February, the patient's daughter-in-law brought him to one of the facility's CBOCs where he was evaluated by Psychiatrist A via tele-mental health (TMH). The progress note reflects that there was evidence of worsening dementia but there were no affective (mood) or psychotic symptoms at that time. According to family members, the

³ Cognition refers to mental processes such as attention and memory, and the ability to produce and understand language, solve problems, and make decisions. Cognitive decline is a reduction in the ability to engage in conscious intellectual activity such as thinking, reasoning, or remembering.

patient's cognitive functioning had improved on his current treatment. The patient was instructed to continue his medications at the current dosages and to follow up with TMH in 6 weeks.

One week later, the patient's son and daughter-in-law brought him to the facility's emergency room with a complaint of altered mental status. They stated that while in the personal care home, the patient attempted to flee multiple times, "coveted"⁴ small items like salt shakers, and was increasingly agitated. The patient and family met with a social worker who arranged for them to be seen by a mental health provider the following morning.

The following day, psychiatrist A evaluated the patient and diagnosed him with adjustment disorder with anxiety secondary to [personal care home] placement. Psychiatrist A prescribed quetiapine, a medication approved by the Food and Drug Administration for treating mania (frenzied, abnormally excited, or irritated mood), schizophrenia, and certain types of depression, but it is also sometimes prescribed for its nonspecific sedating effects. Additionally, providers discussed with the family the possible need for placement in a secured dementia unit as a means to assure the patient's care and safety. The family was reportedly not agreeable to a change of placement at that time as the patient's personal care home was closer to where they lived.

Two weeks later, the patient was brought to the facility by his daughter-in-law who reported several recent falls and periods of agitation. Psychiatrist A discontinued the quetiapine due to concerns that it may have contributed to his falls and prescribed lorazepam 0.5 milligrams (mg) as needed for anxiety and 1 mg at night for insomnia. The patient returned to his personal care home.

In mid-March, the patient was seen at the CBOC for his follow-up TMH appointment. Psychiatrist B noted the patient was alert and oriented to person and place, but only partially to time. His thought processes were generally "relevant and linear," and he was "cognitively intact with patchy deficits in memory." Psychiatrist B discontinued the lorazepam (with instructions to take it as needed for 14 days to address any possible withdrawal symptoms) and prescribed haloperidol 0.5 mg dose at bedtime for agitation.

In early April, the patient was admitted to the facility after experiencing more than 20 falls during the 2 months he resided in the personal care home. The inpatient provider submitted a consult request to Geriatrics and Extended Care Service to evaluate the patient for placement on the dementia unit. Two days later, he was accepted for transfer to the facility's dementia unit. The family provided a copy of the DPAHC designating the patient's son as the primary health care agent and his daughters and daughter-in-law as secondary agents.

⁴ The EHR uses the term "covet," although it is more likely that the patient was collecting small items.

The patient was alert and cooperative on admission. His medication regimen included donepezil, citalopram, memantine, and lorazepam 1 mg at bedtime. He participated in restorative activities to maintain his functional independence to the extent possible, and he participated in group activities such as bingo, dancing, and cookouts. The patient continued to experience falls as he would forget to use or lock the brakes on his rollator walker, so a protective helmet and hip protectors were ordered. His general medical condition remained the same and he continued to require supervised nursing care.

In late July, the patient was transferred to the facility's acute care ward after experiencing a fall which resulted in a non-displaced hip fracture. Surgical intervention was not recommended so the patient was transferred to the facility's rehabilitation unit. He had limited ability to participate in therapy due to general weakness and dementia, and in early August, the family was informed that the patient might be aspirating (inhaling food, drink, or secretions into the lower airways) due to his poor nutritional status. The family declined a feeding tube and the patient was referred for palliative care⁵ related to his weight loss. While on the palliative care unit, his oral intake, strength, weight, and ambulatory status improved. In October, the patient was transferred back to the dementia unit as he continued to be at risk for elopement.

From October 2009 to December 2010, the patient's dementia unit stay was relatively uneventful. In addition to his history of falls, nursing staff also suspected bulimic behaviors, in which the patient would go to his room after eating and presumably force himself to vomit. While staff did not directly observe any actual vomiting, family members indicated that the patient had deliberately vomited his food in the past, and reported, "He does that when he doesn't get what he wants." Nursing staff began observing the patient after meals to minimize this behavior.

In January 2011, the patient began to continually verbalize to staff his desire to live out the rest of his life in Florida. The IDT social worker began exploring possible assisted living placements in Florida, but no specific discharge planning occurred. Several e-mails between the social worker and family members reflect that while they were aware of their father's request, they felt he was in the best possible place and that they were satisfied with his care.

The patient's primary provider, a nurse practitioner (NP), told us that around June 2011, she began to question whether the patient's cognitive impairments were as severe as the treatment team once thought. Specifically, the NP described a story that the patient repeatedly told, but that his adult children later refuted. When the NP asked the patient about this discrepancy, the patient never repeated the story again. The NP told us that after this exchange, she felt that to some extent, the patient's communications and actions related to this story may have been reasoned and deliberate, possibly reflecting a higher

⁵ To relieve or lessen symptoms or stress without curing, and to mitigate or to alleviate pain and suffering.

level of cognitive functioning and ability than staff previously believed. In light of the patient's ongoing requests to move to Florida, multiple evaluations were completed to determine whether the patient had decision-making capacity, and therefore the right to decide where he wanted to live.

In early July, a clinical psychologist evaluated the patient's capacity to make informed decisions about where he wanted to live. This evaluation found that the patient "had a satisfactory grasp of his status and circumstances," that his "comprehension and reasoning ability in the here and now" were satisfactory, and that he was able to make informed decisions about where he chose to reside with care assistance. In response, the IDT social worker began contacting assisted living facilities in Florida that offered the same safety and security features as the dementia unit.

In late August, the IDT social worker sent a notice to family members about the patient's upcoming annual treatment and goal-setting meeting. While we were unable to determine the content of the letter, the patient's son apparently thought that actions were underway to discharge his father from the dementia unit. A progress note reflects that the annual meeting would focus on the results of the decision-making capacity evaluations and the patient's desire to move to Florida, but the family was not supporting the decision.

In early September, the CLC NP submitted a consult to the Ethics Committee noting, "Veteran continuously expresses his wishes to [unit] staff to be discharged to Miami, FL to live out the remainder of his life; family conference held and family/HCPOA [health care power-of-attorney] not agreeable to this, indicating that veteran has exhibited same type of manipulative behavior in former placements in an attempt to get his way." The consult request described the results of the July psychologist's evaluation. The consult (completed in late September) referred the team to Regional Counsel for guidance related to the legal issues of the case.

In mid-September, psychiatrist A conducted a second evaluation as to whether the patient had capacity to decide where he wanted to live. The reason for the second evaluation is not clear, although it was likely to confirm the findings of the first evaluation completed by the psychologist. Psychiatrist A found that at the time of the evaluation, the patient's capacity and reasoning were satisfactory, and he could choose where he wanted to live with 24-hour supervisory care.

That same day, the annual IDT meeting was held with the patient, his son and daughter-in-law, and one daughter from Florida in attendance. The primary focus of the meeting centered on results of the two evaluations of the patient's capacity to make decisions on his own behalf and his desire to move to Florida. The family did not support the patient's transfer or discharge from the facility's dementia unit. The following day, clinical staff

and facility leadership discussed the case and the Chief Nurse Executive directed staff to transfer the patient to a less restrictive unit.

Four days later, the patient was transferred to another unit, reportedly so that staff could evaluate the patient's ability to function when not on a secure unit. A special attendant had to be assigned to him because he continually tried to leave the unit. When asked where he was going, he stated, "I'm going to Florida." He was transferred back to the dementia unit for safety the following day. On this date, the son sent two letters to the facility Director expressing his concerns about the transfer to the less restrictive unit and the plans for discharge. Twice over the next week, the son contacted VISN 7 to report his concerns and advise that no one had replied to his concerns.

Two days later, facility staff participated in a conference call with a Regional Counsel attorney regarding the legal issues of the case. Regional Counsel recommended a decision-making capacity exam for "everything," including health care. Regional Counsel sent an extensive follow-up e-mail to the facility one week later outlining the important legal issues discussed during the September conference call.

In response to the Regional Counsel recommendation, psychiatrist A completed a mental status examination. Psychiatrist A documented that the patient's mental status was variable at times for making medical decisions and recommended that a panel of psychiatrists review this case in view of "strong family concerns." This panel evaluation did not occur.

In mid-October, the CLC attending provider submitted a consult request to the Ethics Committee seeking guidance on the validity of the January 2009 DPAHC given that the patient had a diagnosis of dementia at the time. Regional Counsel had already advised that due to a lack of medical documentation, there was no way to determine the patient's cognitive status and ability to designate a DPAHC in January 2009.

In November, the CLC attending provider evaluated the patient and documented that he appeared to have decision making capacity to determine his preferences for medical treatment. She wrote, "Specifically, he did not want to be resuscitated but wanted to be treated for any illnesses that might arise." This evaluation would not have constituted a decisional capacity exam for "everything" as recommended by Regional Counsel.

In early December, the Ethics Committee completed the October consult and documented that as a matter of record: he (the patient) had not been evaluated to be incompetent at any time by this facility or other facilities in Florida; it was stated twice at this facility by different mental health providers that he was found competent to decide whether to remain in Georgia or return to Florida; that the medical record contained multiple entries that he had made known his wish to revoke the DPAHC held by his son; and that it was noted that he never refused needed care, that he had ample funds to pay for private care if

necessary, and that he wished to return to Florida. The Committee recommended that the patient be transferred to a facility in Florida that was able to provide his care and that he be assisted in obtaining his own legal counsel if necessary.

In January 2012, the patient began spitting out food and exhibiting bulimic behaviors again. Staff observed him for 15 minutes after meals which seemed to alleviate the behavior. Also in January, family members agreed to a possible transfer to Florida but requested additional information about placement and finances. Staff made contact with Regional Counsel about the family's stipulations for transfer, and the IDT social worker began pursuing placements again.

In mid-February 2012, while his son and daughter-in-law were visiting him at the facility, the patient was found slumped over in his chair. The patient had a blood urea nitrogen level of 99 (normal 8-24) and creatinine of 7 (normal .6-1.2) which were thought to be related to dehydration and BPH. A chest x-ray revealed a left lung base pneumonia. The family requested comfort care, so the patient was transferred to the palliative care unit with orders for intravenous hydration and antibiotics to treat the dehydration and pneumonia. The patient's condition deteriorated and he passed away in late February.

Inspection Results

Issue 1: Violation of Patient Rights

Patient Confinement

We did not substantiate that the patient was held against his will, thereby violating his rights.

For more than 2 years, the patient resided on a locked unit in the CLC due to behavioral issues and safety concerns attributed to his dementia. During that time, the patient's son, who was the designated health care agent, was included in quarterly treatment team meetings, was consulted for treatment decisions, and provided informed consent when needed.

The patient began voicing his desire in January 2011 to return to Florida to "live out his final days." While the IDT social worker began a preliminary search for appropriate assisted care facilities, the patient was presumed to *not* have decision-making capacity because of his dementia, and the son, as health care agent, would need to approve of placement. At the time, the patient's son and daughters were satisfied that their father's care and safety needs were being addressed in the CLC.

Two evaluations, conducted months apart, established that the patient had decision-making capacity regarding which State he wanted to live in; however, he still had limited

insight and judgment in other areas and he would not be able to independently complete the tasks necessary to move to Florida. Family members typically visit and select the assisted living facility, complete the admission paperwork, arrange payment for all fees and costs, and essentially serve as the point of contact for matters that the patient either can't participate in due to physical or mental deficits or for other reasons chooses not to be involved in.

Because the family (including the son who was still the designated health care agent and managed the patient's finances) was initially opposed to moving the patient to Florida and would not take a proactive role in arranging for his transfer, the facility had to address some practical and legal issues before they could honor the patient's wishes. Specifically, the facility needed to determine whether the patient could make his own health care decisions. If so, the DPAHC would not be invoked and the patient would be free to make his decisions about care and placement, regardless of whether his family agreed. If the patient did not have decision-making capacity related to his health care needs, then the facility had to determine whether the designated agent was making decisions on behalf of the patient that aligned with the patient's previously stated wishes.⁶ If it was found that the agent's actions were not consistent with the patient's wishes, then a new agent may need to be appointed to ensure that the patient's rights were being upheld.

We found that the IDT team took appropriate actions to address the complicated medical, ethical, and legal considerations that delayed the patient's discharge to a Florida assisted care facility. Multiple mental health evaluations were conducted to determine decision-making capacity, and the Ethics Consultation Team met several times to discuss the case and provide guidance to the clinicians. Further, the IDT team met with the facility's legal counsel to assess and address the legal aspects of the case. The IDT team social worker also contacted nursing facilities in Florida in an effort to facilitate the transfer.

Between September and December 2011, while the multiple evaluations and consultations were being completed, the patient resided on a secured unit where he knew other patients and staff, understood the day-to-day routine, and received care in a safe environment. While the patient continued to voice his desire to move to Florida, the facility was obligated to ensure the patient's care and safety until the transfer could be effected. In January 2012, the patient's family agreed to his transfer to a facility with the same capabilities; however, the patient's condition had already started to deteriorate and he was no longer stable for transfer.

⁶ In this context, those wishes that were verbalized or documented before the patient lost decision-making capacity.

DPAHC Issues

Validity of initial DPAHC designation. During our interview, the complainant questioned the validity of the DPAHC, as follows:

- The document was apparently completed during or shortly after the patient's private-sector psychiatric hospitalization in January 2009. The patient was hospitalized because of erratic behavior and mental status changes, and the complainant wondered whether he (the patient) had decision-making capacity at that time to be able to legally designate a DPAHC.
- The patient and his son allegedly had a difficult relationship, making it unlikely that the patient would select his son to be his health care agent.
- EHR documentation in early April 2009 (when the patient was initially admitted to the CLC) reflected that the patient only had a Power-of-Attorney for financial matters, but that several days later, family members produced the DPAHC allegedly completed in late January.

Although smudged, it appears that the DPAHC paperwork was executed sometime in mid- to late January 2009.⁷ The document contains the signatures of two witnesses who attested to having watched the patient sign the document; they did not have a role in judging whether the patient met other criteria for completing the document. The document designates the son as his health care agent, with his two daughters and daughter-in-law as successors if the son was unable to perform the necessary duties. The document permits the agent to make any and all decisions concerning personal care, medical treatment, hospitalization, and health care.

Due to a lack of overall medical record documentation specifically addressing the patient's cognitive status and ability to make decisions at the time the DPAHC paperwork was completed, a Regional Counsel attorney was unable to determine whether the document was legally executed, and therefore, valid. However, the EHR clearly reflects that for more than 2 years, facility providers and the other family members did not question the son's status as the designated agent and routinely communicated with him or his wife about the patient's condition and care needs. It appears that questions about the validity of the DPAHC arose after the son expressed opposition to the patient's possible discharge plan.

Validity of ongoing DPAHC. The EHR contains several entries, including an October 13 progress note written by the social worker and co-signed by the NP and attending physician, which reflected the patient did not want his son to be his health care agent. The complainant implied that the DPAHC should have been revoked in accordance with the patient's wishes.

⁷ There are two digits on the date line, but the numbers are not readable.

According to Georgia law (O.C.G.A. § 31-32-4.), a Georgia Advance Directive for Health Care may be revoked at any time, regardless of the declarant's mental state or competency. Revocation can occur in several ways, to include:

1. By completing a new advance directive for health care.
2. By burning, tearing up, or otherwise destroying the existing advance directive for health care.
3. By writing a clear statement expressing the intent to revoke the advance directive for health care.
4. By orally expressing the intent to revoke the advance directive for health care in the presence of a witness 18 years of age or older who confirms this in writing within 30 days. The revocation is effective when the treating physician documents it in the medical record.

As the patient would not have known the law's requirements, facility staff would have needed to assist him in completing the revocation. It did not appear, however, that staff considered the patient's statements to be requests for assistance in revoking or amending his DPAHC until the Ethics Committee discussed and documented this on December 2, 2011. The son subsequently deferred decision-making to his older sister.

DPAHC treatment decisions. The complainant alleged that the son, as agent, authorized a Do Not Resuscitate (DNR) order contrary to the patient's previously expressed wishes. VHA requires the use of "substituted judgment" whereby surrogate decision makers (agents) base decisions on their specific knowledge of the patient's values and wishes pertaining to health care choices; in other words, what the patient would have wanted if the patient were capable of expressing those preferences. That decision may not necessarily coincide with what the agent and health care team otherwise would consider optimal for the patient.

The patient was considered a "full code" upon admission to the CLC in April 2009. However, after the patient's hip fracture in July and subsequent clinical deterioration, the son and both daughters agreed that the patient should not be aggressively resuscitated if he should experience a cardiopulmonary event. The CLC attending provider wrote a DNR order on August 3, 2009. While this order may have been a reasonable decision given the patient's age and clinical condition at the time, it nonetheless did not conform to the patient's expressed wishes as documented in the January 2009 DPAHC, where the patient initialed the line that stated, "I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures."

On November 23, 2011, the CLC attending provider evaluated the patient and found him to have decision making capacity to determine his preferences for medical treatment. She documented, "Specifically, he did not want to be resuscitated but wanted to be treated for

any illnesses that might arise.” Per the patient’s wishes, the DNR was continued. The patient did not experience any events requiring cardiopulmonary resuscitation from August 3, 2009 (the DNR date), to the time of his death.

In early February 2012, when the patient became ill with pneumonia, the family’s instructions to provide comfort care, which included hydration and antibiotics, was consistent with the patient’s expressed wishes in November 2011 when end-of-life care was specifically addressed with him.

During most of the patient’s nearly 3-year stay at the facility, the son was the patient’s health care agent. Facility providers acknowledged his role and routinely communicated with him and his wife about the patient’s status and needs. We noted, however, that providers did not consistently communicate with the son about the actions they were taking related to the patient’s possible transfer to a Florida facility. The son did not know about the July psychologist’s evaluation or September psychiatrist’s evaluation of decisional capacity. Further, in spite of specific instructions from the associate COS to “keep family aware of decisions we make,” the son did not learn of his father’s brief transfer to a less secure unit in September until after it occurred. While the capacity evaluations and unit transfer were not medical treatments or procedures requiring the son’s consent, they still represented a deviation from the patient’s existing treatment plan and should have been discussed with the son in a timely manner.

Issue 2: Leadership Responsiveness

We confirmed that facility leaders did not appear to respond to clinicians’ requests for assistance in resolving this case. Further, it did not appear that facility leaders responded to at least two of the family’s letters outlining their concerns. We discussed this with facility leadership and were assured that they discuss complicated cases such as this at the daily executive clinical meeting which includes the Service chiefs and the Chief of Staff. Further, they reported that they routinely have discussions with families over the phone.

After an IDT meeting in September 2011, family members sent several letters to the facility director in which a response was requested.⁸ Facility leaders told us that, per local practice, those letters and VISN 7 correspondence were forwarded to the appropriate Service chiefs for response. While it is a common practice for providers with the most knowledge about the circumstances to respond to complaint letters, the addressee (in this case, the facility director) typically tracks complaint letters as “controlled correspondence” to ensure that family members receive adequate and timely responses. Facility leaders were unable to locate any formal written response to the family’s concerns.

⁸ The son also contacted VISN 7 on two occasions to express his displeasure with the noted events and the facility’s lack of a response to his letters.

During interviews, multiple staff members told us that, because of the family's opposition, they did not feel they could move forward with transferring the patient to a Florida assisted care facility until facility leaders approved the placement. A January 2012 Long Term Care note stated, "We are awaiting administration's recommendations regarding how to respond to his request," and several e-mails sent to the COS on both October 7 and December 13, reflected the IDT team's ongoing requests for guidance.

We found no documented evidence that facility leaders responded to these requests. Facility leaders told us that this case was routinely discussed in the Director's morning meeting and that clinical staff members were empowered to move forward with their action plan in accordance with the recommendations of legal counsel and the Ethics Committee. However, the complicated nature of this case, coupled with the threat of litigation by the patient's son, would reasonably require facility leadership to be involved in, and approve of, discharge plans that the patient's family opposed.

Conclusions

We did not substantiate that a patient with dementia, who was deemed to have decision making capacity regarding where he wanted to live, was held against his will for an extended period of time. The IDT team made efforts to address the complicated medical, ethical, and legal considerations that delayed the patient's discharge to a Florida assisted care facility. While these actions were underway, the patient continued to reside on a secure CLC unit where he knew other patients and staff, understood the day-to-day routine, and received care in a safe environment.

We could neither confirm nor refute the validity of the patient's DPAHC. Due to a lack of available medical record documentation, a Regional Counsel attorney was unable to determine whether the document was legally executed. However, during most of the patient's nearly 3-year stay at the facility, the son was the patient's health care agent—a designation that providers and other family members did not question. Although the patient expressed on a few occasions that he did not want his son to be his DPAHC, it did not appear that facility staff considered these statements to be requests for assistance in revoking or amending his DPAHC until the Ethics Committee discussed and documented this in December 2011. In fact, facility providers' actions regarding the DPAHC were inconsistent. For example, they did not communicate with the son about the patient's capacity evaluations or unit transfer (which would have been appropriate if the patient *did not* have decision-making capacity); alternatively, they did not document that the patient consented (which would have been appropriate if he *did* have decision-making capacity). Based on our review of the EHR, it appeared that questions about the DPAHC's validity arose after the son disagreed with transferring his father to a Florida-based assisted care facility.

We confirmed that facility leaders did not appear to respond to the clinicians' requests for assistance in resolving this case nor did they document their responses to family

concerns. We discussed these issues with facility leadership and were assured that complicated cases will continue to be discussed at the daily executive clinical meeting that includes the Service chiefs and the Chief of Staff. Further, facility leaders reported that they routinely have discussions with families over the phone but also acknowledged the need to document follow-up of controlled correspondence.

We made no recommendations.

Comments

The VISN and Facility leaders agreed with the report. No further action is required.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 29, 2012

From: Director, VA Southeast Network (10N7)

Subject: Healthcare Inspection–Alleged Violation of Patient Rights, Carl Vinson VA Medical Center Dublin, GA

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, VHA Management Review Service (VHA 10AR MRS)

1. I have reviewed and concur with the report regarding the above referenced Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, GA.
2. We appreciate the opportunity for the review as a continuing process to improve the care we provide to our veterans.
3. If you have any questions or need additional information, please contact Jahmel Yates, Quality manager (478) 272-1210.

(original signed by:)

Charles E. Sepich, FACHE

Director, VA Southeast Network (10N7)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 17, 2012

From: Director, Carl Vinson VA Medical Center (557/00)

Subject: Healthcare Inspection—Alleged Violation of Patient Rights, Dublin VA Medical Center Dublin, GA

To: Director, VA Southeast Network (10N7)

1. I have reviewed and concur with the report regarding the above referenced Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, GA.
2. We appreciate the opportunity for the review as a continuing process to improve the care we provide to our veterans.
3. If you have any questions or need additional information, please contact Jahmel Yates, Quality Manager (478) 272-1210.

(original signed by:)

John S. Goldman

Director, Dublin VA Medical Center (557/00)

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	Karen Sutton, BS, Project Leader Victoria Coates, LICSW, MBA Alan Mallinger, MD

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