



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues in the Geriatrics and Extended Care Service VA North Texas Health Care System Dallas, Texas

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding quality of care issues in Geriatric and Extended Care Service at the VA North Texas Healthcare System. The purpose of this review was to determine whether the allegations had merit. The complainant alleged:

- Two patients' medical records contained inaccurate medical diagnoses of osteomyelitis and coronary artery bypass graft.
- A physician providing weekend coverage failed to evaluate a very ill patient who later developed cardiac tamponade.
- Home based primary care providers failed to diagnose two patients with hypercalcemia and/or vitamin D deficiency.
- A physician had poor understanding of deep vein thrombosis prophylaxis.
- A patient's pain was poorly managed with morphine sulfate administered on a pro re nata (as needed) basis.
- A physician requested removal of a cognitive impairment diagnosis without performing a required test.
- The Geriatric and Extended Care Service failed to perform and monitor quality improvement activities.

We substantiated that a diagnosis of a coronary artery bypass graft was inaccurately documented in a patient's history and physical examination and that a physician recommended removal of a patient's cognitive impairment diagnosis based on a brief cognitive exam. However, neither of these occurrences adversely affected patient care. We did not substantiate any of the other allegations.

We made no recommendations.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Heart of Texas Health Care Network (10N17)

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues in the Geriatrics and Extended Care Service, VA North Texas Health Care System, Dallas, Texas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, reviewed allegations regarding quality of care issues in the Geriatric and Extended Care (GEC) Service at the VA North Texas Health Care System (the system), Dallas, Texas. The purpose of the review was to determine whether the allegations had merit.

Background

The system is comprised of a tertiary care facility in Dallas, TX, with community living centers (CLCs) in Dallas and Bonham and nine community based outpatient clinics (CBOCs) in the Dallas/Ft. Worth area. The system has 314 hospital beds and 195 CLC beds. The CLCs provide post hospital/sub acute care, skilled nursing care, rehabilitation, respite, hospice, and palliative care services. The system also provides home based primary care (HBPC) services through an interdisciplinary team to homebound veterans within a 50-mile radius of the Dallas facility. In September 2009, HBPC had 340 enrolled veterans. The system serves veterans in 41 counties in northern Texas and is part of Veterans Integrated Service Network (VISN) 17.

A complainant contacted the VA OIG Hotline regarding the care received by nine patients at the system over 6 years. The complainant alleged:

1. Two patients' medical records contained inaccurate medical terms, specifically, references to osteomyelitis¹ and coronary artery bypass graft (CABG) surgery.²

¹ Osteomyelitis is an inflammation of the bone marrow and adjacent bone.

² CABG surgery replaces damaged sections of the coronary arteries with arterial or venous grafts to improve blood flow to the heart.

2. A physician providing weekend coverage failed to evaluate a very ill patient who later developed cardiac tamponade.³
3. HBPC providers failed to diagnose two patients with hypercalcemia⁴ and/or vitamin D deficiency.
4. A physician had poor understanding of deep vein thrombosis (DVT) prophylaxis.
5. A patient's pain was poorly managed with morphine sulfate (MS) administered on an as needed, pro re nata (PRN) basis.
6. A physician requested removal of a cognitive impairment diagnosis without performing a required test.
7. GEC Service failed to perform and monitor quality improvement (QI) activities.

Scope and Methodology

We conducted a telephone interview with the complainant prior to a site visit November 9–10, 2009. We interviewed administrative staff and providers involved in the patient's care. We reviewed relevant system and VHA policies, medical records, quality management documents, and other documentation pertinent to the allegations.

This review was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Medical Record Discrepancies

We did not substantiate that one patient's medical records contained inaccurate medical diagnoses. However, we did substantiate that the records for a second patient contained an inaccurate medical diagnosis.

Patient 1: The complainant alleged that an infectious disease (ID) note dated July 2009, contradicted a wound care nurse's notes and a bone scan result. Medical records revealed that the ID note did not contradict the wound care nurse's notes or the bone scan results. The nurse's notes reflected only that the patient had a stage IV ulcer and treatment to promote healing. The patient had two bone scans in 2009. The first scan was in May and indicated sacral and coccygeal osteomyelitis; this was the scan available at the time of the ID assessment. A second scan in July showed no evidence of osteomyelitis.

³ Cardiac tamponade is an emergency condition in which fluid accumulates in the pericardium, the sac in which the heart is enclosed. If the fluid significantly elevates the pressure on the heart, it will prevent the heart's ventricles from filling properly.

⁴ Hypercalcemia is an abnormally high level of calcium in the blood.

Patient 2: Medical record documentation revealed that in early September 2003 the patient had the term CABG entered into a history and physical (H&P) examination report. Although this term should not have been used for this patient, the inaccurate reference did not appear again in the patient's medical record, and the patient was not harmed by the error.

Issue 2: Delay in Treatment

We did not substantiate that a physician providing weekend coverage failed to evaluate a very ill patient who later developed cardiac tamponade.

In July 2009, a patient was admitted to the CLC after hospitalization and radiation treatment (XRT) for squamous cell carcinoma of the lung. Prior to the patient's admission to the CLC, an echocardiogram (echo)⁵ had revealed a moderate pericardial effusion⁶ without cardiac tamponade. In the absence of tamponade, the attending cardiologist did not consider it necessary to proceed with further intervention. However, the cardiologist documented that "the echo was worrisome for pericardial seeding,⁷ which makes this patient at high risk for worsening of this effusion."

On a week-end in early August 2009, the patient's wife notified the nurse that the patient had slurred speech and increased swelling around his eyes. The nurse assessed the patient and found him to be alert, oriented, and able to speak clearly. His vital signs were within normal limits (WNL) and oxygen saturation (blood oxygen level) was documented at 98 percent with the use of a nasal cannula providing oxygen at a rate of 2 liters per minute. At 11:10 a.m., the nurse notified the physician on call, who provided instructions to have the patient remain in bed and for the swelling to be monitored. The medical record documented, "If the swelling persisted, the on-call physician would increase the furosemide." At 12:59 p.m., the nurse documented that furosemide 20 mg was given to the patient by mouth. The medical records did not indicate any further concerns by the nurse or complaints by the patient, or that the nurse called the physician for additional instructions.

The next day the attending physician evaluated the patient and documented prominent facial puffiness and lower extremity swelling. The physician ordered a computed tomography (CT)⁸ scan of the chest and abdomen. The CT scan of the chest, when compared with a previous scan, revealed that the right pleural effusion had substantially increased in size and that there was a new small left pleural effusion. However, the CT scan did not reveal worsening of the pericardial effusion. The next morning, hospital day (HD) 1, the GEC attending physician admitted the patient to the inpatient service. A

⁵ An echocardiogram is a noninvasive procedure that studies the structure and motions of the heart.

⁶ Pericardial effusion is an accumulation of fluid between the lining of the lung and the chest cavity.

⁷ Pericardial seeding is an increased fluid accumulation in the pericardium.

⁸ Computed tomography is an x-ray procedure, which provides cross-sectional images.

progress note on HD 2 documented that a transesophageal echocardiogram⁹ showed evidence of cardiac tamponade. At that time the patient described no change from his usual shortness of breath. In fact, the patient thought his shortness of breath was improved. On admission for the pleural effusion, a consult was requested for Cardiothoracic Surgery and on HD 3 a cardiothoracic surgery consultant performed pericardiocentesis.¹⁰

This patient had symptoms related to his lung cancer and prior history of pleural effusions. A nurse assessed the patient and notified the on-call physician, who prescribed furosemide and instructed the nurse to monitor the patient for worsening signs and symptoms. The GEC attending physician took the appropriate steps to ensure patient safety by requesting a CT scan and consulting cardiothoracic surgery.

Issue 3: Failure to Diagnose

We did not substantiate that HBPC providers failed to diagnose two patients with hypercalcemia or vitamin D deficiency.

Patient 1: Medical record documentation revealed that the patient's highest calcium level was 11.6 milligrams/deciliter (mg/dL) in March 2007 (normal range, 9-10.5 mg/dL). The patient had prescriptions for calcium/vitamin D and multivitamins from April 2005 through April 2009. These prescriptions were discontinued because of hypercalcemia. The patient was also on hydrochlorothiazide (HCTZ), which increases calcium levels, for high blood pressure.

In late August 2009, an endocrinologist documented his assessment that the patient had hypercalcemia due to immobility and HCTZ use. He discontinued HCTZ and initiated physical therapy to assist with mobilization. In late October 2009, the patient's calcium blood level was WNL at 10.2 mg/dl.

We concluded that Patient 1 had multiple possible causes of hypercalcemia. The patient received calcium/vitamin D and multivitamin supplements dating back to 2005. The endocrinologist evaluated and treated the patient appropriately, and the calcium levels returned to normal.

Patient 2: We determined that the patient was diagnosed and received treatment for vitamin D deficiency in mid June 2009. He was prescribed calcium/vitamin D tablets in addition to ergocalciferol 50,000 units monthly.

⁹ Transesophageal echocardiography provides ultrasonic imaging of the heart from a retrocardiac vantage point, thus preventing the interposed subcutaneous tissue, bony thorax, and lungs from interfering with the ultrasound.

¹⁰ Pericardiocentesis is the removal by needle of pericardial fluid from the sac surrounding the heart for diagnostic or therapeutic purposes.

We concluded that the primary care physician of Patient 2 diagnosed and treated the patient appropriately.

Issue 4: Treatment Modalities

We did not substantiate that a physician had poor understanding of DVT prophylaxis.

We evaluated the care of a patient who was reported by the complainant to have inadequate preventive treatment for DVT. That patient's H&P dated July 2009, documented treatment with warfarin and aspirin for a previous mitral valve replacement. This treatment was also sufficient for DVT prophylaxis.

Issue 5: Pain Management

We did not substantiate that a patient's pain was poorly managed.

We determined that the patient's pain was managed appropriately by medications administered at scheduled intervals and on a PRN basis. A pain management note in July 2009 documented a plan which included intravenous morphine patient controlled analgesia¹¹ not to exceed 40 mg daily in addition to controlled release oral morphine 90 mg 3 times a day. Despite this regimen, the patient continued to have pain. Approximately 2 weeks later, a medication reconciliation note documented adjustment of the pain medication. The physician prescribed controlled release morphine tablets 120 mg 3 times a day along with liquid morphine 20 mg every 6 hours as needed. Over the course of the patient's stay in the CLC, staff frequently monitored and adjusted pain medications to provide comfort to the patient.

We concluded that clinical staff managed the patient's pain appropriately and that the patient received pain medication at scheduled intervals in conjunction with PRN medication.

Issue 6: Cognitive Impairment

We substantiated that a physician recommended removal of a patient's cognitive impairment diagnosis based on a brief cognitive exam.

Medical record documentation revealed that an attending physician diagnosed the patient with cognitive impairment in May 2006. In February 2008, a second attending physician recommended removal of the diagnosis after he performed a brief cognitive exam which revealed no deficits. A subsequent detailed evaluation was performed by a mental health provider, which confirmed cognitive impairment, and the diagnosis was not changed.

¹¹ Patient controlled analgesia is a continuous infusion of pain medication with an additional dose, which the patient may administer, as needed.

Issue 7: Quality Improvement

We did not substantiate that the GEC Service failed to perform and monitor QI activities including chart audits.

We determined that the GEC Service followed local policies and procedures for monitoring QI activities. Upon review, the QI data reflected several areas such as accidents, nutrition, fecal impaction, falls, pain, and cognitive patterns. In addition, the service conducted peer reviews, initiated incident reports, and performed chart audits. Providers' QI activities were included in the re-privileging process. The results were reported to the appropriate committee.

To strengthen QI activities, the GEC Service appointed a new Quality Manager in April 2009 to monitor patient care activities and to coordinate improvement efforts.

We concluded that the GEC Service performed and monitored QI activities to evaluate patient outcomes.

Conclusions

We substantiated that a diagnosis of a CABG was inaccurately documented in a patient's H&P and that a physician recommended removal of a patient's cognitive impairment diagnosis based on a brief cognitive exam. However, neither of these occurrences adversely affected patient care.

We did not substantiate any of the other allegations and made no recommendations.

Comments

The VISN and System Directors' concurred with our findings. See Appendixes A and B, pages 7–8 for the full text of their comments.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 1, 2010

From: Acting Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues in the Geriatrics and Extended Care Service, VA North Texas Health Care System**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, Management Review Office (10B5)

I have reviewed and concur with the attached response from VA North Texas Health Care System concerning the above referenced Healthcare Inspection.

(original signed by:)
Joseph M. Dalpiaz

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 29, 2010

From: Acting Director, VA North Texas Health Care System (549/00)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues in the Geriatrics and Extended Care Service VA North Texas Health Care System**

To: Acting Director, VA Heart of Texas Health Care Network (10N17)

1. The Director concurs with the findings and has no recommendations.
2. Geriatrics and Extended Care will continue to monitor the quality of care provided in the Community Living Centers.
3. We have examined our current process used in the CLC to determine when a resident is cognitively impaired and will continue to monitor documentation to ensure that this diagnosis is accurate.

(original signed by:)
Shirley M. Bealer

OIG Contact and Staff Acknowledgments

OIG Contact	Linda G. Delong Director, Dallas Office of Healthcare Inspections (214) 253-3331
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Acknowledgments	Annette Robinson, Team Leader Marilyn Walls Jerome Herbers, MD Laura Dulcie, Program Support Assistant Misti Kincaid, Program Support Assistant
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