Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Mismanagement and Patient Care Issues
Martinsburg VA Medical Center
Martinsburg, West Virginia

Report No. 07-02388-68 **January 31, 2008**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to determine the validity of allegations received from a complainant. These allegations included environment of care (EOC) concerns (for example, presence of mold in various locations), inaccurate radiology image readings, and poor quality of care at the Martinsburg VA Medical Center (the medical center), Martinsburg, WV. A Quality task force from Veterans Integrated Services Network 5 (VISN) visited the medical center to investigate the allegations. We made our own visit to the medical center and reviewed the VISN's documentation of the investigation.

We substantiated that mold had been identified in multiple areas by the medical center. At the time of our visit on October 23, 2007, the medical center had completed mold remediation and had instituted programs to identify and prevent mold and to remediate it when it occurred. We did not substantiate other EOC allegations.

We found that the Radiology Department did not have a quality review program. However, we did not substantiate the other allegations regarding radiology.

We found that an official report on delays in the OR was changed because the report was submitted identifying a surgeon by name. The name was removed to comply with the reporting format.

We could not substantiate or refute the allegation that a patient's surrogate decision-maker was inappropriately persuaded by medical center physicians to withdraw active treatment following surgery that resulted in complications. We requested that the complainant provide further detailed information, and he refused. Therefore, we were unable to investigate this allegation further.

An allegation regarding the misdiagnosis of a patient in the emergency room and his subsequent death was addressed in a separate OIG report.

We did not substantiate the allegation that the complainant spoke with the Medical Center Director and Chief of Staff regarding these issues and that they did nothing to improve the situation.

We recommended that management continue to monitor and implement the task force recommendations until completion.

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

TO: Director, Veterans Integrated Service Network (10N5)

SUBJECT: Healthcare Inspection – Alleged Mismanagement and Patient Care Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations received from a concerned surgeon (the complainant). These allegations included environment of care (EOC) concerns (for example, presence of mold in various locations), inaccurate radiology image readings, and changing official reports by management officials, poor quality of care, unsanitary/unhygienic conditions, and overall mismanagement at the VA Medical Center, Martinsburg (referred to in the report as the medical center).

Background

The medical center provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics located in Hagerstown and Cumberland, MD; Stephens City and Harrisonburg, VA; and Franklin and Petersburg, WV. The medical center is part of Veterans Integrated Services Network (VISN) 5 and serves a veteran population of about 129,000 in a primary service area that includes 23 counties in West Virginia, Maryland, Virginia, and Pennsylvania. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services and also provides rehabilitation domiciliary care. The medical center is affiliated with West Virginia University's School of Medicine and School of Dentistry, the George Washington University School of Medicine and Health Sciences, and the West Virginia School of Osteopathic Medicine.

The complainant sent the same list of allegations to the medical center Acting Director, the U. S. Office of Special Counsel, and several members of Congress. In response to the complainant's allegations, the VISN Director appointed a multidisciplinary task force (the task force) to review the allegations concerning quality of care, timeliness of care, environmental concerns, and leadership at the medical center.

Scope and Methodology

On October 23, 2007, we conducted an onsite inspection. We interviewed employees from Quality Management Service, Engineering Service, and Infection Control Service. We also interviewed the Industrial Hygienist, the Chief of Staff, and employees knowledgeable about the issues raised by the complainant. We reviewed available documents and toured various locations at the medical center to evaluate the environment of care and Operating Room (OR) security. We also toured the areas where the presence of mold had been identified. On December 11, we conducted telephone interviews with the Acting Medical Center Director, the Chief of Staff, and the previous Medical Center Director. We also reviewed the task force's report of their findings and recommendations and the medical center's December 6 response to a U.S. Senator's inquiry.

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

Findings

Issue 1: Mold Identified in Supply Processing and Distribution and Same Day Surgery Kitchen.

We substantiated the allegation that mold had been identified and was widespread in the Supply Processing and Distribution (SPD) unit and in the kitchen of the Same Day Surgery unit.

The task force reported that mold had been identified by medical center staff in Same Day Surgery near a defective ice machine, in the SPD mechanical room and decontamination area, and in the old chapel on a wall. The information was provided to the Facility Safety Manager and the Chief, Engineering Service. On November 17, 2006, a contractor was hired to chemically clean the identified areas.

In April 2007, the VISN identified mold in SPD during their Annual Safety Health and Fire Protection Program Evaluation. When the VISN inspection team notified the medical center Acting Director, the Chief of SPD, and the Infection Control Nurse of the mold, the medical center immediately closed SPD and initiated mold remediation.

On June 21 and July 3, members of the task force conducted site visits to the medical center to assess the mold remediation projects. During the July 3 visit, task force members found that chemical remediation of the mold (in all areas) and the required structural changes in the Same Day Surgery unit had been completed. However, the structural repairs in SPD and the old chapel where still in process. Personnel from the VA Center for Engineering and Occupational Safety and Health made a visit to the medical center in September to review mold remediation efforts.

On October 23, we toured the medical center's SPD unit, Same Day Surgery unit, and the old chapel and found that the contaminated walls in the Same Day Surgery unit kitchen, the SPD unit, and the old chapel had all been repaired/replaced per policy requirements. We interviewed the Industrial Hygienist, the Infection Control Nurse, and the Facility Management Service Manager to determine what other actions had been taken. They described the following initiatives taken for prevention and identification of mold and the remediation of it when necessary.

- Employee education on mold in the environment provided by the VA Central Office Director of the Occupational Health Program.
- Developed action plans to ensure that environmental cleanliness and dryness are addressed daily by responsible employees.
- Established a monitor to track all reports of mold from employees and the actions taken.
- Developed a new policy on mold identification and remediation.
- Conduct monthly mold detection rounds.

In November 2007, the medical center was inspected by the Occupational Health and Safety Administration and was cited for two unsafe working conditions. Those issues remain open at this time.

The medical center initiatives should improve overall detection and early removal of mold and ensure timely notification of affected employees.

Issue 2: An Employee Became Ill from Mold.

We could not substantiate or refute the allegation that an employee became ill after being exposed to mold in the medical center.

On October 18, 2006, an employee from Facilities Management Service was in the Same Day Surgery unit kitchen replacing a piece of drywall that had gotten wet when an ice machine leaked. During the repair, he discovered evidence of mold on the drywall. On November 13, the employee reported to the Occupational Health office and filed a claim for on-the-job illness. The employee claimed that he had become ill after being exposed to mold while replacing the wet drywall in the medical center Same Day Surgery unit. He was evaluated by the medical center's Occupational Health physician, as required by policy. The employee was provided medications and placed on light duty until he could be seen by his private physician. On March 8, 2007, the Department of Labor notified the medical center that the employee's claim was denied. The basis for the denial was that evidence did not establish that the claimed condition resulted from an on-the-job exposure. The employee is currently being followed by the Occupational Health physician for potential work-related mold exposure symptoms.

Issue 3: Inaccurate Readings in Radiology Department.

We substantiated the allegation that there were inaccurate readings in the Radiology Department. The complainant specifically identified four allegedly misread radiology studies. Each of these studies was reviewed by two physicians on the task force, a radiologist and a surgeon. The physicians determined that two of the cases met the standard of care and that two cases did not meet the standard of care.

At the time of the task force visit, the medical center was conducting a review of 74 radiographic studies read by one radiologist whom the complainant had specifically named. The review identified one case where another provider might have read the study differently.

While we substantiated the allegation of misread films in the Radiology Department, the task force and medical center reviews identified 3 misread studies out of the 78 studies they reviewed. Further, the medical center reestablished the quality monitor to conduct double readings of random samples of films, which should provide the necessary quality control oversight.

Issue 4: Delays in Obtaining Radiographic Studies.

We did not substantiate the allegation that patients were subjected to unreasonable delays in obtaining radiographic studies because the Radiology Department secretary position was vacant.

The administrative support clerk (secretary) resigned on March 2, 2007, to return to school, and the vacancy was filled on June 24. According to the Chief of Staff, during the time that the position was vacant, the duties were performed by other medical center employees. The Chief of Staff was not aware of any significant delays in obtaining studies during this period. In addition, our review of the Patient Advocate's complaint log for that period did not find any reports of unreasonable delays in obtaining radiographic studies.

Issue 5: Postponement of Surgery.

We substantiated the allegation that the former Chief of Surgery reportedly postponed an operation so that he could eat his lunch and that the Chief of Staff requested that the surgeon's name be removed from a routine morning report, which showed that he postponed the surgery.

We spoke with the Chief of Staff who acknowledged that a surgeon's name was removed from a morning report as alleged. She told us that the Chief of Surgery had postponed a procedure for 1 hour while he had lunch. The patient was notified of the postponement but declined to wait, and the surgery was canceled. This incident was listed on the morning report and included the surgeon's name. The Chief of Staff told us that she

requested that the Chief of Surgery's name be removed from the report because the names of surgeons who cancel or postpone procedures are not supposed to be included on this report.

Issue 6: Falsification of a Housekeeping Report.

We did not substantiate the allegation that the Houskeeping supervisor falsely reported that there were no problems with the level of cleanliness in the men's locker room in the OR suite.

The complainant raised a concern regarding the cleanliness of the men's locker room. The Housekeeping supervisor inspected the area soon after the complaint was raised, found that the bathroom was indeed in need of cleaning, and found someone to clean it. We did not find any evidence that the Housekeeping supervisor reported that there were no problems with the locker room on the date the complainant raised his concerns.

Issue 7: Construction Filth in the Operating Room.

We did not substantiate the allegation that during a recent construction project in the OR, staff had to contend with extraordinary filth coming from the vents and that multiple reports of this situation were ignored.

The complainant did not list a specific improvement project; however, the OR flooring was replaced while the complainant was employed at the medical center. The project was done over a weekend so that staff would be at a minimum and so as not to disrupt patient care. The task force found that the project was in compliance with Interim Life Safety Measures (ILSM), including sealing off the area to prevent dust/debris from spreading through the vents. The OR was fully functional on Monday morning, and the task force found no adverse outcomes for patients scheduled for procedures both before and after project completion.

We reviewed incident reports and employee complaint documents and did not find any complaints from employees regarding problems with dust and debris during this construction project.

Issue 8: Hastening a Patient Death.

We could not substantiate or refute the allegation that a patient who had surgery for a perforated ulcer developed an abscess and needed to be transferred to a facility that had x-ray support for the procedure to drain the abscess. However, a doctor persuaded the patient's wife to withdraw active treatment, and another doctor stopped the patient's intravenous infusion so that he would die faster.

In order to review this issue, the task force needed more information. However, when the members of the task force asked the complainant for the name of the patient and the

approximate date of the incident, the complainant did not provide the information. The complainant did not provide this information to the OIG either. Therefore, this allegation could not be reviewed.

Issue 9: Misdiagnosis in Emergency Room Led to a Patient Death.

The complainant alleged that a patient in the Emergency Room was misdiagnosed as having congestive heart failure when what he actually had was an upper airway obstruction which went undiagnosed for 24 hours. The patient had a cardiac arrest and died.

This allegation was previously investigated by OHI. Please refer to the OIG report *Quality of Care and Patient Safety Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia* (Report No. 07-02191-147, June 18, 2007).[1]

Issue 10: Delay in Obtaining Fresh Frozen Plasma.

We substantiated the allegation that fresh frozen plasma (FFP) took up to 7 hours to obtain when in most hospitals it is available within 45 minutes. He alleged that a patient hemorrhaged because his clotting factors malfunctioned, and it took hours to get FFP for the patient, putting the patient at risk and necessitating a return trip to the OR.

The task force found an incident where the OR requested multiple bags of FFP for a procedure, and a decision was made to thaw the FFP bags utilizing the wet water bath method, thawing two bags at a time. During the thawing of the first pair of FFP bags, one bag broke in the bath; therefore, delivery of the first two bags was delayed.

The Chief of Staff informed the OIG that the delay in obtaining the FFP was actually 3 hours and 40 minutes and since that incident the medical center obtained a new mechanism for thawing plasma in July 2007, and can now thaw FFP and have it available within 15–30 minutes of the time of request.

Issue 11: Housekeeping Employee with Open Sores.

We did not substantiate the allegation that an employee who cleaned the OR suite had open leg sores.

The task force interviewed the OR nurse manager and the Housekeeping supervisor to address this allegation. They were told that no Housekeeping employees had been observed with open sores on their legs nor had any incidents been reported. Also, medical center policy requires OR staff to wear scrub suits that cover their legs; therefore, any open sores would be covered and would not present a risk.

[1] Available at http://www.va.gov/oig/publications/reports-list.asp.

Issue 12: Allegations of an Unsanitary Cafeteria.

We did not substantiate the allegation that the cafeteria was unsanitary and unhygienic and that patients with pulmonary problems were occasionally seen coughing up secretions over the salad bar.

Task force members found that the cafeteria had a salad bar with a sneeze shield. The shield is protective for the average standing adult. However, the shield will not protect the food from small children or those bound by wheelchair. According to the Canteen Chief, the sneeze guard meets all safety standards. The Canteen chief told us that he had attempted to purchase a shield that was longer on the sides, but none were available on the market.

The Canteen chief voiced concern about the occasional inadequate cleaning performed by Housekeeping staff. However, during our visit, inspectors toured the cafeteria several times and found it to be clean and to have the salad bar sneeze shield in place.

Issue 13: Food Preparation Employees with Infectious Diseases.

We did not substantiate the allegation that a doctor at the medical center told the complainant that the medical center employed domiciliary patients with open skin lesions who were carriers of hepatitis to work as food handlers.

Nutrition and Food Service managers employ domiciliary patients who are in the Compensated Work Therapy Program to work in food preparation. Nutrition and Food Service managers evaluate all food service workers daily to ensure appropriate personal hygiene. Also, all employees must undergo a physical before being allowed to work in the food preparation area. The task force found no evidence that employees with infectious diseases were working in the Canteen or for the Nutrition and Food Service.

Issue 14: A Radiologist Sleeping on Duty.

We did not substantiate the allegation that a radiologist frequently fell asleep at his work station.

The task force interviewed Radiology Department staff, including the Business Manager and Acting Chief, but found no evidence to support this allegation. We found that the complainant had previously complained to the Chief of Staff about this radiologist's performance, but according to her, the complainant did not mention the radiologist falling asleep during his tour of duty. We did not find any incidents or "Reports of Conduct" concerning this radiologist sleeping on duty.

Issue 15: Senior Management's Unresponsiveness to Allegations.

We did not substantiate the allegation that the complainant discussed all of the prior issues mentioned above with the Chief of Staff, the Medical Center Director, and the Compliance Officer and that no corrective action had been taken to resolve these issues.

The task force requested more specific information from the complainant regarding this allegation; however, no other information was provided.

The previous Medical Center Director did not recall having conversations with the complainant related to these issues. We interviewed the Acting Medical Center Director, who was appointed in April of 2007. He acknowledged discussing the issues in the complainant's letter with the complainant and stated that he referred these issues to the Chief of Staff for resolution.

We interviewed the Chief of Staff who recalled speaking with the complainant on one occasion. The topic of their conversation concerned a misread radiology study and the complainant's perceived poor performance of a radiologist. The complainant did not address any other issues with her during this meeting. However, the Chief of Staff did state that she was aware of the issues raised in the complainant's letter. She asserted that based on his complaints, a number of corrective actions had been taken to resolve the issues.

We reviewed multiple documents detailing actions taken to resolve the complainant's issues, and during our follow-up visit, we noted that many of these actions had been completed (as discussed throughout this report). In addition, the task force has also made follow-up visits to the medical center to monitor follow-up actions for completion.

Recommendation

We recommended that the VISN Director ensure that the Acting Medical Center Director continues to monitor and implement the task force recommendations until completion.

Comments

The VISN and Acting Medical Center Directors concurred with the findings and recommendation and provided acceptable improvement plans. (See Appendixes A and B, pages 9–10, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

January 4, 2008

From: Network Director, VA Capitol Health Care Network (10N5)

Subj: Healthcare Inspection, Alleged Mismanagement and Patient Care Issues, Martinsburg VAMC

To: VA Office of Inspector General (54DC)

Thru: Director, Management Review Service (10B5)

1. Attached please find the Martinsburg VA Medical Center response to the Healthcare Inspection, Alleged Mismanagement and Patient Care Issues (conducted October 23, 2007, and December 11, 2007).

2. I have reviewed and concur with the findings outlined in the OIG Report. I concur with the facility on Issue 10 regarding the timeframe not being 7 hours as alleged by the complainant.

3. The Acting Medical Center Director, as outlined in the implementation action plan, will improve processes as identified by the VISN Task Force. Monthly reporting to the VISN on the status of recommendations will continue until completion by September 2008.

4. We appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

5. If further information is required, please contact Linda J. Morris, M.D., Chief of Staff, at (304) 263-0811, extension 4007.

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Appendix B

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 28, 2007

From: Acting Medical Center Director, VA Medical Center, Martinsburg, WV (613/00)

Subj: OIG Response

To: Network Director (10N5)

1. The Chief of Staff and I have reviewed the issues and findings outlined in the OIG Report. We concur with all findings but one. In Issue 10, the complainant alleged that fresh frozen plasma (FFP) took up to 7 hours to obtain. The OIG substantiated the allegation. The Chief of Staff has reviewed the documentation again. The actual time from physician order to the time the first fresh frozen plasma was ready for administration was actually 3 hours and 40 minutes, not a 7-hour delay.

2. We concur with the recommendation. We will continue to monitor and implement the VISN Task Force recommendations until completion. The biweekly status reports to the VISN Director will continue until completion of recommendations.

3. We appreciate the professionalism demonstrated by the OIG Team during this review process and the opportunity to review the report.

4. Should you have any questions or require additional information, do not hesitate to contact Linda J. Morris, M.D., Chief of Staff, at (304) 263-0811, extension 4007.

(original signed by:)

Pedro Garcia, Acting Director

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Donna Giroux, RN Health Systems Specialist Washington, DC, Regional Office of Healthcare Inspections 202 565-8305
Acknowledgments	Nelson Miranda, Director, Washington, DC, Regional Office of Healthcare Inspections Randall Snow, JD

Appendix D

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