Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues
Claremore Veterans Center
Claremore, Oklahoma

Report No. 06-03158-64

January 23, 2007

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

An inspection was conducted to determine the validity of the allegations regarding quality of care issues at the Claremore Veterans Center (CVC), a State facility in Claremore, OK. We concluded that the patient received appropriate care and that nursing staff turned the patient as ordered. We could not substantiate or refute allegations that the patient did not receive adequate pain medication and that one time the complainant was not told why the patient was started on antibiotics. However, documentation supports that the patient received pain medications on a regular basis and that the clinical staff had frequent conversations with a son of the patient who lives in the local area, informing him of changes in the patient's condition and treatment modalities. We made no recommendations.

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

TO: Medical Center Director, Muskogee VA Medical Center

SUBJECT: Healthcare Inspection – Quality of Care Issues, Claremore Veterans Center, Claremore, Oklahoma

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed allegations regarding quality of care issues at the Claremore Veterans Center (CVC), Claremore, OK. The purpose of the inspection was to determine the validity of the allegations.

Background

The complainant, a son[1] of the patient, alleges his father was transferred to a private hospital in Tulsa, OK, on two occasions due to lack of care at the CVC. Specific allegations included:

- Staff at the CVC failed to turn his father causing him to develop a large pressure ulcer.[2]
- Staff failed to administer his father's pain medication when he was crying and moaning in pain.
- The complainant was unable to find out from staff on one occasion why his father was being administered antibiotics.

The CVC is a 302-bed State veterans facility that provides 24-hour intermediate, skilled nursing, and domiciliary care for veterans. It is under the jurisdiction of the State of

[1] One son lives near the CVC; another son lives in different state.
[2] A pressure ulcer is defined as any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers are usually located over bony prominences and are graded or staged to classify the degree of tissue damage observed. The staging of pressure ulcers is defined in accordance with the National Pressure Ulcer Advisory Panel guidelines.

Oklahoma Department of Veterans Affairs, which has an annual inspection program for their own facilities.

The CVC is also inspected annually by the Muskogee VA Medical Center, which is part of the Veterans Integrated Service Network (VISN) 16. Their annual inspection conducted in 2005 had no deficiencies. The latest inspection was conducted in August 2006; the report had not been issued at the time of our inspection.

Scope and Methodology

We visited the CVC on September 25–27, 2006. We interviewed administrative staff, primary care providers, the wound care nurse, and other nursing staff assigned to care for the patient. We reviewed medical records, local policies and procedures, and quality management documents. We visited the patient to assess the current status of his pressure ulcer and conducted a general inspection of the CVC patient care areas where the patient had been transferred. We also reviewed the patient's medical records for his last admission to the private hospital.

Clinical Case Review

The patient is an 86-year-old male with a long-standing history of dementia, coronary artery disease, dyslipidemia, hypertension, diabetes mellitus, and gastroesophageal reflux. In October 2005, he was diagnosed with sick sinus syndrome, which required the insertion of a pacemaker.

On May 04, 2006, the patient was admitted to the CVC (Unit 2B, medical ward) from a private nursing home. Documentation upon admission indicated he was ambulating with a walker, incontinent of stool and urine, and was having increased periods of forgetfulness. His general appearance was one of being well developed, adequately nourished (weight 156 pounds), pleasant, sociable, and oriented to person and location. The CVC primary care provider (PCP) referred the patient to physical therapy for general conditioning and ambulation three to five times per week. The PCP also prescribed acetaminophen for pain or elevated temperature, lorazepam for anxiety or restlessness, and medications for dementia and other chronic conditions.

The patient's behavior and dementia status declined, and on May 11 he was transferred to a dementia care locked unit (1C West). On June 4, he was placed on intravenous antibiotic therapy for pneumonia. On June 12, the patient's medical condition deteriorated, and he was transferred to a private hospital with a diagnosis of pneumonia. During this hospitalization, the patient had difficulty chewing and swallowing and a feeding tube was inserted into his stomach to provide nutrients. His condition improved, and he was transferred back to the CVC on June 19.

At the CVC, the patient received medication as needed for symptoms, which included agitation with yelling and restlessness and pain. He also received tube feedings and a July 7 note documents that he had been experiencing diarrhea since starting the tube feeding. Clinicians changed and modified the tube feeding formula supplements as needed to control the patient's diarrhea. On July 13, the patient developed a fever and respiratory distress, and he was again diagnosed with pneumonia and treated with intravenous antibiotics. He also developed peripheral edema.[3] On July 19, the night shift nurse documented that the patient had a 2 centimeter (cm) x 1 cm stage II[4] open area pressure ulcer on his coccyx[5] with a 5 cm x 4 cm area of discoloration surrounding the area. Later that morning, the patient's condition declined and he was transferred to the private hospital where he was diagnosed with congestive heart failure,[6] atrial fibrillation,[7] and dementia.

The patient's condition stabilized, and on July 22 he was transferred back to the CVC. The PCP documented that the patient had a stage II pressure ulcer measuring 5 cm x 2 cm on his coccyx and red areas on both ankles. The PCP wrote orders to turn the patient every 2 hours and apply a skin protectant to the unbroken skin at every diaper change. The patient was also placed on an air mattress to relieve pressure on boney prominences and restarted on physical therapy to promote better circulation and healing of his wound.

August and September medical record documentation shows that the patient was repositioned as ordered; however, because of his restlessness, it was difficult to keep him off his back. Nursing staff frequently documented that the patient would not stay on his side, that he "…keeps putting himself on his back…." He continued to have frequent episodes of diarrhea, and his dementia deteriorated with increased periods of disorientation, yelling, and agitation. The patient received medications for pain and restlessness on several occasions. There is also frequent documentation of conversations between clinicians and the son who lives in the area regarding the patient's deteriorating condition.

[3] Fluid retention in the tissues.
[4] Partial thickness skin loss involving epidermis, dermis, or both.
[5] The lowest part of the spine, commonly called the "tail bone."
[6] Form of heart failure in which the heart is unable to pump away the blood returning to it fast enough, causing congestion in the veins.
[7] Irregular heart rhythm.

Results

Issue 1: Pressure Ulcer

We did not substantiate the allegation that, because nurses failed to turn the patient, he developed a pressure ulcer. While it is true that the patient developed a pressure ulcer on his coccyx, it was not because nurses failed to turn him. Medical record documentation supports that nurses turned the patient every 2 hours as ordered. However, because of the patient's dementia and restlessness, he was usually able to turn back to the supine position. Nurses used foam wedges in an attempt to keep him on his side, but this did not always work. Nurses also put the patient on an air mattress in an attempt to reduce the chances of the patient getting a pressure ulcer.

During our site visit, we observed nursing staff repositioning the patient on his side using foam wedges for support, and we noted that the patient was able to move around in bed and return to the supine position. We also noted that the stage II pressure ulcer on the patient's coccyx was clean, without drainage, and appeared to be healing.

Issue 2: Pain Medication

We could neither substantiate nor refute the allegation that the patient had not received adequate pain management. Medical record documentation supports that the patient received pain medications on a regular basis; however, the effectiveness of the pain medication was not documented on a consistent basis.

Nursing staff told us that they gave the patient pain medication when he appeared to be in pain. Because of his dementia, he was not able to verbalize his needs. The nurses also told us that they felt they were able to accurately recognize the difference in the patient's moaning and yelling when he was in pain as opposed to just wanting someone in his room.

Issue 3: Administration of Antibiotics

We could not substantiate or refute the allegation that, on one occasion, nursing staff would not tell the complainant why the patient was receiving antibiotics. The complainant did not provide a specific date for this inquiry nor could the nursing staff we interviewed recall this incident. However we did find documentation in the patient's medical record to support that the PCP communicated regularly with the patient's son who lives in the local area, keeping him abreast of changes in his father's condition and/or treatment modalities.

Conclusion

We concluded that the patient received appropriate care and that nursing staff turned the patient as ordered. We could not substantiate or refute the allegations that the patient did not receive adequate pain medication and that one time the complainant was not told why the patient was started on antibiotics. However, documentation supports that the patient received pain medications on a regular basis and that the clinical staff had frequent conversations with the son who lives in the local area, informing him of changes in the patient's condition and treatment modalities. We made no recommendations.

Comments

The Medical Center Director concurred with the findings in this report. We plan no further action.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Department of Veterans Affairs **Memorandum**

Date: 12/05/06

From: Medical Center Director

Subject: **Quality of Care Issues, Claremore Veterans Center, Claremore, Oklahoma**

To: VA OIG

The Jack C. Montgomery VAMC concurs with the findings.

(original signed by:)
Adam C. Walmus, Director

OIG Contact and Staff Acknowledgments

OIG Contact	Marilyn Walls, Healthcare Inspector, Dallas Office of Healthcare Inspections (214) 253-3331
Acknowledgments	Linda DeLong, Director Karen Moore, Associate Director Wilma Reyes George Wesley, M.D.

Appendix C

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