Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Delay in Diagnosis and Treatment
VA Eastern Colorado Health Care System
Denver, Colorado

Report No. 07-01923-183

August 6, 2007

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The purpose of the review was to determine the validity of a complainant's allegations of a right shoulder dislocation during back surgery, a delay in diagnosis and treatment of the injury, and poor communication with medical center staff at the VA Eastern Colorado Health Care System (the system), Denver, CO.

We substantiated the allegation of right shoulder dislocation immediately after surgery. The patient's post operative record indicated a right shoulder dislocation that was not noted prior to surgery. The patient awoke very abruptly from anesthesia after surgery and began to thrash violently. Staff were able to maintain the patient on the surgical table without a fall. We concluded that the patient had a dislocated right shoulder after his back surgery, but we could not determine conclusively what caused the dislocation. We found that the written report of the operating room incident was correctly initiated, but was not forwarded to system management in a timely fashion.

We did not substantiate a delay in diagnosis or treatment of the shoulder dislocation. The patient was appropriately assessed and treated in the post anesthesia care unit. When the patient continued to have pain, orders for x-rays and additional medication were obtained. The patient had a closed reduction of his dislocated shoulder when the orthopedic surgeon became available. We found that the clinical treatment of the patient's dislocated shoulder was appropriate and provided in a reasonable time frame.

We did not substantiate that communication with the patient was poor. The patient told us that he was told he awoke abruptly after surgery and that was when his shoulder was dislocated. However, communication with the patient and his wife was not always documented in the medical record or service level patient advocate tracking software package.

We recommended that management hold a meeting with the patient to discuss the incident and answer any questions regarding his treatment, ensure that all incidents are captured and reported to system management, and ensure that all patient advocate interactions are documented in the computer software tracking system.

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

TO: Director, Veterans Integrated Service Network (10N19)

SUBJECT: Healthcare Inspection ─ Alleged Delay in Diagnosis and Treatment, VA Eastern Colorado Health Care System, Denver, CO

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed a complainant's allegations of right shoulder dislocation during back surgery, a delay in diagnosis and treatment of the injury, and poor communication with medical center staff at the VA Eastern Colorado Health Care System (the system), Denver, Colorado. The purpose of the inspection was to determine whether the allegations had merit.

Background

The system is located in Denver, Colorado, and is under the jurisdiction of Veterans Integrated Service Network (VISN) 19. The system is a major referral center providing a full range of primary, tertiary, and long term care. The system has seven community based outpatient clinics located from Denver to the southern tier of Colorado.

The system is affiliated with the University of Colorado, with residency programs in medicine, surgery and their subspecialties, as well as psychiatry, neurology, physical medicine and rehabilitation, anesthesia, pathology, radiology, and dentistry. Neurosurgery and orthopedics are just two of the surgery subspecialties available.

On April 16, 2007, the OHI Hotline Division received an allegation from the complainant (a patient) who alleged that he awoke from back surgery on February 15, 2007, with a dislocated right shoulder. The patient alleged that he told nursing about his shoulder problem, that nurses paged the physician, but it took 5 hours for a physician to evaluate him and provide treatment. He further alleged that he has asked the patient advocate what happened to his shoulder, but she could not provide information and has not returned his calls.

The patient advocate program is decentralized within the system. As such, patient advocates are at the service level providing service recovery and patient complaint resolution at the point of service. In this case, the complainant was referring to the surgery service patient advocate.

Scope and Methodology

We interviewed the patient by telephone on April 23, 2007, and in person on April 27, 2007. We visited the system on April 26–27, 2007, and interviewed physicians and nurses involved in the patient's care. In addition, we interviewed quality management (QM) staff and the service level patient advocate who had knowledge of issues related to the patient. We reviewed the patient's VA medical records and system policies and procedures. We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Case Review

The patient is a 35-year-old male with a history of asthma, hypertension, post-traumatic stress disorder, kidney stones, migraines, and is 70 percent service-connected for organic brain syndrome, duodenal ulcer, dermatophytosis, paralysis of radicular nerve groups, upper arm condition, tinnitus, and limited flexion of the knee. The system has provided services to the veteran since 1999.

While in the military, the patient was in a motor vehicle accident in 1994, resulting in a closed head injury as well as injuries to his left shoulder. He received care for these injuries at Evans Military Hospital until his discharge from the Army in 1995. He received episodic care at the Boise VAMC from 1996 through 2000. In 2000, the patient had left shoulder reconstruction due to frequent shoulder dislocations related to injuries sustained in the accident. He has taken multiple pain medications since 1994.

On January 26, 2007, the patient was bending over to pick up a piece of wood when he had sudden pain in his back and lower extremity weakness. He was admitted to a private hospital for one night where treatment was limited to medications only. On January 28, he went to the system's urgent care clinic to have his prescriptions filled. On January 29, his primary care provider referred him to neurosurgery for his back pain. On January 31, neurosurgery evaluated the patient and ordered a magnetic resonance imaging x-ray (MRI). The MRI showed a bulging disc and severe canal stenosis as the cause of his pain. On February 15, the patient had back surgery at the system.

During back surgery, the patient was in a prone position with his arms extended on a special operating table called a frame. After surgery, at approximately 10:30 a.m., the patient awoke abruptly from anesthesia and began to flail his body and push himself up

by his arms. Three operating room (OR) staff were able to maintain the patient on the surgical table without a fall to the floor; however, they had to reposition him on the frame. The OR staff lifted the patient from the operating table to the transport stretcher and moved him to the post anesthesia care unit (PACU) at 10:35 a.m. The PACU nurse evaluated the patient on admission and the patient complained of pain. The PACU nurse administered pain medications at 11:05 a.m. and again at 11:10 a.m. The Chief of Anesthesiology evaluated the patient at 11:10 a.m. Documentation in the medical record indicates that the shoulder pain was most likely due to the positioning during back surgery. Patients are placed on a special bed, face down, with arms extended forward. According to the Chief of Orthopedics, this position is optimal for lower back surgery but can cause temporary discomfort post operatively.

The patient was transferred to a surgical floor at 11:50 a.m. for routine post-operative care. The initial nursing assessment reflected no complaints of pain. At 1:04 p.m., the patient received hydrocodone (pain medication) for right shoulder pain. At 3:52 p.m., physical therapy (PT) noted the patient had pain in the right upper extremity with difficulty moving his right arm. At 3:56 p.m., a right shoulder x-ray indicated an anterior dislocation of the shoulder (glenohumeral) joint. The orthopedic surgeon performed a closed reduction of the dislocation under general anesthesia at 4:30 p.m. The surgeon instructed the patient to wear a sling for 2 weeks and to follow up with primary care or orthopedics at the next available appointment. The remainder of the hospital stay was uneventful and the patient was discharged home on February 17, 2007.

On February 28, a primary care physician (PCP) evaluated the patient and noted complaints of right shoulder pain. The PCP ordered PT and an orthopedic consult. On April 2, an orthopedic physician evaluated the patient. The medical record indicated the successful realignment of the patient's right shoulder with no further dislocations since that time. The orthopedic physician ordered an MRI to further evaluate the shoulder since the patient continued to complain of pain. An MRI done on April 6 showed a labral (cartilage) tear. The patient cancelled his April 10 PT appointment. An orthopedic shoulder specialist evaluated the patient on April 27 and noted a history of three dislocations of the patient's right shoulder; one approximately 5 years ago while working on a car, one postoperatively which led to this complaint, and one since the patient's February 17 discharge, sustained while turning over in his sleep. The shoulder specialist ordered PT for improved strength and range of motion, to achieve greater stability and lessen the risk of further dislocations. The orthopedic surgeon will re-evaluate the patient at the completion of PT to determine if further interventions are needed.

Issue 1: Right Shoulder Dislocation

We substantiated the allegation of right shoulder dislocation immediately after surgery on February 15, 2007.

The patient's post operative record on February 15, 2007, indicates a right shoulder dislocation that was not noted prior to surgery. OR staff told us the patient awoke very abruptly from anesthesia after surgery and began to thrash violently. He attempted to push himself to an upright position using both arms to push off the table. He slid toward one side of the operating room table, but three OR staff were able to maintain the patient on the surgical table without a fall. The OR staff transferred the patient to a stretcher and transferred him to PACU. It is likely that the right shoulder dislocation occurred during the period when the patient awoke abruptly from surgery; however, we cannot determine that conclusively.

Issue 2: Delay in Treatment

We did not substantiate that it took 5 hours for physician evaluation and treatment of the patient's dislocated shoulder.

The patient first complained of right shoulder pain at 11:15 a.m. in the PACU. He was re-evaluated by the Chief of Anesthesiology and received pain medication at that time. Because the patient was recovering from anesthesia, he has no recollection of the event; however, medical records document the evaluation.

The PACU nurse and anesthesiologist thought the patient's shoulder pain was a result of positioning during his surgery, as this is not an unusual complaint for patients after back surgery. Appropriate pain medications were ordered and provided in the PACU.

On transfer to the surgical unit, the patient denied pain at 11:50 a.m. At 12:52 p.m., the patient complained of right shoulder pain. Nurses obtained an order for oxycodone (pain medication) from the physician and administered it at 1:04 p.m. At 3:52 p.m., PT evaluated the patient and noted pain in the right upper extremity with difficulty moving his right arm. At 3:56 p.m., a shoulder x-ray indicated an anterior dislocation of the shoulder (glenohumeral) joint.

Orthopedic surgeons were scheduled for surgery all day February 15, but they were available by phone in the OR. Orders for x-rays and medications were obtained and the patient had a closed reduction of his dislocated shoulder at 4:30 p.m. The orthopedic specialist told us a dislocated shoulder is not an emergency that would require an orthopedic surgeon to leave the OR; nor would it require an emergency room physician to intervene. We concluded that the patient received appropriate clinical treatment for his right shoulder dislocation.

Issue 3: Poor Communication

We found that, in general, the system staff did communicate with the patient. However, we were unable to determine if the service level patient advocate returned the patient's calls.

The advocate and clinicians were very familiar with the patient and relayed multiple conversations with him and his wife to us. However, we did not find that communication with the patient or his wife was always documented in the medical record or service level patient advocate tracking software package.

We did not substantiate that the patient was not told of what happened to his shoulder in the OR. He related the incident of the abrupt wake up after anesthesia in the OR to us during his interview; he told us the surgeon had told him what had happened. Interviews with staff lead us to believe the patient was given information by a variety of staff. Lack of consistent documentation by clinicians contributed to information being given in a piecemeal manner to the patient and his wife.

4. Other Issues: Incident Reporting Process

We found that the written report of the OR incident was correctly initiated, but it was not forwarded to system management in a timely fashion. These reports serve as a communication tool for follow-up and tracking purposes, as well as for identification of opportunities for improvements. Without these reports, the system is unable to communicate with patients and families in a knowledgeable manner, and it is unable to conduct root cause analysis for possible areas of improvement.

Patient care providers should discuss clinically significant facts (to the extent that they are known) with patients about unusual events. These discussions should occur within 24 hours of discovery and should be documented in the medical record. The more time that passes prior to disclosure, the more likely it is that patients will think information is being deliberately withheld. This is especially true for patients who are aware of or who suspect an adverse event.

The service level patient advocate reported knowing the patient and had many telephone conversations with him. The advocate reported numerous contacts and was unaware of the patient's dissatisfaction regarding the contacts. However, documentation of contacts was not available. A recent change from a centralized patient advocate program to a service level patient advocate program placed these duties within the role of the administrative staff for surgery service. Training on the documentation program had been provided, but it had not been implemented at the time of our visit. This electronic documentation system serves as a tracking mechanism for issues related to patient complaints and assists staff in recalling details and events which lead to consistent disclosure to patients.

Conclusion

We concluded that the patient had a dislocated right shoulder after his back surgery in February 2007, but we could not determine conclusively what caused the dislocation. A report was generated about the unusual incident in the OR, but it was never forwarded to

the appropriate system managers. There was a lack of consistent medical record documentation which led to the patient being given conflicting information which further led to mistrust about his care. We found that the clinical treatment of the patient's dislocated shoulder was appropriate and provided in a reasonable time frame.

Recommendations

Recommendation 1. The VISN 19 Director needs to ensure that the System Director takes action to hold a meeting with the patient to discuss the OR incident and answer any questions regarding his treatment.

Recommendation 2. The VISN 19 Director needs to ensure that the System Director takes action to ensure that all incidents are captured and reported to system management.

Recommendation 3. The VISN 19 Director needs to ensure that the System Director takes action to ensure that all patient advocate interactions are documented in the computer software tracking system.

Comments

The VISN and System Directors concurred with the findings and recommendations of this inspection and provided acceptable improvement plans (see Appendixes A and B, pages 7─10, for the full text of the Directors' comments). 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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 30, 2007

From: Director, Veterans Integrated Service Network (10N19)

Subject: **Healthcare Inspection, Alleged Delay in Diagnosis and Treatment, VA Eastern Colorado Health Care System, Denver, Colorado**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Office (10B5)

I have reviewed and concur with the action plan to the recommendations as outlined by the VA Eastern Colorado Health Care System.

(original signed by:)

JAMES R. FLOYD

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 30, 2007

From: Director, VA Eastern Colorado Health Care System (554/00)

Subject: **Healthcare Inspection, Alleged Delay in Diagnosis and Treatment, VA Eastern Colorado Health Care System, Denver, Colorado**

To: Director, Veterans Integrated Service Network (10N19)

In response to the IG letter dated June 14, 2007, we are responding to the open items from the Hotline 2007-01923-HI-0332.

(original signed by:)

LYNETTE A. ROFF

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

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommendation 1. The VISN 19 Director needs to ensure that the System Director takes action to:hold a meeting with the patient to discuss the OR incident and answer any questions regarding his treatment.

Concur **Target Completion Date:** July 18, 2007

Response: The neurosurgeon discussed the incident with the patient several times after the incident; however, there has not been a formal face-to-face meeting with the patient and his wife.

Action: This is planned for the week of July 16, 2007.

Recommendation 2. The VISN 19 Director needs to ensure that the System Director takes action to ensure that all incidents are captured and reported to system management.

Concur **Target Completion Date:** September 4, 2007

Response: The current paper process of sending a report of all incidents to the Executive Team is in place; unfortunately the report related to this incident was misplaced, but located during the investigation.

Action: The facility is transitioning to a paperless reporting process.

Recommendation 3. The VISN 19 Director needs to ensure that the System Director takes action to ensure that all patient advocate interactions are documented in the computer software tracking system.

Concur **Target Completion Date:** September 4, 2007

Response: ECHCS recently transitioned from a centralized patient advocate system to a decentralized system. The Lead Patient Advocate and CBOC Patient Advocate use the computerized software tracking system exclusively. The Service Level Liaisons (patient advocates) are in the process of learning the tracking system and many of the liaisons are using the system; however, not all interactions have been documented.

Action: The Service Level Liaisons received training and have monthly sessions to review the process. All Service Level Liaisons will document all interactions in the tracking system as instructed by the Lead Patient Advocate.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections 816/426-2016
Acknowledgments	Jennifer Kubiak Dorothy Duncan Marilyn Stones

Appendix D

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