



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection Quality of Care Issues VA Nebraska-Western Iowa Health Care System Omaha, Nebraska And VA Central Iowa Health Care System Des Moines, Iowa

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of care received by a patient at both the Omaha, Nebraska (system 1) and Des Moines, Iowa (system 2) VA Health Care Systems. The complainant alleged that:

- While at system 1 a patient: (1) suffered a stroke that was unnoticed by the Intensive Care Unit (ICU) nursing staff, (2) did not receive assistance with his meals and other activities of daily living (ADLs) while on the general medicine unit, (3) did not receive rehabilitative therapy, (4) did not receive a scheduled pulmonary therapy treatment, (5) did not receive pain medication in a timely manner, and (6) had a substantial delay in receiving prescribed seizure medication by mail.
- While at system 2 the same patient: (1) did not receive assistance with his ADLs, (2) did not receive speech therapy, and (3) was discharged abruptly without discharge planning.

We substantiated the following allegations:

- The patient did not receive a scheduled pulmonary therapy treatment.
- There was a substantial delay in receiving seizure medication by mail.

We determined that the patient was not reassessed for pain medication effectiveness according to policy.

We recommended that the System 1 Director ensure that clinicians review the delay in this patient's receipt of his non-formulary medications and take action as deemed necessary and ensure that pain assessments and reassessments are done according to policy.



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

TO: Director, VA Midwest Health Care Network (10N23)

SUBJECT: Healthcare Inspection–Quality of Care Issues Omaha, Nebraska and Des Moines, Iowa VA Health Care Systems

Purpose

At the request of Senator Charles Grassley, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of care received by a patient at both the Omaha, Nebraska (system 1) and Des Moines, Iowa (system 2) VA Health Care Systems.

Background

VA Omaha, Nebraska (system 1) is comprised of two campuses located in Grand Island and Omaha, Nebraska. System 1 is part of Veterans Integrated Service Network (VISN) 23, serving an estimated total veteran population of 91,000 in 44 counties in Nebraska, western Iowa, Missouri, and parts of Kansas. System 1 provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics (CBOCs) located in North Platte, Grand Island, Holdrege, Bellevue, Lincoln, and Norfolk, NE, and Shenandoah, IA.

VA Des Moines, Iowa (system 2) is also part of VISN 23, serving a veteran population of over 100,000 from more than 42 counties in central Iowa and northern Missouri. System 2 provides acute and specialized medical and surgical services, residential outpatient treatment, mental health, and long-term care services. In addition, system 2 operates five CBOCs located in Knoxville, Marshalltown, Mason City, Fort Dodge, and Carroll, IA.

The complainant alleged that the patient received poor quality care while at both system 1 and system 2. Specifically, the complainant alleged that:

- While at system 1, the patient: (1) suffered a stroke that was unnoticed by the Intensive Care Unit (ICU) nursing staff, (2) did not receive assistance with his

meals and other activities of daily living¹ (ADLs) while on the general medicine unit, (3) did not receive rehabilitative therapy, (4) did not receive a scheduled pulmonary therapy treatment, (5) did not receive pain medication in a timely manner, and (6) had a delay in receiving prescribed seizure medication by mail.

- While at system 2, the patient: (1) did not receive assistance with his ADLs, (2) did not receive speech therapy, and (3) was discharged abruptly without discharge planning.

Scope and Methodology

On May 10, 2011, we interviewed the complainant by telephone and we reviewed the patient's electronic medical record (EMR). We conducted a site visit at system 1 on May 16–18 and at system 2 on May 18–19. We interviewed senior managers, service chiefs, physicians, medical residents, and other staff involved in the patient's care. We also reviewed local policies and other related documents.

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

Case Summary

The patient was a male in his sixties with a history of atrial fibrillation,² left ventricular hypertrophy, hypertension, and chronic obstructive pulmonary disease. He was on long-term anticoagulation therapy³ for atrial fibrillation.

The patient was first seen at the Shenandoah CBOC in June 2009. Documentation notes that he had an elevated prostate-specific antigen⁴ and was referred to the system 1 urology clinic for treatment. He had a prostate biopsy in August, which was positive for prostate cancer. The urologist recommended surgical treatment after a pre-operative evaluation, and the patient was cleared for surgery.

In December, the patient requested a radiation oncologist consultation. He was referred to nearby Creighton University Medical Center. The radiation oncologist reviewed the treatment options with the patient, and the patient chose radiation therapy instead of surgery. Radiation therapy treatments began in December 2009 and were completed in March 2010. The patient was followed in the system 1 primary care and urology clinics throughout this time and experienced no apparent complications.

¹ There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking), and continence.

² Atrial fibrillation is an irregular and often rapid heart rate that commonly causes poor blood flow to the body.

³ During anticoagulation therapy, medications “blood thinners” are administered to slow the rate in which a patient's blood clots.

⁴ This is a protein produced by cells of the prostate gland.

In mid-June, 2010, the patient presented to system 1's Emergency Department with generalized complaints of not feeling well. The patient was diagnosed with hyponatremia (low sodium level) and hyperkalemia (high potassium level). He was advised to discontinue one of his medications and to follow up in 2–3 days with his primary care provider (PCP). The patient was planning to go out of town and would not be returning for 5 days. He was advised against traveling, and was given an appointment for the day of his return, with instructions to seek urgent care if his symptoms did not resolve or worsened while traveling.

The patient returned to system 1's Emergency Department six days later with pain and redness around the buttocks and scrotum with associated purulent drainage and fever. He was admitted to the medical unit with a diagnosis of gluteal abscess and cellulitis. He was placed on intravenous antibiotics and evaluated by infectious diseases, urology, and surgery consultants within 5 hours from the time of his admission. His anticoagulation therapy was discontinued upon admission because of the need for surgical debridement⁵ of his wounds.

The next day, the patient's abscess was debrided, and he was found to have right gluteal and pre-sacral abscesses complicated by necrotizing fasciitis.⁶ Two days later, the patient underwent extensive surgical debridement of the perineum, right groin, right gluteal region, and scrotum. While in the post-operative recovery unit, he became hypoxic and unresponsive. He was intubated (mechanical ventilation) and transferred to the intensive care unit (ICU). He was monitored and examined with standard ICU protocols. On post-operative day (POD) 3, his respiratory status had stabilized, and he was removed from mechanical ventilation (extubated). An ICU nurse documented right-sided weakness, facial droop, and an inability to speak. Less than 3 hours after extubation, an ICU physician ordered further evaluation to include a head computerized tomography (CT) scan. The head CT scan showed a left parietal infarct.⁷ The ICU physician requested both cardiology and neurology consultations. The neurologist and cardiologist documented that they suspected the cause was an embolic stroke⁸ as opposed to a thrombotic stroke. The latter was believed to be less likely due to the inability to anticoagulate given this patient's history of atrial fibrillation with anticoagulant therapy. Stroke treatments and therapies were initiated, which included physical and speech therapy with a swallowing assessment.

⁵ Debridement is a surgical procedure used to cut away dead or contaminated tissue or foreign material from a wound to prevent infection.

⁶ Necrotizing fasciitis is commonly known as "flesh-eating disease or syndrome" is caused by bacteria, and can destroy skin, fat, and tissues covering the muscles.

⁷ An infarct is an area of tissue death due to a local lack of oxygen caused by obstruction of the tissue's blood supply.

⁸ An embolic stroke is caused by the blockage of an artery by an arterial embolus which is a traveling particle or debris in the arterial bloodstream originating from elsewhere.

The patient was transferred to a medical unit on POD 5, and his treatments for wound infections and post-stroke therapies continued. Anticoagulation therapy was resumed 2 weeks after his stroke.

The patient's wounds showed progressive healing until mid-July when he developed more drainage from the pre-sacral area. The wound tested positive for both methicillin-resistant *Staphylococcus aureus*⁹ and vancomycin-resistant enterococci¹⁰ organisms. A peri-rectal abscess was identified by a CT scan.

On POD 24, the patient's hospitalization was further complicated by a partial bowel obstruction. He was treated with conservative therapies with gradual resolution. He was also followed closely by the nutrition team, which ordered parenteral nutrition¹¹ with gradual oral intake and diet modifications.

On POD 28, the patient was discharged to system 2's long-term care facility for continued antibiotics, wound care, and stroke therapies. At the time of discharge, his functional capacity assessments indicated that his speech was understandable, but he had residual mild to moderate dysarthria.¹² His wounds were allowed to heal through gradual granulation tissue growth. He was discharged from system 2 in early September. Prior to discharge, his functional status was re-assessed, and adaptive home assistance devices were ordered. Home wound care and speech therapy were ordered prior to the patient's discharge.

Inspection Results

Issue 1: Intensive Care Unit Monitoring

We did not substantiate that the nurse caring for the patient during this time was unaware of changes in the patient's condition. The patient did suffer a stroke while in the ICU at system 1 and this was recognized in a timely manner.

Local policy¹³ states that patients in the ICU are to have vital signs¹⁴ monitored every 2 hours. In addition, patients are to be reassessed by a registered nurse at least twice in an 8-hour shift or three times in a 12-hour shift, or when the patient's status/condition changes. Our review of the patient's EMR and the ICU flow sheet¹⁵ for the date in

⁹ This is an infection caused by a strain of staphylococci bacteria that has become resistant to the antibiotics commonly used to treat ordinary staphylococci infections.

¹⁰ Vancomycin-resistant enterococci is a bacteria strain of the genus *Enterococcus* that is resistant to the antibiotic vancomycin.

¹¹ Parenteral nutrition is feeding a person intravenously, bypassing the usual process of eating and digestion.

¹² Dysarthria is a motor speech disorder caused by impairment of the muscles used in speech.

¹³ Nebraska-Western Iowa HCS, Policy PCS-114, *Acute Care: Assessment of Patients*, April 30, 2010.

¹⁴ Vital signs are measures of various physiological statistics, taken to assess the most basic body functions.

¹⁵ An ICU flow sheet is a graphic summary of several changing factors, especially the patient's vital signs and any treatments and medications given during a 24-hour period.

question revealed that a nursing reassessment, including vital signs, was done according to policy. Our interview with the nurse revealed that during the last reassessment, just prior to the wife's visit, there were no significant changes in the patient's condition.

Issue 2: Activities of Daily Living

We could not substantiate or refute that the patient did not receive assistance with his ADLs, on several occasions, as reported by the complainant at both system 1 and system 2.

According to the complainant, the patient was not given assistance with feeding on several occasions at both systems. On one occasion at system 1, while the patient received assistance getting up to a chair, it was observed that he needed to be cleaned. Allegedly, the nurse said she would return to clean him up; however, she did not return. A subsequent request was made to clean the patient. The nurse stated she would come in 15 minutes; however, the nurse returned only to drop off linen and did not clean the patient. When the wound care doctors came to examine the patient, they were asked, "how long would it take the patient's open wound to get infected from sitting in his own [feces]?"

We interviewed nurses at both systems and reviewed the patient's medical record and could not find any evidence to support or refute this allegation.

Issue 3: Rehabilitative Services

We did not substantiate that the patient did not receive rehabilitation services following his stroke. The patient's EMR notes that the patient received speech, occupational, and physical therapy treatments at system 1. The patient also received speech therapy at system 2. The patient was discharged home from system 2 with four fee basis speech therapy scheduled sessions. We reviewed documentation of the four sessions from the approved fee basis provider who is located near the patient's home.

Issue 4: Pulmonary Therapy Treatments

We substantiated that the patient did not receive at least one of his scheduled pulmonary therapy treatments at system 1. The treatment order was written for four times a day. Four times a day at system 1 is: 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. According to the complainant, the therapist entered the room while the doctors were examining the patient and said they would return later but never did. Documentation in the EMR verifies that the therapist administered a total of two treatments on July 5: one treatment at 5:26 p.m. and another at 8:43 p.m. Taking into consideration the time the order was written (12:44 p.m.), time for staff to review, transcribe, and notify the therapists; the patient could reasonably have expected to receive three treatments that day.

Issue 5: Pain Medication

We could neither substantiate nor refute the allegation that the patient did not receive pain medication in a timely manner when requested at system 1.

On one particular occasion, the nurse allegedly was asked several times to give the patient something for pain. Reportedly, the nurse became annoyed with the continued requests. The nurse administered the pain medication later; however, during our inspection, we could not determine the time difference.

Our review of the patient's EMR confirms that the patient was assessed for pain and given pain medication at 5:00 p.m. on the date in question. Local policy¹⁶ states that post-intervention documentation for pain medication's effectiveness will be documented prior to the end of the staff's tour of duty. We found no documentation in the patient's EMR of a reassessment for pain medication effectiveness.

Issue 6: Discharge Planning

We did not substantiate that the patient did not receive discharge planning in accordance with system 2's policy. Allegedly, the facility provided the patient's family no prior notification regarding his discharge other than a telephone call during the morning of September 9, when the facility informed the family the patient was ready to be picked up.

Local policy¹⁷ states that a patient and/or significant other(s) shall have an active involvement in developing his/her discharge plan. Documentation in the EMR shows that on several occasions prior to discharge, the patient and his wife were involved in discharge planning discussions. Our interview with the discharge planning nurse revealed that the patient went home on a weekend pass just prior to discharge as a trial to better assess his discharge needs. We found that the patient's discharge process was managed according to policy including documented family involvement.

Issue 7: Mail Order Medication

We substantiated that the patient did not receive prescribed mail order medication within the timeframe indicated by the prescribing physician. Further action should have been taken to ensure that the patient's prescription was filled and mailed as ordered. In addition, the patient reportedly did not receive a temporary medication supply to take during the interim. This was confirmed by the prescribing physician.

A timeline of encounters from the time the patient first presented to the Shenandoah CBOC PCP on September 14 until receiving his prescribed medication by mail on November 10 is displayed in the Table below.

¹⁶ VA Nebraska-Western Iowa Health Care System, Policy PCS-020, *Pain Assessment and Management*, October 18, 2009.

¹⁷ VA Central Iowa Health Care System, Patient Care Program-6, *Discharge Planning Policy*, September 1, 2008.

Table. Timeline of Encounters from first Patient Shenandoah CBOC PCP Visit to Receiving Medication by Mail.

Day #	Date	Electronic Medical Record Documentation
1	September 14	Patient seen by the PCP for seizures and a neurology consult was submitted.
3	September 16	Neurology physician contacted patient by telephone to discuss plan of care.
14	September 27	Patient seen in the neurology clinic and seizure medication was ordered. A non-formulary consult was not completed.
15	September 28	Medication order was placed on hold by pharmacy. View Alerts ¹⁸ were sent by the pharmacist to the neurology physician.
36	October 19	Patient suffered another seizure at home while waiting for medication to arrive by mail. Patient was seen by the CBOC PCP.
37	October 20	View Alerts were acknowledged by the neurology physician, and a non-formulary consult was completed.
38	October 21	Pharmacy filled the mail order prescription. Wife returned to system 1 to pick up the medication, however, she was told the medicine had been mailed.
51	November 04	Wife returned again to system 1 and received a temporary supply of medication while still awaiting medication by mail.
57	November 10	Patient received the seizure medication by mail.

Conclusions

We found that the patient had suffered a stroke while in the ICU at system 1. However, we did not substantiate that the nursing staff were unaware of changes in the patient's condition. We determined that the patient did not receive one scheduled pulmonary therapy treatment on the day in question. We substantiated that there was a substantial delay in the patient receiving his medication by mail.

We did not substantiate that the patient: (1) did not receive assistance with his ADLs at both systems, (2) did not receive rehabilitative therapy at both systems, (3) did not receive pain medication in a timely manner at system 1, and (4) was discharged from system 2 abruptly without discharge planning.

We determined that the patient was not reassessed for pain medication effectiveness.

¹⁸ View Alerts are computer system warnings used by the pharmacy to flag orders, alerting the physician that the order is incomplete.

Recommendations

Recommendation 1. We recommended that the System 1 Director ensure that clinicians review the delay in this patient’s receipt of his non-formulary medications and take action as deemed necessary.

Recommendation 2. We recommended that the System 1 Director ensure that pain assessments and reassessments are completed according to policy.

Comments

The VISN and Facility Directors agreed with the findings and recommendations (see Appendixes A and B, pages 10–14, for the full text of their comments). The implementation plans are acceptable, and 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: August 12, 2011

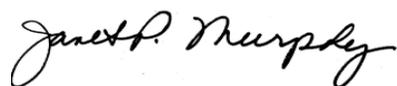
From: Director, VA Midwest Health Care Network (10N23)

Subject: **Healthcare Inspection–Quality of Care Issues Omaha, Nebraska
and Des Moines, Iowa VA Health Care Issues**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Thru: Director, Management Review Services (10A4A4)

We concur with the action plans regarding the recommendations identified in this report.



Janet P. Murphy, MBA

System 1 Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 12, 2011

From: Acting Director, VA Nebraska-Western Iowa Health Care System (Omaha Division) (636/00)

Subject: **Healthcare Inspection–Quality of Care Issues Omaha, Nebraska and Des Moines, Iowa VA Health Care Systems**

To: Director, VA Midwest Health Care Network (10N23)

This is to acknowledge the receipt and review of the findings and recommendations of the Office of Inspector General Healthcare Inspection. Nebraska-Western Iowa Health Care System concurs with the findings and recommendations. Corrective action plans have been developed or implemented for the recommendations.

Our appreciation is extended to the OIG Healthcare Inspection team. We appreciate the thorough review and the opportunity to further improve the quality of care we provide to our Veterans.



Nancy A. Gregory, FACHE

System 2 Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 3, 2011

From: Director, Des Moines VA Health Care System (636A6/00)

Subject: **Healthcare Inspection–Quality of Care Issues Omaha, Nebraska
and Des Moines, Iowa VA Health Care Systems**

To: Director, VA Midwest Health Care Network (10N23)

VA Central Iowa Health Care System (VACIHCS) appreciates the opportunity to have provisions of care to Veterans served by the system critically reviewed by the VA Office of Inspector General.

I concur with the findings of the Draft Report pertaining to the quality of care provided at VACIHCS. There are no recommendations requiring corrective action by VACIHCS.



Donald C. Cooper
Director, Des Moines VA Health Care System (636A6/00)

Nebraska Western Iowa HCS concurs that pain assessments and reassessments should be completed according to policy. In May, an inpatient committee, consisting of representatives from the inpatient medical-surgical units, was formed to discuss pain data per unit, develop pain education for nursing staff, and review data. Members of this committee also serve as nurse champions. These champions will serve as a resource for the inpatient nursing staff and assist with monitoring of prn effectiveness on their unit. The Pain Policy is undergoing review with an anticipated concurrence data of recommended changes by September. Changes to the nursing staff's daily use of the prn effectiveness worksheet have been implemented. Work with the Data Analyst Team is being done to create an electronic automatic report to monitor for prn effectiveness. Pain policy/procedure education was completed at the annual nursing Education Fair. This education is also provided to new nursing staff during nursing orientation. Pain competency was assessed during this year's annual nursing competency evaluations.

Status: In progress

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	Wachita Haywood, RN, Project Leader Verena Briley-Hudson, ARNP, MN JoDean Marquez, RN Monika Gottlieb, MD Judy Brown, Program Support Assistant

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