Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues
Huntington VA Medical Center
Huntington, West Virginia

Report No. 09-02988-66 **January 19, 2010**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections reviewed the validity of allegations regarding quality of care issues provided by a surgeon at the Huntington VA Medical Center (medical center). An anonymous complainant alleged that a surgeon:

- Had poor infection control practices.
- Had a higher incidence of Methicillin Resistant Staphylococcus Aureus (MRSA).
- Altered records to reflect lower blood loss for a procedure.
- Performed surgery on a patient who subsequently developed significant complications.

We could not substantiate or refute that the surgeon did not follow infection control protocols. We did not substantiate that the surgeon had a higher incidence of MRSA infections than other surgeons for the same procedure. We did not substantiate that the surgeon altered the medical record to reflect a lower blood loss. We did not substantiate that an identified patient developed complications related to the surgeon's practice. We did identify a lack of integration of infectious disease information between surgical services, National Surgical Quality Improvement Program, Infection Control, and MRSA programs.

We recommended that the Veterans Integrated Service Network Director ensure that the Medical Center Director provides trended and analyzed infection control data to key committees and clinical managers. The VISN and Medical Center Director agreed with our findings and recommendations and provided acceptable improvement 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, VA Mid South Healthcare Network (10N9)

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections received allegations regarding quality of care issues provided by a surgeon at the Huntington VA Medical Center (medical center). The allegations concerned infection control issues, altered blood loss records, and a specific surgical case. The purpose of this review was to determine whether these allegations had merit.

Background

The medical center is part of the Veterans Integrated Service Network (VISN) 9. It is an 80 bed, acute medical and surgical care facility, offering primary care, outpatient mental health services, and subspecialty outpatient care. The medical center is a principal teaching facility for the Marshall University School of Medicine for undergraduate and postgraduate medical education.

We reviewed allegations from an anonymous complainant who reported that a surgeon:

- Had poor infection control practices.
- Had a higher incidence of Methicillin Resistant Staphylococcus Aureus (MRSA)[1] infections than those of other surgeons for the same procedure.
- Altered records to reflect lower blood loss during a procedure.
- Performed surgery on a patient who developed an infection, significant loss of range of motion, sepsis,[2] and MRSA pneumonia.

[1] MRSA is a common bacterial organism, most frequently the cause of skin, soft tissue, surgical site, bloodstream, and pulmonary infections.
[2] Sepsis is commonly called a blood stream infection.

Scope and Methodology

We conducted a site visit at the medical center August 25–28, 2009, and interviewed senior management, physicians, nurses, scrub technicians, quality management staff, the MRSA and National Surgical Quality Improvement Program (NSQIP) coordinators, and the infection control nurse. We reviewed the patient's VA medical record, relevant medical center policies and procedures, meeting minutes; and available infection control, MRSA and NSQIP data.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case Summary

The patient is a male in his late seventies with a history of rheumatoid arthritis, osteoporosis, nontoxic multi-nodular goiter, dyspepsia, hypertension, chronic steroid use, pan-diverticulosis,[3] and a total knee arthroplasty. In mid-November 2008, the patient was diagnosed with a fractured patellar implant.

In early December, the patient had surgery to repair the fractured patellar implant. The patient refused rehabilitation placement and went home on postoperative (PO) day 2. The discharge MRSA screen was negative.

On PO day 23, the surgeon documented the surgical incision was healing. At the end of January, the patient's cast was removed, he was instructed to ambulate with a walker for a few weeks and then use a cane. The patient refused physical therapy (PT).

In late March, the patient went to the emergency room (ED) stating that he noticed drainage and a wire sticking out of his knee. He was admitted and taken to surgery for incision and drainage (I&D), and removal of the wire. A MRSA screen was negative. The patient was discharged home the next day (PO day 1) with a knee immobilizer, orders for ambulation with a walker, PT, and skilled nursing visits.

On PO day 2, the home health nurse reported that the patient's knee was gushing blood when moved, and the patient had not been wearing the knee immobilizer. The nurse was instructed to change the dressing, apply the knee immobilizer, and send the patient to the orthopedic clinic where an immobilization cast was applied. On PO day 10, the cast was removed, and the patient was instructed to keep his leg straight. On PO day 16, the sutures were removed and wound care instructions were reviewed with the patient.

Four days later, the patient went to a private hospital ED because he had a fever, and his knee was painful and draining. Blood and wound cultures were taken. A MRSA swab was positive. The private ED physician documented that there was an open area in the

[3] Pan-diverticulosis is the condition of having weak spots that bulge within the colon.

center of the incision. Antibiotics were given intravenously prior to transfer to the medical center. The patient was transferred via ambulance to the medical center.

The patient was admitted to the medical center and his knee was red, swollen, and tender with a small amount of drainage. The patient was unable to straighten his leg. The surgeon withheld antibiotic therapy pending I&D and cultures. That afternoon, the patient had an I&D, synovectomy, removal of total knee implants, and placement of an antibiotic spacer and a drain. The patient went to the recovery room where he was responsive and breathing on his own with 100% oxygen. Approximately 10 minutes later the patient became unresponsive. While being examined by a pulmonologist consultant, the patient started to desaturate and was reintubated. The patient was transferred to the intensive care unit (ICU) where he was placed on a ventilator and remained in contact isolation. The patient remained on a ventilator for 8 days where supportive care was provided including antibiotics, cardiac medications, nutrition, and hydration.

On PO day 9, the patient was transferred to the inpatient surgical unit where he remained in contact isolation and continued to receive supportive care before transfer to a rehabilitation facility on PO day 16.

Two weeks later, the patient was readmitted to the medical center for a debridement with synovectomy[4] and deep cultures. One end of the surgical incision was left open, and a hemovac and wound vac were placed. The patient was discharged on PO 5 to a nursing home.

On PO day 15 the patient was examined by the surgeon who documented an intact wound with moderate drainage. On PO day 16, the patient was transferred to a different nursing home where he continued to receive antibiotics and wound therapy.

On PO day 22, the patient was transferred to the medical center ED because of increased drainage and an opening in the wound. The surgeon admitted the patient and noted an area of necrosis at the incision and that the antibiotic spacer was visible. Surgery was performed the next day, and the incision was left open and packed with gauze.

On PO day 8, a wound vac system was applied, and the surgical sites were clean and dry. On PO day 12, the patient was transferred to a rehabilitation center with antibiotics and wound vac therapy. Healing progressed normally and the patient was discharged home on one month later with home health care.

[4] Synovectomy is the surgical removal of the joint lining.

Inspection Results

Issue 1: Infection Control Practice

We could not substantiate or refute that the surgeon did not follow infection control protocols.

During our interviews, some nurses reported infection control practice concerns regarding the surgeon and other physicians such as lack of hand washing between patients and carrying a medical bag from one isolation room to another. No one provided us with supporting documentation such as an incident report or report of contact. The Nurse Manager told us that no one had reported infection control concerns to him. Staff told us they did not feel comfortable addressing physicians regarding infection control practices.

While on site, we reported the nurses concerns regarding physician infection control practices to senior managers. Senior managers told us they would immediately address the staff concerns. Therefore, we did not make a recommendation.

Issue 2: Higher Incidence of MRSA Cases

We did not substantiate that the surgeon has a higher incidence of MRSA infections than other surgeons for the same procedure.

We reviewed the MRSA Infection Control Report, dated July 1, 2007, through August 25, 2009, and the MRSA Performance Improvement Reports for 2008 and 2009. Based on the data review, we did not find evidence that the surgeon had a higher incidence of MRSA than his peers.

Issue 3: Blood Loss Documentation

We did not substantiate that the surgeon altered the medical record to reflect a lower blood loss.

Documentation of estimated blood loss is recorded in the electronic medical record (EMR) by the surgeon and operating room (OR) nurse and cannot be altered without EMR tracking. In the OR, the anesthesiologist documents blood loss on a paper record. The surgeon and the anesthesiologist discuss estimated blood loss and agree upon the amount before the surgeon leaves the OR.

We compared the patient's five hand written anesthesia records with the EMR documentation of blood loss. In four of the five cases, a tourniquet was used so there was no appreciable blood loss. For the fifth case, anesthesia documented 200 milliliters and the surgeon did not document blood loss in the EMR. All five cases had the same blood loss recorded by both anesthesia and the OR nurse. The EMR had not been altered to

reflect a lower blood loss. We found that there was no alteration of blood loss in the medical record.

Issue 4: MRSA Complication

We did not substantiate that the patient developed complications related to the surgeon's practice.

While we found that the patient had developed MRSA, we also noted multiple instances of patient noncompliance with post discharge instructions. This resulted in additional surgeries, removal of total knee implants, and a significant loss of range of motion. MRSA screens in December 2008 and March 2009 were negative. In mid-April, the private hospital ED documented that the MRSA screen was positive. The patient was admitted to the medical center where he developed sepsis and a MRSA pneumonia. There was no evidence that the surgeon's care caused the MRSA infection.

Issue 5: Infection Control Data

We identified an additional issue that requires senior managers' attention. We found a lack of integration of infectious disease information between surgical services, NSQIP, Infection Control, and MRSA programs. While there was raw data collected and provided for surgical site infections and MRSA, we did not find any evidence of trending or analysis in key committee minutes such as the Infection Control Functional Group, OR, and the Surgical Services Committee. The Nurse Managers and surgeons told us they did not receive trended infection control reports.

Conclusions

We did not substantiate any of the hotline allegations. We found that the medical center needed to trend and analyze infection control data and provide the data to key committees and clinical mangers.

Recommendation

We recommended that the VISN Director ensure that the Medical Center Director provides trended and analyzed infection control data to key committees and clinical managers.

Comments

The VISN and Medical Center Directors agreed with the finding and recommendation (see Appendixes A and B, pages 7–10, for the Director's comments). The implementation plans are 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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 22, 2009

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia**

To: Assistant Inspector General for Healthcare Inspections

I have reviewed and concur with the attached response from Huntington VAMC regarding the above referenced Healthcare Inspection.

(original signed by:)
John Dandridge, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 22, 2009

From: Director, Huntington VA Medical Center (581/00)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia**

To: Director, VA Mid South Healthcare Network (10N9)

We have reviewed the findings from the Healthcare Inspection on allegations regarding quality of care issues provided by a surgeon at the VA Medical Center in Huntington, West Virginia. We concur with the findings and have implemented an action plan to address the single recommendation listed in the report.

(original signed by:)
Edward Seiler

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

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

OIG Recommendation

We recommended that the VISN Director ensure that the Medical Center Director provides trended and analyzed infection control data to key committees and clinical managers.

Concur

Facility's Response: The Infection Control Practitioner is collecting patient specific data on Class I Surgical Site Infections (SSI) specific to orthopedic cases, 30 day surgical readmissions with SSI, and drug resistant SSI. Data will be trended by month and reported on a quarterly basis to the Infection Control Functional Group, the Operating Room (OR) Committee, and the Medical Staff Council. Medical Staff Council activities and concerns are reported to the Leadership Council through Chief of Staff.

Additional sharing of the data will include the Chief, Surgical Service and the Operative and Other Invasive Procedures Committee as appropriate. Data will be displayed in either a control chart or a run chart as appropriate to the area being monitored and will include an analysis of the data and actions taken to address any negative findings. A standard report card for reporting infection control surveillance will be established and distributed monthly from Quality Management to the appropriate clinical services and the Patient Safety Manager.

The Infection Control Practitioner and NSQIP Coordinator are both members of the Infection Control Functional Group and the OR Committee. The NSQIP Coordinator is a member of Operative and other Invasive Procedures Committee and the MRSA Coordinator will be added to the membership of the Committee. Both the Infection Control Practitioner and the MRSA Coordinator attend the ICU Committee meeting.

The Infection Control Practitioner and the NSQIP coordinator are both members of the Infection Control Functional Group and the OR Committee. The NSQIP Coordinator is a member of Operative and other Invasive Procedures Committee and the MRSA Coordinator will be added

to the membership of the Committee. Both the Infection Control Practitioner and the MRSA Coordinator attend the ICU Committee meeting.

Data Collection	Responsible for Collection	Reported To	Frequency of Reporting	Response to Service/Unit
MRSA Screening	MRSA Coordinator	1) Infection Control Functional Group 2) Medical Staff	Quarterly	1)Inpatient Nursing Units 2) Emergency Department
Ventilator Associated Pneumonia	MRSA Coordinator	1)Infection Control Functional Group 2) ICU Committee 3)Medical Staff Council	Quarterly	ICU
Central Line Associated Bacteremia	MRSA Coordinator	1)Operative & Other Invasive Procedures Committee 2) Medical Staff Council	Quarterly	Medical and Surgical Service
MRSA Wound Infections	MRSA Coordinator	1) Infection Control Functional Group 2) OR Committee Medical Staff Committee 3) Medical Staff Council	Quarterly	Medical and Surgical Service
Readmissions within 30 days of surgical procedure with an SSI	Infection Control Practitioner	1)Infection Control Functional Group 2)OR Committee Medical Staff Committee 3)Medical Staff Council	Quarterly	Surgical Service
Orthopedic SSI	Infection Control Practitioner	1)Infection Control Functional Group 2) OR Committee 3) Medical Staff Council	Quarterly	Surgical Services
Drug Resistant SSI Following Surgical Procedure		1)Infection Control Functional Group 2) OR Committee 3) Medical Staff Council	Quarterly	Surgical Services

Target Completion Date: February 25, 2010.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Denver Office of Healthcare Inspections (303) 270-6500
Acknowledgments	Ann Ver Linden, Team Leader Kathleen Shimoda Laura Dulcie

Appendix D

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