Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Respiratory Care and Other Clinical Concerns
VA Northern Indiana Health Care System
Fort Wayne, Indiana

Report No. 11-03462-17 October 24, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The Department of Veterans Affairs Office of Inspector General Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of anonymous complainants' allegations regarding inappropriate respiratory and clinical care at the Fort Wayne campus (the facility) of the VA Northern Indiana Health Care System, Fort Wayne, IN. The complainants alleged that "ineptness and indolence has cost lives and has put patients at great risk, with nothing being done about it." The allegations were general in nature and did not include patient names. The complainants did provide approximate dates of two alleged incidents that occurred in 2011. The complainants stated that the incidents had been reported to facility managers, but no actions were taken. We were able to identify the two patients referred to in the allegation from a review of administrative and patient safety documents.

While onsite, we also evaluated actions taken in response to recommendations from a recent OHI review. We found that the facility now has continuous in-house coverage by staff with demonstrated competence in airway management, and has appropriate physician coverage for the intensive care unit.

We determined that the clinical care provided for the two patients was appropriate. We substantiated the allegation that respiratory care policies were absent or ignored, and found that oxygen therapy was being initiated without a provider order. We substantiated that an identified physician had a higher readmission rate than other facility physicians, and also found that the Peer Review Committee did not ensure specific actions are taken in response to deficiencies identified.

We did not substantiate the allegations that another physician admitted patients with a diagnosis of pneumonia without obtaining appropriate diagnostics tests, patients were overmedicated due to short staffing, staff were leaving due to inferior patient care, and when patients became Do Not Resuscitate they were considered do not treat. We could not determine if arterial blood gases (ABGs) were performed when not indicated because there were no written criteria for ordering ABGs.

We recommended that the facility Acting Director ensure that facility respiratory care policies are updated, including specific guidance and expectations for ordering oxygen therapy; that peer review processes comply with Veterans Health Administration policy; and that an assessment of ABG usage is completed.

The Veterans Integrated Service Network and Acting Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans.

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

TO: Director, Veterans in Partnership (10N11)

SUBJECT: Healthcare Inspection – Respiratory Care and Other Clinical Concerns, VA Northern Indiana Health Care System, Fort Wayne, Indiana

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of anonymous complainants' allegations regarding inappropriate respiratory and clinical care at the Fort Wayne campus (the facility) of the VA Northern Indiana Health Care System (HCS).

Background

The HCS is a two-division, tertiary care facility in Veterans Integrated Service Network (VISN) 11. The Fort Wayne division provides primary and secondary medical and surgical services. It has 22 medical/surgical and 4 intensive care unit (ICU) beds.

The complainants alleged that "ineptness and indolence has cost lives and has put patients at great risk, with nothing being done about it." The allegations were general in nature and did not include patient names. The complainants did provide approximate dates of two alleged incidents that occurred in 2011. The complainants stated that the incidents had been reported to facility managers, but no actions were taken. The allegations were:

- A patient (Patient 1) was administered supplemental oxygen (O_2) at an inappropriately high delivery rate using a humidification system that "filled his lungs…"
- A patient (Patient 2) had inappropriate tracheostomy management that resulted in respiratory distress.
- Respiratory therapy (RT) protocols are absent or ignored.
- A physician (Physician A) discharges patients prematurely, causing early readmissions.
- A second physician (Physician B) admits patients with the diagnosis of pneumonia without adequate diagnostic testing.

- Patients are routinely overmedicated to "keep them quiet" due to insufficient staffing, and "good people [employees] are leaving" the facility.
- Patients with Do Not Resuscitate (DNR) orders do not receive appropriate treatment.
- Arterial blood gases (ABGs) are ordered unnecessarily.

Scope and Methodology

We conducted a site visit January 10–12, 2012. We interviewed managers, nurses, pharmacists, physicians, respiratory therapists, and patient safety and quality management (QM) staff. We reviewed Veterans Healthcare Administration (VHA) directives, electronic health records (EHR), policies, administrative documents, patient safety documents, and QM data and documents.

We were able to identify the two patients referred to in the allegation from a review of administrative and patient safety documents.

While onsite, we evaluated actions taken in response to recommendations from a recent OIG review (*Healthcare Inspection – Quality of Care in the Intensive Care Unit, VA Northern Indiana Health Care System, Fort Wayne, Indiana*, Report No. 10-02816-200, June 20, 2011).

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: Appropriateness of O_2 Delivery System for a Patient

Regarding the care of Patient 1, we did not substantiate the allegation that a high O_2 delivery rate "filled his lungs," and found no evidence that the patient suffered any harm. The facility Patient Safety Officer (PSO) was aware of the alleged incident and had recommended a change in procedures for the management of O_2 therapy; we confirmed that appropriate changes were instituted.

The patient was an elderly man with end-stage Parkinson's disease, dysphagia, and recent aspiration pneumonia; he also had congestive heart failure and renal insufficiency. The patient was admitted to the facility for placement of a percutaneous endoscopic gastrostomy (PEG) feeding tube. On hospital day (HD) 4, a PEG tube was placed and tube feedings started. On HD 5 the patient was receiving O_2 at 2 liters per minute (LPM) by nasal cannula (NC). On that day he had an increase in his white blood cell count, a chest x-ray was felt to be consistent with pneumonia, and he was treated with broad-spectrum antibiotics. Over the next 5 days, the rate of O_2 delivery was increased to

6 LPM and attempts to use a mask to deliver O_2 failed because the patient kept removing it. On HD 10, nursing notes indicate that the patient was receiving O_2 at 15 LPM by NC. Early on HD 11 staff moved the patient to a different room on the same unit due to a water leak and potential electrical hazard. A nurse noted that the patient was "sleeping on and off throughout night tour. Respirations shallow, labored on 15L high flow." A chest x-ray later that day showed that the "upper lungs are clear" but "underlying pneumonia in lower lobes cannot be excluded." A physician described the patient as being "verbally not responsive. He opens his eyes, looking around, very lethargic." The physician wrote that examination of the chest "showed diminished air entry bilaterally." On HD 13, the patient was discharged to the facility's community living center (CLC) for hospice care. He died at the CLC 16 days after discharge.

During our onsite review, nursing staff reported that some of the components of the high flow O_2 administration system were not moved when the patient changed rooms on HD 11, and O_2 was connected using a regular flow O_2 meter. However, registered nurses (RNs) caring for the patient after the transfer denied there was any excess water in the tubing and reported there was no change in the patient's condition.

On Patient 1's HD 13, an anonymous entry to the electronic patient safety reporting system stated that a patient had nearly drowned 2 days earlier from water in O_2 tubing. The facility PSO completed a review of the report and determined that no harm had occurred but identified an opportunity to expand the nursing staff's knowledge of the different types of O_2 administration systems. Facility managers provided education to nursing staff and also modified procedures so that respiratory therapists are now responsible for transferring and assembling all equipment for O_2 administration when patients are moved within the facility.

Issue 2: Tracheostomy Care for a Patient

We did not substantiate that clinical staff mismanaged a patient's tracheostomy, causing respiratory distress. Medical record documentation did not support that the patient had respiratory distress at the time the tracheostomy tube was capped. Further, we did not find that inappropriate equipment or procedures were employed.

Patient 2 was a middle-aged man with a history of sleep apnea, ischemic cardiomyopathy, and chronic obstructive pulmonary disease. He was admitted to the facility with dyspnea and tachycardia. Although his condition improved somewhat initially, he subsequently developed respiratory failure, required intubation and ventilator support, and was transferred to a local community hospital for continuing intensive care. A tracheostomy tube was placed at the community hospital and he required continued mechanical ventilation. After 33 days, he was transferred back to the facility for continued care, weaning from the ventilator, and removal of the tracheostomy tube.

On HD 11, ventilator support was discontinued and on HD 12, the tracheostomy tube was capped at 9:15 a.m. in anticipation of tube removal. During that day, ICU nursing staff documented that O_2 saturation levels were 99–100 percent while the patient was receiving supplemental O_2 at 3 LPM per NC. Nursing documentation indicates that he was taking ice chips and watching TV, had no respiratory distress, and his respiratory rate ranged from 10 to 26 per minute.

In a note signed at 7:10 p.m. on HD 12, a respiratory therapist wrote in a progress note that the patient had been:

> …placed back on the cool mist and the cap was pulled. This pt did not have the proper trach in to be on a nasal cannula and to have a cap in place. To be placed on a n.c. and a cap this pt needed to have a fenestrated trach in place. He was also making large amounts of mucous and his respirations were 38. Spo2 was 100% on 3L nc.

On HD 13, after consultation with an ear, nose, and throat specialist, the patient's tracheostomy tube was changed to a smaller size to facilitate eventual removal. The tracheostomy tube was removed on HD 19 and after an additional 3 days, the patient was discharged to a community nursing home for further care.

We found no documentation that this alleged incident had been reported through the electronic patient safety program and the PSO was not aware of the event.

Issue 3: Respiratory Care Policies

We substantiated the allegation that respiratory care policies were absent or ignored. We selected 10 respiratory care policies for review and found that 7 had not been updated since 2003. The facility requires that all local policies and protocols be updated when necessary or appropriate and at least every 3 years. In addition, the respiratory care policy book listed policy numbers that had no corresponding policies.

We reviewed EHRs for 10 inpatients that received O_2 administration the first week of June 2011 and found that 5 EHRs had no physician order for O_2 administration. RT staff reported that there was no requirement for a physician order, and the respiratory care protocol for O_2 administration dated July 30, 2003, provides no specific guidance. However, physicians and the RT supervisor stated that there is a requirement for a physician's order for O_2 administration.

RT staff reported that physicians often give verbal orders for routine O_2 administration but do not document the order. This practice does not comply with facility policy, which requires that verbal orders only be used in emergent/urgent situations.

Issue 4: Patient Discharges and Readmissions

We substantiated that Physician A had a higher readmission rate related to discharge issues than other facility physicians.

We reviewed QM data and found the physician had a higher rate of patient readmissions within 10 days of discharge compared to other similar physicians. Physician A also had a higher rate of cases referred for peer review. While we were onsite, the physician's supervisor initiated action to improve clinical care provided by Provider A.

During our review of the peer review process, we determined that the Peer Review Committee (PRC) did not comply with VHA requirements. The PRC is required to provide recommendations for non-punitive, non-disciplinary actions to improve the quality of health care delivered or the utilization of health care resources.[1] The supervisor of the individual reviewed is responsible for initiating appropriate action and follow-up and reporting back to the PRC upon completion of the action.

We found that PRC minutes did not include discussion of specific actions recommended. The PRC minutes stated that the action taken in response to Level 3[2] reviews was a letter sent to the provider with the results of the peer reviews. The letter did not include actions for improving care. Physician A told us that no one had ever discussed the peer review results with him or recommended any actions to improve delivery of care.

Issue 5: Diagnostic Testing for Patients Admitted with Pneumonia

We did not substantiate the allegation that Physician B regularly admits patients with a diagnosis of pneumonia without obtaining appropriate diagnostics tests.

QM staff routinely monitor individual provider compliance with admission criteria. Our review of QM data for August and September 2011 showed that Physician B was 100 percent compliant with nationally accepted admission criteria.[3]

Issue 6: Use of Sedating Medications

We did not substantiate that "patients are routinely overmedicated to keep them quiet due to short staffing." In addition, we did not substantiate that "good people are leaving, finding it more palatable to change employers than to continue to witness inferior care..."

No one we interviewed had ever witnessed an incident where patients were overmedicated. Managers and clinicians reported that Pharmacy Service tracks patients'

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] Level 3 = Most experienced, competent practitioners would have managed the case differently.
[3] VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.

medication usage and no outliers were identified. Additionally, the PSO had received no reports of possible patient overmedication.

Managers reported that nurse-staffing levels are reviewed daily and if there are staffing shortages, no additional patients are admitted. At the time of our review, the RN turnover rate for the facility was 7.29 percent, compared with the VISN rate of 7.7 percent, and the national rate of 7.8 percent. Managers reported that most of the RNs who leave the facility are retiring or transferring within the VA system.

Issue 7: Treatment of Patients with DNR Orders

We did not substantiate that "when patients become a "DNR" they are considered "Do Not Treat."

We reviewed the care of 10 patients who were designated DNR and had been admitted to the ICU between April and September 2011. All 10 patients received some type of treatment, such as medications, intravenous fluids, and blood products. Managers and clinicians stated there were no reported deficiencies in the care of DNR patients.

Issue 8: ABG Testing

We did not substantiate or refute that ABGs are performed when not indicated. A complainant alleged that ABGs were being performed unnecessarily in circumstances when less invasive tests would have been more appropriate, and RT staff told us that there had been an increase in the number of ABGs being ordered. In the course of an evaluation of patient deaths at the facility, VISN 11 reviewers had questioned the low rate of ABGs performed for patients with pneumonia and congestive heart failure.

Issue 9: Follow-up of Findings from Prior Inspection

We reviewed documentation of actions taken in response to recommendations from a recent OIG review regarding out-of-operating room airway management and ICU physician coverage. We found that the facility now has staff with demonstrated competence in airway management continuously present in-house. We also found that the facility now has appropriate physician coverage for the ICU.

Conclusions

We determined that the clinical care provided for Patients 1 and 2 was appropriate. We substantiated the allegation that respiratory care policies were absent or ignored, and found that oxygen therapy was being initiated without a provider order. We substantiated that Physician A had a higher readmission rate than other physicians, and also found that the PRC did not ensure specific actions are taken in response to deficiencies identified.

We did not substantiate the allegations that Physician B admitted patients with a diagnosis of pneumonia without obtaining appropriate diagnostics tests, patients were overmedicated due to short staffing, staff were leaving due to inferior patient care, and when patients became "DNR" they were considered "Do Not Treat."

We could not determine if ABGs were performed when not indicated because there were no written criteria for ordering ABGs.

We found that the facility now has continuous in-house coverage by staff with demonstrated competence in airway management, and has appropriate physician coverage for the ICU.

Recommendations

Recommendation 1. We recommended that the facility Acting Director ensures that facility respiratory care policies are updated, including specific guidance and expectations for ordering oxygen therapy.

Recommendation 2. We recommended that the facility Acting Director ensures that peer review processes comply with VHA policy.

Recommendation 3. We recommended that the facility Acting Director implements procedures to complete an assessment of ABG usage.

Comments

The VISN Director and facility Acting Director concurred with the inspection results (see Appendixes A and B, pages 8–11, for the full text of their comments and completed actions). The actions taken are acceptable and we will follow up on the planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 3, 2012

From: Director, Veterans In Partnership (11N15)

Subject: Healthcare Inspection – Review of Quality of Care Issues at VA Northern Indiana Health Care System, Fort Wayne, IN

To: Director, Kansas City Office of Healthcare Inspections

Thru: Director, Management Review Service (VHA 10AR MRS)

1. Please find NIHCS' response to the Respiratory Care and other clinical concerns review.
2. If you have any questions, please contact Kelley Sermak, Quality Management Officer, at 734-222-4302.

Michael S. Finegan

Appendix B

Facility Acting Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 3, 2012

From: Acting Director, VA Northern Indiana Health Care System, Fort Wayne, IN (610A4/00)

Subject: Healthcare Inspection – Review of Quality of Care Issues at VA Northern Indiana Health Care System, Fort Wayne, IN

To: Director, Veterans In Partnership (11N15)

If there is any additional information required, you may contact Barbara Lyons, Chief of Quality Management, at (765) 674-3321, extension 76116.

Helen M. Rhodes, for and on behalf of
Brent A. Thelen, Ph.D.

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

The following facility Acting Director's comments are submitted in response to the recommendation in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the facility Acting Director ensures that facility respiratory care policies are updated, including specific guidance and expectations for ordering oxygen therapy.

Concur **Target Completion Date:** 10/31/2012

All respiratory care policies have been updated as of January 28, 2012. A new Standard Operating Procedure has been created in order to provide guidance and expectations for ordering oxygen therapy.

Recommendation 2. We recommended that the facility Acting Director ensures that peer review processes comply with VHA policy.

Concur **Target Completion Date:** 11/15/2012

The Peer Review Policy has been revised to require the Service Chief to share the Peer Review Results and Recommendations to the Provider within 7 working days of the receipt of the results. The peer review form is being revised to include documentation by the service chief. The documentation will include a synopsis of the discussion, opportunities for improvement that were identified, actions taken at the individual level, and opportunities that that will require system improvements to improve the care for Veterans in the future. The supervisor will now ensure that appropriate non-disciplinary, non-punitive action is implemented and written feed-back provided to the Peer Review Committee upon completion and compliance will be tracked through the Peer Review Committee. The Peer review policy will also include triggers for Focused Professional Practice Evaluation.

Recommendation 3. We recommended that the facility Acting Director implements procedures to complete an assessment of ABG usage.

Concur **Target Completion Date:** 11/21/2012

Cardio Pulmonary will conduct a review of 30 percent of all ABGs for the past 6 months. The review will focus on the appropriateness of ABG orders. The ABG review findings will be reported to the Clinical Executive Board for follow-up actions if necessary.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Acknowledgments	Dorothy Duncan, RN, MHA, Project Leader James Seitz, RN, MBA, Team Leader Jerome Herbers, MD Larry Selzler, MSPT Jennifer Whitehead, Program Support Assistant

Appendix D

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