Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04516-229

Healthcare Inspection

Quality of Care Concerns of a Surgical Patient Central Arkansas Veterans Healthcare System Little Rock, Arkansas

May 17, 2017

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection in response to complaints received in 2015 about a patient's care in the Surgical Intensive Care Unit at the Central Arkansas Veterans Healthcare System (system), John L. McClellan Memorial Veterans Hospital, Little Rock, AR. Specifically, the complainant alleged:

- The patient was not examined daily; instead, the surgical team reviewed the patient's paperwork from outside the room.
- Nursing staff did not get the patient out of bed during meal times, as ordered by the patient's physician, but kept him sedated instead.
- The patient was placed in bilateral wrist restraints continuously for over 30 days without removal.
- The use of the wrist restraints caused the patient's skin to "rot to the bone."
- The patient's family requested the patient be transferred to another hospital, but the attending physician denied the request.
- Staff did not address the patient's new foot drop.
- Nursing staff were heard making bets on how much medication they could give another patient to keep him quiet.

We did not substantiate the allegation that physicians failed to examine the patient daily. Electronic health records included documentation of daily examinations by physicians, and interviews confirmed that the physicians did conduct the examinations. We did not substantiate that nursing staff failed to get the patient out of bed as ordered by the patient's physicians. Nursing staff followed physician orders related to the patient's activity level. Initially, the ordered activity level was bedrest. As the patient's condition improved, the physicians removed the order for bedrest and nursing staff assisted the patient out of his bed. Due to the patient's protracted withdrawal from alcohol, he was necessarily limited in activity during extended portions of his post-operative period.

We did not substantiate the allegation that the patient was in bilateral wrist restraints continuously for over 30 days. Although the patient was in these restraints for over 30 days, documentation in the electronic health record showed they were removed periodically throughout the day by nursing staff in accordance with the system's policy. While not one of the complainant's allegations, we found that the system's policy did not include a requirement to inform facility leaders of the duration a patient is in medical restraints, and leaders were not aware of the use of bilateral wrist restraints for over 30 days for this patient.

We did not substantiate the allegation that the use of physical restraints caused the patient to develop a stage IV ulcer (full thickness tissue loss) on his wrist. The patient did develop a wound on his forearm, which was treated. The forearm wound, however, was not described in the electronic health record as a stage IV ulcer. While not one of

the complainant's allegations, we found that the system's policy on documentation of wound care was not being followed.

Although we substantiated that the attending physician denied the family's request to transfer the patient to the Veterans Health Care System of the Ozarks, in Fayetteville, AR, we did not substantiate that the denial was inappropriate. Transferring the patient to the requested hospital would not have provided access to the services required by the patient's medical condition at the time.

We did not substantiate the allegation that staff failed to address the issue with the patient's foot and ankle. While no definitive diagnosis as to the condition of the foot and ankle was made, staff did address the clinical symptoms of the foot and ankle that the patient was experiencing.

We could not substantiate the allegation that nursing staff were making bets on how much medication they could give another patient to keep him quiet. The non-nursing and managerial nursing staff we interviewed stated that they had never heard of the nursing staff making bets on patients, or giving medications to keep patients quiet. They also stated that the Surgical Intensive Care Unit nursing staff behaved professionally. The patient advocate received no complaints concerning Surgical Intensive Care Unit nursing staff during the time-period identified by the complainant.

We had concerns about whether the patient should have been informed of the surgical risks associated with alcohol withdrawal and given an opportunity for alcohol detoxification prior to his hospitalization for vascular surgery in 2015. The electronic health record does not reflect that a risk assessment for alcohol withdrawal was made in the vascular clinic in the weeks after it became clear that surgery had become more urgent. During this time the patient was at high risk for alcohol withdrawal based on multiple clinical factors. According to the vascular surgeon, the patient's risk of losing his limb outweighed the benefit of delaying surgery for the amount of time required for alcohol detoxification. Whether or not the patient would have chosen to undergo a preoperative attempt at detoxification is not known, but the option was not presented to him for consideration.

We recommended that the System Director:

- Ensure a peer review is conducted of this case to determine whether the risk of alcohol withdrawal was adequately assessed prior to the patient's aortofemoral bypass graft surgery in 2015 and whether this patient's inpatient medical management, including the complications presented by the patient's prolonged alcohol withdrawal, was reasonable.
- Modify the system's restraint policy to include leadership notification of patients in medical restraints after a specified timeframe in restraints.
- Ensure wound care documentation is consistent with system policy, and monitor compliance.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 17–20 for the Directors' comments.) We consider Recommendations 2 and 3 closed. We will follow up on the planned actions for Recommendation 1 until they are completed.

JOHN D. DAIGH, JR., M.D.
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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations made by a complainant regarding the quality of care a patient received in the Surgical Intensive Care Unit (SICU) at the Central Arkansas Veterans Healthcare System (system), John L. McClellan Memorial Veterans Hospital (facility), Little Rock, AR.

Background

The system consists of two hospitals: the facility and the Eugene J. Towbin Healthcare Center located in North Little Rock, AR. The system provides a broad spectrum of inpatient and outpatient health care services; however, only the facility provides acute medical and surgical inpatient services. The system also includes eight community based outpatient clinics in Arkansas and provides care for more than 65,000 veterans annually.

The facility has 255 operating beds, including 46 surgical beds; 15 of the surgical beds are located in the SICU. Surgical specialties that use the SICU in addition to general surgery include, but are not limited to, vascular surgery, cardiothoracic surgery, otorhinolaryngology,[1] orthopedic surgery, neurosurgery, urology, and ophthalmology.

Delirium Tremens

For a person with a physical dependence on alcohol, the cessation of alcohol may cause withdrawal symptoms, which can include shakiness, headaches, and anxiety. Delirium tremens (DTs) is a severe form of alcohol withdrawal that can include body tremors, changes in mental function, agitation, delirium, restlessness, seizures, and death. Symptoms of withdrawal most often occur within 48 to 96 hours after the last drink. DTs are a medical emergency with a high mortality rate, making early recognition and treatment essential. Initial treatment of DTs includes sedation.

SICU Services

The medical director of the facility's SICU is an intensivist and is responsible for ensuring that the quality, safety, and appropriateness of patient care services are monitored, evaluated, and recommendations are made for improvement, both in care and necessary equipment and supplies.[2] SICU nurses are accountable for direct nursing care. Inpatient support services, such as psychiatry and Physical Medicine and Rehabilitation Services, are available on a consult basis.[3]

[1] Otorhinolaryngology is the medical specialty concerned with the ear, nose, and throat.
[2] CAVHS SICU/MICU/CCU P&P 1.1, *Administrative Guidelines*, January 2015.
[3] CAVHS Surgical Intensive Care Policy and Procedure 1.1, *Unit Level Scope of Care Surgical Intensive Care Policy/Procedure No. 1.3*, January 2013.

Medical Examination Requirements

Per the system's by-laws, providers are required to write progress notes at least once daily on all acutely ill patients.[4] In addition, the attending physician[5] must document supervision of patient care in the medical record.[6] The frequency of supervisory notes is dependent upon the severity of the patient's illness.[7] Per the system's resident supervision policy, attending physician involvement is expected at least daily and more frequently as needed for patients in the intensive care units because of their unstable medical condition.[8]

Restraint Usage

The system's restraint policy allows the use of physical restraint after less restrictive alternatives have been tried without success.[9] The policy requires an active order from the patient's provider for a restraint and a rationale for the use of the restraint. The policy also requires daily review of the use of the restraint by the provider and the removal of the restraints at the earliest possible time. When a patient is in restraints, nursing staff must perform hourly observations and conduct interventions at least every 2 hours (when the patient is awake). Interventions include skin assessment and care, release of the restrained limbs for at least 10 minutes, and range of motion exercises of extremities. Staff must document these observations and interventions.[10]

The policy also requires the Associate Director for Patient Care Services/Nurse Executive to report the number of patients in restraints each day to facility leadership. Daily reports must include the time-period during which a patient has been in restraints for behavioral issues.[11]

Pressure Ulcers/Wound Care

A pressure ulcer is an area of skin that breaks down when something keeps rubbing or pressing against the skin. The elderly, those with mobility or circulation issues, or those with poor nutrition are more likely to develop pressure ulcers.[12] The severity of a

[4] Bylaws and Rules of the Medical Staff of Veterans Health Administration, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, October 2013.
[5] An attending physician is a physician responsible for supervising, teaching, and training of interns, residents, fellows, and medical students. The attending physician is ultimately responsible for the care of patients.
[6] Bylaws and Rules of the Medical Staff of Veterans Health Administration, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, October 2013.
[7] Ibid.
[8] CAVHS Memorandum No. 11-50, *Monitoring of Resident Supervision*, December 10, 2014.
[9] CAVHS Memorandum No. 118-116, *Restraint Prevention Program*, September 29, 2011.
[10] Ibid.
[11] Ibid.
[12] Pressure Ulcer descriptions, https://vaww.portal.oig.va.gov/directorates/54/Hotlines/2015-04516-HI-0620/Work%20Papers/pressure%20ulcer_medlineplus.pdf. Accessed November 23, 2015.

pressure ulcer is graded based on four stages. The National Pressure Ulcer Advisory Panel describes the stages as:[13]

- Stage I: Intact skin with non-blanchable redness.
- Stage II: Partial thickness loss of the dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, macerations, or excoriation.
- Stage III: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is *not* exposed.
- Stage IV: Full thickness tissue loss with exposed bone, tendon, or muscle.

The facility has established a skin and wound management program. Part of this program requires nursing staff to complete a skin assessment within 24 hours of admission to the facility, daily in the SICU and acute care units, when the patient's condition significantly changes or the patient is transferred to a different unit, and at discharge.

The program policy defines how and when wounds are to be assessed. Assessments are required when the wound is first noted and with each dressing change. Documentation of assessments is required weekly. The policy requires the following be included in each wound assessment:[14]

1. Location
2. Wound type
3. Staging (pressure ulcers only)
4. Wound dimension in centimeters (length, width, and depth)
5. Exudate: serous, serous sanguineous, sanguineous, purulent
6. Tissue in wound bed: granulation, slough, eschar, epithelialization, purple/ecchymosis, clear fluid filled blister, dark or blood filled blister
7. Undermining, tunneling, sinus tract
8. Pain
9. Odor
10. Surrounding skin: intact, scattered tearing, bruised, macerated, induration, erythema

[13] http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/. Accessed November 23, 2015.
[14] CAVHS Nursing Service Policy/Procedure No. 42, *Skin and Wound Management Program,* March 2013.

Foot Drop

"Foot drop describes the inability to raise the front part of the foot due to weakness or paralysis of the muscles that lift the foot."[15] Foot drop is a symptom of an underlying problem and is either temporary or permanent, depending on the cause. One of the causes of foot drop is a lower extremity peripheral nerve injury. Compression causes many nerve injuries in the lower extremities; however, other causes are nerve ischemia (lack of oxygen), nerve transection, inflammation, toxins, and degeneration.

Foot drop is commonly caused by compression of "the common peroneal nerve...just below the knee as the nerve wraps around the lateral aspect of the fibula…[c]ompression at this site is frequently produced by external pressure on the nerve due to prolonged lying, such as during surgery or prolonged hospitalization."[16] Neuropathy after vascular surgery can also cause nerve ischemia from a lack of blood flow to the vessels supplying the nerve.[17,18]

Allegations

In 2015, the OIG Hotline Division received allegations concerning the quality of care a patient received in the SICU. Specifically, the complainant alleged:

- The patient was not examined daily; instead, the surgical team reviewed the patient's paperwork from outside the room.
- Nursing staff did not get the patient out of bed during meal times as ordered by the patient's physician but kept him sedated instead.
- The patient was placed in bilateral wrist restraints continuously for over 30 days without removal.
- The use of the wrist restraints caused the patient's skin to "rot to the bone."
- The patient's family requested the patient be transferred to another hospital, but the attending physician denied the request.
- Staff did not address the patient's new foot drop.
- Nursing staff were heard making bets on how much medication they could give another patient to keep him quiet.

[15] National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/foot_drop/foot_drop.htm,. Accessed November 23, 2015.
[16] Up to Date - Overview of lower extremity peripheral nerve syndromes. http://www.uptodate.com/contents/overview-of-lower-extremity-peripheral-nerve-syndromes?source=search_result&search=lower+extremity+peripheral+nerve+syndrome&selectedTitle=1%7E150. Accessed November 23, 2015.
[17] National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/foot_drop/foot_drop.htm. Accessed November 23, 2015.
[18] Up to Date - Overview of lower extremity peripheral nerve syndromes, http://www.uptodate.com/contents/overview-of-lower-extremity-peripheral-nerve-syndromes?source=search_result&search=lower+extremity+peripheral+nerve+syndrome&selectedTitle=1%7E150. Accessed November 23, 2015.

Scope and Methodology

We conducted our review from mid-2015 through early 2016. We conducted a site visit in 2015.

We interviewed the complainant, facility managers, physicians, nurses, and other employees knowledgeable about the patient's care. We reviewed relevant facility policies and procedures, external standards, the patient's electronic health record (EHR), and relevant medical literature.

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.

Case Summary

In 2015, the patient was a male in his sixties whose past medical history included alcohol dependence with prior documented DTs, peripheral vascular disease, and other chronic conditions. He was receiving his primary care at the Veterans Health Care System of the Ozarks (VHSO), Fayetteville, AR.

In 2011, the patient was experiencing severe low back and hip region pain, limiting his ability to walk. Computed tomography imaging revealed the patient had severe compression of lumbar nerve roots ("spinal stenosis").[19] Magnetic Resonance Imaging confirmed severe spinal stenosis. Citing a history of smoking two packs per day and drinking 6 to 12 beers per day for 40 years, neurosurgery staff recommended non-surgical management of the patient's spinal stenosis at that time. In 2013, the neurosurgery consultant documented that the patient did not appear to be a good surgical candidate. Due to continued pain symptoms and neurosurgery staff's concern as to a possible vascular component to the pain, the patient underwent vascular studies which revealed severe obstructive disease of multiple major blood vessels. A vascular surgery consult was placed to the facility, as that service was not available at VHSO.

The patient was seen at the facility in 2013. A computed tomography angiogram[20] of the abdomen showed extensive atherosclerotic[21] disease in the vessels of the lower abdomen, pelvis, and bilateral lower extremities. A vascular surgeon noted that the patient would require an extensive vascular procedure to correct the leg pain.[22] The patient had been having increasing leg pain for the last 4 years with claudication.[23] The vascular surgery team opined that due to the patient's co-morbidities and lack of rest pain or tissue loss the risks of surgery outweighed the benefits at that time. For approximately the next 2 years, the vascular surgery team monitored the patient in clinic every 3–6 months.

In early 2014, the patient noted new developments of right foot tenderness with an associated skin ulcer and fissures. He continued to be non-surgically managed until developing "rest pain" in early 2015. At that time, he was scheduled to undergo an extensive vascular procedure within 3 weeks. In his admitting history and physical note, the surgeon documented the patient's ongoing alcohol use (10–12 beers per day for

[19] Spinal stenosis is a narrowing of the open spaces within the spine, it may result in pressure on the spinal cord and/or the nerve roots that extend off the cord and travel to the extremities. Spinal stenosis in the lumbar spine may mimic the symptoms of vascular insufficiency such as leg pain with walking.
[20] A computed tomography angiogram is a computerized technique to visualize arteries and veins throughout the body.
[21] Atherosclerosis is a hardening and narrowing of an artery that decreases blood flow through the artery.
[22] An aortofemoral bypass graft is a surgical procedure redirecting blood flow around diseased blood vessels in the abdomen and groin to increase flow to the lower extremities.
[23] When a patient's extremities do not get enough blood supply, this often causes pain, otherwise known as claudication. When the pain occurs at rest (when oxygen demand to the legs is not increased by exertion), this heightens concern that the blockages are significant enough to compromise the health of tissues in the legs.

greater than 10 years). The anesthesiologist's admission note also cited the patient's chronic alcoholism and history of DTs.

On hospital day (HD)-1, the patient was given a dose of a long-acting benzodiazepine (sedative A).[24] The next day, the patient underwent surgery. No complications were reported during surgery, and the patient was extubated and taken to the post-anesthesia care unit and then to the SICU. On admission to the SICU, he was started on sedative A every 6 hours. A dietician conducted a nutrition assessment and determined the patient was severely compromised. The morning of HD-3, the patient began to have episodes of confusion that improved with his scheduled dose of sedative A.

On HD-3, an additional dose of sedative A was given due to agitation. Later that day, nurses noted the patient had become anxious, defiant, and confused. In early evening, a short acting benzodiazepine (sedative B)[25] was given intravenously, and a continuous infusion with sedative B was started to be titrated to maintain moderate sedation.[26] Over the next several hours, the patient's alcohol withdrawal worsened and his overall condition deteriorated. He required endotracheal intubation[27] and mechanical ventilation to adequately support respiratory function; a continuous intravenous infusion with pain medication for further sedation and pain control; and wrist restraints to prevent self-inflicted injury. According to physician notes and orders placed on HD-4, sedation would be tapered until the patient was easily arousable. The intravenous infusion with pain medication continued through HD-4 and the infusion with sedative B through HD-5. The patient developed hypertension, a fever, and a low blood oxygen level that required three invasive procedures. By HD-6, the patient was off continuous sedation and was placed on a different short-acting benzodiazepine (sedative C)[28] intravenously every hour as needed for agitation. Antibiotics were started for presumed pneumonia. On HD-7, the patient was arousable with stimulation.

On HD-8, the patient became agitated with minimal stimulation and did not follow commands. Hospital staff placed a temporary feeding tube through the patient's nose into his stomach to support nutritional needs. An area of redness was noted at the sacrum, and physicians requested that the wound care nurse evaluate the patient and recommend preventive measures for a sacral ulcer.

By HD-9, the patient was less agitated, following commands, and successfully weaned from the ventilator. The dietician and wound care nurse evaluated him. The dietician made initial, and subsequent, recommendations for tube feedings and followed the

[24] Long-acting benzodiazepines may be used to treat alcohol withdrawal and DT prophylaxis.
[25] Short-acting benzodiazepines (with rapid onset and intermediate half-life) are widely used in managing alcohol withdrawal symptoms.
[26] Moderate sedation is a drug-induced depression of consciousness during which patients can respond purposefully to verbal commands.
[27] Endotracheal intubation is the passage of a tube through the nose or mouth into the trachea (windpipe) to support and/or maintain an airway.
[28] Sedative C has been used in critically ill patients with DTs.

patient throughout his hospitalization. The wound care nurse recommended that nurses offload pressure from the patient's heels, follow shear precautions,[29] and use topical protective ointments. For the remainder of HD-9, the nurses documented the patient to be calm and cooperative during range of motion exercises. They also noted several skin tears of the upper extremities and dressed the areas protectively.

The patient remained mildly to moderately sedated until HD-10, at which time he became agitated. This agitation persisted for the next 6 weeks and was felt to be due to prolonged alcohol withdrawal (until HD-52).

The wound care nurse saw the patient again on HD-13. The patient was extubated, placed on sedative A every 8 hours and an antipsychotic medication (antipsychotic A)[30] intravenously and continued on sedative C given every hour. Nurses noted the patient had become hyperactive and was moving all over the bed despite being in wrist restraints. An alcohol withdrawal assessment reflected the patient to be anxious, thrashing, and disoriented.

On HD-14, the patient's heart rate and respiratory rate became elevated and oxygen saturation dropped; he remained agitated and writhing in bed but was following commands. He was re-intubated and vital signs improved. He was diagnosed with bronchopneumonia. An alcohol withdrawal assessment described the patient to be anxious, fidgety, restless, and disoriented. Due to ongoing alcohol withdrawal related agitation, the patient failed multiple extubation attempts, and a tracheostomy tube[31] was placed on HD-17.

Entries in the EHR for the next 2 weeks include references to tremors, anxiety, disorientation, and tactile and visual hallucinations that were attributed to ongoing alcohol withdrawal.

On HD-29, the patient was restless and attempted to get out of bed by himself; he sustained several bruises and skin tears to the upper extremities. On HD-30, a swallow evaluation revealed poor swallowing ability, and a speech therapist recommended the patient not take anything by mouth and that a percutaneous endoscopic gastrostomy (PEG) tube[32] be placed to accommodate nutritional maintenance.

On HD-33, a social worker (SW) met with the patient's spouse at the spouse's request. Per documentation, the patient's spouse stated she did not see any "forward progress" with her husband and was concerned that he was "drugged" and in restraints. She

[29] Shear precautions are an attempt to minimize the mechanical force created when the outer layers of the skin (epidermis and dermis) remain stationary while the deeper layer (fascia) follows skeletal movement.
[30] Antipsychotic medications are used to manage delirium, agitation, and the hallucinations associated with alcohol withdrawal.
[31] A tracheostomy is a surgically created opening through the front of the neck into the trachea (windpipe) to facilitate breathing.
[32] A percutaneous endoscopic gastrostomy tube involves passing a tube into a patient's stomach through the abdominal wall while using an endoscope to ensure correct positioning; the tube allows nutrition, fluids and/or medications to be put directly into the stomach.

requested physicians transfer her husband to VHSO to be closer to family. The SW documented being aware that the surgical team had talked to the patient's spouse about her concerns of the patient being in bed and in restraints. A plan for a family meeting was suggested to discuss care plans. Also on HD-33, a nurse performing routine care noted a skin tear on the patient's forearm. The patient's spouse, upset by the skin findings, requested the physician evaluate the wound. The physician examined the skin; the wound was cleaned; and a consult placed requesting the wound care nurse see the patient again.

On HD-34, physicians changed the patient restraint order from wrist restraints to a Posey® vest,[33] and placed consults to psychiatry and physical therapy. Psychiatry offered management recommendations to optimize care of the patient's alcohol withdrawal. The physical therapist who had done the original consult in the case noted the patient's left ankle was contracted into plantar flexion[34] and that the patient had poor balance with standing; he recommended a trial of therapy to see if improvement was possible. Although the patient initially declined starting physical therapy services on HD 37, efforts to improve conditioning and improve transfer activities were initiated the next day.

On HD-35, a resident physician documented that the attending physician had a discussion with the patient's spouse the prior day.

On HD-37, a repeat swallow study was done and again revealed poor swallowing capability. The patient was not a candidate for oral feedings and was recommended for PEG tube placement.

Over HDs 38 and 39, the patient developed infections for which he received a tailored antibiotic regimen.

By HD-41, the patient's spouse reported dramatic overall improvement in the patient's condition. On HD-43, the physician consulted Occupational Therapy for splints to prevent further foot drop (the physician's note had observed some foot drop bilaterally).

On HD-46, the physical therapist noted significant improvement in the patient's activity tolerance and ability to stand. An Occupational Therapist assessed the patient for upper extremity strengthening, dressing, cognitive tasking, and fine motor skills.

The wound care nurse again saw the patient on HD-48, did a comprehensive assessment of his skin integrity, and documented a new left heel ulcer.

A family meeting was held on HD-51. Participants included the patient's spouse, the attending physician, resident physician, SICU nurse manager, SW, and patient representative. Documentation reflects all participants agreeing that the treatment team

[33] A Posey® vest is a type of sleeveless medical restraint used to help prevent injuries sustained by falling or climbing out of bed or a chair.
[34] Plantar flexion is movement at the ankle joint that points the foot downwards and away from the leg.

would continue to monitor and provide medical treatment to the patient. They planned to reevaluate his condition at week's end for possible transfer from the SICU, with the understanding that the family's desire was to have the patient eventually return home with his spouse.

Following the family meeting, a swallowing assessment was performed again and demonstrated poor function. Therefore, the patient remained off oral feedings and received enteral nutrition via his PEG tube. A trial period of exercises directed at improving the patient's swallowing mechanics was recommended and discussed with the patient and his spouse; the spouse expressed understanding of the concept; the patient did not.

At this point, HD-52, multiple chart entries documented the patient's physical ability to be out of bed. However, per nursing notes, the patient was again exhibiting combative, aggressive behavior, and a one-to-one sitter was assigned.

By HD-58, the patient's overall condition was improving, with greater independent ambulation, completion of antibiotic courses, and less agitation. He was transferred out of the SICU to a surgical ward bed, and the Posey® vest restraint was removed. An improvement in the status of several skin ulcers was documented in the EHR on HD-60. In addition, a swallowing assessment showed some improvement in function. While the patient was to continue his PEG tube feedings for primary nutrition, he was felt to be safe for recreational eating[35] of a modified diet. The patient had no other significant issues after HD-64 except for a fall while in a physical therapy session, which caused a small skin tear.

On HD-68, physicians discharged the patient. During the patient's hospitalization, he received extensive ancillary services including repeated visits by the speech therapist (for assessment and care of swallowing issues), 21 sessions with the physical therapist, 10 sessions with the occupational therapist, 5 evaluations by the wound care team, and repeated assessments by the dietician.

Inspection Results

Issue 1: Medical Care

History of Alcohol Dependence

A vascular surgeon followed the patient as an outpatient at the facility for 2 years prior to scheduling what is described in the vascular surgery notes as an AFBG. During that time, repeated reference was made in the EHR to the patient's medical co-morbidities without specifically mentioning alcohol dependence. During our interview with the attending vascular surgery physician, despite the lack of specific documentation, he

[35] Recreational eating is when a person obtaining his or her nutritional support via a non-oral feeding, such as through a feeding tube due to swallowing difficulties, eats small quantities of food for enjoyment purposes.

acknowledged he had been aware of the patient's alcohol history during the years he was seeing the patient in clinic.

The EHR does not reflect a risk assessment of alcohol withdrawal made in the months that vascular surgery staff monitored the patient in clinic or in the 3 weeks after it became clear that the decision to proceed with surgery had been made. The patient was at high risk of alcohol withdrawal based on multiple clinical factors including age, quantity of daily alcohol consumed, a prior history of having experienced DTs, and the recent consumption of alcohol prior to admission for surgery. The attending physician stated he did not present the patient with the option of postponing surgery until completing alcohol detoxification to lessen the risk of DTs because he felt the patient could lose a limb if they postponed surgery.

Physician Examinations

We did not substantiate the allegation that the patient was not examined daily, and instead, the surgical team reviewed the patient's EHR from outside his room.

Through interviews of facility staff and review of the EHR, we identified the daily routine of the surgical team. One resident physician would examine the patient in the morning between 5:00–5:30 a.m. and develop the treatment plan. The resident physician then would discuss the patient with the team's chief resident, and the two resident physicians would reassess the patient together and adjust the patient's treatment plan if needed. Typically, around 6:45 a.m., the resident physicians would discuss the patient with the attending physician, giving him or her information about what happened overnight, the patient's assessment and status for the day. The attending physician did not necessarily examine the patient every day; however, the attending physician was physically present in the SICU several times a day. Additionally, every evening a surgical team discussion would take place addressing the status of the patient.

According to interviews with staff, the attending vascular surgeon saw this patient whenever medical problems occurred and every 2 to 3 days otherwise. Daily notes by the resident physician, which included a physical examination, were present in the EHR. These notes also included a statement that the patient's condition was discussed with the attending physician and that he concurred with the patient's treatment plan.

Delirium

The patient showed evidence of alcohol withdrawal symptoms soon after admission and developed DTs on HD-3. The patient remained in the SICU for 57 days with signs and symptoms of delirium present most of that time, which were attributed to the patient's underlying chronic alcoholism.

During interviews, surgeons agreed that the patient developed a severe case of DTs and persistent delirium. On HD-34, the surgeons consulted Psychiatry Service concerning the patient's agitation and confusion. A psychiatrist made recommendations for medication changes. In the EHR, we did not find that the surgeons consulted the SICU intensivist during the patient's ICU admission.

Issue 2: Bedrest and Sedation

We did not substantiate the allegation that nursing staff failed to get the patient out of bed during meal times and kept him sedated instead.

The day after surgery, the patient experienced significant alcohol withdrawal symptoms, which quickly progressed into DTs. He received continuous intravenous sedating medications for 3 days followed by intermittent sedating medications as needed. He became agitated despite medications and remained in a delirious state for several weeks. During periods of agitation, when the staff or the patient's spouse could not calm the patient, nurses administered anti-anxiety/sedative and/or antipsychotic medications as needed. The EHR documentation included the reasons for administration of sedating medications when they were given.

The physicians had written orders for the patient's activity level to be "bedrest" after he developed DTs. When he began to recover mental clarity, the physicians wrote new activity level orders and staff assisted him out of bed on HD-34.

The patient had significant swallowing debility (repeatedly assessed) throughout most of his hospitalization and required nutritional supplementation until he was cleared by speech therapy to eat recreationally on HD-60. The patient did not have scheduled meals, but according to the EHR, ate what he could tolerate.

Issue 3: Restraints

We did not substantiate the allegation that the patient was placed in bilateral wrist restraints continuously for over 30 days without removal.

The patient was placed in bilateral wrist restraints from the evening of HD-3 until HD-34; however, EHR documentation and interviews with the SICU staff indicated that the restraints were removed, as required, more than one time during each 12-hour nursing shift. The policy did not describe a particular way to release the restraint. According to SICU nursing staff interviewed, release of restraints could mean either release of the restraint strap from the bed or release of the restraint from the patient's wrists. The nursing staff we interviewed did a combination of these.

During interviews, we were informed of the facility's process of reporting daily restraint data to leadership. Facility policy requires leadership to be informed of the number of patients in medical restraints each day but does not require reporting the duration a patient is in medical restraints. The patient was in bilateral wrist restraints for over 30 days and then placed in a Posey® vest restraint for over 20 days. Facility leaders were not informed that the patient was restrained for over 50 days.

Issue 4: Wounds

We did not substantiate the allegation that the use of wrist restraints caused the patient's skin to "rot to the bone." However, we did find that nursing documentation of

skin care was not consistent with facility policy requiring weekly documentation of wound assessments.

Documentation showed, and staff interviews supported, that the patient's skin was examined on a regular basis while the patient was in restraints. The restraints were either removed or moved on the patient's forearm so the skin under the restraints could be examined.

The wound care nurse did not cite the development or occurrence of a stage IV pressure ulcer. To consider the possibility that bone was exposed, there would have been a very high likelihood of osteomyelitis (infection involving the bone) being present. However, the EHR does not indicate the presence of a stage IV pressure ulcer nor a diagnosis or suspicion of osteomyelitis.

Staff first noted the wound on the patient's left wrist on HD-33, and the wound care nurse described it on HD-34. The wound care nurse documented a description of the wound again on HD-46 and HD-60. On HD-60, the wound was almost healed. No further description of the wound is noted, and it is not mentioned in discharge notes.

At the time of admission, the patient had an ulcer on his left ankle. Descriptions of this ulcer and other wounds were made by the wound care nurse on HD-9, HD-13, HD-46, and HD-60 and by the surgical floor nurse on HD-66.

Staff did not meet the facility policy requirement for weekly documentation of wound assessments.

Issue 5: Transfer

We substantiated the allegation that the attending physician denied the family's request to transfer the patient to another hospital; however, this denial was based on the patient's medical needs and the patient's spouse ultimately agreed with the decision.

The patient lived closer to VHSO than to the facility. During an interview with the patient's family, they stated that requests for the patient to be transferred to VHSO for care began while the patient was still in the facility's SICU. The family felt it would be easier for them if the patient was closer to home and stated that facility staff were not doing anything for him, just leaving him to lie in bed. The family stated that resident physicians treating the patient initially thought a transfer might be possible; however, after discussions with the attending physician, the family was informed that the patient was too ill for transfer. VHSO did not provide vascular surgery services, and the attending vascular surgeon did not think VHSO was capable of meeting the patient's treatment requirements. In addition, one resident physician stated that he was being called to care for the patient at all hours of the day and night, and he did not think VHSO had that type of coverage available. VHSO did not employ surgical residents.

An SW arranged a family meeting with the attending physician. The surgeon explained the patient's condition and treatment plan to the family and stated that a transfer was not in the patient's best interest, as VHSO could not provide the level of care that the

facility was providing. The SW documented that the patient's spouse stated she was in agreement with the team at the conclusion of the meeting.

Issue 6: Foot and Ankle Issues

We did not substantiate the allegation that the staff did not address the issue with the patient's foot and ankle. While the allegation specifies new foot drop, we could not confirm this diagnosis.

The physical therapist who performed the patient's initial evaluation on HD-34 documented the finding of a contracted left ankle. The physician on HD-43 documented that the patient had "some foot drop noted bilaterally" and consulted occupational therapy for splints.

The physical therapist who treated the patient during his hospitalization did not describe a foot drop in his notes. During an interview with the therapist, he described the patient as having increased extensor tone[36] in his left lower extremity. This condition, different from foot drop but sometimes confused with it, caused increased muscle rigidity to the lower extremity and prevented the patient from walking with a straight leg and flat-foot. He felt that the patient's walking improved with the use of splints, as the patient was walking on his toes and forefoot without the splints. He stated that by the time the patient was discharged, he did not require the splints at all times to walk.

When we interviewed the patient just prior to our site visit, he stated his left ankle was still sore with full movement and that he walks on his toes but is able to place his foot fully on the ground with effort.

Based on available documentation and interviews, we determined facility staff reasonably addressed the patient's ankle and foot complaints.

Issue 7: Nursing Staff Professionalism

We could not substantiate the allegation that nursing staff were making bets on how much medication they could give another patient to keep him quiet. The non-nursing and managerial nursing staff we interviewed stated that they had never heard the SICU nursing staff making bets and that they behaved professionally. The patient advocate did not receive complaints concerning the professionalism of SICU nursing staff during the patient's stay in the SICU. We could not interview the nurse who was the SICU manager at the time of the patient's SICU stay, as he/she was no longer employed at the facility.

[36] Tone is the resting state of muscles. Increased extensor tone refers to greater stiffness in the extensor musculature which prevents normal relaxation and positioning.

Conclusions

We did not substantiate the allegations that the surgical team did not examine the patient daily nor that nurses did not get the patient out of bed as ordered by the patient's physician.

In addition, we did not substantiate the allegation that the patient was placed in bilateral wrist restraints continually for over 30 days without removal. Although the patient was in bilateral wrist restraints for over 30 days, nursing staff regularly and periodically removed the restraints as per facility policy.

Facility leaders were not aware the patient was in either bilateral wrist restraints or a Posey® vest for over 50 days. Per policy, facility leadership is notified of patients who are in restraints for behavioral issues for over 12 hours, but the policy does not have a requirement to notify facility leadership of patients who are in restraints for medical issues over a defined period. If facility leaders were aware of patients in restraints for extended periods for any reason, the patient's care could be reviewed and further perspective and intervention provided if appropriate.

We did not substantiate the allegation that wrist restraints caused the patient's skin to "rot to the bone." The patient did develop a wound in the area of the left wrist restraint, but EHR documentation did not support that the wound was "to the bone." In reviewing the patient's EHR, we found that the facility's policy on frequency of documentation of wound care was not followed.

We substantiated that the attending physician denied the patient's family request to transfer to another hospital; however, the decision was based on the complexity of the patient's medical condition. The patient was in the SICU at the time of the request, and the family asked for a transfer to a hospital that could not provide the same level of care as the facility. The family ultimately agreed.

We did not substantiate that staff failed to address the patient's new foot drop. While providers did not document a definitive diagnosis in the EHR related to the patient's left ankle condition, physical therapy staff evaluated the ankle and foot and managed the condition with splint supports.

We could not substantiate the complaint concerning the SICU nursing staff making bets about patients. SICU nursing staff denied the allegations, and no one corroborated the allegation in interviews that nursing staff had been making bets about patients. We found no complaints regarding the professionalism of SICU nursing staff during the time of the patient's hospitalization.

We had concerns about select clinical decisions made prior to hospitalization for elective vascular surgery in 2015. The EHR does not reflect a risk assessment for alcohol withdrawal during the months that the vascular surgeon monitored the patient in clinic or in the weeks after it became clear that the decision to proceed with surgery had become more urgent. The patient was at high risk of alcohol withdrawal based on

multiple clinical factors including age, quantity of daily alcohol consumed, and a prior history of having experienced DTs. Notably, the necessity for extended SICU care and the complicated course chronicled in this report occurred because of ongoing, severe, alcohol withdrawal. Whether or not the patient would have chosen to undergo a preoperative attempt at detoxification is not known, but the option was not presented for him to consider.

Recommendations

1. We recommended that the System Director ensure a peer review is conducted of this case to determine whether the risk of alcohol withdrawal was adequately assessed prior to the patient's aortofemoral bypass graft surgery in 2015 and whether this patient's inpatient medical management, including the complications presented by the patient's prolonged alcohol withdrawal, was reasonable.

2. We recommended that the System Director modify the system's restraint policy to include leadership notification of patients in medical restraints after a specified timeframe in restraints.

3. We recommended that the System Director ensure wound care documentation is consistent with system policy and monitor compliance.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 6, 2016

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

To: Director, Dallas Office of Healthcare Inspections (54DA)
Director, Management Review Service (VHA 10E1D MRS Action)

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the response submitted by the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, regarding the draft report: Healthcare Inspection – Quality of Care Concerns of a Surgical Patient.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN 16 Accreditation Specialist, at 601-206-7022.

Skye McDougall, PhD
Director, South Central VA Health Care Network (10N16)

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: December 2, 2016

From: Director, Central Arkansas Veterans Healthcare System (598/00)

Subj: Healthcare Inspection—Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas.

To: Director, South Central VA Health Care Network (10N16)

I have reviewed and concur with the action plans regarding Healthcare Inspection Report—Quality of Care Concerns of a Surgical Patient at the Central Arkansas Veterans Healthcare System.

Medical Center Director
Central Arkansas Veterans Healthcare System (598/00)

Appendix B

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure a peer review is conducted of this case to determine whether the risk of alcohol withdrawal was adequately assessed prior to the patient's aortofemoral bypass graft surgery in March 2015 and whether this patient's inpatient medical management, including the complications presented by the patient's prolonged alcohol withdrawal, was reasonable.

Concur

Target date for completion: April 1, 2017

Facility response: The case will be sent out for peer review.

Recommendation 2. We recommended that the System Director modify the system's restraint policy to include leadership notification of patients in medical restraints after a specified timeframe in restraints.

Concur

Target date for completion: January 31, 2017

Facility response: The facility MCM 118-16, Restraint Prevention Program will be updated to include our current practice of managing patients in restraints.

OIG Comment: we have reviewed the January 28, 2017 MCM 118-16, Restraint Prevention Program policy and consider this recommendation closed.

Recommendation 3. We recommended that the System Director ensure wound care documentation is consistent with system policy and monitor compliance.

Concur

Target date for completion: October 28, 2016

Facility response: Compliance with Pressure Ulcer wound care documentation is attached for the last three quarters of FY 16. The overall compliance rate increased from 41 percent in 2QFY15 to 100 percent in 4QFY16 with a minimum target of 80 percent compliance. This data was reported through VISN 16 to the Office of Nursing Service. These quarterly monitors continue to be conducted internally, and any deficiencies will be addressed. Based on 4th Quarter FY16 data revealing inconsistency in the documentation of date acquired (HAPU), the WOCN staff will utilize a CPRS

template for documentation. The audit tool was revised November 18, 2016 and changes include additional elements such as presence of exudate, pain, odor, wound dimensions etc.

OIG Comment: based on information received from the system, we consider this recommendation closed.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Gayle Karamanos, PA-C, Team Leader Cathleen King, CRRN, MHA Trina Rollins, PA-C Thomas Jamieson, MD Roneisha Charles, BS

Appendix D

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