Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Provided at Corpus Christi Community Based Outpatient Clinic
VA Texas Valley Coastal Bend Health Care System
Harlingen, Texas

Report No. 11-02548-291 **September 29, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to determine the validity of allegations made by a complainant regarding quality of care at the Corpus Christi Community Based Outpatient Clinic (CBOC) in Corpus Christi, TX. The CBOC is part of VA Texas Valley Coastal Bend Health Care System in Harlingen, TX (the facility). The complainant specifically alleged that:

- A provider did not diagnose a patient's fractured ankle when the patient presented with right foot pain after a fall.
- A provider diagnosed a patient with pressure ulcers rather than abscesses caused by medication injections, and treated the patient with antibiotics without obtaining wound cultures.

We substantiated that a CBOC primary care provider did not diagnose a patient's fractured ankle when the patient presented for evaluation. The facility had taken appropriate action prior to our review.

We substantiated that a CBOC primary care provider prescribed antibiotics without first obtaining wound cultures. The primary care provider acknowledged that it was the usual practice to obtain a specimen for culture when drainage was present in a wound prior to starting antibiotics.

We identified two additional factors that affected this patient's care:

- Failure to implement the facility's Skin Integrity Management Program Policy for managing the skin integrity of outpatients.
- Fee-basis records are not always available in the medical record. The facility identified opportunities for improvement prior to our review. We found their plan acceptable.

We recommended that the Medical Center Director ensure that the CBOC follow the Skin Integrity Management Program Policy.

The Veterans Integrated Service Network and Medical Center Directors concurred with our findings. We will follow up until the planned actions are completed.

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

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

SUBJECT: Healthcare Inspection – Quality of Care Provided at Corpus Christi CBOC, VA Texas Valley Coastal Bend HCS, Harlingen, Texas

Purpose

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a complainant regarding quality of care at the Corpus Christi Community Based Outpatient Clinic (CBOC) in Corpus Christi, TX.

Background

The CBOC is part of VA Texas Valley Coastal Bend Health Care System (HCS) in Harlingen, TX (facility) and Veterans Integrated Service Network 17 located in Arlington, TX. The CBOC provides outpatient healthcare including primary care, mental health, orthopedic, nutrition, podiatry, social work, and physical therapy services. The clinic serves a population of approximately 15,000 veterans. The CBOC is approximately 135 miles from the facility.

The Veterans Health Administration (VHA) established the facility in December 2008 to provide a variety of outpatient specialty care. The facility provides inpatient care via contracts. The facility uses fee-basis referrals for specialty care that are not available at the CBOCs or facility. VHA policy[1] requires facilities to scan the reports and other results of fee-basis referrals into the patient's medical record.

In May 2011, a complainant contacted OIG's Hotline Division with allegations that CBOC physicians were not following standards of care when treating their patients. The complainant specifically alleged that:

[1] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

- A provider did not diagnose a patient's fractured ankle when the patient presented with right foot pain after a fall.
- A provider diagnosed a patient with pressure ulcers rather than abscesses caused by medication injections and treated the patient with antibiotics without collecting wound cultures.

Scope and Methodology

We made a site visit to the CBOC on June 14–15, 2011. We interviewed facility and CBOC managers, clinicians, and other staff with knowledge of the complaints. We reviewed patient medical records and facility documents. We interviewed one patient for clarification after our medical records review.

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.

Case Summaries

Patient 1

In February 2011, a man in his fifties with a history of diabetes with peripheral neuropathy,[2] hypertension, high cholesterol, and leg swelling presented to the CBOC for a routine primary care appointment. A licensed vocational nurse (LVN) assessed the patient prior to the appointment and documented that the patient described loss of consciousness, falling, and injuring his right foot. The patient complained that walking was painful and rated the pain as an 8 on a scale from 0 to 10. The LVN's note documented primary care provider (PCP) notification of the new, acute pain in the patient's foot radiating to the ankle.

The PCP's note documented that the patient presented for management of chronic medical problems. The PCP's note contained a vital signs section with the pain scale of eight, but did not address the pain in the body of the note. The PCP documented that examination of the extremities showed no swelling and normal pulses. The note states that the PCP reviewed images; however, there were no x-rays on record since August 2009. The PCP documented that a diuretic was controlling the patient's leg swelling.

Nine days later, the patient returned to the CBOC requesting a walk-in appointment with complaint of right ankle pain. A registered nurse (RN) documented that the patient had fallen 12 days prior and was walking slowly with a very swollen right ankle and discolored foot. Per triage clinic protocol, the RN sent the patient for an x-ray prior to a physician's examination. A different CBOC physician examined the patient during this

[2] Peripheral neuropathy refers to damage of nerves of the peripheral nervous system. Symptoms include numbness, pain, and problems with muscle control.

visit and the note documented the patient's fall, subsequent swelling and tenderness of the patient's ankle, and x-ray evidence of an ankle fracture. The physician consulted an orthopedic surgeon who recommended a follow-up appointment in 3 days. The surgeon discharged the patient with an ankle wrap, crutches, and recommended using ice and elevating the ankle. The patient already had an active prescription for pain medication.

Patient 2

In September 2010, a female in her fifties with a history of chronic back pain, hypertension, tobacco use, and bipolar disorder[3] that required intramuscular risperidone[4] injections (given in the hip) every 2 weeks presented to the CBOC complaining of chronic pain and skin ulcers at the hip injection sites. The patient's PCP did not document the ulcers in the examination, assessment, or plan during this visit.

Four days later, the patient returned to the CBOC requesting antibiotics for infections of the left and right hip injection sites. The patient's PCP's documentation noted small, infected lesions. The PCP prescribed an antibiotic for 10 days and instructed the patient to return if the symptoms did not improve.

Over the next two weeks, the patient twice reported to the pharmacist that the wounds had not improved, and remained painful and irritated. After a second notice from the pharmacist, the PCP scheduled the patient for a return appointment 4 days later.

At the appointment, the PCP noted the patient's non-healing hip ulcers. A blood test revealed the patient had a normal white blood cell count. The PCP's plan included daily iodoform gauze[5] dressing changes until the ulcers healed with follow up in 3 months. The patient's home care RN was to continue weekly visits and perform the dressing changes. The patient's roommate changed the dressings when the RN was not scheduled to visit.

In November 2010, the home health RN documented that both hip ulcers were not improving, were tunneling,[6] and had purulent drainage[7] that required dressing changes up to 3 times per day. The RN requested a PCP appointment for re-evaluation.

In Mid-November at the next primary care appointment, the PCP noted a deep, non-healing, non-draining ulcer with slight redness. The PCP prescribed two antibiotics for 10 days, recommended continuing daily dressing changes, and requested the patient follow up in 2 months.

[3] Bipolar disorder involves periods of elevated or irritable mood, alternating with periods of depression.
[4] Risperidone is a medication used to treat the symptoms of bipolar disorder.
[5] Iodoform gauze is a type of sterile gauze treated with iodoform (an antiseptic). The gauze is placed in wounds to help the wound drain.
[6] Tunneling is a narrow opening or passageway underneath the skin that can extend in any direction through soft tissue and results in dead space with potential for abscess formation.
[7] Purulent drainage is thick, yellow, green, or brown in color with a pungent, strong, foul odor.

The home health RN continued to document that the ulcers were not healing, had large amounts of purulent drainage, and had tunneled deep into subcutaneous tissue.[8] After 2 weeks, the RN requested a consult for surgical incision and drainage.

Three days later, a CBOC physician entered a fee-basis consult at the request of the RN for surgical incision and drainage of tunneling abscesses. The consult was approved 15 days later in mid-December. The next day, the home RN scheduled an appointment with a fee-basis surgeon.

In Mid-December, the patient saw a fee-basis surgeon and reported to the home health RN that the surgeon did not prescribe an incision and drainage of the hip ulcers. The home health RN contacted the surgeon's office to confirm the surgeon's recommendations directly. The surgeon requested a home health wound care RN for daily wound care using saline irrigation and dry packing, rather than iodoform gauze, for optimal wound healing. The surgeon also requested a bone scan[9] for the patient to rule out osteomyelitis.[10] Home health daily wound care began the next day. A bone scan was completed the end of December.

Two days after the bone scan was completed, the patient presented to the CBOC with draining hip abscesses that were without redness or tenderness. The physician changed the diagnosis from pressure ulcers to abscesses. The physician ordered wound cultures, wound packing, and continuation of home health wound care. This physician prescribed a different antibiotic and requested an appointment for the patient to return in 4 days for wound checks and culture results.

In early January, on the day of the patient's scheduled follow-up appointment, the patient cancelled due to illness. On that same day, a CBOC physician reviewed the wound culture results that indicated the infection was not sensitive to the current antibiotics, and a CBOC RN called the location where the patient had the bone scan and obtained the results. The CBOC physician noted that the scan was suggestive of osteomyelitis in the left hip region and decided to admit the patient for treatment with intravenous antibiotics. The patient agreed with the physician's plan for hospital admission. Further testing during the hospital admission showed the patient did not have osteomyelitis.

Inspection Results

Issue 1: Delayed Diagnosis

We substantiated that the PCP did not diagnose the patient's fractured ankle when the patient first presented with ankle pain.

[8] Subcutaneous tissue is the third layer of the three layers of skin and contains fat, connective tissue, larger blood vessels, and nerves.
[9] A bone scan is a nuclear imaging test that helps diagnose and track several types of bone disease, including bone infection, that are undetectable on a standard x-ray.
[10] Osteomyelitis is an infection of the bone that is usually bacterial.

The LVN's note documented the patient "blacked out," fell, and was complaining of right foot pain. During our interview, the LVN stated that the PCP was informed of the patient's fall and foot pain. During a phone interview, the patient stated that the PCP examined his foot, assured him that there was nothing wrong, and that his right leg swelling was from water retention. The patient informed the PCP that the fall resulted from the episode of loss of consciousness. One week later, the patient returned to the clinic, the RN triaged the patient and obtained an x-ray of his ankle. A different PCP diagnosed an ankle fracture and referred the patient to orthopedic surgery. The orthopedic surgeon told us that the delay in diagnosis caused no adverse effects.

Issue 2: Inappropriate Treatment of Wounds

The concerns we had with this patient's care are that her abscesses (caused by intramuscular injections) continued to worsen without appropriate interventions. Specifically, the PCP continued to treat these lesions as if they were pressure ulcers, rather than abscesses. Although there was visiting nurse support, there was insufficient clinic follow-up, re-evaluation, and re-assessment. Ultimately, clinicians became concerned about the possibility of osteomyelitis and hospitalized the patient. Much of this may have been avoided with better wound care.

The CBOC had not implemented the facility Skin Integrity Management Program Policy for managing the skin integrity of outpatients as required. Local policy states that a clinic RN trained in wound care coordinates and assists the team with wound management and continuity of wound care in ambulatory care clinics. Although the policy targets the management of pressure ulcers, had it been implemented, this nurse would have been involved in the care of this patient when the PCP initially diagnosed the patient.

Issue 3: Fee-basis Consult Tracking

In October 2010, the CBOC became part of the new facility that does not have all specialty services readily available. The lack of in-house specialty care required the use of fee-basis care in the local community. To obtain fee-basis care a CBOC physician must submit a fee-basis consult for approval. VHA requires consults be addressed within 7 days.[11] Once the fee-based care is approved, the patient is notified and told to make an appointment with a community provider that can provide the specified care. The referring CBOC physician is not always aware if, when, or with whom an appointment is made. Further, the fee-basis provider's results that are sent to the clinic are not always present in the patient's medical record. During this episode of care, neither the surgical consult nor bone scan report were available to the CBOC physicians.

The facility and CBOC had identified opportunities for improving the fee-basis process prior to our review. The plan includes hiring and assigning a fee-basis clerk to each of the facility's CBOCs, assigning duties to primary care team members to facilitate

[11] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.

scheduling and obtaining results, and hiring specialty physicians at the facility to reduce the need for fee-basis consults.

Conclusions

A CBOC PCP failed to diagnose a patient's fractured ankle when he first presented with ankle pain; however, the facility took appropriate action prior to our review.

A CBOC PCP did not obtain wound cultures before prescribing antibiotics. The physician acknowledged that wound cultures should have been obtained prior to starting the course of antibiotics.

CBOC management did not implement the facility's Skin Integrity Management Program as required. Involvement of a CBOC RN trained in wound care early in this patient's care would have been prudent.

We found that it took 15 days to get fee-base approval for this patient to see a surgeon. In addition, the fee-basis bone scan report was not available to the CBOC staff until after they requested the report in early January. The facility is actively addressing these issues.

Recommendation

Recommendation. We recommended that the Medical Center Director ensure that the CBOC follow the Skin Integrity Management Program Policy.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with our findings (See Appendixes A and B, pages 7-9, for the full text of their comments). We will follow up until the planned actions are completed.

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

Appendix A

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 2, 2011

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

Subject: **Healthcare Inspection – Quality of Care Provided at Corpus Christi CBOC, VA Texas Valley Coastal Bend HCS, Harlingen, Texas**

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

Thru: Director, VHA Management Review Service (10A4A4)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding the Quality of Care provided at the Corpus Christi CBOC, VA Texas Valley Coastal Bend HCS, Harlingen, Texas.

2. I concur with the recommendation and have ensured that an action plan has been developed.

3. If you have further questions regarding this inspection, please contact Judy Finley, Quality Management Officer at 817-385-3761 or Denise B. Elliott, VISN 17 HSS at 817-385-3734.

(*original signed by*:)
Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 1, 2011

From: Jeffery L. Milligan, Director, VA Texas Valley Coastal Bend HCS (740/00)

Subject: **Healthcare Inspection – Quality of Care Provided at Corpus Christi CBOC, VA Texas Valley Coastal Bend HCS, Harlingen, Texas**

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

1. I concur with the findings noted in this report. Action plans have been developed and monitoring will be conducted on a regular basis.

2. Should you require additional information, please contact Cathy Mezmar, Chief, Quality Management, 956-430-9343.

(*original signed by*:)
Jeffery L. Milligan
Director, VA Texas Valley Coastal Bend HCS (740/00)

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. We recommended that the Medical Center Director ensure that the CBOC follow the Skin Integrity Management Program Policy.

Concur **Target Completion Date:** October 19, 2011

Facility's Response:

A mandatory training addressing PM 118-10-04 Skin Integrity Management Program Policy and basic wound management will be conducted by Nursing Education for Patient Aligned Care Teams (PACT) nurses, dietitians, social workers, and a designated physician at each CBOC.

Status: Open

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Cathleen King, MHA, CRRN, Project Leader Gayle Karamanos, MS, PA-C, Team Leader Larry Ross, MS Monika Gottlieb, MD, Medical Consultant Misti Kincaid, BS, Program Support Assistant

Appendix D

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