Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04976-191

Healthcare Inspection

Alleged Quality of Care Concerns VA Greater Los Angeles Healthcare System Los Angeles, CA

March 31, 2017

Washington, DC 20420

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to the privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

Web site: www.va.gov/oig

Table of Contents

Page

Executive Summary i

Purpose 1

Background 1

Scope and Methodology 2

Case Summary 4

Inspection Results 6
- Issue 1. Alleged Poor Care While Hospitalized 6
- Issue 2. Alleged Maggots in Patient's Underwear 6
- Issue 3. Alleged Poor Services from a Home Health Agency 7
- Issue 4. Other Observation—Pressure Ulcer Documentation 7

Conclusions 9

Recommendation 9

Appendixes
- A. VISN Director Comments 10
- B. System Director Comments 11
- C. OIG Contact and Staff Acknowledgments 13
- D. Report Distribution 14

Executive Summary

The VA Office of Inspector General conducted a healthcare inspection at the request of the then Congresswoman Lois Capps to assess quality of care concerns in the management of a patient at the VA Greater Los Angeles Healthcare System (system), Los Angeles, CA. The specific allegations were that a patient received poor care while hospitalized at the system, had maggots in his underwear the day after he left the system, and received poor services from home health agency staff.

We did not substantiate the allegation that the patient received poor care while an inpatient at the system. We determined that the patient received appropriate care in response to his medical needs. Throughout his almost 3-week stay, the patient had 12 consultations from various clinical services and 2 gastrointestinal procedures.

We could not substantiate the allegation that the patient had maggots in his underwear while he was in the system because it could not be proven if or when the presence of maggots occurred. We found no documentation regarding maggots prior to the patient leaving the system or by the Emergency Department staff who examined the patient at a local community hospital a few hours after the patient left the system and again the following day.

We could not substantiate the allegation that the home health agency provided poor care to the patient once he was in his own home because the office that provided services to the patient had since closed, the staff who cared for him were no longer employed by the agency, and no agency treatment records could be located.

We identified inconsistent compliance with the documentation requirements of the patient's pressure ulcers in the electronic health record. Of the 34 nursing staff entries made during the hospitalization at issue, nurses generally documented the daily Braden risk scale, daily skin inspections, and the weekly wound care team assessments. However, we found deficiencies regarding documentation of wound location, drainage information, any improvement, and wound characteristics, as required.

We also found inconsistent documentation of collaboration and participation by providers/physicians related to the patient's pressure ulcer. We found minimal documentation in the electronic health record of providers' participation in the pressure ulcer prevention plan. Of the 10 provider notes, one progress note contained pressure ulcer documentation while the patient was in the Medical Intensive Care Unit. None of the 22 non-intensive care unit progress notes contained information regarding the patient's pressure ulcer.

We recommended that the System Director ensure that nursing staff comply with pressure ulcer documentation requirements and physician providers routinely document participation in the interdisciplinary plan for patients with pressure ulcers.

Comments

The Veterans Integrated Service Network and System Directors concurred with our findings and recommendation 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 the then Congresswoman Lois Capps, the VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations about quality of care concerns in the management of a patient while hospitalized at the VA Greater Los Angeles Healthcare System (system), Los Angeles, CA.

Background

The system, part of Veterans Integrated Service Network 22, is a 628-bed tertiary facility located in Los Angeles, CA, and provides both inpatient and outpatient health care services, including acute care, long term care, mental health, and home health. Primary and specialized outpatient care is provided at community based outpatient clinics. The system serves a veteran population in a primary service area that includes Los Angeles, Santa Barbara, San Luis Obispo, Ventura, and Kern counties.

A pressure ulcer (PU) "is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear."[1] Persons at highest risk of developing a PU include those who have significant limited mobility, previous or current PUs, nutritional deficiencies, or an inability to reposition themselves.[2]

A staging system is one method to summarize characteristics of PU, including the extent of tissue damage. The National Pressure Ulcer Advisory Panel developed the most widely used system in the United States, rating PUs from Stage I (superficial tissue damage) to Stage IV[3] (full thickness skin loss involving muscle or bone).[4]

In 2011, VHA issued Handbook 1180.02 that addressed a standardized interprofessional[5] strategy involving representatives from multiple clinical disciplines for the assessment and prevention of PU in all clinical settings, use of the Braden scale[6] for initial and ongoing assessments, and standardized documentation and education requirements.[7] The Handbook outlines specific documentation requirements including the location of the PU, wound characteristics, and drainage.

---

[1] National Pressure Ulcer Advisory Panel, NPUAP Pressure Ulcer Stages/Categories. Accessed August 23, 2016. We noted the NPUAP April 2016 recommendation to use the term pressure injury in lieu of PU; however, as we discuss events that occurred prior to April 2016 and to conform to the references we have cited, we use the term PU in this report.

[2] National Guideline Clearing House, *Pressure Ulcers Prevention and Management of Pressure Ulcers*, accessed August 23, 2016.

[3] Stage I–IV (Roman numerals) is equivalent to stage 1–4 (Arabic) and we use these interchangeably in this report.

[4] Hughes RG editor. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville, MD: Agency for Healthcare Research and Quality (US). April 2008.

[5] Interprofessional and interdisciplinary are used interchangeably in this report.

[6] A clinically reliable and valid tool used to score or predict a person's level of risk for developing PUs. The Braden Scale is a PU risk scale.

[7] VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011. This VHA Handbook was scheduled for recertification on or before the last working day of July 2016 and has not yet been updated.

We conducted a review of PU prevention and management at the system during its Combined Assessment Program inspection in August 2013.[8] The inspection identified high compliance in many areas, including system PU policies and the use of standardized risk assessment tools. After review of relevant documents, electronic health records (EHR) of selected patients with PUs, selected employee training records, and inspection of selected patient rooms, we recommended that the system strengthen its processes to ensure that clinical staff accurately document location, stage, and/or risk score for all patients with PUs. We monitored the system's responses until adequate compliance was reached. At that time, we accepted the responses and closed the referenced recommendation in December 2014.

Allegations

OIG received a request from the then Congresswoman Lois Capps to assess a complaint that a patient received poor care while hospitalized at the system, that the patient had maggots in his underwear the day after he left the system, and that he received poor services from home health agency staff.

Scope and Methodology

We conducted the inspection from July 2014 to May 2016. We conducted a site visit October 27–28, 2015, which included both entrance and exit briefings with system leadership. We made three attempts to schedule an interview with the patient but were unsuccessful. We interviewed the complainant, one of the complainant's family members, system staff knowledgeable about the patient, the home health agency coordinator, and a physician who is a myiasis (maggot) subject matter expert.

We reviewed relevant VA/VHA and system policies and procedures,[9] the patient's VA EHR and non-VA records that had been scanned into the VA EHR, invoice documents from the home health agency, and documents from the Santa Barbara Police Department.

VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011, cited in this report, is beyond its July 31, 2016 recertification date. We considered the policy to be in effect because it had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[10] the then VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[11] The then USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under

[8] *Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, CA*, Report No. 13-02640-06, October 30, 2013.
[9] VHA Handbook 1180.02.
[10] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[11] VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document,* June 29, 2016.

Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[12]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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.

[12] VA Under Secretary for Health Memorandum, Validity of VHA Policy Document, June 29, 2016.

Case Summary

The patient was in his mid-60s and is a bilateral below-knee amputee with multiple medical conditions including diabetes mellitus. In 2013, he sustained a number of fractures and a collapsed lung following a motor vehicle accident. The patient was emergently transported to a non-VA tertiary medical center where he was evaluated and stabilized. He subsequently underwent surgery to address some of his injuries.

Approximately 2 weeks later (Day 1), he was transferred to the system and placed in the Medical Intensive Care Unit (MICU). At the time of his transfer, the patient was very weak and unable to turn or move himself. Following admission to the MICU, a nursing assessment described a possible new sacral PU and a suspected deep tissue injury. Nursing implemented a multipronged intervention addressing the condition of the sacral skin to include pressure redistribution, managing moisture, nutrition, and reducing friction and shear. Within his first hours at the system, physicians requested a Wound Care Team consultation. A wound care nurse saw the patient later that day, with subsequent weekly visits during his almost 3-week hospitalization. In addition to wound care evaluations, nurses documented the patient's sacral "pressure ulcer/wound skin inspection" and care daily with the exception of 2 Sundays.

After being stabilized overnight in the MICU, the patient transferred to a general medicine floor. On Day 13, after developing bleeding that required an endoscopic procedure, he transferred back to the MICU for several days. After again being stabilized, the patient returned to the general medicine floor on Day 17. Due to complications of poorly controlled blood glucose and other medical conditions, the patient was seen in consultation by the endocrinology, gastroenterology, hematology, nephrology, neurology, physical medicine and rehabilitation, orthopedic, and neurosurgery services in addition to wound care, physical therapy, occupational therapy, speech pathology, and nutrition.

As the patient's multiple issues improved, he became increasingly dissatisfied with continued hospitalization. Provider notes reflected the patient as being "frustrated" with his inpatient status and voicing the intent, for several consecutive days, to depart from the system against medical advice. Although the attending physician was aware of the patient's frustrations with continued hospitalization, he was concerned that there were practical limitations for the patient if he was not in a controlled care setting (such as a limited ability to transfer from bed to chair). In addition, the patient was incontinent of stool, a potentially aggravating factor for sacral skin integrity. The attending physician was considering an eventual transfer to a rehabilitation or skilled care facility. According to the provider note in the EHR, the patient began to "refuse all medications and blood draws" and declined therapeutic intervention ("hypertensive but refusing intervention"). On Day 21, after refusing to be examined by his physician, the patient signed himself out of the system against medical advice stating, "I'm not ill enough to be in the hospital." The patient "was informed of the risk involved and hereby released the attending physician and the hospital from all responsibility and any ill effect which may result from their action." He departed without his medications, as he "did not want to wait."

A few hours after discharge from the system on Day 21, the patient fell trying to open the gate to his home and was transported via ambulance to a community hospital. He was treated in the Emergency Department (ED) and released to home a few hours later. The community hospital ED provider who examined the patient noted an "abrasion vs decubitus ulcer to the sacral area, no erythema or drainage, stage 1 if decubitus ulcer." A nurse noted a possible ulcer on the patient's coccyx and that the patient was incontinent of stool. She cleaned the coccyx wound with normal saline and provided incontinence care. Neither the provider nor the nurse documented the presence of maggots.

On Day 22, according to a local police department report, officers responded to a telephone call, went to the patient's home, and left the patient's home 2 hours later. The patient was transported again to the local community hospital and evaluated for body aches and inability to care for himself at home. Neither the ED provider nor an ED nurse who examined the patient documented the presence of maggots but both noted the presence of a stage 2 sacral PU. The patient was admitted to the local community hospital.

The patient's VHA provider submitted a consult for home health aide services on Day 22. The home health agency accepted the referral; however, it did not start services for several weeks. The patient was admitted to the community hospital twice after discharge from the system. Home health aide services had not been initiated by the time of his second community hospital discharge. The system submitted another consult prior to his second discharge from the community hospital. The home health service initiated visits, but we found no documentation in the EHR regarding the care the agency may have provided.

Inspection Results

Issue 1: Alleged Poor Care While Hospitalized

We did not substantiate the allegation that the patient received poor care while an inpatient at the system. We determined that the patient received appropriate care in response to his medical needs. Throughout his almost 3-week stay, the patient had 12 consultations from various services and 2 GI procedures. Examples include:

- The patient had a sacral PU upon his admission. Providers immediately submitted a wound consult, and the patient was seen that day by the wound care team.
- The patient developed an acute GI bleed during his stay. Providers transferred him to the MICU from the general medicine nursing unit. GI physicians performed a colonoscopy[13] and an esophagogastroduodenoscopy (EGD).[14] Providers intubated[15] him, placed him on a ventilator to protect his airway, and adjusted his medications to decrease bleeding.
- The patient had multiple medical problems. His providers consulted with different services to address his medical issues.

The patient's providers did not consider him ready for discharge, but the patient exercised his right to leave against medical advice and took public transportation home.

Issue 2: Alleged Maggots in Patient's Underwear

We could not substantiate the allegation that the patient had maggots in his underwear while he was at the system because it could not be proven if or when the presence of maggots occurred.

We found no documentation regarding maggots prior to the patient leaving the system on Day 21 or by the ED provider or ED nurse who examined the patient at a local community hospital a few hours after the patient left the system and again the following day.

According to the complainant, the patient arrived at his home on the same day he left the system but could not access his home. The complainant informed us the patient fell out of his wheelchair and slept in his backyard that night. He reportedly called out for help, but no one responded until the next day. Another interviewee told us the patient called him the following day (Day 22), stating that he (the patient) was home. The interviewee went to the patient's home, cleaned the patient, and got him into bed. The interviewee stated that at the time he cleaned/assisted the patient, he found the patient's underwear full of maggots.

---

[13] A colonoscopy is a procedure that allows a clinician to directly view the entire large intestine.
[14] An EGD is a procedure that allows a clinician to directly view the esophagus, stomach, first part of small intestine.
[15] In this context, the term "intubate" means the placement of a tube into the trachea to maintain an open airway.

A physician expert on medicinal maggot therapy told us that since the patient had a PU in his sacral area and was incontinent of feces, maggots could have been attracted by the feces. Further, he stated that a finding of maggots was not evidence by itself of poor care because flies (whose larvae are maggots) can be attracted to well-managed wounds.

Issue 3: Alleged Poor Services From a Home Health Agency

We could not substantiate that the patient received poor services from the home health agency staff after discharge from the system on Day 21 because of insufficient information. The home health agency manager informed us that the office that provided services to the patient had since closed; the staff who cared for him were no longer employed by the agency; and no agency treatment records could be located.

We found one EHR progress note from a system social worker who documented that home health aides were ordered through the system or through the community hospital. According to the social worker's note, the patient described himself as a loner, finding it hard to be with people, was not used to people in his apartment, and was uncomfortable when they (home health aides) were "wandering around, opening doors." The social worker noted that the patient apparently told the home health aides not to return. We found no other scanned notes in the patient's EHR related to the home health agency services.

Issue 4: Other Observation—PU Documentation

We found that staff did not consistently comply with VHA policy requiring documentation of assessments and findings related to PU management.[16] We reviewed 34 nursing staff entries in the patient's EHR. Nursing staff generally complied with the requirement to document daily Braden risk scores, daily skin inspections, and the weekly wound care team assessments. However, we identified system weaknesses regarding other required elements. The system's wound care nurse and Acting Chief Nurse acknowledged deficiencies with the overall documentation. The following table shows the nursing documentation deficiencies.

[16] VHA Handbook 1180.02.

Table: Inpatient PU Nursing Documentation

PU Elements Reviewed	Number of Entries Reviewed	Number of Entries Meeting Requirements	Compliance Rate (percent)
Stage of ulcer(s)	34	30	88
Surrounding skin	34	30	88
Pain	34	29	85
Location of ulcer(s)	34	27	79
Drainage	34	8	24
Improvement or deterioration	30	6	20
Wound characteristics - Size of ulcer(s) - Odor	34	4	12

Source: OIG EHR Review

VHA requires PU education be provided to patients with PU or at risk for developing PU. Nursing staff documented patient education in 25 of 34 entries (74 percent).[17] We could not determine what specific education was provided to the patient and to what extent he actually understood. At times, the patient was in MICU and intubated, so he could not verbally respond; at other times, he was noted to be alert but confused or lethargic or only able to respond to verbal and touch stimuli.

VHA policy also requires an interdisciplinary approach to the PU prevention program. While nursing plays a primary role in the interdisciplinary approach, physician providers are required to collaborate with the plan and document participation; dietitians, pharmacists, and rehabilitation staff participate according to their specific roles.[18] Two medicine attending physicians and the Acting Chief of Staff told us that resident physicians are expected to document information on PUs as evidence of their participation.

We found minimal documentation in the EHR of physician providers' participation in the PU prevention plan. In the MICU, resident physicians were expected to enter daily progress notes, including information on PUs. We found a total of 10 provider notes while the patient was in the MICU. However, only one progress note, entered by a physical medicine and rehabilitation provider, contained PU documentation. Attending physicians that we interviewed did not define timeframe expectations for PU documentation on non-ICU patients. None of the 22 non-ICU progress notes contained information regarding the patient's PUs.

[17] VHA Handbook 1180.02.
[18] Ibid.

Conclusions

We did not substantiate the allegation that the patient received poor care while an inpatient at the system. However, we found that staff did not consistently document assessments and findings related to PU management during the patient's hospitalization.

We determined that the patient received appropriate care in response to his medical needs. Throughout his almost 3-week stay, the patient had 12 consultations from various clinical services and 2 GI procedures.

We found no documentation regarding maggots prior to the patient leaving the system or by the ED staff who examined the patient at a local community hospital a few hours after the patient left the system and again the following day. As a result, we could not substantiate the allegation that the patient had maggots in his underwear while he was at the system because it could not be proven if or when the presence of maggots occurred.

We could not substantiate the allegation that the home health agency provided poor care to the patient once he was in his own home because the office that provided services to the patient had since closed; the staff who cared for him were no longer employed by the agency; and no agency treatment records could be located.

We identified inconsistent compliance with the documentation requirements of the patient's PUs in the EHR. Of the 34 nursing staff entries in the patient's EHR, nurses generally documented the daily Braden risk score, daily skin inspections, and the weekly wound care team assessments. However, we identified documentation deficiencies regarding wound location, drainage information, improvement, and wound characteristics.

We also found inconsistent documentation of collaboration and participation by providers. We found minimal documentation in the EHR of providers' participation in the PU prevention plan. Attending physicians expect resident physicians to include PU documentation in progress notes. Of the 10 MICU provider notes, one progress note contained PU documentation while the patient was in the MICU. None of the 22 non-ICU progress notes contained information regarding the patient's PUs.

Recommendation

1. We recommended that the System Director ensure that nursing staff comply with pressure ulcer documentation requirements and physician providers routinely document participation in the interdisciplinary plan for patients with pressure ulcers.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 10, 2017

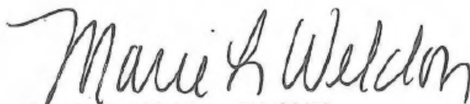
From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Alleged Quality of Care Concerns VA Greater Los Angeles Healthcare System, Los Angeles, California

To: Director, Los Angeles Office of Healthcare Inspections (54LA)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, "Alleged Quality of Care Concerns, VA Greater Los Angeles Health Care System, Los Angeles, California.

2. If you have any questions or need further information, please contact Jimmie Bates, Quality Management Officer for VISN 22 at (562) 826 5963.



Marie L. Weldon, FACHE
Network Director, VISN 22

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: January 10, 2017

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subj: Healthcare Inspection— Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California

To: Director, Desert Pacific Healthcare Network (10N22)

1. Attached you will find the facility response to Recommendation 1 for OIG report entitled, "Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California."

2. If you have any questions or need further information, please contact Therese Cortez, Chief, Quality Management at (310) 478 3711 x41389.

Ann Brown, FACHE
Medical Center Director

Comments to OIG's Report

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

OIG Recommendation

Recommendation 1. We recommended that the System Director ensure that nursing staff comply with pressure ulcer documentation requirements and physician providers routinely document participation in the interdisciplinary plan for patients with pressure ulcers.

Concur

Target date for completion: April 30, 2017

Facility response: GLA Policy# 00-10B-118-19, Prevention of Pressure Ulcers, requires an interdisciplinary approach to reduce the incidence of pressure ulcers across all clinical practice settings, to include an interdisciplinary treatment plan. GLA Interprofessional Pressure Ulcer Committee (IPUC), comprised of multiple clinical disciplines across the continuum of care, establishes, implements, and monitors the facility's pressure ulcer prevention program.

GLA will continue to ensure that nursing staff comply with pressure ulcer documentation requirements and physician providers routinely document participation in the interprofessional plan for patients with pressure ulcers. Ongoing review of documentation will be completed to ensure documentation by the nursing staff and physician providers. A review of 20 randomly selected charts will be audited each month for compliance with pressure ulcer documentation requirements until the target of 90 percent has been sustained for 3 consecutive months. The results will be monitored and reported to the Interprofessional Wound Care Committee and Medical Executive Council for ongoing compliance.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Kathleen Shimoda, BSN, Team Leader Thomas Jamieson, MD Yoonhee Kim, PharmD

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Desert Pacific Healthcare Network (10N22)
Director, VA Greater Los Angeles Healthcare System (691/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Dianne Feinstein, Kamala Harris
U.S. House of Representatives: Nanette Diaz Barragan, Karen Bass, Julia Brownley, Salud Carbajal, Tony Cárdenas, Stephen Knight, Ted Lieu, Kevin McCarthy, Lucille Roybal-Allard, Linda T. Sanchez, Brad Sherman, Maxine Waters

This report is available on our web site at **www.va.gov/oig**.