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Office of Healthcare Inspections

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Healthcare Inspection

Pressure Ulcer Prevention and Management
VA New York Harbor Healthcare System
New York, New York

August 17, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations regarding pressure ulcer prevention and management at the Brooklyn and Manhattan campuses of the VA New York Harbor Healthcare System (system), New York, NY.[1] Specifically, the timeline of events and allegations were:

- In April 2014, the OIG Hotline Division received a letter from a complainant alleging that Patient A developed pressure ulcers following admission to one of the system's campuses. The complainant also alleged that clinical staff did not appropriately manage the patient's pressure ulcers. Initially, the OIG Hotline Division requested that the system conduct a review of the complainant's allegations and submit a response. We reviewed the response and determined it to be insufficient because documentation in the patient's electronic health record (EHR) appeared to contradict statements made in the response. We subsequently referred the matter to the Veterans Integrated Service Network (VISN) for a response and included specific questions for VISN leadership to address.
- In November 2015, the OIG Assistant Inspector General for Healthcare Inspections received a letter from another complainant alleging that Patient B developed pressure ulcers following admission to one of the system's campuses. The complainant also alleged that clinical staff did not appropriately manage the patient's pressure ulcers.
- In April 2016, after determining that the second response regarding Patient A was insufficient and reviewing the complaint regarding Patient B, we initiated this healthcare inspection.

Care of Patient A

We substantiated that Patient A developed pressure ulcers following admission to one of the system's campuses. He had risk factors for pressure ulcer development, including impaired bed mobility and prolonged exposure to moisture. We found that clinical staff failed to recognize that Patient A developed pressure ulcers on his sacrum, right calf, and heels that subsequently worsened, and did not implement timely and appropriate interventions. We also noted that clinical staff skin care documentation was incomplete and inconsistent.

Additionally, clinical staff had no effective tracking system to ensure patients received a pressure relieving mattress or overlay once ordered by the skin care specialist. The lack of a tracking system delayed Patient A's placement on a pressure relieving mattress by at least 6 days until after the pressure ulcer developed and staff placed a second order.

[1] Pressure ulcers (also known as decubiti or bedsores) are localized injuries of the skin and underlying tissues caused by unrelieved pressure.

Care of Patient B

We substantiated that Patient B developed pressure ulcers following admission to one of the system's campuses. Patient B had risk factors for pressure ulcer development, including impaired bed mobility and prolonged exposure to moisture. We noted that clinical staff skin care documentation was incomplete and inconsistent. However, we found that clinical staff timely identified and took steps to address Patient B's pressure ulcer, which healed prior to his initial discharge from Campus B. Unrelated to the care during Patient B's initial hospitalization, he developed a large, unstageable pressure ulcer and other significant complications during his subsequent 21-day stay at a community nursing home, which eventually resulted in readmission to the system.

Contemporary Issues with Skin Care Documentation

To further evaluate the system's quality of pressure ulcer documentation, we reviewed EHRs of acute care patients with pressure ulcers who were discharged from December 1, 2015 through May 31, 2016, and January 2017. We identified noncompliance with requirements for pressure ulcer prevention and management-related documentation. For example, we found that 2 of 22 patients (9.1 percent) with hospital-acquired pressure ulcers (HAPU) and 10 of 63 patients (15.9 percent) with community-acquired pressure ulcers (CAPU) did not have documented skin inspections and Braden scores[2] at the time of discharge. Since the time of our onsite visit in late June 2016, some issues with the quality of pressure ulcer documentation persisted. For example, for acute care patients with pressure ulcers who were discharged in January 2017, we found that 1 of 7 patients (14.3 percent) with HAPUs and 4 of 11 patients (36.4 percent) with CAPUs did not have documented skin inspections and Braden scores proximal[3] to the time of discharge. However, clinical staff did document skin inspections and Braden scores on the day of discharge[4] for all 7 patients with HAPUs and 11 patients with CAPUs. We note that patients' skin conditions could have deteriorated between the time of assessment and discharge, particularly among less mobile patients.

We recommended that the System Director:

- Consult with the Office of Chief Counsel regarding possible institutional disclosure to Patient A's family.
- Ensure that processes are developed to track whether and when orders for pressure-reducing mattresses or overlays are satisfied.

[2] The Braden Scale is a tool commonly used to predict a patient's risk for developing pressure ulcers. This scale assesses sensory perception, moisture, activity, mobility, nutrition, and friction and shear. Braden scores range from 6–23, with *lower* scores indicating *higher* risk for developing pressure ulcers. Patients with a total score of 18 or less are considered to be at risk for developing a pressure ulcer.
[3] We considered proximal to the discharge to be documentation of skin inspections and Braden scores that were done within a few hours of the patient's discharge.
[4] The phrase "on the day of discharge" indicates that documentation was not proximal to discharge but may have been done 18–24 hours before discharge.

- Ensure that staff have the capability to order and receive pressure-reducing mattresses and overlays during "off tour" hours, including nights, weekends, and holidays.
- Ensure that pressure ulcer-related documentation adheres to Veterans Health Administration policy.
- Consider the appropriateness of updating the nursing discharge documentation to prompt staff to complete skin assessments proximal to the time of discharge.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B and C, pages 19–23, for the full text of 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
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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations regarding pressure ulcer[5] prevention and management at the Brooklyn and Manhattan campuses of the VA New York Harbor Healthcare System (system), New York, NY.

Background

The system is comprised of two hospital campuses located in Manhattan (153 beds) and Brooklyn (88 beds), a community living center (CLC) located in Queens (179 beds), and two community based outpatient clinics. The system is affiliated with the New York University School of Medicine and other medical institutions and is part of Veterans Integrated Service Network (VISN) 2.[6]

Overview of Pressure Ulcers

Pressure ulcers (also known as decubiti or bedsores) are localized injuries of the skin and underlying tissues caused by unrelieved pressure. Causes of pressure ulcers include lying or sitting in one position for a long period of time. Factors that increase the risk of pressure ulcer development include friction and shearing forces, malnutrition, and prolonged exposure of the skin to urine, feces, or sweat.[7] Patients are at increased risk for redeveloping pressure ulcers in areas where pressure ulcers recently healed. Serious complications of pressure ulcers include tissue, bone, and blood infection, gangrene, and death.

Many pressure ulcers are avoidable.[8] For hospitalized patients, clinical staff can often prevent pressure ulcers by reducing pressure on the patients' skin. To accomplish this, clinical staff should shift and reposition patients frequently and/or place them on specialty pressure-reducing mattresses or overlays. Other preventive measures include avoiding friction and shear forces when repositioning patients, ensuring patients have adequate caloric and protein intake, and keeping patients' skin dry and free from exposure to urine, feces, and sweat.

[5] In 2016, The National Pressure Ulcer Advisory Panel began using the term "pressure injury" instead of "pressure ulcer." However, we use the term pressure ulcer throughout this report because that term is still very commonly used and we received the allegations discussed in this report before this terminology changed.
[6] The system was previously in VISN 3. However, in June 2015, former VA Secretary McDonald initiated an integration plan to decrease the number of VISNs from 21 to 18. The plan included a merger of VISNs 2 and 3, which was effective in October 2015.
[7] Friction is the force on skin as it is dragged across a surface. Shear force is the interaction of friction and gravity on the skin. VHA Handbook 1180.02, *Prevention of Pressure Ulcers,* July 1, 2011 (corrected copy). This VHA Handbook was scheduled for recertification on or before the last working date of July 2016 and has not yet been recertified.
[8] Black JM, Edsberg LE, Baharestani MM, et al. *Pressure ulcers: avoidable or unavoidable? Results of the national pressure ulcer advisory panel consensus conference.* Ostomy Wound Manage. 2011; 57 (2):24-37.

Assessing Pressure Ulcer Risk

The Braden Scale is a tool commonly used to predict a patient's risk for developing pressure ulcers. This scale assesses sensory perception, moisture, activity, mobility, nutrition, and friction and shear. Braden scores range from 6–23, with *lower* scores indicating *higher* risk for developing pressure ulcers. Patients with a total score of 18 or less are considered to be at risk for developing a pressure ulcer. Specifically,

- Patients with scores 15–18 are classified "at risk."
- Patients with scores 13–14 are classified "moderate risk."
- Patients with scores 10–12 are classified "high risk."
- Patients with scores 9 or below are classified "severe risk."

Requirements for Pressure Ulcer Prevention and Management

Under Veterans Health Administration (VHA) Handbook 1180.02, *Prevention of Pressure Ulcers*, clinical staff are expected to employ a standardized, evidence-based approach for the assessment and prevention of pressure ulcers in all clinical settings.[9] Under this policy, clinical staff in acute care settings are required to:

- Perform skin inspections and document the results of the inspections daily. The skin assessment documentation should include detailed information about pressure ulcers including the length, width, and depth of the wound, when present.
- Calculate and document Braden scores daily.
- Monitor patients daily for changes in condition.
- Revise the pressure ulcer prevention plan if risk level changes.
- Consider referral to a wound care specialist.

Pressure Ulcer Staging

The system adopted the National Pressure Ulcer Advisory Panel pressure ulcer staging, which reflects the degree of visible tissue damage. Pressure ulcers are staged as follows:[10]

> ***Stage 1: Non-blanchable erythema (persistent reddening) of intact skin.*** *Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin (i.e. blue or purple)…*
>
> ***Stage 2: Partial-thickness skin loss with exposed dermis.*** *Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also*

[9] VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
[10] The National Pressure Ulcer Advisory Panel serves as the authoritative voice for improved patient outcomes in pressure injury prevention and treatment through public policy, education and research. http://www.npuap.org Accessed April 10, 2017.

present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present…

Stage 3: Full-thickness skin loss. *Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar (dark scab or falling away of dead skin) may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed…*

Stage 4: Full-thickness skin and tissue loss. *Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled [wound] edges), undermining and/or tunneling often occur. Depth varies by anatomical location…*

Unstageable: Obscured full-thickness skin and tissue loss. *Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.*

Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration. *Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4).*

Prior OIG Reviews

From April 2013 through March 2014, OIG conducted a follow-up evaluation of pressure ulcer prevention and management at 47 VA medical facilities, and published a summary report.[11] We noted high compliance with VHA policy in many areas, but also identified opportunities for improvement. We made nine recommendations to the Under Secretary for Health (USH), in conjunction with VISN and facility leaders. The following four recommendations, relevant to this review, were to ensure that:

- Clinicians provide and document patient/caregiver pressure ulcer education.
- Clinicians provide and document skin inspections and risk assessment scales daily during hospitalization, including the day of discharge.
- Facilities establish processes to monitor consistency in pressure ulcer-related documentation and take appropriate actions to address inconsistencies.
- Clinicians document wound care follow-up plans for patients discharged with unhealed pressure ulcers and that the facility provides needed supplies.

[11] *Healthcare Inspection – Combined Assessment Program Summary Report, Evaluation of Pressure Ulcer Prevention and Management at Veterans Health Administration Facilities, (*Report No. 14-05132-90, February 3, 2015).

The then-USH concurred with our findings and recommendations, and submitted an acceptable action plan. The Office of Deputy USH and the Office of Nursing Services developed and implemented an action plan to standardize pressure ulcer prevention and management care at all VHA facilities. We reviewed VHA compliance data that supported completion of corrective actions, which included data that indicated that the system met VHA's benchmark of an 80 percent compliance rate. We subsequently closed all recommendations from the 2015 report effective August 3, 2016.

See Appendix A for relevant OIG reports published in the past 3 years.

Timeline of Events and Allegations

In April 2014, the OIG Hotline Division received a letter from a complainant alleging that Patient A developed pressure ulcers following admission to one of the system's campuses (Campus A). The complainant also alleged that clinical staff did not appropriately manage the patient's pressure ulcers. Initially, the OIG Hotline Division requested that the system conduct a review of the complainant's allegations and submit a response. We reviewed the response and determined it to be insufficient because documentation in the patient's electronic health record (EHR) appeared to contradict statements made in the response. We subsequently referred the matter to the VISN for a response and included specific questions for VISN leadership to address.

In November 2015, the OIG Assistant Inspector General for Healthcare Inspections received a letter from another complainant alleging that Patient B developed pressure ulcers following admission to one of the system's campuses (Campus B). The complainant also alleged that clinical staff did not appropriately manage the patient's pressure ulcers.

In April 2016, after determining that the second response regarding Patient A was insufficient and reviewing the complaint regarding Patient B, we initiated this healthcare inspection.

Scope and Methodology

We initiated our review on May 30, 2016 and completed our work in March 2017. We conducted a site visit from June 27–30, 2016.

We interviewed one of two complainants, system leadership, the quality management officer, and inpatient acute care staff, including physicians and nursing staff.[12] We reviewed VHA and local policies and guidance as well as pertinent incident reports. We assessed the pressure ulcer prevention and management for the patients identified by the complainants by reviewing their EHRs.

To further evaluate the system's quality of pressure ulcer documentation, we reviewed EHRs of acute care patients with pressure ulcers who were discharged from either of

[12] Our attempts to contact the second complainant were unsuccessful.

the system's campuses from December 1, 2015 through May 31, 2016. This included EHRs of 26 patients with hospital-acquired pressure ulcers (HAPU) and 68 patients with community-acquired pressure ulcers (CAPU). We did not review EHRs for patients who were at the end of life, on 23-hour observation status, or had wounds that were documented as pressure ulcers, but were actually skin tears, diabetic foot ulcers, or venous stasis ulcers. Our EHR review of pressure ulcer-related documentation focused on the following:

- Patient education. We reviewed clinical notes to determine whether clinicians documented that they provided pressure ulcer-related education and that the patient understood the information, as required. We excluded 4 patients with HAPUs and 16 patients with CAPUs from this part of our analysis because the patients had cognitive deficits and would not have benefited from pressure ulcer education.
- Progress note consistency. We assessed clinician documentation of pressure ulcer stage, location, Braden score, and date acquired for consistency between work shifts and employees responsible for this documentation. For patients with HAPUs, we reviewed documentation for the 3-day period beginning with the day the clinical staff identified the pressure ulcer. For patients with CAPUs, we reviewed documentation for the 3-day period beginning with the date of admission.
- Discharge documentation. We reviewed clinical notes proximal to patients' discharge from the facility to determine whether clinicians documented that they performed skin inspections and Braden scores, as required. We excluded four patients with HAPUs and five patients with CAPUs from this part of our analysis because the patients died of unrelated causes prior to discharge. For patients with pressure ulcers at the time of discharge, we assessed whether the documentation described wound care follow-up plans and whether the system provided the patient/caregiver needed supplies to continue pressure ulcer care.

To determine whether the quality of pressure ulcer documentation improved following our onsite visit, we reviewed EHRs of acute care patients with pressure ulcers who were discharged in January 2017. This included EHRs of 8 patients with HAPUs and 13 patients with CAPUs. We applied the same exclusion criteria for this group of patients as described above. Additional patients were excluded from aspects of our analysis as follows:

- Patient education. We excluded two patients with HAPUs and six patients with CAPUs from this part of our analysis because the patients had cognitive deficits and would not have benefited from pressure ulcer education.
- Discharge documentation. We excluded one patient with a HAPU and two patients with CAPUs from this part of our analysis because the patients' pressure ulcers healed or the patient died from unrelated causes prior to discharge.

VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, cited in this report was scheduled for recertification on or before the last working day of July 2016 and has not been updated: [13]

We considered this policy to be in effect as 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),[14] the 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."[15] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[16]

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.

[13] VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
[14] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[15] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[16] Ibid.

Patient Case Summaries

Patient A

At the time of the events leading to this review, Patient A was a male in his late 60s residing at the system's CLC. His medical history included diabetes with neuropathy, peripheral vascular disease, and right sided paralysis caused by a stroke. Patient A required a wheelchair for locomotion, maximum assistance for transfer, and moderate assistance for bed mobility.[17] He was incontinent of both bowel and bladder. His diet was 1,800 calorie controlled, no added salt, and lactose restricted.

Overview of Medical Events

In 2014 (Day 1), Patient A was transferred by ambulance from the CLC to one of the system's campuses (Campus A) for a scheduled admission for an endoscopy and biopsy of a suspicious nodule. He was lying on a stretcher for up to 2.5 hours from the time he left the CLC to when he was admitted to the medical floor.

The next day (Day 2), Patient A underwent a biopsy, which revealed the nodule was non-cancerous. However, his post procedure course was complicated, requiring monitoring in the intensive care unit (ICU) due to an altered level of consciousness (confusion). Patient A developed an infection that was treated with intravenous antibiotics, and bleeding that was treated with blood transfusions and another endoscopy. During his stay at Campus A, Patient A developed a large, unstageable sacral pressure ulcer and lower extremity pressure ulcers that required treatment.

Patient A was transferred back to the CLC on Day 16. Patient A died approximately 2 months later.

Pressure Ulcer Development and Treatment

About a week prior to Patient A's transfer to Campus A for his procedure, a CLC registered nurse (RN) documented in Patient A's EHR that he had no wounds or pressure ulcers and calculated a 17 Braden score (at risk). One day prior to the transfer to Campus A, another RN documented that the patient's skin was "intact and normal-appearing."[18]

Shortly after the patient was admitted to Campus A on Day 1, an RN documented the patient had reddened areas on his buttocks and both legs were discolored but indicated that the patient had no wounds, pressure ulcers, or other skin problems.

[17] Assistance for transfer and for bed mobility indicates that the patient needs help to get in and out of bed and help turning and repositioning in bed, respectively.
[18] EHR documentation indicated Patient A had a history of a partial-thickness wound to the right buttocks, which was reportedly healed prior to his transfer to Campus A for his initial endoscopy.

The next day (Day 2), a skin care specialist documented that the patient's sacrum and bilateral heels were intact. In contrast, on the same day, an RN documented a reddened area on Patient A's sacrum (tail bone).

On Day 9, a skin care specialist documented that the patient had developed deep tissue injuries to his sacrum, right calf, and heels. On Day 12, a skin care specialist documented the first measurement of Patient A's wound and described the sacral wound as non-stageable. On Day 16, the patient was discharged to the CLC for ongoing wound care.

On Day 23, 7 days after his discharge from Campus A, Patient A was admitted to the system's other campus (Campus B) for fever and treatment of his pressure ulcers. On Day 26, Patient A received intravenous antibiotics and underwent debridement (removal of damaged tissue) of one of his pressure ulcers. On Day 34, the patient returned to the CLC on palliative care and received hospice services.

Patient B

At the time of the events leading to this review, Patient B was an ambulatory male in his early 60s living independently in the community. His medical history included hypertension, a stroke with residual right-sided weakness, and vascular insufficiency.

Overview of Medical Events

In 2015 (Day 0), Patient B experienced weakness, lightheadedness, and fatigue. He was seen at the system's Emergency Department (ED) for severe hypertension, given intravenous blood pressure medications, and admitted to the telemetry unit for further evaluation. A computed tomography (CT) scan showed an acute hemorrhagic stroke[19] involving his thalamus.[20] The next day, Day 1, Patient B was transferred to the system's Campus B ICU.

Patient B received ICU care for 7 days. On Day 8, he was transferred to the telemetry unit. On Day 10, the patient was readmitted to the ICU for another 2 days after he experienced acute respiratory distress with hypoxemia (low blood oxygen levels). While in the ICU, Patient B required mechanical ventilation (breathing machine) and antibiotics for severe sepsis (blood infection) and aspiration pneumonia.

On Day 15, after his condition improved, Patient B was transferred to a medical floor. On Day 42, he was discharged to a community nursing facility.

[19] An acute hemorrhagic stroke is when bleeding occurs directly into the brain parenchyma (functional tissue).
[20] The thalamus is a large ovoid mass of gray matter situated in the posterior part of the forebrain that relays sensory impulses to the cerebral cortex.

Pressure Ulcer Development and Treatment

Clinical staff documented that Patient B had no wounds, pressure ulcers, or other skin problems at the time of admission to Campus A and transfer to Campus B's ICU and medical floor.

On Day 16, a skin care specialist documented a small Stage 2 pressure ulcer located in Patient B's sacrum/coccyx (tailbone) area and recommended wound care treatments. On Day 22 and Day 35, the skin care specialist documented the sacral wound had healed. On Day 42, the day Patient B was discharged to a community rehabilitation facility, the system's clinical staff and ambulance staff indicated that the patient's skin was intact.

Hospital Readmission

On Day 63, 21 days after discharge from Campus B, Patient B was admitted to a community hospital's ICU with altered mental status, diarrhea, fever, sepsis, and kidney failure. He had large wounds to his sacrum and scrotum.[21] He received intravenous antibiotics. On Day 70, his wounds were surgically debrided.

On Day 73, Patient B was transferred to the ICU at Campus B for further care as requested by the patient's family. A physician documented a large Stage 4 pressure ulcer located on Patient B's scrotum that connected posteriorly to a 10 cm sacral pressure ulcer. The patient continued to receive antibiotics. On Day 76 and 79, the patient underwent additional surgical debridement of his wounds. On Day 85 and 87, he underwent colon surgery and reconstructive surgery. A special vacuum dressing was used on one of his wounds to promote healing. Antibiotics were continued to treat a bone infection.

On Day 134 the patient was discharged to a community nursing home for continued wound care.

Inspection Results

Issue 1: Care of Patient A

We substantiated that Patient A developed pressure ulcers following admission to one of the system's campuses. He had risk factors for pressure ulcer development. We noted that clinical staff documentation of Braden scores, wound descriptions and measurements, and skin assessments was incomplete and inconsistent. Further, we found that clinical staff failed to recognize that Patient A developed pressure ulcers to his sacrum, right calf, and heels that subsequently worsened and did not implement timely and appropriate interventions.

[21] The documentation we reviewed from the community hospital did not reflect the stage of Patient B's pressure ulcer.

Risk Factors for Pressure Ulcer Development

We were unable to determine whether clinical staff at Campus A could have prevented Patient A's development of pressure ulcers. Patient A's risk factors for the development of pressure ulcers included:

- Impaired bed mobility. Patient A had an impaired ability to reposition himself while sitting or lying in bed. He had paralysis on one side of his body caused by a stroke. As a result, he needed assistance for bed mobility and transfers from bed to wheelchair.
- Inadequate nutrition prior to hospital admission. In the week prior to Patient A's admission to Campus A, CLC nursing assistants documented that the patient ate 75 percent or less of some meals. On Day 1, Patient A's serum protein and albumin levels were low suggesting that Patient A was malnourished.
- Impaired sensory perception. Particularly while Patient A was sedated and suffered from an altered level of consciousness, he had an impaired ability to sense discomfort that would prompt a patient to move or reposition himself.
- Prolonged exposure to moisture. Patient A was incontinent of both bowel and bladder, though the use of urinary catheters likely reduced exposure of the patient's skin to urine. For several days of his hospitalization, he had a fever, which could result in sweating.

Documentation

Clinical staff documentation of pressure ulcer risk and skin assessments was incomplete and inconsistent. This likely made it difficult for staff to recognize that Patient A had developed pressure ulcers and that those ulcers were worsening. For example, on Day 1, the Braden score should have been consistent throughout that day; however, staff documented Braden scores ranging from 18 (at risk) to 14 (moderate risk). In addition, some clinical staff noted that the patient had a Stage 1 pressure ulcer on Days 1, 2, and 3, though a skin care specialist note from Day 2 and nursing notes from days 5, 6, and 7 indicated that the patient had no wounds. Documentation was also incomplete because clinical staff who noted that the patient had pressure ulcers did not, in general, measure the size of the wound. In fact, clinical staff did not document the size of the patient's large, sacral pressure ulcer until Day 12.

Pressure Relief

Documentation in Patient A's EHRs indicated that clinical staff did not prevent and manage his pressure ulcers by failing to adequately relieve pressure over the patient's bony prominences.

On Day 2, a skin care specialist documented that Patient A was lying on a standard mattress and ordered a specialty mattress to reduce pressure. It appears that the patient was on a specialty mattress during his ICU admission on Days 2 and 3. However, the patient was returned to a standard mattress from Day 4 until Day 10 when

a skin care specialist re-ordered a specialty mattress. Staff at Campus A informed us that the system had no process for ensuring timely delivery of a specialty mattress. They also told us that only skin care specialists could order specialty mattresses. As a result, specialty mattresses generally were not ordered and/or delivered to patients during off tours, including evenings, weekends, and holidays.

Throughout Patient A's admission, nursing staff documented a plan to turn and reposition the patient every 2 hours. We were unable to determine whether the patient was turned regularly, as planned.

Wound Dressings

Clinical staff did not document initiating additional pressure ulcer prevention and management measures when Patient A developed a pressure ulcer. During Day 2, the skin care specialist evaluated the patient, documented that his skin was intact, and recommended a treatment plan comprising preventive measures. That treatment plan included the application of barrier ointments to protect the patient's skin against episodes of incontinence. Despite Patient A's increased risk for pressure ulcers and worsening skin integrity, clinical staff did not change their interventions until Day 10.

Nutritional Support

Patient A's nutritional intake was suboptimal during his hospital stay, but clinical staff did not timely initiate interventions. On the day of his Campus A admission, his ordered diet was for 1,800 calories, 2 grams of sodium. During the course of this admission, his diet consistency was downgraded from full on admission, to pureed, and then to honey-consistency due to swallowing difficulties. His nutritional intake was poor during multiple days, including when he fasted in advance of his first endoscopy. On Day 4, Patient A's serum albumin and protein levels (indicators of nutrition status) had dropped precipitously (see Table below) and staff did not document that they recognized this drop nor did they order a dietary consult until Day 12. The same day, a clinical dietitian responded to the consult and determined the patient was at severe nutritional risk. Only then did clinical staff order oral supplements three times a day to supplement his meals.

Table: Serum Albumin and Protein Levels

Day	Serum Protein (Normal Range 6.4–8.2 g/dL*)	Serum Albumin (Normal Range 3.8–5.1 g/dL)
Day 2	5.8 Low	3.5 Low
Day 3	6.1 Low	3.6 Low
Day 4	6.4	3.9
Day 5	4.8 Low	3.0 Low
Day 6	4.7 Low	2.9 Low
Day 13	4.6 Low	2.6 Low

Source: OIG EHR Reviews
*grams per deciliter

Issue 2: Care of Patient B

We substantiated that Patient B developed pressure ulcers following admission to one of the system's campuses. He had risk factors for pressure ulcer development. We noted that clinical staff documentation of Braden scores, wound description and measurement, and skin assessments was incomplete and inconsistent. However, we found that clinical staff timely identified and appropriately managed his pressure ulcer. Patient B's pressure ulcer healed prior to his initial discharge from Campus B. Unrelated to the care during Patient B's initial hospitalization, he developed a Stage 4 pressure ulcer and other significant complications during his subsequent 21-day stay at a community nursing home.

Risk Factors for Pressure Ulcer Development

We were unable to determine whether clinical staff at Campus B could have prevented Patient B's small pressure ulcer. Patient B's risk factors for the development of pressure ulcers included the following:

- Impaired mobility. Patient B had an impaired ability to reposition himself. During part of his hospital stay, when the patient was sedated and intubated, he was dependent on staff to turn and reposition him. After his condition improved, Patient B continued to need assistance with repositioning because of weakness.
- Impaired sensory perception. Patient B experienced a stroke (acute thalamic hemorrhage) that can cause a variety of neurological deficits, including an impaired ability to feel pain over bony prominences that would ordinarily prompt a patient to move or reposition him or herself.
- Prolonged exposure to moisture. Following his stroke, Patient B was incontinent of both bowel and bladder. For part of his hospitalization, Patient B had a urinary catheter in place that prevented skin exposure to urine. The catheter was later removed to help prevent catheter associated urinary tract infections. For several days of his hospitalization, Patient B had a fever, which could result in sweating.

Documentation

Clinical staff documentation of Braden scores and skin assessments was incomplete and inconsistent. For example, on Day 28, the patient's documented Braden score ranged from 17 (at risk) to 13 (moderate risk). In addition, during the time when Patient B had a Stage 2 pressure ulcer, some clinical staff noted that the patient had a pressure ulcer whereas others documented that the patient had no wounds. Also, clinical staff who documented that the patient had a pressure ulcer did not, in general, measure the size of the wound. Despite this, it appears that clinical staff timely identified the patient's pressure ulcer before it worsened.

Pressure Relief

Documentation in Patient B's EHR indicated that clinical staff took several steps to prevent and manage pressure ulcers by relieving pressure over the patient's bony prominences. These interventions included placing the patient on a pressure-reducing mattress and putting the patient's feet in boots to reduce pressure on his heels. Throughout Patient B's admission, nursing staff documented a plan to turn and reposition the patient every 2 hours. We were unable to determine whether the patient was turned regularly, as planned.

Wound Dressings

After clinical staff determined that Patient B had developed a small, sacral pressure ulcer, they initiated additional interventions. Those interventions included applying a cream and dressing to the ulceration.

Nutritional Support

Clinical staff initiated timely interventions to address Patient B's nutritional status. Those interventions included obtaining consultation from dietary staff and ordering dietary supplements and tube feedings.

Issue 3: Contemporary Issues with Skin Care Documentation

We identified noncompliance with requirements for pressure ulcer prevention and management-related documentation for patients discharged from December 1, 2015 through May 31, 2016. This noncompliance persisted in January 2017.

For patients discharged from December 1, 2015 through May 31, 2016, we found the following:

- Patient education. Clinicians did not document pressure ulcer education for 2 of 22 patients (9.1 percent) with HAPUs and 15 of 52 patients (28.9 percent) with CAPUs.[22]
- Progress note consistency. We identified inconsistencies in documentation[23] for 14 of 26 patients (53.8 percent) with HAPUs and for 32 of 68 patients (47.1 percent) with CAPUs.
- Discharge documentation. We found that 2 of 22 applicable patients (9.1 percent) with HAPUs and 10 of 63 applicable patients (15.9 percent) with CAPUs did not have documentation of both skin inspections and Braden scores at the time of discharge. The discharge template completed by nursing staff has a check box indicating Braden Scale completed on the day of discharge. For all 12 patients without documentation proximal to the time of discharge, the nursing discharge note stated 'yes' the Braden Scale had been 'completed the day of discharge.' However, nursing staff did not actually document a Braden score for those patients. Further, 2 of 12 patients (16.7 percent) only had skin inspections, documented without Braden scores recorded on the day of discharge.[24] For patients with HAPUs that were unhealed at the time of discharge, 2 of 3 applicable patients (66.7 percent) did not have documented wound care follow-up plans, such as a return for further assessment in an outpatient clinic or follow-up by a visiting nurse.[25] Further, the EHR of one patient without a follow-up plan (33.3 percent) did not contain documentation that the facility provided needed wound care supplies at discharge. For patients with CAPUs that were unhealed at the time of discharge, 9 of 59 applicable patients (15.3 percent) with CAPUs did not have documented wound care follow-up plans. Further, 13 of 24 applicable patients' EHRs (54.2 percent) did not contain documentation that the facility provided needed wound care supplies at discharge.

[22] We excluded 4 patients with HAPUs and 16 patients with CAPUs from this part of our analysis because the patients had cognitive deficits and would not have benefited from pressure ulcer education.
[23] Documentation inconsistencies included Braden score, skin assessment, and pressure ulcer location, stage, and/or date acquired or identified.
[24] Although the two skin inspections were completed the day of discharge, the Braden scores were not done.
[25] We excluded 14 patients from this part of our analysis because they were discharged to another facility.

For patients discharged in January 2017, we found the following:

- Patient education. Clinicians documented pressure ulcer education for all 6 patients (100 percent) with HAPUs and all 7 patients (100 percent) with CAPUs.[26]
- Progress note consistency. We identified inconsistencies in documentation[27] for 1 of 8 patients (12.5 percent) with HAPUs and for 5 of 13 patients (38.5 percent) with CAPUs.
- Discharge documentation. We found that 1 of 7 patients (14.3 percent) with HAPUs and 4 of 11 patients (36.4 percent) with CAPUs did not have documentation of both skin inspections and Braden scores proximal to the time of discharge.[28] However, clinical staff did document skin inspections and Braden scores on the day of discharge for all 7 patients (100 percent) with HAPUs and 11 patients (100 percent) with CAPUs. We noted that patients' skin conditions could have deteriorated between the time of assessment and discharge, particularly among less mobile patients.[29] The patient with a HAPU that was unhealed at the time of discharge had a documented wound care follow-up plan, such as a return for further assessment in an outpatient clinic or follow-up by a visiting nurse. Further, that patient's EHR contained documentation that the facility provided needed supplies at discharge. For patients with CAPUs that were unhealed at the time of discharge, both patients (100 percent) with CAPUs had documented wound care follow-up plans. Further, both patients' EHRs (100 percent) contained documentation that the facility provided needed supplies at discharge.

Conclusions

We substantiated that Patient A developed pressure ulcers following admission to one of the system's campuses; however, we could not determine if it could have been prevented. He had risk factors for pressure ulcer development, including impaired bed mobility and prolonged exposure to moisture. We noted that clinical staff documentation of Braden scores, wound descriptions and measurements, and skin assessments was incomplete and inconsistent. Additionally, clinical staff had no effective tracking system to ensure patients receive a pressure relieving mattress or overlay once ordered by the skin care specialist. The lack of a tracking system delayed Patient A's placement on a pressure relieving mattress for at least 6 days until after the pressure ulcer developed and staff placed a second order. Further, we found that

[26] We excluded two patients with HAPUs and six patients with CAPUs from this part of our analysis because the patients had cognitive deficits and would not have benefited from pressure ulcer education.
[27] Documentation inconsistencies included Braden score, skin assessment, and pressure ulcer location, stage, and/or date acquired or identified.
[28] We excluded one patient with a HAPU and two patients with CAPUs from this part of our analysis because the patients' pressure ulcers healed or the patient died prior to discharge.
[29] The phrase "on the day of discharge" indicates that documentation was not proximal to discharge but may have been done 18–24 hours before discharge.

clinical staff failed to recognize that Patient A developed pressure ulcers to his sacrum, right calf, and heels that subsequently worsened, and did not implement timely and appropriate interventions.

We substantiated that Patient B developed pressure ulcers following admission to one of the system's campuses; however, the pressure ulcer healed prior to the patient's discharge. Patient B had risk factors for pressure ulcer development, including impaired bed mobility and prolonged exposure to moisture. We noted that clinical staff documentation of Braden scores and skin assessments was incomplete and inconsistent. However, we noted that clinical staff timely identified and managed his pressure ulcer. Patient B's pressure ulcer healed prior to his initial discharge from Campus B. Unrelated to the care during Patient B's initial hospitalization, he developed a large, unstageable pressure ulcer and other significant complications during his subsequent 21-day stay at a community nursing home.

Skin Care Documentation

We identified noncompliance with requirements for pressure ulcer prevention and management-related documentation of acute care patients with pressure ulcers who were discharged from December 1, 2015 through May 31, 2016. For example, we found that 2 of 22 patients (9.1 percent) with HAPUs and 10 of 63 patients (15.9 percent) with CAPUs did not have documentation for both skin inspections and Braden scores at the time of discharge. Since the time of our onsite visit in late June 2016, some issues with the quality of pressure ulcer documentation persisted. For example, for acute care patients with pressure ulcers who were discharged in January 2017, we found that one of 7 patients (14.3 percent) with HAPUs and 4 of 11 patients (36.4 percent) with CAPUs did not have documented skin inspections and Braden scores proximal to the time of discharge. However, clinical staff documented skin inspections and Braden scores on the day of discharge for all 7 patients with HAPUs and 11 patients with CAPUs. We note that patients' skin conditions could have deteriorated between the time of assessment and discharge, particularly among less mobile patients.

Recommendations

1. We recommended that the VA New York Harbor Healthcare System Director consult with the Office of Chief Counsel regarding possible institutional disclosure to Patient A's family.

2. We recommended that the VA New York Harbor Healthcare System Director ensure that processes are developed to track whether and when orders for pressure-reducing mattresses or overlays are satisfied.

3. We recommended that the VA New York Harbor Healthcare System Director ensure that staff have the capability to order and receive pressure-reducing mattresses and overlays for patients during "off tour" hours, including nights, weekends, and holidays.

4. We recommended that the VA New York Harbor Healthcare System Director ensure that pressure ulcer-related documentation adheres to VHA policy.

5. We recommended that the VA New York Harbor Healthcare System Director consider the appropriateness of updating the nursing discharge documentation to prompt staff to complete skin assessments proximal to the time of discharge.

Appendix A

Prior OIG Reports

System Reports

Healthcare Inspection – Operating Room Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor Healthcare System, New York, New York

9/29/2016 | 14-04274-418

Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System

8/18/2016 | 15-04945-331

Review of Alleged Supervisory Influence To Expedite a Friend's Disability Claim at VA Regional Office New York, New York

1/7/2016 | 14-04302-12

Administrative Investigation: Inappropriate Use of Position and Misuse of Relocation Program and Incentives in VBA

9/28/2015 | 15-02997-526

Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York

8/14/2014 | 14-01293-243

Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA New York Harbor Healthcare System, New York, New York

8/1/2014 | 14-00934-221

Topic Related Reports

Healthcare Inspection – Patient Care Concerns at the Community Living Center, Hampton VA Medical Center, Hampton, Virginia

5/11/2017 | 15-02009-227

Healthcare Inspection – Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California

3/31/2017 | 15-04976-191

Combined Assessment Program Summary Report - Evaluation of Pressure Ulcer Prevention and Management at Veterans Health Administration Facilities

2/3/2015 | 14-05132-90

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Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: Date: July 14, 2017

From: Director, VA NY/NJ Veterans Healthcare Network (10N2)

Subj: Healthcare Inspection— Pressure Ulcer Prevention and Management, VA New York Harbor Health Care System, New York, New York

To: Director, Hotline Coordination, Office of Healthcare Inspections (54HL)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Attached please find the response to the draft pressure ulcer prevention and management report for VA New York Harbor Healthcare System (VANYHHS).

2. The VISN concurs with the action plan submitted by the facility.

(original signed by:)

Joan E. McInerney, MD
VISN Director

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: Date: July 14, 2017

From: Director, VA New York Harbor Health Care System (630/00)

Subj: Healthcare Inspection— Pressure Ulcer Prevention and Management, VA New York Harbor Healthcare System, New York, New York

To: Director, VA NY/NJ Veterans Healthcare Network (10N2)

1. This is to acknowledge receipt and review of the draft pressure ulcer prevention and management report for VANYHHS. Thank you for the opportunity to comment on the recommendations for improvement contained in this report.

2. If you have any questions, please contact Kim Arslanian, Performance Improvement Manager at 718-630-2865

Martina A. Parauda
Director

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 VA New York Harbor Healthcare System Director consult with the Office of Chief Counsel regarding possible institutional disclosure to Patient A's family.

Concur

Target date for completion: 7/31/2017

Facility response: VA New York Harbor Healthcare System (VANYHHS) consulted with the Office of Chief Counsel regarding possible institutional disclosure to Patient A's family. The opinion of the Office of Chief Counsel is pending. Once received, VANYHHS will take the appropriate action

Recommendation 2. We recommended that the VA New York Harbor Healthcare System Director ensure that processes are developed to track whether and when orders for pressure-reducing mattresses or overlays are satisfied.

Concur

Target date for completion: 10/1/2017

Facility response: The current process for ordering pressure-reducing mattresses or overlays is as follows: the Skin Care Nurse requests needed pressure-reducing mattresses or overlays by sending an email to a mail group that includes the Skin Care Team, key nursing staff, and Logistics. Logistics places the order with the vendor and replies to the mail group. The vendor has 24 hours to deliver the items. To ensure that orders are satisfied, we will add the following to this process:

- The Nursing Supervisor will email the mail group once the items are received.
- If the items are not received within 24 hours of when the order was placed, the following process will be followed:
    - During administrative hours, the Nursing Supervisor will send a message to the mail group to inform them that the item has not arrived. Logistics will follow up with the vendor to get an expected time for the delivery and convey that information to the mail group.

- During the off tours (weekends, holidays, evenings and nights), the Nursing Supervisor will contact the vendor directly to follow up to ensure delivery of requested items.

Recommendation 3. We recommended that the VA New York Harbor Healthcare System Director ensure that staff have the capability to order and receive pressure-reducing mattresses and overlays for patients during "off tour" hours, including nights, weekends, and holidays.

Concur

Target date for completion: 8/15/2017

Facility response: The process for ordering bed pressure-reducing mattresses and overlays during the off tours, including weekends, holidays, evenings and nights is as follows: The Nursing Supervisors are authorized to contact the vendor to request a mattress or overlay. The vendor will deliver the items as requested within 24 hours. Once added to the mail group, the Nursing Supervisor will send an email to the mail group to confirm delivery of the requested items. If the items are not delivered within 24 hours, the Nursing Supervisor will contact the vendor directly to follow up to ensure delivery of requested items.

Recommendation 4. We recommended that the VA New York Harbor Healthcare System Director ensure that pressure ulcer-related documentation adheres to VHA policy.

Concur

Target date for completion: 12/1/2017

Facility response: To ensure that pressure ulcer-related documentation adheres to VHA policy, the following actions are being taken:

- Opportunities for improvement in skin care documentation were identified through monthly monitoring and reporting to the Nursing Best Practice Committee and Nurse Executive Council (NEC). The VHA Handbook 1180.02 will be reviewed once more to ensure that all documentation requirements are being met.
- Skin care note templates are being reviewed and revised as per the documentation requirements in the VHA Handbook.
- Training of staff on pressure ulcer assessment, prevention, prediction, treatment and documentation:
    - Skin Care Training (face to face) will continue to be held at all 3 campuses.
    - One-on-one, and "just in time" training during rounds with staff and other members of the team will continue.

- Online training on Skin Care Assessment to capture staff working the off tours will continue.

Recommendation 5. We recommended that the VA New York Harbor Healthcare System Director consider the appropriateness of updating the nursing discharge documentation to prompt staff to complete skin assessments proximal to the time of discharge.

Concur

Target date for completion: 12/1/2017

Facility response: The NURS Discharge Note template is being revised to make the Braden Scale scoring section of the note a mandatory field to ensure that the skin assessment is completed at discharge, as required by VHA Handbook 1180.02. The documentation compliance will be monitored monthly and reported to Nursing Best Practice Committee and Nurse Exec Council (NEC).

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Donald Braman RN, BSN, Team Leader Alicia Castillo-Flores, MBA, MPH Stephanie Hensel, RN, JD Gayle Karamanos, MS, PA-C Melanie Krause, PhD, RN Carol Lukasewicz, RN, BSN Patrice Marcarelli, MD Tanya Smith-Jeffries, LCSW, MBA Jolynette Spearman, RN Larry Ross, Jr., MS Thomas Wong, DO Valerie Zaleski, RN Debra Zamora, RN, DNP

Appendix E

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