Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues
VA Nebraska-Western Iowa
Health Care System
Omaha, Nebraska

Report No. 07-03037-43 **December 18, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of the review was to determine the validity of allegations of quality care issues at the Omaha Division of the VA Nebraska-Western Iowa Health Care System (the system). The anonymous complainant alleged that patients in the outpatient clinics who experience chest pain were not being treated with oxygen.

We substantiated that clinicians had not administered oxygen to two patients who experienced chest pain in the Cardiology Clinic area. Outpatient clinics are located on the first and second floors of the Omaha Division. We verified that oxygen was available in all clinic areas, and clinical staff we interviewed knew that patients who experience chest pain should be given oxygen. Ambulatory care managers had developed a standard operating procedure (SOP) for treatment of patients with chest pain in ambulatory care areas. The SOP requires that all patients experiencing chest pain be started on oxygen and that clinical staff immediately transport the patients to the ER. However, the Executive Committee of the Medical Staff had not approved the SOP. First floor clinic managers had posted the SOP and discussed with staff, but it was not posted on the second floor and clinic staff were not aware of the SOP. Because the SOP had not been approved and disseminated to all outpatient clinic staff, not all staff were aware of standard procedure requirements.

We recommended that system management approve and disseminate the SOP regarding patients who experience chest pain while in the system clinic areas.

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

TO: Director, Veterans Integrated Service Network (10N23)

SUBJECT: Healthcare Inspection ─ Alleged Quality of Care Issues, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, conducted an evaluation to determine the validity of allegations of quality care issues at the Omaha Division of the Nebraska-Western Iowa Health Care System (the system).

Background

The system includes facilities in Omaha, Lincoln, and Grand Island, Nebraska, and is part of Veterans Integrated Service Network (VISN) 23. The system provides services to a veteran population of approximately 172,500.

The Omaha VA Medical Center is a tertiary care facility that provides primary and specialized outpatient health care and acute inpatient medical, surgical, and psychiatric care. Outpatient clinics are located on the first and second floor of the medical center.

The anonymous complainant alleged that patients in the outpatient clinics who experience chest pain were not being treated with oxygen. The complainant also alleged that patients with alcohol withdrawal symptoms were not given proper care.

Scope and Methodology

We conducted an onsite inspection August 14–15, 2007, and interviewed clinical, administrative, and quality management (QM) staff and the patient safety officer. We reviewed the medical records of two patients identified through the patient safety officer, QM documents, and Veterans Health Administration (VHA) and local policies and procedures. We conducted the review in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

VHA's Office of the Medical Inspector is reviewing the allegation that patients with alcohol withdrawal symptoms were not given proper care. Therefore, this report does not address that allegation.

Inspection Results

Clinical Case Reviews

Patient 1

On January 31, 2007, a 57-year-old male with past medical history of hypertension, hyperlipidemia, and chronic obstructive pulmonary disease underwent a treadmill exercise stress test.[1] A nurse practitioner administered the test. During the test, the patient developed chest pain and decreased blood pressure (78/40 mmHg). A volunteer transported the patient, without oxygen, by wheelchair to the Emergency Room (ER). The patient was evaluated and subsequently admitted because of the possibility of myocardial infarction.

Patient 2

On March 30, 2007, a nurse practitioner administered an adenosine thallium test to a 60-year-old male with past medical history of coronary artery disease, diabetes, hypertension, and hyperlipidemia.[2] During the test, the patient became nauseated and experienced chest pain that he rated as 9 on a pain scale of 1 to 10 (10 being the most severe). A medical technician transported the patient, without oxygen, by wheelchair to the ER. Physicians evaluated the patient and subsequently admitted him for recurrent angina.

Issue: Treatment of Patients with Chest Pain

We substantiated that two patients who experienced chest pain while in the Cardiology Clinic area did not receive oxygen before transfer to the ER.

Clinic staff did not start oxygen on two patients when they experienced chest pain during cardiology procedures. While both patients were immediately transported to the ER, one of the patients was transported by a volunteer. Ambulatory care managers had developed a standard operating procedure (SOP) for treatment of patients with chest pain in ambulatory care areas. However, the Executive Committee of the Medical Staff had not approved the SOP. The SOP requires that all patients experiencing chest pain be started on oxygen and that clinical staff immediately transport the patients to the ER. Clinic

[1] The exercise stress test is a well-established procedure for answering clinical questions related to exercise tolerance and heart disease.
[2] For patients who are unable to exercise on a treadmill, medication and imaging is used for the evaluation of known or suspected coronary heart disease.

managers on the first floor had posted the SOP and discussed the procedure with staff but managers on the second floor had not.

We inspected all the clinic areas and verified that oxygen was readily available. While we determined that some clinic staff were not aware of the new SOP, all the staff we interviewed told us that if a patient experienced chest pain they would start oxygen and transport the patient to the ER.

Both patients in this case had their cardiac procedures administered by the same nurse practitioner (NP). This NP told us that when her patients experience chest pain she starts oxygen and transports them to the ER. Because the NP could not remember either of the two patients discussed in this report, she could not explain why she deviated from her standard procedure. We found no indications that delay in starting oxygen adversely impacted the patients' outcomes.

Conclusion

We substantiated that outpatient clinic staff had not administered oxygen to two patients who experienced chest pain in the Cardiology Clinic area. We verified that oxygen was available in all clinic areas and that clinical staff knew that patients who experience chest pain should be given oxygen. However, because the Executive Committee of the Medical Staff had not approved the SOP and it had not been disseminated to all clinic staff, not everyone was aware of an SOP outlining specific procedural requirements.

Recommendation: We recommended that the VISN Director ensure the System Director approves and disseminates the SOP regarding patients who experience chest pain while in the system clinic areas.

Comments

The VISN and System Directors concurred with the finding and recommendation of this inspection and provided acceptable improvement plans (see Appendixes A & B, pages 4–7, 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**

Date: November 1, 2007

From: Director, Veterans Integrated Service Network 23 (10N23)

Subject: **Alleged Quality of Care Issues, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Office (10B5)

I have reviewed and concur with the System Director's comments.

Robert A. Petzel

ROBERT A. PETZEL, M.D.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 1, 2007

From: Director, VA Nebraska-Western Iowa Health Care System (636/00)

Subject: **Alleged Quality of Care Issues, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska**

To: Director, Veterans Integrated Service Network (10N23)

Attached is the response and action plan to the Healthcare Inspection.

AL WASHKO

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommendation: We recommended that the VISN Director ensure the System Director approves and disseminates the SOP regarding patients who experience chest pain while in the system clinic areas.

Concur **Target Completion Date:** November 15, 2007

10/30/07: NWI Response. The SOP on the topic, Chest Pain Policy in Non-Inpatient Areas, has been converted to a Chief of Staff level policy, which is now approved, and in the process of being implemented. Ambulatory care, patient care, cardiology, and other procedural area staff will be trained and the policy will be disseminated to ensure understanding and compliance. The policy states that any patient while visiting non-inpatient areas with complaints of chest pain will be provided timely life support (i.e. oxygen administration, EKG, medication administration and transportation) and clinical monitoring under the direction of a provider. Specific procedures are as follows.

1. When a patient displays any signs or symptoms of chest pain, personnel will immediately notify the first available provider and/or call the Rapid Response Team by dialing x3333 on a hospital phone.

2. These patients must be constantly attended until additional assistance is available.

3. The provider determines the condition of the patient and necessary treatment.

4. All personnel assisting in the situation will remain available until relieved by other qualified personnel.

5. Personnel will locate necessary supplies as requested and needed, such as oxygen, crash cart, AED.

6. Information will be communicated utilizing the SBAR hand-off format and documented in the electronic record.

We would like to close this recommendation as of November 15, 2007.

The subject policy, dated August 21, 2007, is available for review upon request.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 426-2016
Acknowledgments	James Seitz, Project Manager Dorothy Duncan, Associate Director Marilyn Stones, Program Support Assistant

Appendix D

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