Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Mid-Level Provider Oversight
George E. Wahlen VA Medical Center
Salt Lake City, Utah

Report No. 12-02476-103 February 1, 2013

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merits of allegations concerning the quality of mid-level provider[1] patient care in an Intensive Care Unit (ICU) and the failure of leadership to take action when complaints concerning care in the ICU were reported at the George E. Wahlen VA Medical Center, Salt Lake City, UT.

We did not substantiate that a mid-level provider ordered the wrong doses of patient medications, failed to follow glucose monitoring protocols, or failed to remove a central line when it was determined to be in the wrong place. We did substantiate that a mid-level provider restarted a patient's home medications without adjusting for the elevated liver function tests, but the error was caught by the ICU pharmacist and the patient did not suffer any harm.

We did substantiate that a mid-level provider inappropriately administered hydralazine to a patient resulting in cardiogenic shock; and that a mid-level provider failed to timely notify attending physicians when a patient experienced prolonged bradycardia. We did not substantiate that a mid-level provider inappropriately advanced a diet order causing a patient to vomit, followed by aspiration and cardiopulmonary arrest.

We did not substantiate allegations that facility leadership failed to take any action regarding these complaints. We found that facility leadership convened a preliminary investigation board, and took personnel action.

We also identified issues concerning Physician Assistant (PA) supervision and scope of practice reviews, lack of a process equivalent to credentialing and privileging of physicians for the PAs and nurse practitioners, and confusion among the ICU staff and attending physicians regarding the reporting of adverse events.

We recommended that the facility Director establishes a process for mid-level provider scope of practice reviews equivalent to Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations; ensures that mid-level Professional Standards Boards forward their recommendations for the granting of scopes of practice to the Medical Executive Committee for review; provides adverse event reporting training for the ICU staff and attending physicians; and strengthens the ICU near miss and adverse events reporting procedures.

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

[1] Mid-level providers include Physician Assistants and Advance Practice Registered Nurses.

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

TO: Director, VA Rocky Mountain Network (10N19)

SUBJECT: Healthcare Inspection – Mid-Level Provider Oversight, George E. Wahlen VA Medical Center, Salt Lake City, Utah

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine whether allegations concerning poor patient care provided by mid-level providers in an Intensive Care Unit (ICU) had merit at the George E. Wahlen VA Medical Center (facility) in Salt Lake City, UT.

Background

The facility is part of Veterans Integrated Service Network (VISN) 19, has 121 inpatient beds, and provides a broad range of inpatient and outpatient health care services including medical, surgical, mental health, geriatric, and rehabilitation services. The facility is affiliated with the University of Utah Medical and Nursing schools, Weber State University, and Utah State University.

Definitions and Qualifications

PAs are medical professionals who work in a team with a supervisory attending physician. PAs have:

- Completed 2 years of study in basic and behavioral science
- Graduated from an accredited PA program (usually with a masters degree)
- Passed the national certification examination[2]

APRNs in the state of Utah[3] are Licensed Independent Practitioners (LIP) who have:

- Completed a Bachelor of Science in Nursing or other appropriate baccalaureate degree
- Licensure as a registered nurse
- Completed a minimum of a master's degree from an accredited nurse practitioner program, including a minimum of 500 faculty supervised clinical hours
- Passed the national certification examination[4]

VHA Directive[5] and the State of Utah[6] require that each PA be appointed a primary supervising physician. The supervising physician is not required to be physically located with the PA, but must be available by telephone or e-mail. In Utah, APRNs are considered LIPs and only require supervision for the writing of schedule II and III narcotic prescriptions.[7] In the facility, both PAs and APRNs are mid-level providers and subject to physician oversight.

Allegations

In April 2012, an anonymous complainant contacted the OIG Hotline Division and alleged that a mid-level provider in the facility's ICU:

- Gave patients the wrong doses of medications including antibiotics, insulin, and blood pressure medications.

[2] National Commission on Certification of Physician Assistants website, http://www.nccpa.net/
[3] Utah Division of Occupational and Professional Licensing, Advanced Practice Registered Nurse, http://www.dopl.utah.gov/licensing/nursing.html .
[4] American Nurses Credentialing Center-Requirements for Acute Care Nurse Practitioner Certification website, http://www.nursecredentialing.org/Documents/Certification/Application/NursingSpecialty/AcuteCareApplication_1.aspx, accessed on 7/20/2012.
[5] VHA Directive 2004-029, *Utilization of Physician Assistants* (July 2, 2004).
[6] Utah Division of Occupational and Professional Licensing, Physician Assistant http://www.dopl.utah.gov/licensing/physician_assistant.html .

[7]The US Department of Justice, Drug Enforcement Division defines classifies schedule II narcotics as those drugs with a high potential for abuse. Schedule III drugs have a potential for abuse less than schedule II drug. http://www.deadiversion.usdoj.gov/schedules/index.html# .

- Failed to follow ICU protocols for glucose management.
- Failed to promptly remove a central line when it was determined to be in the wrong place.
- Ordered that the patient's home medications be re-started without adjusting for elevated liver function tests, leading to the patient's intubation and increased length of stay.

The complainant further alleged that facility leadership failed to take any actions when the ICU staff reported these allegations.

While on-site we received additional allegations that a second mid-level provider misadministered hydralazine to a patient resulting in cardiogenic shock; failed to timely notify attending physicians when a patient experienced prolonged bradycardia; and inappropriately advanced a diet order, causing a patient to vomit, followed by aspiration and cardiopulmonary arrest.

Scope and Methodology

We conducted a site visit from June 4–8, 2012, and additional telephone interviews from August 16–21, 2012. We interviewed a Chief of Service, ICU attending physicians, ICU PAs and APRNs, the Associate Director for Patient Care Services, the ICU nurse manager, the facility PA Professional Standards Board (PSB) Chair, the Director of Quality Management, ICU nursing staff, and pharmacy staff. We reviewed patient Electronic Health Records (EHR's), facility quality management documents, credentialing and privileging documentation, and PA and APRN PSB committee minutes. In addition, we reviewed relevant facility, VHA, and The Joint Commission (JC) policies, and Utah State regulations concerning PA and APRN scopes of practice.

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

Inspection Results

Issue 1: Allegations

We did not substantiate that a mid-level provider administered the wrong doses of antibiotics, insulin, and blood pressure medications or failed to follow glucose monitoring protocols. We identified one incident where a mid-level provider ordered a patient's home medications restarted without adjusting for changes in liver function. This oversight was detected by the ICU pharmacist before any inappropriate doses of medication were dispensed or administered to the patient. Appropriate QM review and action was taken after this incident.

We did not substantiate that a mid-level provider failed to remove a central line when it was discovered to be in the wrong place. We reviewed facility incident reports and interviewed ICU staff, and no incidents were reported that involved failure to remove a central line when it was discovered to be in the wrong place.

During our inspection, additional allegations of poor care provided by a second mid-level provider in the ICU was brought to our attention. We did substantiate that a mid-level provider inappropriately administered hydralazine to a patient resulting in cardiogenic shock; and that a mid-level provider failed to timely notify attending physicians when a patient experienced prolonged bradycardia. We did not substantiate that a mid-level provider inappropriately advanced a diet order, causing a patient to vomit, followed by aspiration and cardiopulmonary arrest.

In all cases reviewed, we found documentation in the medical record that the mid-levels were being supervised by an attending physician.

Issue 2: Leadership

We did not substantiate that the facility leadership failed to take actions when the ICU staff reported allegations. Staff we spoke to and documents we reviewed indicated that during fiscal year 2010, two mid-level providers engaged in unprofessional behavior with each other, affecting the staff in the ICU. During the same timeframe, facility leadership stated that there was no one person in charge of the ICU's day-to-day management. The attending physicians we interviewed were unaware of the formal requirements of PA supervision and stated that they did not know who they would talk to if they had problems with the mid-level providers.

Prior to our visit, the facility leadership had identified issues in the ICU resulting from the unprofessional behavior of the two mid-level providers and the lack of a defined chain of command. They conducted a preliminary investigation and took personnel action. At the time of our site visit, a new manager had been appointed and was taking initiatives to clarify the roles, responsibilities, and supervision of the mid-level providers

and nursing staff. In addition, ICU staff participated in team building exercises to improve staff morale.

Issue 3: Mid-Level Provider Oversight Requirements

VHA requires that a PA's scope of practice agreement be developed by the PA's primary supervising physician, physicians who substitute for the supervising physicians during their absence, and the PA. The scope of practice grants the PA permission to perform procedures that are consistent with their education, license, certifications, and abilities, and within the scope of the facility. APRNs who prescribe schedule II and III [8] controlled substances are required to have a referral plan (scope of practice) developed with a licensed physician who has agreed to provide consultation on the prescription of narcotics.[9]

JC requires that if facilities choose not to have mid-level providers credentialed and their scopes of practice reviewed through the Medical Executive Committee (MEC), that their process for credentialing and renewal for the scope of practice be equivalent to the MEC process.[10] JC also requires facilities to have a process equivalent to the Focused Professional Practice Evaluations (FPPE) and the Ongoing Professional Practice Evaluations (OPPE) for the mid-level providers.[11] FPPE is a process whereby data is collected for a short period of time after a new provider enters on to duty to ensure they are able to perform the requested privileges. OPPE is ongoing data collection to assess the provider's clinical competence and professionalism. The information gathered is used in decisions regarding privileging and approval of scopes of practice. In addition, if an equivalent process is used, the MEC is to provide input into granting the scope of practice.

The attending physicians we interviewed, scopes of practice, and EHR's we reviewed indicated that scopes of practice were appropriate, and that the attending physicians had day-to-day oversight of the mid-level practitioners' practice. Mid-level notes were co-signed and there was excellent communication between the mid-level providers and the supervising physicians. We observed attending physician rounds in the ICU and noted good communication between the attending physician and the PA.

We reviewed all ICU mid-level providers credentialing, and scopes of practice documentation. The mid-level providers had appropriate scopes of practice that were

[8] The US Department of Justice, Drug Enforcement Division classifies schedule II narcotics as those drugs with a high potential for abuse. Schedule III drugs have a lower potential for abuse than schedule II drugs. http://www.deadiversion.usdoj.gov/schedules/index.html# .
[9] Utah Nurse Practice Act, Utah Code Ann., Title 58, Chapter 31b (2011).
[10] Joint Commission HR. 01.02.05.
[11] Joint Commission HR. 01.02.05.

specific for the provider, facility, and setting in which they practiced. All the mid-level providers' scopes of practice we reviewed had the signature of the supervising physician as required by VHA.[12] The mid-level providers' scopes of practice were reviewed by their specialty's PSB. We did not find evidence that the supervising physicians conducted any structured reviews nor had an ongoing monitoring process equivalent to the FPPE/OPPE process for the mid-level providers.

The PSB's minutes we reviewed did not contain evidence that objective data was reviewed and considered in the process of granting the scopes of practice. The mid-level provider PSB's minutes were sent to the MEC for information only and not for review and comment as required by JC[13]. The facility had recently instituted an APRN peer review process, but it did not meet the requirement for an equivalent FPPE/OPPE process.

Issue 4: Adverse Event Reporting

VHA requires that all staff report any adverse events and near misses to the facility patient safety manager.[14] All levels of staff we interviewed were confused about what constituted a reportable incident, who to report it to, and how to report it. The adverse event logs we reviewed contained few reported ICU adverse events. Staff we interviewed stated that they did not report every incident.

Recommendations:

Recommendation 1. We recommended that the facility Director establish a process for mid-level scope of practice reviews equivalent to Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations.

Recommendation 2. We recommended that the facility Director ensure that the mid-level Professional Standards Board forwards recommendations for the granting of scopes of practice to the Medical Executive Committee for review.

Recommendation 3. We recommended that adverse event report training be provided to all Intensive Care Unit staff, including the attending physicians.

Recommendation 4. We recommended that systems be strengthened to ensure that all Intensive Care Unit near misses and adverse events are reported.

[12] VHA Directive 2004-029.
[13] Joint Commission HR.01.02.05.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–11 for the Directors' comments.) 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: January 9, 2013

From: Director, VA Rocky Mountain Network (10N19)

Subject: **Healthcare Inspection – Mid-Level Provider Oversight, George E. Wahlen VA Medical Center, Salt Lake City, UT**

To: Director, Washington DC Office of Healthcare Inspections (54DC)

I have reviewed the status report regarding the findings to the OIG CAP report provided by the George E. Wahlen VA Salt Lake City Health Care System and concur with the response. I am submitting it to your office as requested. If you have any questions or require additional information, please contact Aggie Worth, VISN QMO at (303) 639-6984.

(original signed by:)

RALPH T. GIGLIOTTI, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 9, 2012

From: Director, George E. Wahlen VAMC, Salt Lake City, UT (660/00)

Subject: **Healthcare Inspection – Mid-Level Provider Oversight, George E. Wahlen VA Medical Center, Salt Lake City, UT**

To: Director, VA Rocky Mountain Network (10N19)

1. I would like to express my appreciation to the OIG Healthcare Inspection Team for their professionalism and consultative feedback during the healthcare inspection specifically examining mid-level provider oversight at George E. Wahlen VA Medical Center which was conducted June 4-8, 2012.

2. I have reviewed the recommendations and concur with the findings. Our comments and planned actions are outlined below.

3. Should you have any questions, please contact Nena Saunders, Associate Director Quality and Safety Systems at (801) 582-1565, ext. 4608.

Steve Young

STEVEN W. YOUNG, FACHE

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

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

OIG Recommendations

Recommendation 1. We recommended that the facility Director establish an equivalent process to Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations for mid-level scope of practice reviews.

Concur **Target Completion Date:** March 1, 2013

Facility's Response: On-going Professional Practice Evaluations (OPPE) and Focused Professional Practice Evaluations (FPPE) will be conducted for all mid-level providers and will mirror the medical evaluation process. Currently, Advanced Practice Registered Nurses (APRN's) evaluations include peer reviews completed six and twelve months after entry on duty. After the initial year, individual peer reviews are completed, at a minimum, annually or as determined by the Nursing Quality Management Peer Review Board. Physician Assistants' supervising physicians provide day-to-day professional oversight and complete annual evaluations. The process for both professions will be modified and modeled after the Medical Peer Review process.

Status: On-going

Recommendation 2. We recommended that the facility Director ensure that the mid-level Professional Standards Board forwards their recommendations for the granting of scopes of practice to the Medical Executive Committee for review.

Concur **Target Completion Date:** January 22, 2013

Facility's Response: Currently, scopes of practice are initially reviewed by the Nurse Professional Standards Board or Physician Assistant Standards Board, as appropriate. The boards' recommendations are forwarded to the Medical Professional Standards Board for review and then to the Medical Executive Committee for review and concurrence. The Professional Standards Boards for

both disciplines will offer more content in their presentation to the Medical Executive Board (termed Clinical Executive Board in this facility). Minutes of the CEB will better document and reflect the depth and rigor of discussion.

Status: On-going

Recommendation 3. We recommended that all staff in the Intensive Care Unit, including the attending physicians, receive training on adverse event reporting.

Concur **Target Completion Date:** February 1, 2013

Facility's Response: The Patient Safety Manager will conduct adverse event training for 100% of Intensive Care Unit Provider Staff, Nursing, and Support Staff. The focus of the training will be what constitutes an adverse event and a near miss, as well as the process and timeliness requirements for reporting events. A list of all attendees will be maintained and recorded in the Talent Management System (TMS).

Status: On-going

Recommendation 4. We recommended that systems be strengthened to ensure that all Intensive Care Unit near misses and adverse events are reported.

Concur **Target Completion Date:** February 1, 2013

Facility's Response: The Patient Safety Manager will develop a checklist of potential adverse events which will be reviewed daily by the Charge Nurse and Nurse Manager to determine if any of those events occurred within the unit. This list will consist of the most common events that occur in Intensive Care settings and will serve as a continuous education tool. The Nurse Manager will then be responsible for insuring that an adverse event report has been or will be completed within 24 hours. The Patient Safety Manager will review the checklists every business day with the Intensive Care Unit Nurse Manager. This redundant system will improve the knowledge of staff regarding what are reportable events and will insure those events are reviewed and evaluated by the Patient Safety Manager

Status: On-going

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Contributors	Randall Snow, JD, Project Manager Donna Giroux, RN, Team Leader Robert Yang, MD Natalie Sadow-Colón, MBA, Program Support Assistant

Appendix C

Report Distribution

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