Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care and Administrative Issues Sheridan VA Medical Center Sheridan, Wyoming

Report No. 12-00602-147 **April 4, 2012**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

At the request of Senator John Barrasso, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding poor quality of care and administrative issues from a patient and his brother at the Sheridan VA Medical Center (the facility), Sheridan, WY.

We did not substantiate that the patient's care for his lung condition resulted in a terminal illness and permanent confinement in a hospice unit. We did not find that the level of care caused the patient's clinical deterioration, subsequent non-VA hospitalization, and need for prolonged inpatient care and rehabilitation. We did substantiate that medical record documentation did not consistently include current clinical assessment of the respiratory problem, lung examinations, or follow-up information regarding the patient's response to antibiotic therapy.

We substantiated that the treatment for the patient's elbow bursa infection was inadequate and the physician's documentation did not meet VHA standards. We found that prolonged conservative management and nonsurgical care delayed the necessary treatment for the patient's infected elbow bursa. This resulted in a more complicated and extensive left upper extremity infection and the need for emergency surgery, numerous subsequent surgeries, and a prolonged recovery period. Physician documentation did not include consistent follow-up assessments, including implications of an abnormal White Blood Count (WBC) and follow-up of the antibiotic therapies.

We did not substantiate that the facility managers responded unprofessionally to the patient's or brother's concerns. We found the facility managers consistently attempted to meet the patient's requests for information. We reviewed documented meetings with facility managers, clinicians, and the Patient Advocate and could not find any evidence of unprofessional responses by the facility staff.

We found that the cessation of prednisone did not meet the accepted practice in the management of long term, daily corticosteroid therapy and the facility did not conduct Peer Review for the lung and elbow issues.

To improve the quality of patient care, as well as to follow-up on quality of care concerns, we recommended that the facility Director: (1) consult with Regional Counsel regarding possible institutional disclosure to the patient for whom quality of care concerns were identified, (2) implement procedures to ensure facility staff comply with VHA policies on peer review and physician privileging, and (3) monitor physicians' documentation to ensure compliance with VHA policies on information management and health records.

The Veterans Integrated Service Network and facility Directors concurred with our recommendations and provided acceptable action 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, Rocky Mountain Network (10N19)

SUBJECT: Healthcare Inspection – Quality of Care and Administrative Issues, Sheridan VA Medical Center, Sheridan, Wyoming

Purpose

At the request of Senator John Barrasso, the VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding poor quality of care and administrative issues from a veteran at the Sheridan VA Medical Center (the facility), Sheridan, WY.

Background

The facility has 208 beds and is the tertiary mental health (MH) site for Veterans Integrated Service Network (VISN) 19. The facility provides inpatient acute, transitional, and residential care, as well as domiciliary residential rehabilitation, community treatment, and outpatient care. The facility serves approximately 33,450 veterans and is affiliated with 7 universities and colleges.

In addition to the patient's complaint, the patient's brother also contacted Senator John Barrasso's office who referred the allegations to the OIG hotline. The complainants alleged that:

- Lack of appropriate care for the patient's lung condition resulted in terminal illness and permanent confinement to the hospice care unit.
- The patient received inadequate treatment for an elbow infection.
- The facility staff responded unprofessionally to multiple complaints by the patient and his brother.

Scope and Methodology

To address the allegations, we visited the facility December 6–9, 2011, and interviewed the patient, facility leadership, community living center staff, Quality Management (QM) staff, the Patient Representative, and selected physicians and nurses.

We interviewed the patient's brother and several physicians by telephone. We reviewed QM documents and the patient's relevant VA and non-VA medical records.

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.

Case Summary

The patient is a male in his late 60's who relocated from Colorado to Sheridan, WY, in September 2009. His chronic medical conditions include peripheral neuropathy, chronic pain, and tobacco use disorder.

Between September and October 2009, the patient saw his primary care provider (physician A) four times and had no respiratory complaints. During these visits, physician A noted the patient had an occasional cough and a 15-year history of shortness of breath when walking 50 yards or more. The patient's respiratory rate was consistently normal and his lungs were clear.

In early November, physician A documented that the patient reported he was coughing up brown mucus and his breathing was worse. Physician A noted the patient had a rapid heart rate of 111. However, physician A also listed a heart rate of 80 because he used the cut and paste application of a previous template. A lung examination was not documented.

Fifteen days later, physician A documented that the patient felt as though he couldn't get enough air and that he continued to have a productive cough with light brown sputum. The patient described his shortness of breath as different from his prior shortness of breath. Physician A documented an abnormal right lung examination, a rapid heart rate, and prescribed an antibiotic. No laboratory tests, sputum culture, or chest x-ray were obtained.

In early December, the patient had a rapid heart rate and continued to have a productive cough of light brown sputum. Lung sounds were abnormal on the right side. There was no follow-up documentation regarding the clinical response to the antibiotics given at the previous visit. Fourteen days later, physician A documented a rapid heart rate but did not perform a lung examination.

In mid-January, 2010, the patient continued to have a dry cough, rapid heart rate, and expressed worry that his pulse was too high. Physician A documented abnormal lung sounds in both lungs. A second antibiotic course was ordered for a suspected atypical pneumonia.[1] No laboratory tests, sputum culture, or chest x-rays were ordered.

[1] Atypical pneumonia is a type of infection of the lung caused by certain bacteria.

Eight days later, the patient was emergently admitted to a local community hospital with low blood pressure and extreme respiratory distress, and was diagnosed with community-acquired pneumonia.[2] A chest x-ray showed infection involved all lung fields. The patient's pneumonia was further complicated by acute respiratory distress syndrome.[3] Within 24 hours, the patient required intubation[4] with prolonged mechanical ventilation[5] and eventually required a tracheostomy.[6] Eighteen days later, the patient was transferred to another non-VA hospital for more intense respiratory evaluation and care. The patient experienced worsening respiratory distress which was diagnosed as bronchiolitis obliterans organizing pneumonia.[7] The patient responded favorably to a combination of antibiotics and prednisone.[8] Approximately 1 month later, the patient was transferred to a rehabilitation hospital for further care. Two weeks later the patient was discharged home on daily prednisone and continuous oxygen therapy. During the spring of 2010, the patient's respiratory status stabilized. At the patient's request, he was assigned a new primary care physician (physician B) at the facility. The patient's first appointment with physician B was in early April.

Two months later, the patient saw physician B who noted acute redness and drainage from the patient's left elbow area. Physician B ordered an oral antibiotic and dressing changes for a suspected elbow bursa infection.[9] A culture of the drainage was not ordered. During June and July, the patient was managed with two courses of oral antibiotics and frequent dressing changes. No intravenous antibiotics were given. In addition to the physician's notes, nursing notes documented there was ongoing drainage from open wounds at the left elbow bursa. A complete blood count (CBC)[10] was obtained at the facility during the first week of July which revealed a markedly elevated white blood cell count (WBC).[11] Physician B also suspected the concurrent diagnosis of rheumatoid arthritis,[12] which was confirmed by a rheumatology consultant at the VA Salt Lake City Health Care System.

Fourteen days later, an on-call physician (physician C) examined the patient and noted increased elbow pain, drainage, and redness. Physician C documented that the patient

[2] Community-acquired pneumonia is pneumonia in individuals who have not recently been in the hospital or another health care facility.
[3] Acute respiratory distress syndrome (ARDS) is a life-threatening, acute injury to most or all of both lungs in which abnormal fluid buildup prevents enough oxygen from getting into the blood.
[4] Intubation is a procedure where a tube is placed into the airway to support breathing.
[5] Mechanical ventilation is the use of a machine to assist a patient to breath.
[6] A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe).
[7] BOOP is an inflammation of the bronchioles (small airways) and surrounding tissue in the lungs. It is a non-infectious pneumonia often caused by a pre-existing chronic inflammatory disease.
[8] Prednisone is a corticosteroid used to treat a variety of inflammatory conditions.
[9] Elbow bursa infection is a condition where bacteria enter the closed tissue sac overlying the bony prominence of the elbow.
[10] Complete Blood Count (CBC) is a blood test that gives information about the kinds and number of cells in a person's blood, especially red blood cells, white blood cells, and platelets.
[11] White blood cell (WBC) elevation may indicate an infection, inflammation, or other stress on the body.
[12] Rheumatoid arthritis is an autoimmune disease that causes stiffness, pain, and swelling in the joints.

had an infected elbow bursa and two draining sites with significant tunneling[13] and obtained a wound culture. Physician C documented that he would make an orthopedic referral if the patient did not respond to the second oral antibiotic. Two days later, a wound care team member suggested surgical intervention, and a non-VA orthopedic appointment was scheduled for the first week in August.

Physician B saw the patient in late July for a routine visit. The patient's breathing and overall joint status were described as improving, although no elbow examination was documented. Physician B cited "CBC okay," and scheduled the patient to return in 3 months. We found that the only facility CBC obtained in June or July was the first week in July CBC which showed a markedly elevated WBC of 22,570 K/cmm.[14]

The patient kept his August orthopedic appointment but was immediately sent to a non-VA hospital for surgical management of necrotizing fasciitis[15] of the left arm. Procedures included fasciotomies,[16] and aggressive debridement[17]and irrigation of the arm, forearm, and olecranon bursa. Operative findings included gas in the arm and forearm,[18] as well as necrotic tissue at the elbow bursa and forearm fascia. The patient had a complicated post operative course due to several falls and episodes of dehiscence[19] which necessitated the need for additional surgeries.

Throughout this period, the patient was maintained on prednisone for his underlying pulmonary disease. On admission to the facility in mid-September, physician A wrote that "he [the patient] is not to receive any prednisone." Following the cessation of prednisone, the patient's respiratory status dramatically worsened. Six days later, physician B initiated IV corticosteroid[20] therapy and transferred the patient to a non-VA hospital for Intensive Care Unit care and ventilator support. The patient remained on corticosteroids (prednisone) and his pulmonary condition improved. He was transferred back to the facility eight days later. From October through December, the patient required several plastic surgery procedures of the left upper extremity.

Presently, the patient reported his lifestyle and day-to-day functioning are primarily limited by his breathing capacity. He is maintained on continuous oxygen therapy, is minimally ambulatory, and uses an electric wheelchair. He reports that eating or speaking too quickly will result in shortness of breath. He is able to dress himself, shave

[13] Tunneling wounds have channels that extend from a wound into and through subcutaneous tissue or muscle.
[14] Normal WBC range as defined at the facility is 2,900-11,300 K/cmm.
[15] Necrotizing fasciitis is a serious condition, potentially life-threatening, in which muscle and fat tissue are broken down as a consequence of infection.
[16] Fasciotomy or fasciectomy is a surgical procedure where the fascia is cut to relieve tension or pressure (and treat the resulting loss of circulation to an area of tissue or muscle). Fasciotomy is a limb-saving procedure.
[17] Debridement is the removal of unhealthy tissue from a wound to promote healing.
[18]Gas gangrene is a life-threatening infection of muscle tissue caused mainly by anaerobic bacteria.
[19] Dehiscence is the splitting open of a surgically closed wound.
[20] Corticosteroids are a class of medications used to control inflammation. They are chemically related to hormones, such as cortisol, that are produced naturally by the body to regulate a variety of bodily functions.

and eat with minimal assistance, and attends appointments and activities. He resides in the facility's community living center with hospice level care capability, but does not currently meet the guideline for a hospice diagnosis.

Inspection Results

Issue 1: Pulmonary Quality of Care

We did not substantiate the patient's care resulted in a terminal illness and permanent confinement in a hospice unit.

Physician A's documentation for three visits did not meet VHA standards. VHA policy[21] requires that staff document a pertinent progress note at the time of each visit with specific items to support diagnostic and treatment decisions. Documentation did not consistently include current clinical assessment of the respiratory problem, lung examinations, or follow-up information regarding the patient's response to ordered antibiotic therapy. The use of cut and paste in the electronic medical record documented incorrect vital signs for some visits.

Issue 2: Elbow Quality of Care

We substantiated that the treatment for the patient's elbow infection did not meet accepted quality of care standards[22] and the physician's documentation did not meet VHA standards.[23]

Uncomplicated elbow bursa infection typically responds well to appropriate antibiotic therapy.[24] The indications for surgical intervention (bursectomy[25]) include recurrent or refractory bursitis. The nurses' and physicians' documented throughout June and July 2010 a refractory (resistant to treatment) elbow bursa infection. Intravenous antibiotics were not given. We found that prolonged conservative management and non-surgical care delayed the necessary treatment for the patient's infected elbow bursa. This resulted in a more complicated and extensive left upper extremity infection and the need for emergency surgery, numerous subsequent surgeries, and a prolonged recovery period.

VHA policy requires that staff document a pertinent progress note at the time of each visit with specific items to support diagnostic and treatment decisions. Physician

[21] VHA Handbook 1907.1, *Health Information Management and Health Records,* August 26, 2006.
[22] Lorne N. Small, MD and John J. Ross, MD, *Suppurative Tenosynovitis and Septic Bursistis*, Infectious Diseases Clinics of North America, 19 (2005) 991-1005.
[23] VHA Handbook 1907.1.
[24] Specific antibiotic therapy should be determined by the results of the culture of bursal drainage. Antibiotics may be administered orally or intravenously. However, drug concentration in bursal fluid reaches higher levels with intravenous administration.
[25] Bursectomy is the surgical removal of the bursa sac. The bursa sac is a small sac filled with fluid.

documentation did not include consistent follow-up assessments, the follow-up of the antibiotic therapies, and the implications of the abnormal WBC.

Issue 3: Professionalism of Facility Response

We did not substantiate that the facility managers responded unprofessionally to the patient's or brother's concerns. We found the facility managers consistently attempted to meet the patient's requests for information. We reviewed documented meetings with facility managers, clinicians, and the Patient Advocate and could not find any evidence of unprofessional responses by the facility staff.

Issue 4: Prednisone Cessation

We found that the cessation of prednisone in mid-September, 2010, did not meet the accepted standard of care in the management of long term, daily corticosteroid therapy.[26]

There are many tapering regimens that accomplish withdrawal of corticosteroids. An accepted approach is to taper the prednisone using a rate of change that prevents recurrence of the underlying disease and symptoms of adrenal insufficiency.[27] Sudden discontinuation of corticosteroids in a chronically treated patient may result in acute adrenal insufficiency and/or a flare-up of the disease being treated by prednisone. The patient did not experience adrenal insufficiency but developed worsening respiratory function requiring transfer to a non-VA Intensive Care Unit and intubation. The patient improved when corticosteroids were reinstituted.

Issue 5: Peer Review Process

We found that the facility did not conduct Peer Review for the lung and elbow issues.

Peer review is a non-punitive, confidential process used to evaluate care provided to patients by individual providers. According to VHA policy, the formal process of peer review involves evaluation of specific episodes of care, determination of necessary specific actions based on evaluations, confidential communication with providers, and identification of systems and process issues that may require special actions.[28] Peer review must be performed for occurrences where a patient has experienced an unexpected outcome that may be related to the care provided. Based on VHA and internal peer review policies, the pulmonary issue and elbow infection issue warranted peer review.

[26] Elayne K Garber, MD et al., *Realistic Guidelines in Corticosteroids*, Seminars in Arthritis and Rheumatism, 11 (1981) 231-256.
[27] Adrenal insufficiency is the inability of adrenal glands to produce adequate amounts of steroid hormones.
[28] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008, and updated VHA Directive 2010-025, June 3, 2010

Conclusions

We did not substantiate that the patient's pulmonary care resulted in a terminal illness or permanent confinement in a hospice unit. Nevertheless, we had concerns about medical record charting documentation being inconsistent and lacking requisite details. We found the treatment for the patient's elbow infection was inadequate. We also substantiated that documentation for the pulmonary and left elbow issues did not meet VHA standards. We found no evidence that the facility's response to the patient's and brother's concerns were unprofessional. We found that the cessation of chronic prednisone did not meet the generally accepted clinical practice. Lastly, we found that the facility did not perform peer reviews for the clinical situations where the patient had unexpected outcomes.

Recommendations

Recommendation 1. We recommended that the facility Director consult with Regional Counsel regarding possible institutional disclosure to the patient for whom quality of care concerns were identified.

Recommendation 2. We recommended that the facility Director implement procedures to ensure facility staff comply with VHA policies on peer review and physician privileging.

Recommendation 3. We recommended that the facility Director monitor physicians' documentation for compliance with VHA Handbook 1907.01.

Comments

The VISN and facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 8-11, for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 23, 2012

From: Director, Rocky Mountain Network (10N19)

Subject: **Healthcare Inspection – Quality of Care and Administrative Issues, Sheridan VA Medical Center, Sheridan, Wyoming**

To: Director, Denver Office of Healthcare Inspections (54DV)

Thru: Director, Management Review Service (10A4A4)

I have reviewed and concur on the responses from the Sheridan VAMC regarding the recommendations from the Healthcare Inspection – Quality of Care Issues. If you have any questions, please contact Ms. Susan Curtis, Health Systems Specialist at (303) 639-6995.

Ralph T. Gigliotti, FACHE
Director, Rocky Mountain Network (10N19)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 19, 2012

From: Director, Sheridan VA Medical Center (666/00)

Subject: **Healthcare Inspection – Quality of Care and Administrative Issues, Sheridan VA Medical Center, Sheridan, Wyoming**

To: Director, Rocky Mountain Network (10N19)

1. After reviewing the report, I concur with the recommendations.
2. Following is the Sheridan VAMC response to the recommendations outlined in the report.
3. If you have any additional questions or concerns, please do not hesitate to contact Lisa McClintock, Quality Manager, 307.675.3165.

Debra L. Hirschman
Debra Hirschman
Director, Sheridan VA Medical Center (666/00)

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 Recommendations

Recommendation 1. We recommended that the facility Director consult with Regional Counsel regarding possible institutional disclosure to the patient for whom quality of care concerns were identified.

Concur **Target Completion Date:** 3/21/12

Facility's Response:

Institutional disclosure was completed with the resident [patient].

Status: Closed

Recommendation 2. We recommended that the facility Director implement procedures to ensure facility staff comply with VHA policies on peer review and physician privileging.

Concur **Target Completion Date:** 5/1/12

Facility's Response:

A new protected peer review trigger for the screening of all unplanned interfacility transfers of patients to a higher level of care will be implemented.

The Executive Committee of the Medical Staff and the Medical Executive Board will ensure a method of considering patient complaints is included in the Ongoing Professional Practice Evaluation (OPPE).

Status: Open

Recommendation 3. We recommended that the facility Director monitor physicians' documentation for compliance with VHA Handbook 1907.01.

Concur **Target Completion Date:** 3/19/12

Facility's Response:

Data collected and trended through the Ongoing Professional Practice Evaluation (OPPE) process will be provided to the Medical Center Director on a regular ongoing basis. Items reviewed in the OPPE record reviews include the pertinent and appropriate use of copy and paste, documentation supporting diagnosis, development of suitable management plan, orders placed consistent with the condition of the patient and appropriate follow-up.

Status: Closed

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Thomas Jamieson, MD, Project Leader Cheryl Walker, ARNP, MBA, Team Leader Virginia Solana, RN, MA Laura Dulcie, BSEE

Appendix D

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