Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues
Wilkes-Barre VA Medical Center
Wilkes-Barre, Pennsylvania

Report No. 09-03851-87 **February 23, 2010**

VA Office of Inspector General
Washington, DC 20420

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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 a patient at the Wilkes-Barre VA Medical Center. The daughter of a patient alleged that:

- The third lead wire was not placed during the implantation of a replacement pacemaker, as planned.
- A post-operative surgical site infection was misdiagnosed, causing a delay in treatment.
- Clinicians prematurely discharged the patient to a community nursing home.
- The patient advocate failed to respond to a request that the surgeon not be assigned to the patient during a subsequent readmission.
- The medical center provided substandard care because of unqualified nurses and physicians and insufficient nurse staffing.

We did not substantiate the allegations. However, we concluded that communication and documentation could be improved to ensure a clear understanding of the plan of care by the patient and family.

We recommended that the Veterans Integrated Service Director require that the Medical Center Director ensures that providers on this case improve communication with patients and family members to ensure that instructions and plans of care are clearly understood and that they document instructions, plans, and patient and/or family member understanding in the medical record.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable corrective actions. Since the medical center has already addressed the issue identified in the recommendation, we consider the recommendation closed.

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

TO: Director, Veterans Integrated Service Network 4

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections received allegations regarding quality of care received by a patient at the Wilkes-Barre VA Medical Center (the medical center), Wilkes-Barre, PA. The purpose of this review was to determine whether the allegations had merit.

Background

The medical center is a part of Veterans Integrated Service Network (VISN) 4 and serves veterans in 19 counties in Pennsylvania and in 1 county in New York. Care is provided in a general medical and surgical facility with 79 acute care beds, 105 long-term care beds, and 10 Substance Abuse Residential Rehabilitation Treatment Program beds.

A complainant alleged that during her father's admission at the medical center, the cardiovascular surgeon (surgeon) failed to place a third lead wire, as planned, during the implantation of a replacement pacemaker[1] and misdiagnosed a post-operative surgical site infection, causing a delay in treatment. The complainant further alleged that: (a) the patient advocate failed to respond to a request that the surgeon not be assigned to the patient during a subsequent readmission, (b) clinicians prematurely discharged the patient to a community nursing home, and (c) the medical center provided substandard care because of unqualified nurses and physicians and insufficient nurse staffing.

Scope and Methodology

We conducted a site visit November 4–5, 2009. We interviewed senior managers and employees and reviewed pertinent medical center documents, medical records, and VHA

[1] A device that monitors the electrical impulses in the heart and delivers electrical pulses to make the heart beat in a more normal rhythm.

policies and procedures. Also, we repeatedly attempted to contact the complainant but were unsuccessful.

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, a man in his seventies, had a history of diabetes mellitus, ischemic cardiomyopathy, and other co-morbidities. The patient had two cardiac devices implanted at another VA medical center, the latest of which was a dual-chambered implantable cardioverter defibrillator (ICD).[2]

In February 2009, the patient underwent diagnostic testing which showed that his ejection fraction (EF) was 29 percent, demonstrating further deterioration of his cardiac status.[3]

In mid-March, the patient agreed to a comprehensive surgical treatment plan. He was given the option of having the procedure done at two other VA facilities but he elected to undergo surgery at the medical center. Because of the patient's impending need for a new generator, the patient also decided, in conjunction with his cardiologist and anesthesiologist, to pursue a staged procedure whereby the upgraded ICD with a new generator would be implanted first, and the third left ventricular (LV) lead[4] would be connected at a later date.

In April, the patient signed an informed consent form and underwent an uneventful ICD upgrade procedure. He was discharged home later that day with care instructions for the wound.

During a cardiology clinic follow-up visit on post-operative day 11, a cardiologist noted that the surgical site wound was healing well. A week later, the patient was seen by the surgeon in the cardiovascular surgery clinic for evaluation of a pre-existing aneurysm. Nursing documentation indicated that the patient had no discomfort and that vital signs were within normal limits. There was no documentation regarding the condition of the ICD surgical site during this visit.

Two days later, the patient presented to the cardiology clinic for a functional check of the newly implanted ICD. No problems were noted with the device, but the patient was referred to the emergency department (ED) for a wound check. The ED physician noted

[2] An ICD 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 sensed.
[3] Left ventricular EF is normally 55–70 percent.
[4] A biventricular ICD stimulates both the right and left ventricles to make the heart beat more efficiently. All of today's pacemakers can also work as implantable cardio-defibrillators, which restore a normal heartbeat. A third lead would then be connected to the left ventricle to facilitate its functioning.

the surgical site to be inflamed and admitted the patient for treatment with antibiotics. The patient was transferred to the Philadelphia VA Medical Center later that day because his pacer-dependent status required highly specialized care. Three days later, the patient transferred to the Hospital of the University of Pennsylvania (HUP) for definitive management of the surgical site infection and removal of the ICD.

During the first week of July, the patient transferred from HUP back to the medical center. During this admission, the patient received care from multiple specialties and ancillary departments. He was subsequently discharged and transferred from the medical center to a community nursing home in mid-July.

Inspection Results

Issue 1: Quality of Care

Third Lead Wire Placement

We substantiated that the surgeon did not place a third lead wire during the implantation of a replacement pacemaker. However, we determined that this was appropriate and in accordance with the patient's expressed wishes in the informed consent.

Progress notes documented the plan to upgrade the ICD to a bi-ventricular device. The cardiologist told us that even though there was no documentation of a staged procedure, the final plan prior to surgery was to upgrade the ICD without placement of a third lead wire. The surgeon confirmed this. On the morning of surgery, the patient signed the consent form that did not include placement of the third LV lead, and the procedure took place as authorized by the informed consent. Because the decision to perform the staged procedure was not documented, it is unclear how much of this plan was understood by family members, and we identified improvement opportunities in communicating the plan for surgery to the patient and family.

Misdiagnosis and Delay in Care and Treatment

We did not substantiate the allegation that the surgeon failed to diagnose the surgical site infection during a follow-up appointment, resulting in a delay in care and treatment. The nurse who took the patient's vital signs during the post-operative visit told us that the patient and his wife did not mention any problems. The surgeon confirmed that the clinic visit was specifically to evaluate a pre-existing aneurysm. However, when the wife mentioned that the surgical site might be infected, the surgeon reportedly evaluated the wound and found no evidence of an infection. He did not document his assessment of the wound during this visit but reported that he had advised the wife to take the patient to the ED for a wound check to allay concerns. We concluded that the surgeon appropriately referred the patient to the ED when concerns were initially raised. However, the surgeon should have documented his examination and ED referral.

Premature Discharge

We did not substantiate the allegation of premature discharge from the medical center to a community nursing home after the second admission. Documentation demonstrated agreement among health care team members regarding the patient's readiness for nursing home care and the wife's awareness of the transfer as early as the day prior to discharge.

An ICD check was performed during this admission to ensure adequate functioning. The discharge planner also made arrangements to ensure that the nursing home could accommodate the patient's wound care and dietary needs. Documentation shows the wife's involvement with preparations for the transfer as she visited the nursing home 4 days prior to discharge. We concluded that the patient's discharge from the acute care setting was appropriate and that safe and thorough arrangements had been made for continued care at the nursing home.

Issue 2: Patient Advocate Response

We did not substantiate the allegation that the patient advocate failed to respond to a request that the surgeon not be assigned to the patient during a subsequent readmission. We found evidence that the patient advocate acted on the request by notifying the risk manager and the surgeon's administrative assistant. The surgeon could not recall any verbal contact with the wife regarding the discontinuance of his care of the patient. He confirmed that he assessed the patient's wound as a courtesy for a fellow physician caring for the patient and was not an attending physician on the case.

Issue 3: Physician and Nurse Competencies and Nurse Staffing

We did not substantiate the allegation of substandard care, and that the patient suffered because the wards had insufficient nurses, and that surgeons and nurses were not competent to provide care. We reviewed nurse staffing sheets and nurse competency folders for two inpatient units. We found adequate levels of nurse staffing and appropriate documentation of current clinical competencies.

We also reviewed the credentialing and privileging folders of four cardiologists and one cardiovascular surgeon. Documentation of competencies and qualifications were present for all five physicians. We noted only 1 (0.79 percent) post pacemaker wound infection in 126 procedures performed during fiscal years 2008 and 2009.

Conclusions

We did not substantiate the allegations. We concluded, however, that improved communication and documentation could have ensured a clear understanding of the plan of care by the patient and family.

Recommendation

We recommended that the VISN Director require that the Medical Center Director ensures that providers on this case improve communication with patients and family members to ensure that instructions and plans of care are clearly understood and that they document instructions, plans, and patient and/or family member understanding in the medical record.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable corrective actions. (See Appendixes A and B, pages 6–8, for the full text of the Directors' comments.) Since the medical center has already addressed the issue identified in the recommendation, we consider the recommendation closed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 15, 2010

From: Director, Veterans Integrated Service Network 4

Subject: Healthcare Inspection – Alleged Quality of Care Issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, PA

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

Thru: Director, Management Review Service (10B5)

1. I noted that VA's Office of Inspector General found all allegations to be "Not Substantiated" and that communication and documentation by providers met generally accepted standards.

2. Continuously improving patient care and satisfaction is an important goal in health care and in VISN 4. I concur with the comments by the Director at the VA Medical Center in Wilkes-Barre, PA, and with the action taken.

(original signed by:)
Michael E. Moreland, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 15, 2010

From: Director, Wilkes-Barre VA Medical Center (693/00)

Subject: Healthcare Inspection – Alleged Quality of Care Issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, PA

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

1. The VA Medical Center in Wilkes-Barre, PA, (WBVAMC) concurs with VA's Office of Inspector General that:

   a. Findings for all allegations were "Not Substantiated."
   b. Documentation and communication were within generally accepted standards of practice.
   c. Communication and documentation can be improved.

2. Communication and documentation were discussed by the Medical Center Director and Acting Chief of Staff with the providers.

(original signed by:)
Janice M. Boss, M.S., CHE

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.

Recommendation:

We recommended that the VISN Director require that the Medical Center Director ensures that providers on this case improve communication with the patient and family members to ensure that instructions and plans of care are clearly understood and that they document instructions, plans, and patient and/or family member understanding in the medical record.

Concur

Action taken:

Wednesday, January 13, 2010—Medical Center Director and Acting Chief of Staff met face-to-face with three of the four involved providers to review issues about communication and documentation and to emphasize continuously improving organizational performance includes continuously improving communication with patients and their designated participants (family members, et. al.) and documentation about communication as well as more extensive documentation about care plans, changes to care plans, subsequent patient care issues such as complications, etc. Two days later, Friday, January 15, 2010, the Medical Center Director met face-to-face with the fourth provider and covered the same discussion.

Target date of implementation: January 15, 2010

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Daisy Arugay, Director Los Angeles Regional Office of Healthcare Inspections (213) 253-5134
	Mary Toy, RN (Team Leader) Jerome Herbers, MD

Appendix D

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