Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02235-277

Healthcare Inspection

Alleged Patient Rights, Quality of Care, and Other Issues VA Puget Sound Health Care System Seattle, Washington

August 13, 2013

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Executive Summary

At the request of Senator Patty Murray, the Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to allegations brought forth by a patient related to a dermatology examination the patient received at the Seattle Division of the VA Puget Sound Healthcare System (system), Seattle, WA.

We did not substantiate that the examination was unnecessary as alleged. However, we found the provider did not ensure a chaperone was present during the examination as required. We did not substantiate allegations that the provider nudged and pushed the patient, did not wash her hands, or had ragged and unkempt fingernails. We substantiated that the provider did not wear gloves during the examination as alleged, but determined the use of gloves was not indicated and that this was appropriate practice. We substantiated that the window in the examination room was not covered, but determined the window was not covered to aid the provider's diagnostic exam and it was unlikely the patient's privacy was breached. We found that system staff did not fully respond to the patient's concerns and did not report the patient's allegations in accordance with Federal regulation and VHA policy.

We recommended the System Director ensure the Women Veterans Program Manager provides chaperone policy education to all primary care clinics. We also recommended the System Director ensure all staff are informed about the VHA requirement to report allegations of patient abuse and educated on the processes for reporting the alleged abuse.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 10–12 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

Purpose

At the request of Senator Patty Murray, the Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to allegations brought forth by a patient related to a dermatology examination the patient received at the Seattle Division of the VA Puget Sound Healthcare System, Seattle, WA (system). The purpose of the review was to determine whether the allegations had merit.

Background

The system is part of Veterans Integrated Service Network (VISN) 20. It is a two-division system that provides a broad range of inpatient and outpatient primary and tertiary care. The system is affiliated with the University of Washington Medical School. It is the largest referral medical center in VISN 20 and has divisions located in Seattle (Seattle Division) and Lakewood (American Lake Division), WA.

Dermatology care is offered through the Specialty Care Patient Program at the Seattle Division. Two full-time, board certified dermatologists, two full-time nurse practitioners, one full-time registered nurse, and one full-time health technologist provide dermatology care in examination rooms located in the Specialty Medicine Clinic. During fiscal year 2012, dermatology providers at the Seattle Division had 12,242 patient encounters.

On March 22, 2013, a patient who had been evaluated in the dermatology clinic in mid-January faxed two documents to Senator Patty Murray. The documents, a Voluntary Witness Statement (VA Form 0024) and a typed document titled "Sequence of Events After Official Complaint," contained allegations related to the dermatology examination. Senator Murray forwarded the documents to the OIG.

Specifically, the patient alleged that the dermatology examination was unnecessary, and that the provider nudged and pushed her during the examination, did not wash her hands, had ragged and unkempt fingernails, did not wear gloves, and the window in the examination room was not covered.

Psoriasis:

Psoriasis is a common skin disease characterized by the build-up of cells on the surface of the skin forming thick patches, sometimes referred to as scales or plaques. Psoriasis tends to affect common anatomic locations, which include the scalp, elbows, hands/fingernails, feet/toenails, external ear, umbilicus, and gluteal cleft (the groove between the buttocks above the anus).[1] A visual inspection of the common anatomic locations is necessary to evaluate a patient when psoriasis is a diagnostic consideration. (See Figure 1.) Areas where two skin surfaces may rub together, such

[1] Habif Clinical Dermatology, 5th Ed., Mosby Elsevier, 2010.

as the gluteal cleft, are inspected for pinking.[2] Anatomically, the gluteal cleft is a key area to visually inspect as it is a common site of involvement in psoriasis.

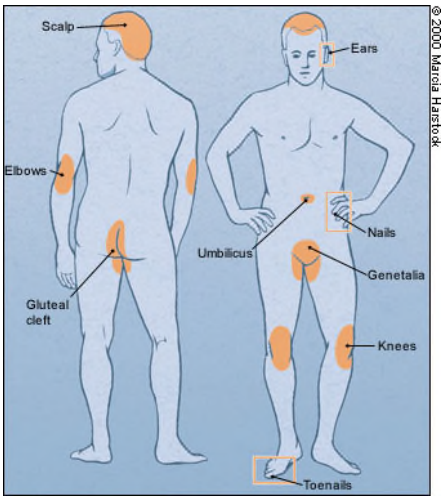

Figure 1. Common areas of distribution of psoriasis.

Scope and Methodology

We conducted site visits at the Seattle and American Lake Divisions April 16–18. We toured areas pertinent to the complaint at both divisions. While on-site, we interviewed the patient, the provider who conducted the dermatology examination, a patient advocate (advocate), a social worker familiar with the patient's complaint, and Dermatology Clinic leadership and staff. While on-site, we also interviewed the system Director, the Director of Quality Management (QM), infection control staff, the system Chief of Police, and the Acting Patient Safety Manager. We interviewed the Chief of Staff, the teledermatology dermatologist, the Acting Service Line Leader for Hospital and Specialty Medicine, and the Women Veterans Program Manager (WVPM) by telephone.

We reviewed the patient's electronic health record, pertinent documents, VHA and system policies and procedures, competency and privileging documentation, performance reviews, hand washing surveillance data, and VA Police reporting documentation.

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.

[2] Gluteal Pinking refers to red appearing hues seen in the anal area, most commonly at the intergluteal fold (or cleft); when present, this finding further raises a diagnostic consideration of psoriasis.

Case Summary

The patient is a female in her mid-forties. In December 2012, during a routine Women's Health (WH) Clinic appointment at the American Lake Division, the patient told her WH provider she had noticed a rash on her left breast for 2 weeks and that this was similar to a rash she had 10 years prior, which was treated with a steroid cream. The WH provider noted there was no nipple bleeding, no palpable breast mass or tenderness, and that the patient's last mammogram was negative. A routine dermatology consult request was placed to further address the left breast rash.

In mid-January 2013, the patient presented to the Seattle Division Dermatology Clinic for the scheduled consult. The dermatology provider noted the patient's self-reported history of the left breast rash and prior treatments, and that a "sister may have psoriasis." The provider noted, "There are flakes of scalp scale, elbows are clear, no gluteal pinking, feet are dry, hyperkeratotic, no fissures." The provider documented a clinical impression of eczema,[3] prescribed clobetasol[4] for 1 week, and advised the patient to follow up in Dermatology Clinic in 8 days. The provider also documented that the patient received education regarding strategies to lessen the discomfort caused by eczema and that the patient was pleasant, friendly, and a good historian.

The following day, the patient presented to the American Lake Division and asked to speak to a patient advocate. The advocate documented the patient was very upset and felt as though the provider who performed the dermatology examination violated her rights during the examination.

Inspection Results

Issue 1: Patient Rights

Patients who elect to receive their health care from VHA have rights and responsibilities that are recognized by VHA.[5] Among these is the right to accept or refuse any aspect of the medical evaluation and treatment, the right to be treated with dignity and respect, the right to privacy, and the responsibility to ask questions when the patient does not understand something about their care.

Necessity and Consent: We did not substantiate the allegation that the gluteal cleft examination was unnecessary and found the patient consented to the examination; however, we determined the level and quality of communication related to the necessity of the gluteal cleft examination was subjective.

The patient told us she believed the examination of her gluteal cleft was not necessary and that the provider "violated her rights" in doing so. In relating the events pertaining

[3] Eczema is a chronic inflammation of the skin. Often, the skin is dry and there may be involvement at skin creases.
[4] Clobetasol is a topical synthetic corticosteroid cream.
[5] Rights and Responsibilities of VA Patients and Residents of Community Living Centers http://www.va.gov/health/rights/patientrights.asp

to the examination, the patient told us she asked the provider if her symptoms could be due to psoriasis because her sister might also have psoriasis. This is supported in the medical record documentation, the provider noting, "sister may have psoriasis." We determined that, because of the patient's self-reported family history and inquiry as to the possibility that her symptoms were indicative of psoriasis, the provider would have been remiss to not examine the gluteal cleft along with the other common anatomic locations of the disease.

The patient did not refuse or verbally question the necessity of the gluteal cleft examination before or after allowing the examination. However, we determined the level and quality of communication related to the gluteal cleft portion of the examination was subjective. The patient told us the provider asked her if she had a rash on her buttocks or anal area, and when the patient said, "No," the provider told the patient she needed to look anyway. The patient told us she did not ask the provider why the examination was necessary, but believed the provider should have noted her confused expression prior to the examination and her changed demeanor after the examination. The provider believed the patient understood that viewing the gluteal area was necessary to rule out psoriasis and told us she did not note confusion before, or a change in demeanor after, the examination. In fact, the provider documented the patient was pleasant and friendly during the examination.

Dignity and Respect: Due to conflicting information, we could not confirm the allegation that the provider nudged the patient, pushed the patient forward, or used a forceful motion during the examination.

The patient told us the provider nudged her, pushed her forward, and used a forceful motion during the examination of her gluteal cleft. The provider agreed that she touched the patient's buttocks in order to separate the soft tissue folds of the buttocks, which allowed for visual observation of the gluteal cleft. The provider told us the examination room was small, which we confirmed, and that she may have brushed up against the patient in the process of positioning herself to conduct the gluteal cleft examination; however, the provider denied nudging the patient, pushing the patient, or using unnecessary force to separate the patient's buttocks during the examination.

Of note, the provider had 2,484 encounters during FY12 and had no patient complaints filed against her prior to this complaint. The provider's last two performance reviews did not indicate any problems with patient interactions, nor were there concerns offered by current and previous supervisors.

While not an allegation, we found the provider did not ensure a female chaperone was in the room during the examination of the patient's left breast and gluteal cleft. VHA policy[6] requires the presence of a female chaperone during examinations involving the breasts or genitalia of female patients, regardless of the provider's gender. During interviews, dermatology staff told us they were unaware of this requirement prior to learning of the patient's complaint.

[6] VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.

Prior to our on-site visit, the WVPM recognized the learning needs of the dermatology staff related to chaperone requirements and provided chaperone policy education to dermatology staff. The WVPM told us health care providers outside of the WH Clinic are not always aware that Handbook 1330.01 applies in all VHA health care settings, and indicated that providing similar education to all primary clinics in the system is planned.

Privacy: We substantiated that the examination room window was not covered during the examination; however, we determined the reason the window was not covered was to aid the provider's diagnostic exam and it was unlikely the patient's privacy was breached due to the room's second floor location and the patient's specific positioning in the room during the examination.

The patient told us the examination room window was not covered and the provider agreed. The provider told us she intentionally left the window uncovered because natural light is the best source of light to use during a dermatology examination. During interviews, the Chief of Dermatology and other dermatology staff concurred, agreeing that natural light is the preferred light when conducting a skin examination. The literature supports this.[7]

The examination occurred on the second story of Building 18, in Room 214. Room 214 has one window, which overlooks a courtyard. A Seattle Division building (Building 1) is situated across the courtyard, approximately 110 feet away. The patient was seated in a chair with her back to the window for most of the examination. While seated, the patient pulled her shirt up to expose her left breast to the provider as part of the examination. During the gluteal cleft examination, the patient stood, turned, and faced the window, partially bent forward, and briefly pulled her pants down below her buttocks. The patient did not allege that anyone observed the examination and the provider did not believe anyone would have been able to observe the patient through the window during the examination. We determined no one in the courtyard would have been able to observe the patient during the examination due to the height of the window and that it was unlikely anyone in Building 1 would have been able to see into the examination room and view the patient's breast or buttocks due to the distance and the patient's positioning in the room during the examination.

Since the complaint, and prior to our on-site inspection, dermatology clinic staff have been instructed to ensure window blinds are closed when examining any sensitive anatomic areas, such as the breasts or buttocks.

Issue 2: Hand Hygiene – Hand Washing, Fingernails, Glove Use

VHA Directive 2011-007[8] and local policy[9] require that all health care workers in direct patient care areas, which includes outpatient clinics, use an alcohol-based hand rub (AHR) or antimicrobial soap and water before and after having direct contact with a

[7] Burns, T., et al. Editor, Rook's Textbook of Dermatology, Eighth Ed., Wiley-Blackwell, St. Louis, 2010.
[8] VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
[9] Memorandum IC-04, *Surveillance Prevention and Control of Infection*, February, 2012.

patient. Directive 2011-007 also requires that all health care workers wear gloves when in contact with blood or other potentially infectious materials, mucous membranes,[10] and non-intact skin is anticipated.

Hand Washing: We did not substantiate the allegation that the provider did not wash her hands before or after examining the patient.

The patient told us she did not see the provider wash her hands before or after the examination. The provider told us she "always tries to wash her hands before each patient encounter." The provider told us sometimes she uses the sink in the examination room and "most often" uses a wall-mounted AHR dispenser, located outside the examination room. We interviewed the provider's supervisor and other Dermatology Clinic staff familiar with the provider, and none voiced concerns related to their observations of the provider's hand hygiene practices.

We conducted an unannounced tour of the Specialty Medicine Clinic on April 18. The clinic was clean, organized, and stocked AHR dispensers were mounted outside examination rooms. We inspected the room where the provider conducted the patient's examination and noted a wall-mounted AHR dispenser outside the door, a sink and soap dispenser in the room, a bottle of AHR on a desk, and non-sterile examination gloves of various sizes in boxes mounted on the wall.

Infection control staff told us the facility uses Purell® AHR, which does not require washing hands with soap and water between uses unless hands become visibly soiled or come in contact with bloodborne pathogens or body fluids. This is supported by the manufacturer's information and instructions.[11] Infection control personnel also told us staff conduct monthly secret surveillance to monitor hand hygiene in all service areas, wards, and clinics and report the surveillance data to infection control staff. During January and February, Dermatology Service hand hygiene surveillance data revealed 97 percent compliance.

Following the complaint, but prior to our on-site inspection, the Chief of Dermatology told us he re-educated dermatology staff regarding the importance of hand hygiene and techniques staff can use to assure patients that they have washed their hands.

Fingernails: We did not substantiate the allegation that the provider's fingernails were ragged and unkempt on the day of the examination.

In her written statements, the patient said the provider's fingernails were "very dirty and unkempt." During our interview, the patient rephrased her statement and told us the provider's nails were not dirty, but that they were "ragged and unkempt." We were unable to determine the condition of the provider's fingernails during the examination. We noted during our interview that the provider's fingernails appeared clean, neatly manicured, and barely extended past the tips of her fingers.

[10] Mucous membranes line body cavities that are exposed to the external environment and internal organs. Examples include the nostrils, the lips of the mouth, the eyelids, the ears, the genital area, and the anus.
[11] http://www.brands2liveby.com/Purell/content/faq.htm#q9

Glove Use: We substantiated the allegation that the provider did not wear gloves during the examination; however, we determined the use of gloves was not indicated. We found the provider followed established Center for Disease Control guidelines,[12] VHA and local policy, and accepted dermatology practice to not use gloves unless necessary. In fact, we determined the use of gloves would have been contrary to accepted dermatology practice for this examination.

The patient and the provider both agreed that the provider did not wear gloves while examining the patient's left breast, scalp, feet, and gluteal cleft. In performing the examination, the provider placed her hands on the middle area of the patient's buttocks for the purpose of spreading the buttocks in order to visualize the gluteal cleft.

The provider told us an important part of a dermatology examination is the tactile sensation of feeling the skin and that gloves lessen this. She stated she does wear gloves if an infectious process is noted in the area(s) to be touched or if it is necessary to perform a biopsy. We interviewed the Chief of Dermatology, the prior Chief of Dermatology, and another provider employed in the Dermatology Clinic. All agreed that the areas examined by the provider did not require gloved hands unless an area appeared to be infected or a biopsy was to be performed. We reviewed the patient's electronic health record and noted there was no documentation of infection and a biopsy was not performed. We reviewed a photograph of the rash on the patient's left breast taken the day of the examination and noted no obvious signs of infection. We also found *Rook's Textbook of Dermatology* supports that touching the skin during a dermatology examination is important in most instances and that gloves should only be worn during a dermatology examination when examining (directly touching) the mouth, genital/perianal region, or in the case of infectious or infected dermatosis.[13]

Issue 3 – System Response to Alleged Abuse

We found that system staff did not report the patient's allegations in accordance with VHA policy. VHA policy requires that staff report events involving alleged or suspected patient abuse of any kind to their supervisor or facility police and the incident must be documented in the VHA Patient Safety Information System (patient safety report).[14] VHA allows medical centers to customize and design site-specific reporting systems and policies that fit within VHA's requirements.

The patient contacted the advocate the day after the dermatology examination. The advocate told us the patient was visibly distraught and tearful when she approached her at the American Lake Division The patient told the advocate she believed her "rights were violated" when the provider conducted an examination of her buttocks area. The advocate documented the encounter in the Patient Advocate Tracking System (PATS)

[12] Centers for Disease Control and Prevention web site with Guideline for Hand Hygiene in Health-Care Settings and related materials. Available at http://www.cdc.gov/handhygiene/.
[13] Burns, T., et al. Editor, *Rook's Textbook of Dermatology*, Volume 4, Chapter 5, Diagnosis of Skin Disease. Wiley-Blackwell, St. Louis, 2010.
[14] VHA Handbook 1050.01, *VHA National Patent Safety Improvement Handbook*, March 4, 2011.

and selected Issue Code R103, Allegations of Abuse, to categorize the documentation in the system.[15]

The advocate notified the Chief of Dermatology and another member of the dermatology staff, and the Chief responded by calling the complainant. However, after speaking with the Chief of Dermatology, the patient returned to the advocate stating her concerns were not resolved. The advocate told us she was uncertain how to proceed and began contacting other system staff including a social worker, the WVPM, and risk management staff. Over a course of 8 weeks, the advocate documented eight contacts related to the allegation with the patient, five face-to-face and three by telephone.

The Chief of Dermatology told us he investigated the allegations himself, but could not provide documentation of his investigation and did not report the allegation as required. A social worker, the WVPM, and risk management staff, who learned of the allegations 10 days after the patient informed the advocate, did not report the allegation as required. The System Director and the Director of QM were not aware of the patient's complaints until April 4, when OIG staff called to inform the Director we were reviewing the complaint.

We reviewed the system's local abuse and neglect reporting policy and found it did not advise staff who become aware of allegations of abuse perpetrated by a VA staff member to notify a supervisor, a management official, or the OIG, and did not advise staff to report allegations of abuse in the patient safety reporting system.

Conclusions

While we did not substantiate the allegation that the gluteal cleft examination was unnecessary, we found the provider did not ensure a chaperone was present during the examination as required, and determined the patient and the provider did not clearly communicate with each other before or after the gluteal cleft examination. We identified system weaknesses that led to missed opportunities to address the patient's misunderstanding of the necessity of the examination prior to our receiving her complaint. Specifically, timely reporting to appropriate leadership did not occur.

We did not substantiate the allegations that the provider nudged and pushed the patient, did not wash her hands, or had ragged and unkempt fingernails. We substantiated that the provider did not wear gloves during the examination, but determined the use of gloves was not indicated. We substantiated that the window was not covered, but determined it was unlikely the patient's privacy was breached. However, dermatology staff now ensure windows are covered when examining sensitive areas.

[15] Patient Advocate documentation is conducted using an electronic documentation system called Patient Advocate Tracking System (PATS), which tracks patient complaints and compliments at each medical center. VHA Handbook 1003.4, VHA Patient Advocacy Program, September 2, 2005.

Recommendations

1. We recommended the System Director ensure the Women Veterans Program Manager provides chaperone policy education to all system primary care clinics and monitors compliance.

2. We recommended the System Director ensure all staff are informed about the VHA requirement to report allegations of patient abuse and educated on the processes for reporting the alleged abuse.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 17, 2013

From: Director, Northwest Network

Subject: **Healthcare Inspection – Alleged Patient Rights, Quality of Care, and Other Issues, VA Puget Sound Health Care System, Seattle, WA**

To: Department of Veteran Affairs, Office of Inspector General

As the Director of VISN 20, I concur with the response that VA Puget Sound HCS has for the recommendations that were provided and the completion date of September 1, 2013.

(*original signed by*)
Lawrence H. Carroll

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 9, 2013

From: System Director, VA Puget Sound Health Care System

Subject: **Healthcare Inspection – Alleged Patient Rights, Quality of Care, and Other Issues, VA Puget Sound Health Care System, Seattle, WA**

To: Network Director, VISN 20 (10N20)

1. Thank you for the opportunity to respond to the recommendations from the OIG Hotline Visit at VA Puget Sound Health Care System, Seattle, Washington.

2. Attached please find the facility responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Jane Penny, Director Quality Improvement at (206) 764-5522 or via e-mail Jane.Penny@va.gov.

(*original signed by*)
Michael J. Murphy, FACHE
Health Care System Director

Comments to OIG's Report

The following System Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended the System Director ensure the Women Veterans Program Manager provides chaperone policy education to all system primary care clinics and monitors compliance.

Concur

Target date for completion: September 1, 2013

Facility response: Based on the preliminary discussion with the OIG team, facility leadership tasked the Women Veterans Program Manager with developing a chaperone policy for the facility. A draft chaperone policy has been completed and requires service lines to monitor compliance. The policy will be posted, fully implemented, and education of primary care staff will be completed by September 1, 2013.

Recommendation 2. We recommended that the System Director develop a policy that complies with Federal regulations and VHA policy to ensure staff and managers understand alleged abuse reporting requirements, processes, and time frames, and educates system staff and managers regarding the policy.

Concur

Target date for completion: September 1, 2013

Facility response: Based on the preliminary discussion with the OIG team, facility leadership tasked the Patient Centered Care Coordinator and Service Line Leader for Social Work with developing a facility policy guiding the response to allegations of abuse against staff. A draft policy has been completed. The policy will be posted, fully implemented, and education of staff will be completed by September 1, 2013.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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