DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Complications Associated with Phototherapy at the Gulf Coast Veterans Health Care System

Biloxi, Mississippi

HEALTHCARE INSPECTION | REPORT #17-03399-140 | JUNE 11, 2019

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate practice and procedure concerns, and leadership response, related to care provided to a patient who was mistakenly treated with phototherapy for bed bugs and developed complications at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi (facility). Two days after receiving the phototherapy treatment, the patient was hospitalized for first and second degree burns.[1]

Phototherapy is ordered by a dermatologist after diagnosis of a skin condition that would be responsive to treatment. Phototherapy is not indicated for the treatment of patients with bed bugs. The OIG determined that a dermatology clinic registered nurse (RN) provided phototherapy to the patient for the treatment of bedbugs without a provider assessment and order, even though a dermatologist was available for assessment the day of treatment. Miscommunications from facility leaders and pest management policy subject matter experts led to confusion about whether phototherapy was appropriate for the treatment of patients with bed bugs. The miscommunication resulted in the dermatology clinic RN providing phototherapy despite the lack of a dermatologist's assessment and order. After several interactions with various leaders and managers, the dermatology clinic RN concluded that phototherapy was permissible as part of the facility pest management policy.

Further, the dermatology clinic RN did not follow facility nursing practice requirements by failing to ensure that an ordering provider obtained informed consent for phototherapy. The dermatology clinic RN documentation reflected general education of the patient on phototherapy treatment and potential side effects, and the dermatology clinic RN provided a handout related to the procedure after which the patient verbally agreed to phototherapy. However, the dermatology clinic RN's actions resulted in the patient consenting to phototherapy that was not indicated.

Patients may experience mild sunburn type reactions after phototherapy; serious injuries are unusual occurrences. The OIG determined that the dose of ultraviolet (UV) light administered during the phototherapy was likely the main contributor to the patient's injuries. The initial dose the patient received was higher than what is recommended by the American Academy of Dermatology for a patient with Type II skin starting phototherapy.[2] In addition, the OIG team

[1] Burns are categorized into three types. First degree burns involve the outer layer of skin; second degree burns involve the deeper layers of the skin. Third degree burns involve the tissue underlying the skin including bones, muscles, and tendons. https://www.hopkinsmedicine.org/healthlibrary/conditions/dermatology/burns_85,p01146. (The website was accessed on March 7, 2019.)

[2] Patients with Type II skin generally have fair skin, burn easily, and tan minimally. The dosage of UV light is prescribed according to an individual's skin type (sensitivity). Daavlin, "Phototherapy Guidebook to the Benefits of Adding Phototherapy to Your Practice." http://www.physiciansofficeresource.com/por-resources/pdf/clinical%20phototherapy%20guidebook.pdf. (The website was accessed on September 10, 2018.)

determined that other factors may have contributed to the complications, including the patient's seated position that resulted in the patient's skin being closer to the lights while receiving phototherapy, extreme obesity, and medication photosensitivity. Equipment malfunction was an unlikely factor in the patient's development of burns after the phototherapy.

The provision of phototherapy is a dermatology clinic-specific competency that requires training and annual competency validation. The OIG team found that phototherapy training for the dermatology clinic RN had not been completed and that the dermatology clinic RN's ongoing phototherapy competency assessments did not meet facility requirements. A nurse manager asserted that the dermatology clinic RN received initial phototherapy training in 2014 from university-affiliated dermatology residents but did not provide documentation to support this assertion.

The dermatology clinic RN's annual competencies did not meet facility requirements as the Specialty Clinic Nurse Manager who signed the competencies did not personally possess the knowledge or competency required to assess phototherapy skills. Additionally, the OIG determined that the Specialty Clinic Nurse Manager and dermatology clinic RN did not demonstrate the technical knowledge required to safely operate the unit as evidenced by the patient's phototherapy burns.

The OIG determined that facility staff actions following the identification of a bed bug indicated a lack of staff understanding of facility policy related to environmental actions to be taken following identification of bed bugs. Specifically, facility staff improperly attributed the need for multiple actions taken throughout the coordination of care of the patient to the Integrated Pest Management policy and completed some environmental actions not required by policy.[3] The policy provided guidance for environmental actions aimed at preventing, controlling, or eliminating pest infestations or re-infestations in the facility. Although an appendix to the facility's Integrated Pest Management policy included information that "there is no specific medical treatment for bed bugs,"[4] staff pursued the initiation of phototherapy for this patient.

The OIG concluded that clinical staff, including the dermatology clinic RN, questioned the need for phototherapy; however, their concerns were not fully addressed. Specifically, the Chief Nurse of Clinical Practice (CNCP) acknowledged to the OIG team that a primary care RN and the Specialty Clinic Nurse Manager stated that phototherapy was not typically administered for the treatment of bed bugs. The CNCP also acknowledged, that in retrospect, the dermatology clinic RN expressed reservations about performing phototherapy and may have felt pressured to

[3] Gulf Coast Veterans Health Care System Memorandum No. 137-07-15, *Integrated Pest Management*, July 24, 2015.

[4] Gulf Coast Veterans Health Care System Memorandum No. 137-07-15.

proceed because multiple facility leaders were consulted in the effort to coordinate the patient's phototherapy.[5]

The facility's policy on confidentiality of documents designated fact-finding reviews as ones that generated confidential documents. Per Veterans Health Administration policy, when a review is initiated to improve quality of care, but it is determined during the review that personnel action may need to be pursued, the quality of care review must be terminated, and a non-confidential review be initiated.[6] The OIG determined that the facility's response to the events, the initiation of a fact-finding review with a charge letter that included language that would be used to produce a confidential document as well as language that would suggest the review was for personnel action, was unclear in its intent. Additionally, if the review was meant to be confidential, it should have been terminated when it became clear that administrative actions would be pursued. The OIG concluded that the proposed disciplinary actions for all staff members involved in the events required further evaluation to ensure that discipline was proportionate to each staff member's involvement and actions taken as appropriate.

The OIG made two recommendations to the Veterans Integrated Service Director related to fact-finding reviews conducted at the Gulf Coast Veterans Health Care System.

The OIG made five recommendations to the Gulf Coast Veterans Health Care System Director related to the dermatology clinic nurse practice requirements, training, and competencies; a review of the Gulf Coast Veterans Health Care System's policy related to environmental actions following identification of bed bugs; necessary training related to the policy; and completion of Gulf Coast Veterans Health Care System's actions recommended by an internal review.

[5] The CNCP was consulted as the wound clinic RN, who initially found the bed bug, was under the CNCP's supervision and the Chief of Environmental Management Service requested the CNCP's assistance. The Chief of Environmental Management Service and other Environmental Management Service employees were consulted as they were in charge of the facility pest management program and managed the treatment of areas where bed bugs have been identified. The Acting Associate Director for Patient Care Services was consulted for permission to cancel appointments and to close the dermatology clinic.

[6] VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents*, November 7, 2008.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 26–31, for the Directors' comments.) The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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Contents

Abbreviations

CNCP	Chief Nurse of Clinical Practice
EHR	electronic health record
EMS	Environmental Management Service
OIG	Office of Inspector General
QM	quality management
RCA	root cause analysis
RN	registered nurse
UV	ultraviolet
UVB	ultraviolet B
U.S.C.	United States Code
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate practice and procedure concerns, and leadership response related to care provided to a patient who mistakenly received phototherapy for bed bugs and developed complications at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi (facility). Two days after receiving the phototherapy treatment, the patient was hospitalized for first and second degree burns.[7]

Background

Facility Profile

The facility is part of Veterans Integrated Service Network (VISN) 16 and provides tertiary care at the main hospital in Biloxi and community based outpatient clinics in Mobile, Alabama; and Pensacola, Eglin Air Force Base, and Panama City, Florida. The facility and associated community based outpatient clinics served 71,013 veterans in fiscal year 2018. The facility operated 245 beds, including 72 inpatient beds, 72 domiciliary beds, and 101 community living center beds in fiscal year 2018. The facility is affiliated with Keesler Air Force Base, Louisiana State University, Tulane University, and the University of South Alabama.

Phototherapy

Phototherapy is used by dermatologists to treat skin disorders. The skin is treated with a lamp that emits ultraviolet (UV) light. Phototherapy is performed under medical supervision and a phototherapy unit can be used to provide full-body phototherapy.[8] Patients typically stand during phototherapy.[9]

A phototherapy order is a communication from the treating provider who is requesting phototherapy for a patient that directs the treatment to be initiated. Facility dermatologists utilize the American Dermatology Association handbook as a guide to determine the initial phototherapy dosage and for increasing dosage during subsequent treatments. Initial dosage

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[7] Burns are categorized into three types. First degree burns involve the outer layer of skin; second degree burns involve the deeper layers of the skin. Third degree burns involve the tissue underlying the skin including bones, muscles, and tendons. https://www.hopkinsmedicine.org/healthlibrary/conditions/dermatology/burns_85,p01146. (The website was accessed March 7, 2019.)

[8] Daavlin, Phototherapy Solutions for Psoriasis and Vitiligo. https://www.daavlin.com/physicians/uv-phototherapy/new-to-phototherapy/. (This website was accessed on March 7, 2019.)

[9] Daavlin Phototherapy Cabinet Description. While not an issue in this case, the cabinet can be modified to accommodate a wheelchair. http://www.daavlin.com/physicians/products/neolux/. (The website was accessed on October 11, 2018.)

determination is based on a patient's diagnosis and skin type. Phototherapy orders include treatment body location, treatment frequency, initial dose, and instructions for increasing dosage during subsequent treatments.

Bed Bugs

Bed bugs are insects that feed on the blood of people and animals. Bed bug bites are not known to transmit diseases, though some people may experience mild swelling, allergic reactions, or secondary skin infections. Therapies are symptom targeted, such as antihistamines for itching caused by the bites. As bed bug infestation generally occurs on objects such as mattresses and box springs, treatment is aimed at the environment.[10] Bed bug control is generally attained through an Integrated Pest Management strategy, which includes pesticides and heat treatment.[11]

Adverse Events

Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries or other adverse occurrences directly associated with care or services provided to patients. Adverse events may result from acts of commission or omission (for example, administration of the wrong medication, failure to make a timely diagnosis, adverse reactions, or negative outcomes of treatment). Adverse events within the facility must be reported to the Patient Safety Manager so that action may be taken to mitigate future events.[12]

Confidentiality of Quality Management Activities

Veterans Health Administration (VHA) Directive 2008-077 outlines "quality management activities that may generate a confidential document under Title 38 United States Code (U.S.C.) Section 5705 and its implementing regulations."[13] In order to meet the requirements for a document to be confidential under these circumstances, the authorizing VHA official must

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[10] Centers for Disease Control and Prevention. Bed Bugs FAQs Page. https://www.cdc.gov/parasites/bedbugs/faqs.html. (The website was accessed on September 12, 2018.)

[11] Centers for Disease Control and Prevention. Centers for Disease Control (CDC) Stacks Page: Joint Statement on Bed Bug Control in the United States from the U.S. CDC and the U.S. Environmental Protection Agency (EPA). Facility staff utilized the terms phototherapy and heat therapy interchangeably. However, the terms are not associated and may have contributed to the confusion that resulted in the patient being treated with phototherapy. Heat is used to treat the medical facility environment including areas and objects where bed bugs have been identified, while phototherapy is used to treat a medical condition. https://stacks.cdc.gov/view/cdc/21750. (The website was accessed on September 12, 2018.)

[12] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This VHA Handbook was scheduled for recertification on or before March 2016 and has not been updated.

[13] VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents*, November 7, 2008. This VHA Directive expired November 30, 2013, and has not been updated.

previously designate in writing that the activity is being conducted to "improve the quality of health care or the utilization of health care resources."[14] The contents of confidential documents may not be disclosed to unauthorized individuals. Confidential documents generated pursuant to such reviews may not be the basis of a personnel action:

> If it appears during a facility Focused Review that disciplinary action may be indicated, the medical center Director must determine if the Focused Review needs to be terminated and a Board of Investigation, whose findings can be the basis of disciplinary actions, initiated.[15]

Fact-Finding Reviews

Fact-finding reviews are generally used to collect information surrounding an event and can be used to determine whether a more formal administrative investigation board or other review is indicated. While information gathered during fact-finding reviews is generally not considered confidential, VHA policy allows facility directors to describe quality management (QM) activities that can generate confidential documents in policy directives or QM plans.[16] At the facility, the relevant policy listed fact-finding reviews as a monitoring and evaluation review that would generate confidential documents.[17]

Administrative investigation boards are appointed by facility directors to evaluate the event and to document findings used to support disciplinary actions based on collected evidence and interviews.[18] Facility directors are responsible for ensuring administrative investigation boards are objective and effective.[19]

OIG Concerns

While completing document reviews for an OIG inspection conducted at the facility in 2017,[20] an OIG team identified a patient who developed burns after phototherapy treatment, which was provided without an order, and resulted in additional medical intervention. The OIG initiated this

[14] VHA Directive 2008-077.

[15] VHA Directive 2008-077.

[16] VHA Directive 2008-077.

[17] VHA Directive 2008-077; 38 U.S.C. Section 5705 – Confidentiality of Medical Quality Assurance Records; System Memorandum 00Q-09-15, *Confidentiality of Quality Management (QM) Documents,* March 31, 2015.

[18] VA Handbook 0700, *Administrative Investigations, July 31, 2002*; VA Directive 0700, *Administrative Investigations*, March 25, 2002; Administrative Investigations: *Do it Right the First Time,* Resource Guidebook, Department of Veterans Affairs Employee Education System, July 2004.

[19] VA Handbook 0700.

[20] VA Office of Inspector General, *Inadequate Intensivist Coverage and Surgery Service Concerns,* VA Gulf Coast Healthcare System, Biloxi, Mississippi, Report 17-03399-150, March 29, 2018.

inspection to evaluate practice and procedure concerns surrounding the phototherapy and the facility's response to the event.

Scope and Methodology

The healthcare inspection was initiated on June 7, 2018, and a site visit was conducted on August 7-9, 2018. The OIG reviewed pertinent clinical, administrative, and regulatory documents. The documents included relevant patient electronic health records (EHRs), VHA and facility policies and procedures, patient safety documents, medical journal articles, human resources documents, staff training records, and the phototherapy unit manufacturer's technical manual/instructions.

The OIG interviewed the Facility Director, the Associate Director of Patient Care Services, and other managers and staff who were knowledgeable about the events at issue.[21] The OIG attempted to schedule an interview with the subject patient; however, the patient's representative declined the interview at the time of the contact.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[21] Other managers and staff included the then-Specialty Clinic Assistant Nurse Manager, then-CNCP, Chief of Quality and Performance Management, Chief of Environmental Management Service and other Environmental Management Service employees, Specialty Clinic Nurse Manager, Risk Manager, Patient Safety Manager, Infection Control Coordinator, facility's dermatologist, university-affiliated dermatology resident supervisor, nurses from the dermatology, wound care, and primary care clinics, a facility primary care physician, and a police officer.

Event Summary[22]

The EHR shows that the patient was in their 60s with a history of mental health issues, extreme obesity, chronic back and neck pain, and chronic venous insufficiency.[23] The patient presented to the facility's wound clinic in mid-2017, for treatment of lower extremity wounds resulting from venous insufficiency. The OIG learned from interviews that after the patient completed treatment and left the wound clinic, the wound care registered nurse (RN) observed an insect on the floor. The wound care RN contacted a supervisor, the CNCP, who reviewed the facility's Integrated Pest Management policy and instructed the wound care RN to contact Environmental Management Service (EMS).[24] The wound care RN retrieved the insect and called EMS.

After an EMS employee identified the insect as a bed bug, the pest management service utilized by the facility was contacted. The treatment room at issue was closed. The wound care RN went home to shower and change clothes after notifying a supervisor.[25] The CNCP messaged the Specialty Clinic Assistant Nurse Manager of the need to locate a room for the wound care RN to use for other scheduled patients after the RN returned to the clinic.

EMS staff attempted to locate the patient and determined the patient had left the facility but planned to return later that day to pick up a prescription. The Chief of EMS contacted facility police for assistance in locating the patient.

The Chief of EMS also contacted the CNCP; the two discussed a need for "light therapy" in the dermatology clinic for the patient at issue based on their understanding that there was a facility

[22] Unless otherwise indicated, information in the event summary was provided to the OIG during interviews with staff. The OIG uses the singular form of they (their) to protect the patient's privacy.

[23] *Obesity* means having a higher body weight than is considered healthy for a given height. Normal body mass index is 18.5 to 25. Obesity defined as having a body mass index of 30 or higher. Extreme obesity is having a body mass index of 40 or higher. https://www.cdc.gov/obesity/adult/defining.html. (The website was accessed on September 13, 2018.) *Chronic venous insufficiency* occurs when valves in leg veins do not work properly, causing blood to pool in the leg veins. The condition can lead to pain, swelling, and skin ulcerations.

[24] Gulf Coast Veterans Health Care System Memorandum No. 137-07-15, *Integrated Pest Management*, July 24, 2015.

[25] Gulf Coast Veterans Health Care System Memorandum No. 137-07-15 directs patients to shower and change clothes. It does not direct employees to do so. The CNCP messaged the Infection Control Coordinator who was unavailable. The Infection Control Coordinator replied that the wound care RN should change clothes and rooms. Additional actions taken, which were also not part of facility policy, included permitting the wound care RN to go home to shower, taking a police officer's gun and shoes, searching the patient's vehicle for bed bugs, and detaining the patient with a police escort.

standard operating procedure outlining the treatment of bed bugs.[26] To help facilitate the treatment, the CNCP located the Specialty Clinic Assistant Nurse Manager who was speaking with the dermatology clinic RN. The dermatology clinic RN was aware of the patient because EMS staff had communicated with the dermatology clinic RN about the search for the patient. The EMS staff member pointed to the phototherapy unit and told the dermatology clinic RN that the patient required treatment for bed bugs.[27] The dermatology clinic RN declined to provide the treatment. The CNCP informed the dermatology clinic RN that the patient needed to be treated per facility policy.[28] The CNCP asked if other patients with bed bugs had undergone treatment with phototherapy and the dermatology clinic RN replied that one patient with bed bugs had previously received phototherapy.[29]

The dermatology clinic RN expressed concern about the need to close the phototherapy room to allow environmental treatment for bed bugs after the patient's phototherapy, which would result in the cancellation of other patients' appointments.[30] After determining that the phototherapy unit was not portable and could not be moved to a different treatment room, the CNCP contacted the then-acting Director of Patient Care Services who granted permission to cancel other patients scheduled for phototherapy for the remainder of the day and the following day.[31]

The Specialty Clinic Assistant Nurse Manager inquired whether the patient could come back the following day for a dermatologist assessment rather than provide immediate treatment that day.[32] The CNCP stated that it would be negligent to let the patient leave without taking action because

[26] In this instance, light therapy referred to phototherapy, a clinical treatment that uses UV light to treat various skin conditions. The facility did not have a specific standard operating procedure related to the clinical treatment of patients with bedbugs. The facility's policy, Gulf Coast Veterans Health Care System Memorandum No. 137-07-15 related to pest management discussed heat therapy, not phototherapy. Phototherapy is not a recommended treatment for bedbugs. Based on interview information, the OIG could not determine what specifically transpired during this conversation. The Chief of EMS denied informing the CNCP that the patient required light therapy. Heat treatment of infested article*s*, such as clothing and bedding, is used as part of an integrated pest management strategy, which may have led to confusion for the Chief of EMS, the CNCP, or both.

[27] The EMS employee denied informing the dermatology clinic RN that the patient required phototherapy for bed bugs.

[28] The CNCP did not serve in a supervisory role over the dermatology clinic RN. As noted above, the facility did not have a standard operating procedure, policy, or other guidance that discussed phototherapy for bed bug treatment.

[29] A patient with known bed bug exposure had been treated previously in the phototherapy unit; however, the phototherapy provided for that patient was for a skin condition, not the bedbugs.

[30] Bed bugs may be exterminated by increasing ambient temperature. The facility did not have the equipment to accomplish this task. Rather, when notified of the presence of bed bugs, the facility's pest management contractor would provide services necessary to increase the temperature to the degree needed for extermination.

[31] The CNCP did not have cell phone service in the phototherapy room and left the room to call the then-acting Director of Patient Care Services; the dermatology clinic RN and Specialty Clinic Assistant Nurse Manager did not hear the cell phone conversation.

[32] A dermatologist was working in clinic on the day the patient was treated with phototherapy but was not consulted regarding the patient at issue.

the VA was paying for a portion of the patient's rent and the patient lived with other veterans. Based on the direction from the CNCP and presumed concurrence from the then-Acting Associate Director for Patient Care Services, the dermatology clinic RN decided to proceed with phototherapy. The dermatology clinic RN asked the CNCP what the treatment dose should be and the CNCP advised the dermatology clinic RN to use the same dose given to the previous patient with bed bugs who received phototherapy.[33]

The EMS staff member, the Assistant Chief of EMS, and a police officer received notification that the patient had returned to pick up a prescription. The patient reported using the valet service to park the car. The car was inspected and found to have bed bugs. The valet who parked the car was notified of the exposure, showered, and changed clothes.

The police officer escorted the patient to the assigned primary care clinic where the patient was placed in a treatment room. Per the primary care RN, the police officer indicated that the patient required "heat therapy." The primary care RN contacted the specialty clinic staff and was directed to the dermatology clinic.

The primary care RN and police officer went to the dermatology clinic and encountered the CNCP and the dermatology clinic RN. The CNCP informed the primary care RN and the police officer that the patient had bed bugs and needed phototherapy. The CNCP stated that they were following the facility's pest management policy, with the *exception* of phototherapy. The CNCP also informed the primary care RN and the police officer that they were contaminated and needed to be quarantined.[34]

The primary care RN and the police officer returned to the primary care clinic as the dermatology clinic RN was not ready for the patient. The primary care RN informed the patient about the need for phototherapy for bed bugs. The primary care RN noted a missed call from an emergency department provider. The primary care RN returned the call and discussed the plan for phototherapy for the patient at issue with the emergency department provider. The emergency department provider stated that phototherapy was not a treatment for bed bugs.[35] The primary care RN reported the emergency department provider's comments to the CNCP. According to the dermatology clinic RN and the Specialty Clinic Assistant Nurse Manager, the CNCP instructed the primary care RN that the plan was to proceed with phototherapy based on a facility policy.

[33] The CNCP subsequently made contradictory statements to interviewers: (1) The dermatology clinic RN told the CNCP that a provider order was not needed, and (2) the CNCP assumed that the dermatology clinic RN would obtain the necessary provider order for treatment.

[34] The police officer changed into scrubs and was instructed to throw away the shoes that had been worn when in contact with the patient. The officer's gun was confiscated because of the exposure to bed bugs.

[35] The purpose of the call from the emergency department provider to the primary care nurse is not known. When interviewed, the emergency department provider did not recall the conversation.

The CNCP contacted the Specialty Clinic Nurse Manager who had previously been unavailable to provide an update on the planned patient's treatment in the dermatology clinic. The Specialty Clinic Nurse Manager told the CNCP that the clinic did not use phototherapy for bed bugs. The CNCP informed the Specialty Clinic Nurse Manager that the dermatology clinic RN was familiar with the use of the "heat therapy" for treating bed bugs. The Specialty Clinic Nurse Manager subsequently recalled a patient with bed bugs that had been treated in the phototherapy unit.

The patient was taken to the dermatology clinic. The dermatology clinic RN explained the procedure and the potential side effects, and gave the patient a handout with additional information. The patient asked the dermatology clinic RN to "slow down" because the patient was having difficulty understanding the explanation. The dermatology clinic RN re-reviewed the instructions and handout. The patient asked if the treatment was going to hurt and how long it would take. The dermatology clinic RN explained that the treatment would be stopped if the patient felt burning or could not tolerate it.

According to the patient's EHR, the dermatology clinic RN placed the patient in the phototherapy unit and set the dose of narrow band ultraviolet B (UVB) treatment to 500 mJ/cm^2. According to an interviewee, the patient's body was close to the bulbs in the phototherapy unit due to obesity. The patient wore goggles and underwear; dressings that had been applied earlier by the wound care clinic RN covered the lower legs. Two to three minutes into the five-minute treatment, the patient complained of thirst and "weak knees." The dermatology clinic RN gave the patient water and placed a stool inside the phototherapy unit so the patient could sit. The patient was seated and given a few minutes to rest. According to documentation in the EHR, the patient expressed a desire to continue "so I can get rid of the bugs." The patient experienced some "mild redness" immediately after phototherapy. The dermatology clinic RN advised the patient to avoid direct exposure to the sun or to wear sunscreen with a protection factor of 35 or higher for 48 hours. The patient left the dermatology clinic.

When interviewed, the Infection Control Coordinator told the OIG about attempting to see the patient while in the dermatology clinic but being told that the patient was receiving treatment and unavailable. The Infection Control Coordinator alerted a specialty clinic social worker about the patient's bed bug infestation because the patient was living in a VA "residential care/foster home." According to the patient's EHR, the specialty clinic social worker spoke with the patient by phone while in the dermatology clinic and was given permission to contact the home owner. An interviewee stated that the home owner informed the specialty clinic social worker that the home was not a VA residential care home. The owner stated that the home had a contract with a pest control service and the service would be contacted for an inspection. The specialty clinic social worker subsequently advised the wound care RN to make a report to Adult Protective Services as the patient received aid and attendance and could be considered a "vulnerable" patient.

Two days after the phototherapy, the patient called the primary care RN to request a monthly refill on a medication and complained of a "lot of pain" since the treatment. The primary care RN forwarded the information to the dermatology clinic RN who called and advised the patient to go to the facility emergency department. According to the EHR, an emergency department provider examined the patient later that day and determined there were first degree burns on 62 percent and second degree burns on 18 percent of the patient's body. The patient was hydrated, treated with pain medications, and transferred to a burn unit at a non-VA community hospital.

The non-VA community hospital providers diagnosed burns covering 69 percent of the patient's total body surface area, including second degree burns to the face, bilateral arms and legs, and trunk. The patient underwent operative wound debridement with pig xenograft application to both legs.[36] The patient's hospital course was complicated by delirium, requiring medication adjustment by a psychiatrist. Ten days after the phototherapy treatment, the patient was transferred back to the facility.

Upon arrival at the facility, the patient was "moaning loudly" and requesting pain medication.[37] During dressing changes, the patient complained of severe pain and was treated with intravenous medications. Fifteen days after the phototherapy treatment, the patient underwent surgical debridement of anterior torso burn wounds. The next day, the patient was transferred to the facility's community living center to complete recovery. The patient was discharged home 38 days after phototherapy. An institutional disclosure was completed prior to discharge.

[36] Pig xenografts are sterilized pig skin grafts used to cover skin defects caused by burns.

[37] The right lower leg dressing was used to treat a chronic venous stasis ulcer. It was not applied as part of the patient's burn treatment.

Inspection Results

1. Practice and Procedure Concerns

Phototherapy Ordering and Nursing Practice

The OIG determined that the dermatology clinic RN provided phototherapy to the patient without a provider assessment and order, even though a dermatologist was available for assessment the day of treatment. Further, the OIG determined the dermatology clinic RN did not follow facility nursing practice requirements.[38]

Phototherapy, the use of UV light to treat various skin conditions, is not indicated for the treatment of bed bugs. In general, phototherapy is ordered by a dermatologist who diagnoses a patient with a skin condition that would be responsive to treatment with phototherapy. [39] The dermatologist assesses the patient and determines the initial dose of phototherapy to be administered as well as the areas of the body that are to be treated. Although a dermatologist was present in the clinic on the day of this patient's phototherapy, facility staff did not seek a consultation from the dermatologist.

The OIG determined that miscommunications from facility leaders and pest management policy subject matter experts led the dermatology clinic RN to provide phototherapy despite the lack of a dermatologist's assessment and order.[40] Facility policy requires RN verification of all patient care orders, including phototherapy orders.[41] In summer 2014, the facility adopted the use of Mosby's Procedure and Competency manual as the official standard of practice for nursing staff.[42] After several interactions with various leaders and managers, the dermatology clinic RN concluded that phototherapy was permissible as part of the facility policy.

Facility policy requires that providers obtain informed consent from patients prior to a clinical treatment or procedure.[43] The dermatology clinic RN's EHR documentation reflected general

[38] The dermatology clinic RN told the OIG of being instructed by a supervisor not to complete a note in the EHR on the day phototherapy was administered.

[39] Privileged refers to a practitioner being permitted by law and the facility to practice independently and to provide medical care within the scope of practice of the individual's license. Gulf Coast Veterans Health Care System Memorandum No. 11-58-18, *Credentialing and Privileging and Reporting to the National Practitioner Data Bank*, June 22, 2018.

[40] Facility leaders and subject matter experts included the CNCP, Chief of EMS, Infection Control Coordinator, Specialty Clinic Nurse Manager, Specialty Clinic Assistant Nurse Manager, and the then-Acting Associate Director of Patient Care Services.

[41] Gulf Coast Veterans Health Care System Nursing Service Policy No. NSG-006, *Nursing Order Verification and Chart Review,* September 1, 2015.

[42] Gulf Coast Veterans Health Care System Nursing Service Policy No. NSG-003, *Mosby's Procedural E-Book Format Adoption, August 2014*.

[43] Gulf Coast Veterans Health Care System Memorandum No. 11-23-13, *Informed Consent*, August 30, 2013.

education of the patient on treatment and potential side effects. The dermatology clinic RN documented that the instructions had to be repeated due to the patient's difficulty in understanding. The dermatology clinic RN also documented that the patient received a handout related to the procedure and verbally agreed to phototherapy. The OIG team determined that the dermatology clinic RN's actions resulted in the patient consenting to phototherapy that was not indicated. The OIG's review of the dermatology clinic RN's EHR documentation revealed a lack of Mosby Procedure and Competency requirements such as verifying the order, ensuring the presence of consent, reviewing the patient history for contraindications, and entering an EHR note after administration of phototherapy.

Development of Burns After Phototherapy

The OIG determined that the dose of UV light administered was likely the main contributor to the patient's injuries.[44] Patients may experience mild burn type reactions after phototherapy; however, serious injuries are unusual occurrences. In addition, the OIG team determined that other factors may have contributed to complications including patient positioning, size, and medication sensitivities.

The most important factor in determining treatment dose is the patient's skin sensitivity to UV light.[45] This dose determination can be made by empirical estimation based on the skin phototype. The dermatology clinic RN estimated the patient's skin type to be Type II and treated the patient with 500 mJ of narrow band UVB therapy.[46]

Dermatologists reference published protocols that use diagnosis and skin phototype to estimate an initial treatment dose. The manufacturer of the facility's phototherapy unit recommends a specific set of published protocols for use in determining phototherapy doses.[47] According to a facility dermatologist, there are no published protocols for the treatment of bed bugs, because

[44] Other possible factors contributing to the burns included sun exposure following treatment or unreported medications or supplements that may have increased the patient's photosensitivity.

[45] H. Moseley et, al., "Guidelines on the Measurement of Ultraviolet Radiation Levels in Ultraviolet Phototherapy: Report Issued by the British Association of Dermatologists and British Phototherapy Group," *British Journal of Dermatology 173 (2015): 333-350.*

[46] Phototyping is a visual assessment based on the Fitzpatrick scale, which takes into account skin color and the patient's propensity to tan or burn. Caucasian skin types are generally I to IV. Patients with Type II skin generally have fair skin, burn easily and tan minimally. The dosage of UV light is prescribed according to an individual's skin type (sensitivity). "The Validity and Practicality of Sun-Reactive Skin Types I Through VI," Arch Dematol, Vol 124, June 1988, p.869-871.

[47] A Minimal Erythemal Dose (MED) test is conducted to expose small areas of the patient's skin to increase doses of or UV light. H. Moseley et, al., "Guidelines on the Measurement of Ultraviolet Radiation Levels in Ultraviolet Phototherapy: Report Issued by the British Association of Dermatologists and British Phototherapy Group," *British Journal of Dermatology 173 (2015): 333-350; Daavlin, "Phototherapy Guidebook to the Benefits of Adding Phototherapy to Your Practice".*

this is not an indication for phototherapy. However, manufacturer-endorsed protocols for other diseases that are treated with phototherapy recommend starting doses for patients with Type II skin substantially below 500 mJ. For instance, patients with psoriasis (one of the diseases most commonly treated by phototherapy) and Type II skin would be treated with an initial dose of 300 mJ of narrow band UVB therapy.[48] The recommended starting dose is also 300 mJ for other conditions treated by phototherapy, such as atopic dermatitis and pruritis, irrespective of skin phototype. The American Academy of Dermatology recommends a starting dose of 220 mJ for patients with Type II skin and psoriasis.[49]

The OIG team determined that other factors that may have contributed to the patient's injuries included the patient's seated position in the phototherapy unit and extreme obesity. In addition to skin phototype, UV effects are determined by the nature of the lamps used in the unit and the distance of the patient's skin from the device.[50] UV output falls towards the ends of lamps in treatment units. Thus, the patient's seated position may have caused more exposure to the higher intensity light source and the obesity may have contributed because the patient's skin would be closer than usual to the bulbs in the unit.

Additionally, a medication review is generally performed prior to phototherapy and if the patient is taking any medications that increase photosensitivity, the dose of phototherapy is reduced.[51] The OIG reviewed the EHR and noted that the patient was taking a medication that has been shown to increase photosensitivity in some patients.[52]

The OIG determined that equipment malfunction was an unlikely factor in the patient's development of burns after the phototherapy. Facility biomedical engineering staff evaluated the phototherapy unit in June 2017, after the patient's treatment.[53] After consulting with the original phototherapy equipment manufacturer, facility biomedical engineering staff determined that the unit was operating within acceptable manufacturer standards. Facility staff also reported that no other patients treated in the phototherapy unit on the same day as the patient received serious burns.

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[48] Daavlin, "Phototherapy Guidebook to the Benefits of Adding Phototherapy to Your Practice."

[49] American Academy of Dermatology, "Psoriasis: Recommendations for Broadband and Narrowband UVB Therapy," January 2010. https://www.aad.org/practicecenter/quality/clinical-guidelines/psoriasis/phototherapy-and-photochemotherapy/uvb-therapy. (The website was accessed on September 24, 2018.)

[50] Carolyn J. Heckman et. al., "Minimal Erythema Dose (MED) Testing," *Journal of Visualized Experiments*, (May 28, 2013)

[51] John Koo and Nakamura, M. "Phototherapy in the Setting of Photosensitizing Medications," Psoriasis and Skin Treatment Center, Department of Dermatology, University of San Francisco, Clinical Cases in Phototherapy, p.93-96, Part of the Clinical Cases in Dermatology book series (CLIDADE).

[52] Steven R. Feldman and Michael D. Zanolli, *Phototherapy Treatment Protocols,* 4th ed. (Boca Raton: CRC Press, 2016), 180.

[53] The facility did not document the results of the inspection, so the specific date of the inspection is unknown.

Initial Training and Competencies

The OIG determined that initial phototherapy training for the dermatology clinic RN had not been completed and that the dermatology clinic RN's ongoing phototherapy competency assessments did not meet facility requirements.[54]

The provision of phototherapy is a dermatology clinic-specific competency that required training and annual competency validation. Facility policy required completion of initial training, (within 90 days of hire) and ongoing annual competency evaluations for all nursing staff.[55] Staff who have not completed the initial training and have not completed specific competency validated by a qualified individual would be unable to perform phototherapy.

During the OIG inspection, a nurse manager indicated that the dermatology clinic RN received initial phototherapy training in 2014 from university-affiliated dermatology residents. Facility staff did not produce documentation of the initial training but told the OIG that the training was limited to one day of orientation consisting of a review of the technical manual for the phototherapy unit. The Specialty Clinic Nurse Manager was unable to produce documentation to verify that the dermatology clinic RN completed the initial training.

The OIG review of the dermatology clinic RN's annual competencies revealed assessment by the Specialty Clinic Nurse Manager who did not personally possess the knowledge or competency required to assess phototherapy skills. Additionally, the OIG determined that the Specialty Clinic Nurse Manager and dermatology clinic RN did not demonstrate the technical knowledge required to safely operate the unit.[56] The dermatology clinic RN stated that the patient may have been too large for the unit leading to the patient burns, but did not refer to the technical manual at the time of the phototherapy to determine if size was an issue. The dermatology clinic RN was also unsure of whether or not the patient could be seated during the procedure; however, had relayed during an interview with the OIG that the patient had been in a seated position during part of the phototherapy. During the interview with the university-affiliated dermatology resident supervisor, the OIG was told that a "super obese" patient would be closer to the light source and would require adjustments to ensure the light intensity would not be a factor and staff normally would not perform phototherapy on a patient in a seated position as there could be an issue with effectiveness.

The OIG interviewed two facility dermatologists who acknowledged confidence in the skills and competency of the dermatology clinic RN while working under their guidance. A facility dermatologist stated that the dermatology clinic RN has a "good understanding of the treatment."

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[54] Gulf Coast Veterans Health Care System Memorandum No. 118-31-16, *Orientation and Competency Evaluation of Nursing Staff, February 04*, 2016.

[55] Gulf Coast Veterans Health Care System Memorandum No. 118-31-16.

[56] A dosimetry-controlled system incorporates a built-in power meter that constantly measures the energy output of the phototherapy unit.

The university-affiliated dermatologist stated during interviews with the OIG that there have not been any other known concerns or incidents of patient burns due to phototherapy provided by the dermatology clinic RN.

The university-affiliated dermatologist stated that the phototherapy unit was purchased by the facility four to five years ago. Upon hiring the current dermatology clinic RN, the training was provided "on-site" as the facility did not have funding to support attendance at formal off-site training. The university-affiliated dermatologist stated that multiple requests had been made to send the dermatology clinic RN to formal training, but facility funding was not available. Facility and university-affiliated dermatologists stated during interviews that the dermatology clinic RN possessed the knowledge and competencies to provide phototherapy, even without formal off-site training and facility-required annual competency assessments.

Pest Management Program

The OIG determined that facility staff actions following the identification of the bed bug indicated a lack of understanding of facility policy related to environmental actions to be taken following identification of bed bugs. Specifically, facility staff improperly attributed the need for multiple actions taken throughout the coordination of care of the patient to the Integrated Pest Management policy and completed some environmental actions not required by policy following the identification of bed bugs.[57]

In 2015, the facility implemented an Integrated Pest Management policy that outlined actions to be taken in the event bed bugs were identified at the facility.[58] The policy designated the Chief of EMS as the Health Care System Pest Control Officer, with overall responsibility for the administration of the pest control program.[59] The policy provided guidance for environmental actions aimed at preventing, controlling, or eliminating pest infestations or re-infestation in the facility. The policy states in an appendix that "there is no specific medical treatment for bed bugs."[60]

Patient Safety Initiative

The OIG determined that clinical staff questioned the need for phototherapy; however, their concerns were not fully addressed. VHA adopted a patient safety initiative which included

[57] Additional actions taken, which were not part of facility policy, included the wound care nurse going home to shower, the escorts and police officer showering in the emergency department, taking the police officer's gun and shoes, searching the patient's vehicle for bed bugs, and detaining the patient with a police escort.

[58] System Memorandum No. 137-07-15.

[59] System Memorandum No. 137-07-15.

[60] System Memorandum No. 137-07-15. One staff member told the OIG that the policy was undergoing review but at the time of the OIG site visit, it had not been finalized.

training to ensure safe practices and methods to communicate safety concerns. This initiative encourages facility staff to speak up when they have a concern regarding safety in any situation. The CNCP acknowledged to the OIG that the primary care RN and the Specialty Clinic Nurse Manager stated that phototherapy was not typically administered for the treatment of bed bugs.[61] The CNCP also acknowledged, that in retrospect, the dermatology clinic RN expressed reservations about performing phototherapy and may have felt pressured to proceed because of the involvement of multiple facility leaders in the efforts to coordinate the patient's phototherapy.

2. Facility Response

The OIG determined that facility leaders took actions to evaluate the circumstances surrounding the patient's phototherapy by completing adverse event and fact-finding reviews.[62] However, the OIG determined the initiation of the fact-finding review with a charge letter that included language that would be used to produce a confidential document as well as language that would suggest the review was for personnel action was unclear in its intent. Additionally, if the review was meant to be protected, it should have been terminated when it became clear that administrative actions would be pursued.[63]

Adverse Event Review

The facility completed an adverse event review; however, the OIG determined that the corrective actions recommended by the review were not taken.

The VA National Center for Patient Safety requires a review, known as a root cause analysis (RCA), for adverse events.[64] The goal of an RCA is to determine potential improvement in facility processes that would decrease the likelihood of future adverse events. The VA National Center for Patient Safety policy requires that each action identified in the RCA have at least one root cause with a corresponding action and a determination as to whether the action resulted in the intended improvement.[65]

An RCA was completed to determine what factors led to the adverse event and identify needed corrective actions. However, the OIG determined that not all corrective actions had been taken,

[61] Department of Veteran Affairs, "Stop the Line for Patient Safety Fact Sheet," February 2015.

[62] Facility leaders were not immediately aware of the provision of phototherapy because the patient's adverse event took 48 hours to manifest itself due to the nature of the treatment.

[63] VHA Directive 2008-077.

[64] VHA Handbook 1050.01.

[65] VA National Center for Patient Safety, Root Cause Analysis Tools: Root Cause Analysis (RCA) Step-By-Step Guide, February 26, 2015.

leaving the facility without a way to measure whether those actions led to an improvement in patient safety.

As a result, the OIG concluded facility leaders were unable to ensure the actions adequately addressed the identified root causes and would result in a decreased likelihood of future reoccurrences.

Fact-Finding Review

Although the Interim Facility Director's fact-finding review charge memorandum indicated the "findings and associated documents are considered confidential, privileged, and protected under 38 U.S.C. Section 5705," the OIG team determined that the review did not address a QM activity and documents generated from the review were not confidential.[66] Further, the OIG concluded that the proposed disciplinary actions for all staff members involved in the events required further evaluation.

In summer 2017, the Interim Facility Director instructed a staff member to conduct a fact-finding of the circumstances surrounding the patient's injury as a result of phototherapy. Although the Interim Facility Director included the language noted above regarding confidential documents in the charge memo, the Interim Facility Director's intent appeared to be for a purpose other than a QM activity.[67] When interviewed, the Interim Facility Director informed the OIG that fact-finding reviews are supposed to be "protected," can be used for disciplinary actions, and that this one was done to determine accountability.[68] These statements are not consistent with VHA and facility policy that confidential reviews may not be used as the basis for disciplinary actions.[69] The OIG determined that the fact-finding review was not initiated for the purpose of a QM activity and was therefore not confidential under 38 U.S.C. Section 5705.[70]

The fact-finding review completed for this event consisted of interviews and witness statements; review of EHR entries; facility policies; and nursing procedures related to phototherapy.[71] After the fact-finding review results were submitted, the dermatology clinic RN was disciplined. In a written response to the proposed disciplinary action, the dermatology clinic RN acknowledged providing phototherapy and indicated that nursing leaders were directing the patient's receipt of

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[66] VHA Directive 2008-077; 38 U.S.C. Section 5705 – Confidentiality of Medical Quality Assurance Records.

[67] VHA Directive 2008-077; System Memorandum 00Q-09-15, *Confidentiality of Quality Management (QM) Documents,* March 31, 2015. Although the activity that generated the information was previously designated in writing as a QM activity, the memorandum directed the fact-finding team to contact the facility's employee relations/labor relations section prior to initiating the review.

[68] Within the context of this report, the OIG considered the terms confidential and protected to be equivalent.

[69] Facility Memorandum 00Q-09-15; VHA Directive 2008-077.

[70] VA Handbook 5021; VHA Handbook 1050.01; 38 U.S.C. Section 5705.

[71] Interviews and written statements were obtained from staff who were involved with the event either directly through contact with the patient or were involved with coordination and communications.

phototherapy. When interviewed by the OIG, the dermatology clinic RN expressed a concern of being perceived as insubordinate if the decisions of nursing leaders to provide phototherapy were not carried out. When interviewed, the Interim Facility Director informed OIG inspectors that other disciplinary actions were proposed for staff members who were involved in the actions taken on the day in question.

Conclusion

Phototherapy is ordered by a dermatologist after diagnosis of a skin condition that would be responsive to treatment; however, phototherapy is not indicated for the treatment of bed bugs. A dermatologist was available for assessment the day of treatment but was not contacted to conduct an assessment or provide an order. Communications from facility leaders and bed bug policy subject matter experts led the dermatology clinic RN to provide phototherapy despite the lack of a dermatologist's assessment and order. After several interactions with various leaders and managers, the dermatology clinic RN concluded that phototherapy was permissible as part of the facility policy.

The dermatology clinic RN did not follow facility nursing practice requirements related to ensuring informed consent prior to phototherapy. EHR documentation reflected education of the patient on treatment and potential side effects, and provision of a handout related to the procedure after which the patient verbally agreed to phototherapy. However, while these actions were required of the dermatology clinic RN prior to initiating therapy, they did not qualify as ensuring the patient's informed consent prior to phototherapy.

The OIG determined that the dose of UV light administered was likely the main contributor to the patient's injuries. Patients may experience mild sunburn type reactions after phototherapy; however, serious injuries are unusual occurrences. The patient received an initial dose at a higher dose than what is recommended by the American Academy of Dermatology for a patient starting phototherapy. In addition, the OIG team determined that other factors that may have contributed to the patient's injuries, including the patient's seated position placing the patient's skin closer to the lights while receiving phototherapy, extreme obesity, and a medication-related photosensitivity. Equipment malfunction was an unlikely factor in the patient's development of burns after the phototherapy.

The provision of phototherapy is a dermatology clinic-specific competency that required training and annual competency validation. The OIG team found that phototherapy training for the dermatology clinic RN had not been completed and that the dermatology clinic RN's ongoing phototherapy competency assessments did not meet facility requirements. A nurse manager asserted that the dermatology clinic RN received initial phototherapy training in 2014 from university-affiliated dermatology residents but did not provide documentation to support this assertion.

The dermatology clinic RN's annual competencies did not meet facility requirements since the Specialty Clinic Nurse Manager who signed the competencies did not personally possess the knowledge or competency required to assess phototherapy skills. Additionally, the OIG determined that the Specialty Clinic Nurse Manager and dermatology clinic RN did not demonstrate the technical knowledge required to safely operate the unit as evidenced by the patient's phototherapy burns.

Facility staff improperly attributed the need for multiple actions taken throughout the coordination of care of the patient to the Integrated Pest Management policy and completed some environmental actions not required by policy. The policy provided guidance for environmental actions aimed at preventing, controlling, or eliminating pest infestations or re-infestations in the facility. Despite an appendix to the policy that stated, "there is no specific medical treatment for bed bugs," facility staff pursued a clinical treatment, phototherapy, for this patient.

The OIG concluded that clinical staff, including the dermatology clinic RN, questioned the need for phototherapy; however, their concerns were not fully addressed. The CNCP acknowledged to the OIG that the primary care RN and the Specialty Clinic Nurse Manager stated that phototherapy was not typically administered for the treatment of bed bugs. The CNCP also acknowledged, that in retrospect, the dermatology clinic RN expressed reservations about performing phototherapy and may have felt pressured to proceed because of the involvement of multiple facility leaders in the efforts to coordinate the patient's phototherapy.

The facility's policy on confidentiality of documents designated fact-finding reviews as ones that generated confidential documents. Per VHA policy, when a review is initiated to improve quality of care, but it is determined during the review that personnel action may need to be pursued, the quality of care review must be terminated, and a non-confidential review be initiated. The OIG determined that the facility's response to the events, the initiation of a fact-finding review with a charge letter that included language that would be used to produce a confidential document as well as language that would suggest the review was for personnel action, was unclear in its intent. Additionally, if the review was meant to be confidential, it should have been terminated when it became clear that administrative actions would be pursued. Further, the OIG concluded that the proposed disciplinary actions for all staff members involved in the events required further evaluation and actions taken as appropriate.

Recommendations 1–7

1. The Gulf Coast Veterans Health Care System Director confirms current dermatology clinic nursing practice requirements related to ensuring informed consent prior to initiating phototherapy are followed and monitors compliance.

2. The Gulf Coast Veterans Health Care System Director ensures dermatology clinic registered nurse training and competencies are completed as required and tracked for compliance.

3. The Gulf Coast Veterans Health Care System Director reviews facility policy to ensure guidance clearly delineates environmental actions to be taken following identification of bed bugs.

4. The Gulf Coast Veterans Health Care System Director ensures that all Gulf Coast Veterans Health Care System staff are trained on the policy addressing environmental actions to be taken following identification of bed bugs and track compliance.

5. The Gulf Coast Veterans Health Care System Director ensures that the Patient Safety Manager completes all actions identified in the subject adverse event review.

6. The Veterans Integrated Service Network 16 Director reviews the Gulf Coast Veterans Health Care System policy related to the confidentiality of fact-finding reviews to evaluate if the initiation of such reviews, including the one conducted in relation to this patient, is consistent with the purpose of maintaining the confidentiality of quality management activities, and takes action as necessary.

7. The Veterans Integrated Service Network 16 Director reviews and evaluates the proposed and actual disciplinary actions taken by Gulf Coast Veterans Health Care System managers related to the events of the day in question, and takes action as appropriate.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 2, 2019

From: Director, South Central VA Health Care Network (I0N16)

Subj: Healthcare Inspection—Complications Associated with Phototherapy at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

To: Director, San Diego office of Healthcare Inspections, (54SD)
Director, GAO/OIG Accountability Liaison (GOAL) office (VHA 10EG GOAL Action)

1. The South Central VA Health Care Network (VISN 16) has concurred and developed an action plan to address recommendations six (6) and seven (7). Further, we have reviewed and concur with the corrective actions to be implemented by the Gulf Coast Veterans Health Care System, Biloxi, MS, regarding recommendations one (1) through five (5) of the draft report on Complications Associated with Phototherapy.

//original signed by//

Skye McDougall, PhD
Director, South Central VA Health Care Network

Comments to OIG's Report

Recommendations 1–5 are directed to, and will be addressed by, the Facility Director.

Recommendation 6

The Veterans Integrated Service Network 16 Director reviews the Gulf Coast Veterans Health Care System policy related to the confidentiality of fact-finding reviews to evaluate if the initiation of such reviews, including the one conducted in relation to this patient, is consistent with the purpose of maintaining the confidentiality of quality management activities, and takes action as necessary.

Concur.

Target date for completion: July 30, 2019

Director Comments

The Veterans Integrated Service Network 16 Director will direct the VISN Human Resources Office in collaboration with the VISN Quality Management Office to review the Gulf Coast Veterans Health Care System policy related to the confidentiality of fact-finding reviews to evaluate if the initiation of such reviews, including the one conducted in relation to this patient, is consistent with the purpose of maintaining the confidentiality of quality management activities. In the event it is determined that the policy is inappropriate, corrective action will be taken to revise the policy and/or provide remedial training on the purpose and intent of the policy as related to quality management activities.

Recommendation 7

The Veterans Integrated Service Network 16 Director reviews and evaluates the proposed and actual disciplinary actions taken by Gulf Coast Veterans Health Care System managers related to the events of the day in question, and takes action as appropriate.

Concur.

Target date for completion: July 30, 2019

Director Comments

The Veterans Integrated Service Network 16 Director will direct the VISN Human Resources Office to review and evaluate the proposed and actual disciplinary actions taken by the Gulf Coast Veteran's Health Care System managers related to the events of the day in question and take appropriate action.

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: May 1, 2019

From: Director, Gulf Coast Veterans Health Care System (520/00)

Subj: Healthcare Inspection—Complications Associated with Phototherapy at the Gulf Coast Health Care System in Biloxi, Mississippi

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

1. Gulf Coast Veterans Health Care System has reviewed and concurs with this Health Inspection report.

2. We recognize opportunities for improvements in our practice and corrective actions have been implemented to address the recommendations.

//original signed by//

Bryan C. Matthews, MBA
Director, Gulf Coast Veterans Health Care System

Comments to OIG's Report

Recommendations 6 and 7 were directed, to and will be addressed by, the VISN Director.

Recommendation 1

The Gulf Coast Veterans Health Care System Director confirms current dermatology clinic nursing practice requirements related to ensuring informed consent prior to initiating phototherapy are followed and monitors compliance.

Concur.

Target date for completion: July 31, 2019

Director Comments

The Director will ensure that current dermatology clinic nursing practice requirements related to ensuring informed consent is obtained from Veterans prior to initiating phototherapy is implemented. To ensure compliance, random audits of patient care records will be conducted for Veterans receiving phototherapy to ensure informed consent has been obtained and is on file. The threshold for compliance will be 100% of Veterans receiving phototherapy will have documented informed consent in their medical record. This monitor will continue until three consecutive months of 100% is achieved.

Recommendation 2

The Gulf Coast Veterans Health Care System Director ensures dermatology clinic registered nurse training and competencies are completed as required and tracked for compliance.

Concur.

Target date for completion: June 30, 2019

Director Comments

The Director will ensure that nurse training and associated competencies are completed for nurses administering phototherapy at Gulf Coast Veterans Health Care System. Those staff with said competencies who provide this service will be tracked through the established yearly competency review process utilized by the Associate Director for Patient Care Services' office as part of the annual nurse proficiency review and submission procedure.

Recommendation 3

The Gulf Coast Veterans Health Care System Director reviews facility policy to ensure guidance clearly delineates environmental actions to be taken following identification of bed bugs.

Concur.

Target date for completion: June 30, 2019

Director Comments

The Director will review the current station policy to ensure guidance clearly delineates environmental actions to be taken following the identification of bed bugs in the health care system. Since this incident, Infection Control has worked collaboratively with Facilities Management Service to develop posters and a response algorithm to better define the expected response to an incident of bed bugs. The policy, and associated documents (e.g., visual aid poster), will undergo an additional review by both bodies to ensure communication is clear and concise in providing guidance to staff.

Recommendation 4

The Gulf Coast Veterans Health Care System Director ensures that all Gulf Coast Veterans Health Care System staff are trained on the policy addressing environmental actions to be taken following identification of bed bugs and track compliance.

Concur.

Target date for completion: August 31, 2019

Director Comments

The Director will ensure that identified staff are trained on the facility policy addressing environmental actions to be taken following the identification of bed bugs. To ensure compliance, random audits of training records and/or training attendance rosters will be conducted to ensure the education has been completed. The threshold for compliance will be 90% or greater of targeted staff will complete the required education.

Recommendation 5

The Gulf Coast Veterans Health Care System Director ensures that the Patient Safety Manager completes all actions identified in the subject adverse event review.

Concur.

Target date for completion: April 30, 2019

Director Comments

All identified RCA actions for the adverse event have been implemented by Gulf Coast Veterans Health Care System. At the time the Patient Safety Manager was interviewed by the OIG Team,

there was specific discussion about the best means to measure the effectiveness of the actions related to training staff on 'Just Culture' principles. The Patient Safety Office completed a variety of promotion activities including Patient Safety Awareness Week events, staff meetings and Thursday Leadership presentations, Training Day presentations, intranet postings, postmaster messages, fliers, and rounding. Since the OIG site visit, results from the 2018 Patient Safety Culture Survey have been released and have captured the efforts of the Patient Safety team's efforts. Participation tripled from the previous survey; 12 of 15 dimensions were above overall VA averages; 8 of 15 dimensions were 'significantly better than previous year'; 'facility 520 is likely to have a healthier patient safety culture than the VHA norm'; 85% of respondents know how to report patient safety issues; and, overall scores were the best they have been since the 2000 survey.

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