



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

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**Healthcare Inspection**

**Quality of Care, Communication, and  
Infection Control Issues  
William Jennings Bryan (WJB) Dorn  
VA Medical Center  
Columbia, South Carolina**

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## Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to determine the validity of allegations of inadequate patient care, poor communications with family, poor coordination of care, and inappropriate infection control practices at the WJB Dorn VA Medical Center (the facility) in Columbia, SC.

The complainant provided a list of allegations regarding the care of a recent hospitalized patient. The complainant alleged inappropriate intravenous (IV) access, improper fluid management, failure to provide hemodynamic monitoring, inadequate bathing, ambulation, and nutritional support, inappropriate end-of-life care, and poor infection control practices. Additional allegations described poor communication and coordination among providers and with family.

We confirmed that it took several nurses multiple attempts to replace the patient's IV; however, we did not confirm that the patient needed a more permanent IV line (central line). We confirmed that a progress note in the patient's medical record reflected "fluid overload;" however, we found that facility staff managed his intake and output appropriately. We did not substantiate that he was a candidate for hemodynamic monitoring in the ICU. We confirmed that the patient did not receive a full bed bath on one day; however, we found that staff provided extensive focal hygiene care. Further, due to the patient's weakness and other risk factors, it was clinically appropriate for him to remain in bed without attempts to ambulate.

We found the patient was not a candidate for intravenous nutrition as he was taking food orally and had a functioning gastrointestinal tract. We confirmed that staff did not initiate an appropriate dietary consultation to evaluate the patient's nutritional needs.

We confirmed that five different physicians and a nurse practitioner saw the patient over the course of the 6-day hospitalization. We found the facility has since hired a full contingent of hospitalists to manage patients' care during hospitalizations. We confirmed the facility followed established procedures regarding the family's request to transfer the patient to a private-sector hospital. We could not confirm or refute whether nursing staff followed all appropriate procedures for contact isolation and biohazard waste disposal.

We recommended that patients assessed to be at nutritional risk are promptly evaluated by appropriate dietary staff, that nursing personnel are trained on the steps required to initiate consult requests through the electronic nursing assessment package, and that actions are taken to evaluate and revise the Do Not Attempt Resuscitation template note to be more patient-specific and patient-centered.

The Veterans Integrated Service Network and facility Directors concurred with our recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.



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

**TO:** Director, Veterans Integrated Service Network (10N7)

**SUBJECT:** Healthcare Inspection – Quality of Care, Communication, and Infection Control Issues, WJB Dorn VA Medical Center, Columbia, South Carolina

## **Purpose**

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to allegations of inadequate patient care, poor communications with family, and unsanitary practices and conditions at the WJB Dorn VA Medical Center (the facility) in Columbia, SC. The purpose of the review was to determine whether the allegations had merit.

## **Background**

The facility provides a broad range of inpatient and outpatient medical, surgical, mental health, and long-term care services. It has 95 operating hospital beds and 75 community living center (CLC) beds. Outpatient care is also provided at seven community based outpatient clinics located in Anderson, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg, and Sumter, SC. The facility serves a veteran population of about 410,000 throughout South Carolina and is part of Veterans Integrated Service Network (VISN) 7.

*Clostridium difficile* (*C. diff*) is a bacterium that causes infection, most often related to the use of antibiotics during healthcare treatment. *C. diff* infections cause diarrhea and more serious intestinal conditions such as pseudomembranous colitis. Salmonellosis is an infection with bacteria of the genus *Salmonella*. *Salmonella* live in the intestinal tracts of humans and other animals and are usually transmitted to humans by eating foods contaminated with animal feces. Most people infected with *Salmonella* develop diarrhea, fever, and abdominal cramps 12 to 72 hours after infection. The illness usually lasts 4 to 7 days, and most people recover without treatment. However, some patients may experience such severe diarrhea that they require hospitalization for rehydration with intravenous (IV) fluids. In other cases, patients may require antibiotic treatment. The

elderly, infants, and those with impaired immune systems are more likely to have a severe illness.<sup>1</sup>

Contact isolation precautions are designed to prevent the spread of infection from one person to another and involve staff using personal protective equipment (PPE), cleaning and decontaminating patient care areas and items, and being vigilant in their hand hygiene practices.

A complainant contacted the OIG regarding the care a patient received at the facility during a 6 day inpatient stay in September. The complainant allegedly met with senior clinical managers 9 days after the patient's discharge to discuss certain concerns, but was dissatisfied with their response. The complainant notified the OIG, Senator Lindsey Graham, and Congressman Joe Wilson of the concerns and provided a list of 11 specific questions for response.

## Scope and Methodology

We conducted a site visit on February 14, 2012. Prior to our visit, we interviewed the facility Director, Chief of Staff, Chief Nurse Executive, physician and nursing staff who cared for the patient, the clinical dietitian, and other staff knowledgeable about the issues. We reviewed the patient's medical record; local policies; staffing plans; and the facility's internal review and response to the complainant's concerns. We also interviewed the patient's daughter.

Some of the 11 questions either alleged or implied poor care or wrongdoing while others appeared to seek clarification and understanding. When we interviewed the complainant, we learned that a question related to the patient's medical records had been resolved. This report focuses on the complainant's remaining 10 questions.

This review was conducted in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

## Inspection Results

### *Case Summary*

The patient was a man in his nineties with a history of Parkinson's disease<sup>2</sup> and heart disease who had last been treated at the facility in late July 2011 for a urinary tract

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<sup>1</sup> <http://www.cdc.gov/salmonella/general/diagnosis.html>. Retrieved November 22, 2011

<sup>2</sup> Parkinsons disease is a progressive disorder of the nervous system that affects movement and is characterized by tremors, rigid muscles, and a shuffling gait.

infection (UTI).<sup>3</sup> He presented to the facility's emergency department (ED) in September 2011 with complaints of multiple foul-smelling stools that day and a poor appetite. An ED nurse triaged the patient at approximately 5:00 p.m.; his documented temperature was 101.1 degrees (°) Fahrenheit (F). ED staff placed an IV line and the ED physician ordered IV fluids and a broad-spectrum antibiotic. The patient was admitted to the medical floor with an initial diagnosis of *C. diff* colitis and acute renal failure caused by dehydration.

#### Tuesday night.

The patient arrived on the floor at approximately 10:00 p.m. accompanied by his daughter. Upon admission, the patient was alert and oriented; his vital signs were stable and his lungs were clear. Because *C. diff* is highly contagious, the admitting staff placed the patient on contact isolation precautions.

The admitting physician (Dr. A) was functioning as the medical officer-of-the-day (MOD), meaning that he was the physician providing medical coverage in the facility from 8:00 p.m.–8:00 a.m. Dr. A reviewed the patient's medical history and treatment plan with the daughter and discussed the patient's wishes in the event his heart or lungs suddenly failed. Dr. A documented that the patient's daughter requested non-invasive treatments only, with no resuscitation or life-support (commonly referred to as "Do Not Resuscitate" or "DNR"). He continued the IV fluids, ordered another antibiotic often used to treat *C. diff*, and placed the patient on a clear liquid diet.

The admitting registered nurse (RN-1) implemented measures to manage the patient's pre-existing skin breakdown and risk for falls. The RN's admission assessment note reflects a request for wound care services and a dietary consult. However, the medical record does not reflect that these consults were actually initiated. The night shift nurse, RN-2, assumed the patient's care just before midnight.

#### Wednesday.

The inpatient care team, consisting of an internal medicine physician (Dr. B) and a nurse practitioner, assumed the patient's care. Dr. A told us that before he left his shift (scheduled to end at 8:00 a.m.), he completed a face-to-face "hand-off" of the patient, which included review of the patient's status and care needs to Dr. B, the oncoming attending physician. Dr. B and the nurse practitioner evaluated the patient around lunchtime. Dr. B continued the IV fluids and antibiotic for *C. diff*, and added a different antibiotic to treat a possible UTI. The patient continued to have multiple loose, foul-smelling stools during the day and evening shifts, and the medical record reflects that nursing staff provided peri-care (washing of the genital and rectal areas and applying an

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<sup>3</sup> The patient had an indwelling catheter to drain urine; it had last been changed 2-3 weeks earlier.

anti-fungal, moisture-barrier cream) after each bowel movement (BM). The day shift nurse, RN-3, documented at approximately 7:00 p.m., “Concerns about patient’s diet. Awaiting late tray now.” At approximately 11:00 p.m., RN-3 documented that the patient’s breath sounds were clear. The daughter remained at the patient’s bedside.

#### Thursday.

The medical record indicates that the patient’s daughter requested to speak with a dietitian about the patient’s food preferences as the patient did not care for, and would not eat, some items on his tray. The dietitian told us that she spoke with the daughter over the telephone and then conferred with the nurse practitioner about advancing the patient to a soft mechanical diet (soft, chopped, or ground food). At approximately 12:15 p.m., the dietitian entered a late tray request for the new diet. The tray was apparently delivered outside the patient’s room (dietary staff do not enter isolation rooms), but the tray was never given to the patient. A second late tray request was entered, but it was not clear when, or if, that meal was delivered. The daughter told us that staff ultimately provided the patient with a peanut butter and jelly (PBJ) sandwich.

During a meeting with a social worker, the daughter reported her father’s room smelled foul because the biohazard waste bin containing soiled bed pads, gowns, and gloves was not removed after each BM clean-up. The social worker advised the nurse manager of the complaint, and the record reflects that the problem was addressed.

The same day, the daughter expressed concerns that her father had not been properly bathed. She told us that she requested a bath for her father and was told that the facility did not have adequate staff to provide a bath that day. The daughter advised us, and facility leaders confirmed, that she hired a private-duty nursing assistant to bathe the patient.

The care coordinator (a nurse) successfully changed the patient’s IV site after one attempt. Dr. B and the nurse practitioner evaluated the patient together at approximately 3:00 p.m. and continued the current treatments. The patient continued to have multiple loose stools throughout the day. His nurse again documented clear breath sounds at approximately 11:00 p.m.

#### Friday.

RN-4 documented at 11:19 a.m. that the daughter voiced several concerns about her father’s care. The daughter spoke with the care coordinator about moving her father to a local private-sector hospital. She also wanted to speak with the dietitian about her father’s nutritional status. However, there is no record that the dietitian was contacted about this request. RN-4 documented diminished breath sounds and a new cough. While

there was no documentation that the patient received a bed bath, the daughter told us that a facility employee did bathe her father on this day.

Dr. B and the nurse practitioner evaluated the patient together at about lunchtime and noted that the patient looked better and his colitis appeared to be resolving. The daughter reported the patient had fewer loose stools. Dr. B noted rhonchi (course tubular rattling sounds in the lungs) and ordered a chest x-ray (CXR). The radiologist's interpretation read, in part, "There is a non-specific opacity of the left lower lobe." Dr. B documented "CXR without acute process." He ordered the head of the patient's bed elevated to 30 degrees, and he decreased the patient's IV fluids. He further noted that the patient's appetite was still poor and ordered a supplemental nutrition shake with each meal.

Laboratory results showed that the patient did not have *C. diff*; rather, he had *Salmonella enteritidis*. Dr. B ordered a new antibiotic to treat the salmonella infection and adjusted the patient's other medications to treat his ongoing conditions.

Dr. B told us that he completed a face-to-face hand-off at approximately 3:00 p.m. with Dr. C, the attending physician who would be managing the patient's care over the weekend. Dr. C agreed that the discussion occurred.

#### Saturday.

Dr. C evaluated the patient during morning rounds. His progress note, timed at 9:57 a.m., reflected that the patient had scattered rhonchi, heart with regular rate and rhythm, stable vital signs, and no fever. Dr. C continued the current antibiotics. The patient's daughter expressed her concern that her father was getting weaker, so Dr. C ordered a physical therapy (PT) consult.

At 10:47 a.m., RN-4 documented that the patient had a cough, described as "productive; [with] thick tan sputum" and bilateral upper lobe rhonchi with diminished breath sounds. She also noted the patient continued to have loose, dark green stools. A bed bath was provided. Shortly after 1:00 p.m., RN-4 notified Dr. D, the Saturday MOD, that the patient's sputum was blood-tinged. Dr. D ordered respiratory therapy nebulizer (aerosolized) treatments. The patient was resting at the time with no acute distress noted. Later, at the daughter's request, RN-4 assisted her father to sit up in bed. The patient complained of feeling dizzy so RN-4 assisted him to lie back down. The patient's appetite remained poor. He received several respiratory therapy treatments throughout the day. As of 6:00 p.m., nursing documentation indicated the patient was still able to cough up secretions on his own and his daughter was feeding him.

Shortly before 9:00 p.m., the night shift nurse, RN-5, documented that the daughter said her father "felt like throwing up now." Dr. D ordered a medication to treat the patient's

nausea. The patient received a respiratory therapy treatment at approximately 9:15 p.m. His oxygen saturation<sup>4</sup> level was 93 percent (normal range is 95-100).

Sunday.

At 5:30 a.m., RN-5 documented that the patient was complaining of shortness of breath and was given supplemental oxygen per the daughter's request. Dr. D ordered a portable CXR. A radiology report, which was not electronically available until the following day, described "interval worsening of bilateral heterogeneous opacities, predominately on the right, possibly worsening edema or even infection."

Dr. C, the weekend attending physician, interpreted the CXR as "appears to be consistent with pulmonary edema" (fluid in the lungs). He noted that the patient appeared to be "fluid overloaded."<sup>5</sup> He discontinued the IV fluids, ordered a diuretic to remove excess fluid, and discussed the patient with Dr. D.

The patient was to receive the diuretic via IV; however, the existing IV line was not functioning properly and needed replacement. While not documented, the nurse who eventually placed a new IV line (at approximately 12:00 p.m.) reported that several nurses had previously attempted to insert a line without success.

Throughout the morning, the patient was congested with labored breathing. At 12:45 p.m., a respiratory therapist provided a breathing treatment and increased the patient's supplemental oxygen from 3 liters (L) to 4L/minute. At approximately 1:30 p.m., a licensed practical nurse (LPN) notified Dr. E, the on-duty MOD, of the patient's declining status with vital signs of pulse 132, respirations 26, blood pressure 140/72, and oxygen saturation 82 percent on 4L/minute. Dr. E saw the patient at bedside, and the LPN documented "continue to monitor."

At approximately 2:30 p.m., the daughter notified a nurse that her father was gasping for breath. The nurse notified Dr. E and called a Code White.<sup>6</sup> At that time, the patient was unable to respond to verbal stimuli, had a very low blood pressure, and had an oxygen saturation level of 52 percent. As the patient had a DNR order, no efforts were made to resuscitate him. The patient died at 2:45 p.m. An autopsy was not performed. The death certificate listed salmonella septicemia as the cause of death.

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<sup>4</sup> Oxygen saturation levels are an indication of whether a person's circulatory system or blood is carrying enough oxygen to the organs in the body.

<sup>5</sup> Fluid overload is a condition in which more fluid is going into the body than is coming out. Excess fluid in the lungs can cause shortness of breath and difficulty breathing.

<sup>6</sup> A Code White is an emergency code that summons the facility's Rapid Response Team.

## **Issue 1: IV Access and PICC Line**

*Question 1: Why was [the patient] continually being stuck for new IV [access]? Why [didn't he receive] a peripherally-inserted central catheter (PICC) line, which can last for weeks?*

It reportedly took five different nurses and multiple attempts to access a vein for an IV. After the IV was placed, nurses reportedly did not start the diuretic for another 2 hours.

We found that an IV was placed in the ED on the day of admission, and another was placed 2 days later (Thursday) while the patient was on the medical floor. When the MOD ordered a diuretic to be given IV on Sunday morning, a nurse noted that the patient's IV was not fully functional and needed to be replaced. While we were unable to determine precisely how many nurses were involved and how many attempts were made, interviewees confirmed that several nurses did attempt but were unable to insert a new IV. We noted that a medical floor nurse successfully replaced the IV at approximately 12:00 p.m..

We were told that facility practice permits a nurse to attempt IV access twice, and if unsuccessful, another nurse should try. It was unclear how many nurses could attempt to gain IV access before notifying a supervisor or physician. At the time of the event, nurses did not routinely document when IV insertions were attempted but not successful. The facility now requires staff to document IV access attempts in the medical record.

In spite of the difficulties with IV access on Sunday, the patient did not meet criteria for a PICC line at the time. There was no indication that he would require a PICC for long-term IV access, or that the need for this invasive procedure outweighed the substantial risks and potential complications that PICC line insertion entails.

## **Issue 2: Hemodynamic Monitoring and Fluid Overload**

*Question 2: Why wasn't there a hemodynamic monitor for fluid management? Why didn't he [the patient] have Intensive Care Unit Bed Management?*

*Question 5: How many IV bags was [the patient] given in 6 days? Why did his medical records state he had a fluid overload?*

### Fluid Management.

The patient's medical record reflected "fluid overload" on Sunday, the day of his death.

Fluid overload may occur in a patient when the circulating fluid volume is more than the heart can effectively cope with. Elderly patients are more prone to changes in fluid status

because of the decreased tone of their vascular system. Signs of fluid overload include skin swelling and pulmonary edema.

For the first 5 days of his hospitalization, the patient was receiving IV fluids to offset the fluid losses of the diarrhea and his minimal oral intake. Fluid intake and output were monitored daily. Over the course of the patient's hospitalization, approximately 12 bags of IV fluid were infused (11,888 milliliters), and his daily output records reflected an approximately equal output.

On Sunday, the patient developed respiratory symptoms. Dr. D reviewed the patient's CXR and interpreted the image as consistent with pulmonary edema attributed to fluid overload. Dr. D stopped the IV fluids and administered IV furosemide to decrease the amount of circulating fluid.

#### ICU Bed Management.

The patient was not treated in the ICU.

Hemodynamic monitoring of a patient's fluid status is indicated when a patient exhibits signs of shock, severe dehydration, or decrease in cardiac function. This monitoring generally involves the use of an intravascular catheter to measure circulatory functions in an effort to detect and treat life-threatening conditions. These procedures increase the risk of infections, blood clots, air embolisms, bleeding, and other complications and require ICU care. Measuring fluid intake and output is non-invasive and appropriate for stable clinical conditions.

By indications documented in the medical record, the patient's condition appeared to be improving for the first several days of hospitalization. When he started to develop respiratory difficulties over the weekend, the clinical staff took reasonable actions to evaluate and address his condition. There was no definitive indication for transfer to the ICU.

### **Issue 3: Bathing and Ambulation**

*Question 3: Why was there lack of ambulation and bathing? If he was in isolation for a contagious bacteria, why couldn't he get daily baths and [help] sitting up? Why did the patient's family need to hire someone to come to the hospital and give him a bath?*

#### Bathing.

The nursing staff reportedly did not bathe the patient for 3 days after his admission to the facility. Nursing staff told the patient's daughter they did not have adequate staff, so the daughter hired a private-duty nursing assistant to bathe her father.

The patient was admitted on a Tuesday evening. The medical record reflects that nursing staff provided peri-care after the patient's frequent episodes of diarrhea (4-5 per 12-hour shift). We interviewed nine nursing employees who consistently described extensive peri-care that included washing up the patient's back and down his legs, as well as changing the patient's linens, bed pad, and tee-shirt or hospital gown. However, there is no documented evidence that he received a complete bath<sup>7</sup> until Thursday when the private-duty nursing assistant provided this service. Facility nursing staff bathed the patient on Friday and Saturday.

We determined that it was not appropriate for the nurse to tell the daughter there was no one to bathe her father, and the daughter should not have had to hire a private-duty nursing assistant to provide this service. It appears that on Wednesday night, RN-3 did not have a nursing assistant assigned to help with her patients. Although not reflected in the medical record, the nurse confirmed that she did tell the daughter there was no one to bathe her father and did suggest she [the daughter] hire a private-duty assistant to provide this service. Nursing managers have addressed this issue with the subject nurse and re-educated nursing staff about appropriate communication to supervisors when patient care needs are not met by current staffing levels.

#### Ambulation.

The complainant reported that the patient had been ambulatory with a walker prior to admission but was never helped out of bed or assisted to ambulate while he was hospitalized. It was implied that a lack of movement and non-ambulation contributed to his debilitated state.

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<sup>7</sup> A complete bath involves bathing the patient from head to toe and is typically done for a patient who is unable to bathe himself or get out of bed.

The nurses documented on Wednesday, Thursday, and Friday that the patient needed assistance with turning and positioning in bed, and that he had generalized weakness. The patient continued to have frequent episodes of diarrhea on these days. On Saturday, the daughter asked about getting her father out of bed. The physician consulted PT; however, therapists only provide services on weekends to total joint replacement patients. Later that day, the nurses sat the patient up on the side of the bed and documented that he was weak and complained of being dizzy. He was assisted back into bed.

Because of the patient's generalized weakness, ongoing diarrhea, and high risk for falls, it was clinically appropriate for him to remain in bed.

#### **Issue 4: Nutritional Status**

*Question 4: Why didn't [the patient] have IV nutrition instead of [an] inadequate and inappropriate oral diet?*

##### IV Nutrition.

IV nutrition, also known as parenteral nutrition (PN), is a method to meet the nutritional needs of a patient who has a non-functioning digestive tract. PN is delivered via IV in a highly concentrated solution, which can result in complications such as thrombosis of the IV catheter, metabolic abnormalities, and infection. The patient did not meet the criteria to receive PN during the 6 days he was hospitalized. In fact, PN was contraindicated because he had a functioning gastrointestinal tract. While the patient's appetite remained poor throughout his hospitalization, he was taking food orally. He was also receiving concentrated shakes to provide supplemental nutrition.

##### Oral Diet.

The complainant alleged that the patient did not receive late meal trays as ordered, and that he was provided meals that he did not like, could not eat, or were otherwise inappropriate given his diet order status.

The patient was placed on a liquid diet at the time of admission, and at his daughter's request, the dietitian and nurse practitioner advanced the diet to mechanical soft 2 days later. While we were unable to determine the precise sequence of events, it appeared that after the dietitian advanced the patient's diet, she ordered a late tray<sup>8</sup> to permit him to start his new diet immediately. Because the patient was on contact isolation, a Nutrition and Food Service (N&FS) staff delivered the tray outside of the patient's room. However, the tray was not given to the patient and was later returned to the kitchen uneaten. Facility policy requires N&FS employees to notify the patient's nurse of the tray delivery, but the responsible nurse told us that she did not receive this notification.

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<sup>8</sup> A meal tray delivered outside of the normal meal hours.

A second tray was ordered, but the patient did not receive this tray either.<sup>9</sup> Since the event, the facility has changed its process and now requires nursing assistants to follow the meal delivery cart and deliver trays directly to patients, including those on isolation precautions.

Because of the meal tray delivery problems, the complainant reported that staff made the patient a PBJ sandwich, but he could not eat this because he was on a liquid diet. While the record did not reflect that the patient received a PBJ sandwich, it would have been an acceptable option given that he had been upgraded to a soft mechanical diet. The daughter also reported that the kitchen started sending meals such as spicy dressing with ground turkey that he could not eat because of his diarrhea. The dietary log reflects that the patient received ground pork with gravy, not spicy dressing, for dinner on Friday. Because the patient was on a soft mechanical diet, ground pork would have been an acceptable meal consistency even though it may not have been his preferred choice.

Nevertheless, we found that a formal nutrition consultation should have been requested earlier in the patient's hospitalization. RN-1 identified during her initial assessment that the patient had nutritional risk factors including diarrhea for 2 days and a poor appetite. In addition, the patient had lost 20 pounds in the past 22 months. RN-1 documented that she initiated a consult to N&FS for these problems; however, the formal consult was never sent. The Clinical Applications Coordinator (CAC)<sup>10</sup> told us that the process is supposed to work as follows: After a nurse initiates the consult request, it has to be "accepted" so that it will appear on the order tab for signature. The CAC could not find any evidence of the order, either signed or unsigned, and there were no formal consults to N&FS that would have triggered a nutritional assessment by a clinical dietitian. We concluded that RN-1 did not follow the necessary steps to formally consult N&FS.

While we do not believe that this lapse had a substantive impact on the patient's overall condition and decline, an earlier nutritional consult and assessment may have improved the patient's oral intake and satisfaction.

## **Issue 5: Coordination of Care**

*Question 6: Why were there so many different doctors who weren't familiar with the patient? Why wasn't there a continuity of medical staff or why wasn't there a case manager?*

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<sup>9</sup> We could not determine through documentation or interviews why the patient did not receive the second meal tray.

<sup>10</sup> CACs have responsibility for clinical applications in the electronic medical record.

### Multiple Physicians.

We confirmed that five different physicians and a nurse practitioner saw the patient over his 6-day hospitalization. Dr. A (functioning as the MOD) admitted the patient on Tuesday night. Dr. B and the nurse practitioner were the attending physician and second-level provider, respectively, and saw the patient Wednesday–Friday. Dr. C, the weekend attending physician, saw the patient during rounds on both Saturday and Sunday. Drs. D and E, both functioning as weekend MODs, saw the patient during their respective shifts.

Because physicians cannot work 24 hours-per-day, 7 days-per-week, hospitals routinely employ contract, part-time, and on-call providers to cover nights and weekends. This model of physician staffing is common; however, it is not ideal for managing patients with complex and changing medical conditions. Since the time of this patient’s hospitalization, the facility has added additional hospitalists (physicians that coordinate patients’ care during their hospitalization) and is now fully staffed in this area.

Because of tour changes and cross-coverage issues, it is important that clinical staff assure appropriate patient “hand-offs.” Hand-off communication should occur when patient care is transferred between caregivers (from shift to shift or between different units or Services) to ensure the continuity and safety of the patient’s care. This is an exchange of information regarding the patient’s care, treatment, and current condition, along with anticipated changes and/or patient needs. Preferably, clinicians meet face-to-face to discuss the patient, but telephone calls are acceptable. This provides the opportunity for questioning between the giver and receiver of the patient’s information.

The providers we interviewed told us that they routinely conduct patient hand-offs to the next provider although it is not always possible to discuss patients face-to-face. The medical record generally reflects that, at the times of patient care transfer, the outgoing providers wrote notes regarding this patient’s status and needs.

### Case Manager.

The facility has two care coordinators whose position descriptions focus more on discharge planning functions than coordination of care activities. The unit’s care coordinator met with the patient’s daughter on Friday to discuss her concerns about nursing care issues and her request to transfer her father. The care coordinator told us that he reviewed the daughter’s complaints with her, and that many of them, such as the bathing and nutrition issues, had already been addressed. He also contacted physician B regarding the transfer request and to arrange a meeting with the daughter. However, the daughter had already left the unit by the time physician B arrived.

## **Issue 6: Assistance with AMA Transfer**

*Question 7: When the daughter requested to take the patient out of the hospital, why wasn't she given help to take him to another facility on request?*

Facility staff followed established procedures when the daughter told them that she wanted to move her father to a private-sector hospital. Medical record documentation reflects that on Friday, the daughter expressed her concerns about her father's care and desire to move him to another hospital. She spoke with the care coordinator, who in turn spoke with the patient's physician, about this request. The care coordinator explained to the daughter that because her father's medical needs were being met, VA would not pay for transport to, or care at, another hospital. The daughter was told that she could take her father to the private-sector hospital, but she would have to sign him out against medical advice (AMA).

The daughter told us she was unable to locate a provider at the private-sector hospital who would arrange for her father's admission. She also advised that she was unable to assist her father into a wheelchair (so she could move him to another hospital) because he was too weak. While we believe that staff followed procedures, the daughter was nonetheless frustrated with what she perceived as an overall lack of helpfulness on the part of the facility staff.

## **Issue 7: Communication with Family**

*Question 9: Why wasn't there communication between the family and dietitians and doctors?*

The complainant reported that Dr. D, the MOD on Sunday at the time of the patient's death, was the first provider to discuss the patient's salmonella infection. We could not confirm or refute this allegation.

The laboratory confirmed the diagnosis on Friday, and both Dr. B and the nurse practitioner told us that they communicated this unexpected finding to the daughter that day. However, this discussion was not documented in the medical record. Dr. B ordered a different antibiotic to treat the salmonella and documented this plan in the record.

The concerns about communication with the dietitian are covered under Issue 4, pages 10-11.

In our review of the medical record, we found that nursing and physician staff interacted with the patient's daughter on a daily basis and that staff made efforts to address the daughter's concerns as they arose. However, we are unable to assess the quality of staff communications with the daughter or whether satisfactory, corrective actions were taken.

The treatment team may have missed an opportunity to meet with a concerned family member and provide a more coordinated and comprehensive response to the concerns.

### **Issue 8: End-of-Life Care**

*Question 10: If [the patient's] diagnosis was terminal, why not have a family consult, or hospice? The family was not told the doctor expected no recovery.*

After her father's death, the daughter reviewed his medical record and found a DNR template note that read, in part, "*The patient's medical condition is debilitating, considered to be incurable or untreatable, expected to cause death, and includes chronic conditions from which there is no hope of recovery and where treatment will be virtually futile or prolong the act of dying.*" The daughter stated that she was never told that hospital staff were "anticipating my father's death, with no hope..." and that had she known, she would have called in family. She further opined that because providers knew her father was dying, they should have referred him to hospice care so that he could die pain-free and with dignity. The daughter told us that her father essentially choked to death and that staff let him suffer.

Upon admission, Dr. A appropriately discussed the patient's DNR status with his daughter. The patient was in his mid 90s, had Parkinson's disease, and was admitted for diarrhea and dehydration from, at the time, an unknown cause. Dr. A and the daughter agreed to a DNR status, meaning that the patient would not be resuscitated if cardiac or respiratory function ceased.

#### Terminal Condition.

We found no evidence that providers thought the patient was terminally ill although it is understandable, based on the wording of the DNR template note, that the patient's daughter concluded this. The template wording attempts to explain the rationale for not performing cardiopulmonary resuscitation. The wording is not patient-specific. Facility leaders agreed that the template wording was inaccurate and unsuitable in this case, and that they would revise the template wording.

#### Hospice Care.

Hospice is a concept of care to provide comfort and support to patients and families when the patient no longer responds to curative measures. None of the providers we interviewed thought the patient's death was imminent and they were surprised upon learning of his death. Hospice was not considered because the patient's caregivers believed the patient was getting better and would go home.

### Code White.

According to the medical record, the Code White was called at approximately 2:30 p.m., and the MOD pronounced the patient's death at 2:45 p.m. As the patient had a previously established DNR order, the code team did not attempt invasive cardiopulmonary resuscitation. However, the event transpired so quickly that it is unclear whether any palliative measures would have made the patient more comfortable at the end.

### **Issue 9: Infection Control Practices**

*Question 11: Why was there inadequate, inappropriate handling of his isolation? There was inappropriate glove use and stool disposal.*

We could not confirm or refute the report that some nursing staff did not change their gloves between providing personal care to the patient and performing other activities, and did not adequately dispose of soiled items, which left a foul odor in the patient's hospital room.

Staff initiated contact isolation precautions because of the suspicion of *C. diff*. Staff wore PPE, which included gowns and gloves, as required. However, we could not determine whether nursing staff followed all appropriate protocols during a specific patient's care 6 months ago. The nurses we interviewed all verbalized the proper procedures for taking care of patients in contact isolation including hand hygiene and glove changes between personal care and other in-room activities. Since the event, the nurse manager has provided feedback and re-education to the nursing staff regarding the importance of following isolation procedures.

Because of the patient's frequent episodes of diarrhea, it is possible that his room periodically had an unpleasant smell. Housekeepers do not maintain logs of trash pick-ups, so we could not determine how frequently the soiled waste bin was removed. Nurses verbalized the correct procedures for disposing of soiled items, and also reported that they could contact a housekeeper at any time for waste removal, or could dispose of soiled waste in a utility area down the hall. The nurse manager told us that when she learned of the complaint, she contacted housekeeping services and arranged for more frequent disposal of the biohazard waste from the patient's room. The daughter told us that she expressed her concerns to staff the first night, and that the problem was resolved for the remainder of her father's hospitalization.

## Conclusions

We confirmed that some of the alleged conditions existed during the patient's hospitalization, and in many cases, facility leaders had already taken actions to improve care and service delivery.

We confirmed that it took several nurses multiple attempts to place the patient's new IV, but these attempts were not well documented. The facility has revised documentation requirements since this patient's hospitalization. The patient, however, was not a candidate for a PICC line.

While a progress note in the patients' medical record reflected "fluid overload," facility staff managed his intake and output appropriately. He was not a candidate for hemodynamic monitoring in the ICU.

The patient did not receive a full bed bath on Wednesday but was provided extensive peri-care after each BM. Nevertheless, when the daughter requested her father be given a bath, nursing personnel should not have told her there were not enough staff available and suggest she hire a private-duty nursing aid to provide this care. Due to the patient's weakness and other risk factors, it was clinically appropriate for him to remain in bed (rather than encouraging ambulation).

The patient was not a candidate for PN as he was taking food orally and had a functioning gastrointestinal tract. However, we confirmed that the patient's nutritional needs were not fully evaluated and addressed by appropriate dietary staff. The admitting nurse did not complete the necessary steps to formally consult the clinical dietitian in spite of the patient's nutritional risk. Further, the patient did not receive late meal trays on two occasions. The facility has since revised policy regarding late meal tray delivery.

We confirmed that five different physicians and a nurse practitioner saw the patient over the course of his 6-day hospitalization. While this is a fairly common practice, it is not ideal for a patient with complex and changing medical conditions. The care coordinator on the unit did meet with the daughter about some of her concerns, but in general, his position description had a discharge planning, rather than case management, focus. The facility has since hired a full contingent of hospitalists to manage patients' care during hospitalizations.

The facility followed established procedures regarding the daughter's request to transfer her father to a private-sector hospital. Further, the medical record reflects multiple interactions between the staff and the daughter regarding the patient's status and her other concerns. However, the level and quality of communication is subjective, and the daughter perceived her father's hospitalization to be marked by episodes of inadequate communication and unhelpful staff responses.

Providers did not believe that the patient's death was imminent and were surprised upon learning of his death. Providers thought the patient was improving and would be discharged home. As such, hospice care was not considered. Because the patient had an established DNR, the Code White team did not attempt resuscitation. It is unknown whether palliative measures would have made the patient more comfortable at the end.

We could not confirm or refute whether nursing staff followed all appropriate procedures related to contact isolation and biohazard waste disposal during the patient's hospitalization. Staff were able to verbalize the appropriate procedures for taking care of patients on contact isolation, and since this patient's hospitalization, the nurse manager has provided feedback and re-education to the nursing staff regarding the importance of following isolation procedures.

## Recommendations

**Recommendation 1.** We recommended that the VISN Director ensure that the facility Director ensures that patients assessed to be at nutritional risk are promptly evaluated by appropriate clinical N&FS staff.

**Recommendation 2.** We recommended that the VISN Director ensure that the facility Director ensures that nursing personnel are trained on the steps required to initiate consult requests through the electronic nursing assessment package.

**Recommendation 3.** We recommended that the VISN Director ensure that the facility Director takes actions to evaluate and revise the DNR template note, as appropriate, to be more patient-specific and patient-centered.

## Comments

The VISN and facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 18-21, for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** April 19, 2012

**From:** VA Southeast Acting Network Director (10N7)

**Subject:** **Healthcare Inspection** - Quality of Care, Communication, and Infection Control Issues, Dorn VA Medical Center, Columbia, SC

**To:** Assistant Inspector General for Healthcare Inspections

1. I have reviewed the Columbia, SC VA Medical Center's action plan, which details their improvement strategies related to the OIG recommendations. Therefore, I support Columbia's process as detailed.
2. Thank you for the comprehensive review and for your assistance in helping us to provide the best care possible to our Veterans.
3. If you have questions or require additional information, please contact Dr. Robin Hindsman, VISN 7 Quality Management Officer at (678) 924-5723.

*(original signed by:)*  
James A. Clark, MPA

## Medical Center Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** April 19, 2012

**From:** Medical Center Director (544/00)

**Subject:** **Healthcare Inspection** - Quality of Care, Communication, and Infection Control Issues, Dorn VA Medical Center, Columbia, SC

**To:** Acting Director, VA Southeast Network (10N7)

1. We thank you for allowing us the opportunity to review and respond to the subject report.
2. We concur with the conclusions and recommendations presented by the Office of Healthcare Inspection, and present you with the plans of action designed to correct those areas with recommendations.
3. If you have questions or need further information, please contact Ruth Mustard, RN, AD for Patient Care Services at 803-776-4000 X6661.

*(original signed by:)*  
Rebecca Wiley



DNR template note, as appropriate, to be more patient-specific and patient-centered.

**Concur**

**Target Completion Date:** May 15, 2012

**Facility's Response:**

DNR template notes will be revised to be more patient-specific and patient-centered.

**Status:** Open

## OIG Contact and Staff Acknowledgments

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Victoria Coates, LICSW, MBA Susan Zarter, RN Monika Gottlieb, MD

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