



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues Martinez Outpatient Clinic and Center for Rehabilitation and Extended Care Martinez, California

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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 quality of care received by six patients at the Martinez Outpatient Clinic (OPC) and Center for Rehabilitation and Extended Care (CLC). The OPC and CLC is a part of the VA Northern California Health Care System (system) within Veterans Integrated Service Network (VISN) 21. The complainant alleged that:

- Five patients received inadequate postoperative care and that one patient was inappropriately admitted as an observation patient.
- The CLC lacked the infrastructure for quality care for observation patients.
- The OPC placed surgical outpatients in a contracted community setting with no nursing care after their procedures.

We substantiated the allegations regarding inadequate care for two of the six patients reviewed. We also substantiated the allegation that the CLC lacked the infrastructure in which to provide quality care for observation patients. We determined that system managers took appropriate actions by discontinuing urology surgeries since May 2010 and observation care since July 2010. Therefore, we did not make any recommendations regarding these allegations.

We did not substantiate the allegation that the OPC placed surgical outpatients inappropriately in a contracted community setting without adequate care after their procedures. However, we concluded that policies need to be developed for the local temporary lodging or Hoptel Program, employees need to be educated about the program, and Gains & Losses sheets should document lodger check-ins and check-outs.

We recommended that the System Director ensure that local temporary lodging or Hoptel Program policies and procedures are developed, implemented, and monitored to ensure compliance with Veterans Health Administration policy.

The VISN and system Directors agreed with our findings and recommendation. The implementation plan is acceptable, and 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, Sierra Pacific Network (10N21)

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues, Martinez Outpatient Clinic and Center for Rehabilitation and Extended Care, Martinez, California

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections received allegations regarding quality of care issues at the Martinez VA Outpatient Clinic (OPC) and Center for Rehabilitation and Extended Care (CLC) in Martinez, CA. The purpose of this review was to determine whether the allegations had merit.

Background

The OPC and CLC is a part of the VA Northern California Health Care System (system) within Veterans Integrated Service Network (VISN) 21. The Sacramento VA Medical Center is the parent facility in this system. It has 60 inpatient beds and offers a full range of services including medical, surgical, outpatient, and mental health. It is approximately 79 miles from Martinez, CA.

The OPC, a satellite outpatient clinic and freestanding ambulatory surgery center, offers medical, surgical, mental health, and diagnostic services and houses two operating rooms and two procedure rooms. Adjacent to the OPC is the 120-bed CLC that provides sub-acute, rehabilitation, and transitional care, as well as a 23-hour observation bed program for patients after ambulatory surgical procedures. The 45-bed Napa Unit, which provides sub-acute and skilled nursing care, houses the postoperative patients requiring observation.¹ The CLC does not designate specific beds for observation stays; bed assignments are made according to availability at the time of need.

The Veterans Health Administration (VHA) defines ambulatory surgery as “surgical or invasive diagnostic procedures performed by qualified providers in ambulatory or dedicated surgical suites with pre-procedural and immediate post-procedural care on the

¹ VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.

same day, or observation admissions without hospitalization.”² Patients selected for ambulatory surgery should require a minimal anticipated recovery period with no postoperative complications expected and be discharged home with a competent adult. Data also needs to be collected regularly for periodic review and reporting. This includes any patients that require unplanned overnight observation, admission to an acute care bed within 14 days of the surgery due to a surgical or anesthetic complication, and deaths that occur within 30 days of ambulatory surgery.

Overnight observation admissions may be required for some ambulatory surgery patients. An observation patient is “one who presents with a medical condition showing a significant degree of instability needs to be monitored and evaluated, receives ongoing short-term treatment assessment and reassessment while a decision is being made as to whether the patient requires further treatment as a hospital inpatient, will be discharged, or assigned to care in another setting.”³ In contrast, admission criteria for long-term care include medical and psychiatric stability, and the goal is to restore the resident to maximum function, prevent further decline, maximize independence, and/or provide comfort when dying.

Local⁴ and VHA policy⁵ define minimum documentation⁶ for observation stays to include performance of an initial assessment and a history and physical examination immediately upon admission to the observation unit. Admission and discharge orders should be timed and dated. Progress notes within the observation period should include the condition of the patient, course of treatment, patient’s response to treatment, and significant findings at the time of documentation of the progress note. The discharge note should also include:

1. Final diagnoses
2. Complications
3. Summary of the reason for the observation admission, the outcomes, and follow-up plans
4. Patient disposition
5. Discharge instructions

On March 4, 2010, VHA further defined appropriate use of observation status for postoperative patients, stating that the system must assign these patients to a service with a clearly identified responsible attending physician. Criteria for observation status do not

² VHA Handbook 1102.5, *Criteria and Standards for Performance of Ambulatory (Same Day) Surgery Performed in Ambulatory or Dedicated Surgical Suites*, May 20, 2003.

³ VHA Directive 2009-064.

⁴ VANCHCS Policy 11-3, Attachment A. *Observation Program*, January 19, 2010.

⁵ VHA Directive 2009-064, Attachment A, *Observation Patient Record Documentation Requirements*, November 30, 2009.

⁶ VHA Directive 2009-064, Attachment A.

include routine recovery from procedures or surgeries. However, use of these beds for patients who develop short-term complications or require extended observation past the routine recovery time from ambulatory surgery or procedures is acceptable.⁷

For ambulatory surgery patients with travel difficulties due to inclement weather or transportation problems, VHA specifies that the system may furnish temporary lodging or Hoptel services to lodgers or veterans who are housed for non-medical purposes and who are not receiving health care services while lodged.⁸ They are not patients. Local policies are required for temporary lodging programs that outline eligibility criteria, delegations of authority, and program oversight responsibilities. All staff, including new employees and trainees, must be familiar with the policies, and the system Gains and Losses (G&L) sheets should document lodger check-ins and check-outs.⁹

The OIG Hotline Division received allegations that patients have not received appropriate care after surgeries and invasive procedures. Specifically, the complainant alleged that: (a) five patients received inadequate postoperative care and that one patient was inappropriately admitted as an observation patient, (b) the CLC lacked the infrastructure for quality care for observation patients, and (c) surgical outpatients were placed in a contracted community setting with no nursing care after their procedures. Allegations were also made regarding the research programs at Martinez as well as the activities of a respiratory therapist. These allegations were not included in this review.

Scope and Methodology

We interviewed the complainant in person and through telephone conversations. We conducted site visits on August 5 and August 18–19, 2010. We interviewed senior managers and employees and reviewed pertinent local documents, medical records, and VHA policies and procedures.

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.

Inspection Results

Issue 1: Quality of Care in Selected Cases

We substantiated the allegations of inadequate care for two of the six patients. We concluded that the remaining four patients were managed appropriately.

⁷ VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.

⁸ VHA Directive 2003-009, *Temporary Lodging and Hoptel Programs*, February 7, 2003.

⁹ VHA Directive 2009-064.

Patient 1

Case Summary. The patient, a man in his late 70s with a bladder tumor, underwent a transurethral resection of the bladder tumor (TURBT) in late March 2010. Prior to surgery, it was noted that the patient failed to follow instructions to discontinue his aspirin. However, the surgeon made the decision to proceed with surgery, as the procedure would be short. After surgery, the patient transferred to the CLC due to postoperative bleeding. He required continuous bladder irrigation and monitoring of his red blood cell levels.

During the night, the patient continued to experience postoperative bleeding with blood clots noted in the urinary catheter tubing. He also complained of severe pain and received Vicodin[®] (medication used to relieve moderate to severe pain) which was minimally effective. Care providers did not order or administer any other pain medication.

The following morning, the patient's condition deteriorated. He was transferred to a community hospital due to an elevated white blood count of 27.7 (normal range: 4.3–10.3 per microliter) and a low hemoglobin level of 7.2 (normal range: 13–18 grams per deciliter). The patient required blood transfusions. After a 3-day stay, the hospital discharged the patient in stable condition.

Findings. We substantiated the allegation of inadequate postoperative care. The patient was actively bleeding and in pain. Interventions did not address underlying problems. The arrangements for transfer to a higher level of care did not take place until 24 hours after surgery. We noted that the system halted all urology surgeries at the OPC since May 28, 2010.

Care providers did not adequately document the patient's post-procedure condition and health care team members' communications in the medical record. The surgeon dictated the operative report more than 2 weeks after surgery.¹⁰ System leadership acknowledged that medical record documentation, including a timely operative report and documentation of post-procedural care and communication between health team members needed to be improved.

Patient 2

Case Summary. The patient is a man in his late 70s with a bladder tumor and a history of congestive heart failure, hypertension, and a positive cardiac surgical history requiring an automatic implantable cardioverter defibrillator.¹¹ The patient withheld his doses of

¹⁰ VHA Handbook 1102.5.

¹¹ An automatic implantable cardioverter defibrillator (AICD) is a device that monitors heart rhythms with leads in the right atrium and right ventricle; it delivers an electrical shock when a dangerous rhythm is detected.

warfarin (medication to prevent blood from clotting) for 5 days prior to his January 2010 surgery as instructed and took subcutaneous enoxaparin as bridging therapy.¹²

In mid-January 2010, the patient underwent a TURBT. Postoperatively, he transferred to the CLC for a 23-hour observation stay.¹³ During the night, the patient had cranberry-colored urine and required an oral dose of pain medication.

The following morning, the patient had blood clots in the urinary catheter tubing, and the nurses initiated bladder irrigations as ordered. The health care team arranged to admit the patient to the CLC for continued nursing care. The lowest hemoglobin level during this postoperative period was within normal limits, and the patient did not require any transfusions.

On postoperative day 3, the blood clots had resolved. The patient urinated without difficulty and was discharged home with oral antibiotics, warfarin, and enoxaparin and instructed to follow up with the urology clinic. That evening, the patient had difficulty urinating and called the VISN 21 Telephone Care Line. The nurse instructed the patient to present to the nearest emergency department.

During the next 2 weeks, the patient required admission to two community hospitals for clot retention requiring bladder irrigation and for chest pain with diagnosis and treatment of a mild myocardial infarction (heart attack). The patient has since stabilized and been scheduled for ongoing outpatient urological care at the OPC.

Findings. We substantiated the allegation of inadequate postoperative care for this patient. The patient required more intensive monitoring for the development of blood clots in an acute care setting. He was not seen by a physician during the 2 days prior to discharge. We noted that the system formally reviewed this case and halted all urology surgeries at the OPC since May 28, 2010.

Patient 3

Case Summary. The patient, a man in his 60s, underwent a colonoscopy with biopsies and removal of polyps under moderate sedation in late April 2010. After the procedure, the patient transferred to the CLC for observation due to lack of transportation home. He also complained of abdominal pain and right-sided tenderness. The gastroenterologist ordered a computed tomography (CT) scan (a special type of x-ray) and an abdominal x-ray.

Later that afternoon, 2 hours after the colonoscopy, CT scan showed a small colonic perforation (hole or tear in the wall of the colon). Within 2.5 hours of the discovery of

¹² Bridging therapy is the practice of protecting a patient from blood clots where enoxaparin, a low molecular weight heparin, is substituted for warfarin 5 days before surgery because its effects are shorter in duration.

¹³ VHA Directive 2009-064.

the micro-perforation, the CLC transferred the patient to a community hospital for continued monitoring and care. The patient did not require surgical intervention, and the hospital discharged him after a short uneventful stay.

Findings. We did not substantiate the allegation of inadequate post procedural care in this case. We determined that the CLC quickly and efficiently transferred the patient to a higher level of care once the need for acute care monitoring was evident. The system also thoroughly reviewed the outcomes of the colonoscopy and the events leading up to the patient's transfer to community hospital to ensure that the patient's care met community standards.

Patient 4

Case Summary. The patient, a male in his late 60s with a history of peripheral vascular disease, bilateral lower extremity bypass grafts, and benign prostate enlargement, underwent a cystoscopy with biopsies to rule out a bladder tumor in early February 2010. Postoperatively, the patient had rose-colored urine and transferred to the CLC for a 23-hour observation stay.

The patient received intravenous (IV) antibiotics and oral pain medications during the overnight stay. The following morning, the urine cleared, and the CLC discharged the patient with instructions for a follow-up urology clinic appointment in a week.

Findings. We did not substantiate the allegation of inadequate care in this case. The patient received IV antibiotics as ordered. The health care team observed him during the overnight stay and then discharged him in stable condition. The patient did not have any adverse occurrences during the immediate or remote postoperative period.

Patient 5

Case Summary. The patient, a man in his 20s with a history of traumatic brain injury, was seen in the Urgent Care Clinic (UCC) in early March 2010 for acute bacterial throat infection. The physician admitted the patient to the CLC for a 23-hour observation stay and ordered IV antibiotics. The patient was not able to tolerate anything more than a liquid diet during the stay and needed IV morphine for pain.

Immediately after discharge from the CLC, the UCC physician examined the patient and gave him a referral to the otolaryngology (ENT) clinic for follow-up. Discharge medications included oral antibiotics. Almost 3 weeks later, the ENT physician examined the patient, and considered the condition resolved.

Findings. We did not substantiate the allegation that this patient received inadequate care. His acute throat infection required the initiation of IV antibiotics in a 23-hour observation setting. The CLC discharged the patient appropriately on oral antibiotics the

following day. Outpatient follow-up care was provided, and the patient’s condition improved.

Patient 6

Case Summary. The patient, a man in his early 60s, underwent sinus surgery in mid-July 2010. During surgery, the surgeon discovered and promptly repaired a cerebrospinal fluid leak. The health care team monitored the patient in the postoperative recovery area and found him to be neurologically intact and medically stable. The surgeons transferred the patient to the parent facility for prophylactic IV antibiotics, observation, and activity restriction (no nose blowing, straining, or coughing).

After transfer, a head CT scan showed pneumocephalus.¹⁴ The remainder of the patient’s postoperative course was uneventful. Symptoms improved while the surgeons followed his progress and provided ongoing care. The parent facility discharged the patient after a 2-day stay with a follow-up appointment in a week.

Findings. We did not substantiate the allegation of inadequate postoperative care. We determined that the system quickly and efficiently transferred the patient to a higher level of care postoperatively. The patient was determined to be stable and did not require transfer to the nearest community hospital. The transfer to the parent facility allowed the surgical team to continue monitoring and caring for the patient in an acute care setting.

Issue 2: Infrastructure for Observation Care

We substantiated the allegation that the CLC lacked the infrastructure in which to provide quality care for observation patients. We determined that urologists have pre-arranged for 23-hour observation stays for surgical patients regardless of the occurrence of complications during surgery. Although the CLC nursing staff had documented competencies for the basic care of surgical patients, the nurse staffing ratios did not support the needs of potentially unstable surgical observation patients. We noted inconsistencies with VHA requirements in the medical record documentation in three of the five observation patient records reviewed. Table 1 below shows the deficiencies.

Table 1. Medical Record Reviews

	Case #1	Case #2	Case #3	Case #4	Case #5
Initial Assessment	Yes	No	Yes	No	Yes
History & Physical	Yes	No	Yes	Yes	No
Admission Orders	Yes	Yes	Yes	Yes	Yes
Discharge Orders	Yes	Yes	Yes	No	Yes
Progress Note	Yes	No	Yes	Yes	No
Discharge Note (with all required components)	Yes	Yes	Yes	Yes	No

¹⁴ This is the presence of air in the skull. This condition often resolves without additional intervention.

Also, according to VHA policy,¹⁵ observation patients “must be assigned a treating specialty code of observation...and that all services and costs associated with the observation treating specialty are captured and assigned to inpatient services.” This process was not in place as we found that the names of observation patients were handwritten by nurses into a unit notebook instead of being systematically and officially recorded in the G&L sheets for administrative workload monitoring and tracking.

Issue 3: Disposition of Patients

We did not substantiate the allegation that the OPC inappropriately placed surgical outpatients in a contracted community setting without adequate care after their procedures. However, the system needs to strengthen administrative and educational processes. Local policies are required for temporary lodging programs, which outline eligibility criteria, delegations of authority, and program oversight responsibilities. All staff, including new employees and trainees, must be familiar with the policies, and the system G&L sheets should document lodger check-ins and check-outs.¹⁶

We found that the OPC places lodgers in available CLC beds and uses a nearby hotel for overflow when CLC beds not available. However, the OPC and CLC were unable to provide policies and procedures about the local temporary lodging and Hoptel program, and did not document lodger check-ins and check-outs in the G&L sheets. In addition, not all employees understand the difference between lodgers and observation patients. There is a perception that the OPC inappropriately sends observation patients requiring nursing care to the nearby hotel after surgery when in fact, these lodgers require no health care services.

Conclusions

We substantiated the allegations regarding inadequate care for two of the six patients reviewed. We also substantiated the allegation that the CLC lacked the infrastructure in which to provide quality care for observation patients. We determined that system managers took appropriate actions by discontinuing urology surgeries since May 2010 and observation care since July 2010. Therefore, we did not make any recommendations regarding these allegations.

We did not substantiate the allegation that the OPC placed surgical outpatients inappropriately in a contracted community setting without adequate care after their procedures. However, we concluded that policies and procedures need to be developed for the local Hoptel Program, employees need to be educated about the program, and G&L sheets should document lodger check-ins and check-outs.

¹⁵ VHA Directive 2009-064.

¹⁶ VHA Directive 2009-064.

Recommendation

We recommended that the system Director ensures that local Hoptel Program policies and procedures are developed, implemented, and monitored to ensure compliance with VHA policy.

Comments

The VISN and system Directors agreed with our findings and recommendation (see Appendixes A and B, pages 10–12, for the Director’s comments). The implementation plan is acceptable, and we will follow up on the planned actions until they are completed.

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 9, 2011

From: Director, Sierra Pacific Network (10N21)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues, Martinez Outpatient Clinic and Center for Rehabilitation and Extended Care, Martinez, California**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Thru: Director, Management Review Service (10B5)

1. Thank you for the opportunity to review the draft report on the Alleged Quality of Care Issues, Martinez Outpatient Clinic and Center for Rehabilitation and Extended Care, Martinez, California. We concur with the recommendation, and will ensure completion as described in the attached plan by the established target date.
2. If you have any questions regarding the attached response or action for the recommendation in the draft report, please contact Ms. Judy Daley, VISN 21 Quality Management Officer, at (775) 328-1774.

(original signed by:)

Sheila M. Cullen

Director, Sierra Pacific Network (10N21)

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 9, 2011

From: Director, VA Northern California Health Care System (612/00)

**Subject: Healthcare Inspection – Alleged Quality of Care Issues,
Martinez Outpatient Clinic and Center for Rehabilitation and
Extended Care, Martinez, California**

To: Director, Sierra Pacific Network (10N21)

1. On behalf of the VA Northern California Health Care System, I would like to thank you for the informative and constructive Health Care Inspection for Alleged Quality of Care Issues at the Martinez Outpatient Clinic and Center for Rehabilitation and Extended Care, Martinez, California. Attached, you will find our corrective action plan and target completion date for the recommendation.
2. If you have questions or need additional information, please feel free to contact Cynthia Knell, Quality Manager, at (916) 843-9290.

(original signed by:)

Brian J. O'Neill, MD

Director, VA Northern California Health Care System (612/00)

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

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendation

We recommended that the System Director ensures that local Hoptel Program policies and procedures are developed, implemented, and monitored to ensure compliance with VHA policy.

Concur

Target Completion Date: April 11, 2011

Facility's Response:

The Quality Manager, Chief of Staff, and Associate Director of Patient Care Services will ensure development of a policy and education of staff to encompass a Hoptel Program for VANCHCS [the system].

The developed policy will incorporate eligibility criteria, delegations of authority, and program oversight responsibilities.

The Chief of BDMS [Benefit and Data Management Service] will conduct a quarterly audit of the Gains and Losses sheets to demonstrate compliance with documentation of lodger check-ins and check-outs. The audit data will be presented and analyzed quarterly at the Provision of Care Committee.

Status: Open

OIG Contact and Staff Acknowledgments

OIG Contact	Daisy Arugay, Director Los Angeles Office of Healthcare Inspections
Acknowledgments	Mary Toy, RN, Associate Director, Team Leader Simonette Reyes, RN Kathleen Shimoda, RN George Wesley, MD Robert Yang, MD

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