Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues
W.G. (Bill) Hefner VA Medical Center
Salisbury, North Carolina

Report No. 09-01104-205 **August 27, 2009**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The purpose of the review was to evaluate allegations that a patient died of a stroke at a private-sector hospital because an emergency department (ED) physician at the W.G. (Bill) Heffner VA Medical Center in Salisbury, North Carolina, did not provide prompt care, an adequate assessment, or proper discharge.

We could not confirm or refute that treatment was delayed for this patient. In this case, we were unable to confirm that the patient or his relative related his symptoms to the clerk or that he appeared to be in acute distress.

We did not substantiate the allegation that the ED staff did not complete a comprehensive assessment. We found that the clinical assessment was reasonable and that the treatment was appropriate, such that the patient's symptoms improved prior to discharge.

We substantiated that the patient was improperly discharged to home from the ED. Admission or further observation could have enabled a continuous assessment of the patient's condition and potentially reduced the risk for another stroke. We concluded that the implementation of an algorithm, as planned by the medical center staff, would be a reasonable step to address this issue. We recommended that the VISN Director ensure that the Medical Center Director completes the plan for development and implementation of an algorithm for ED patients with pre-stroke or stroke symptoms.

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

TO: Director, VA Mid-Atlantic Health Care Network (10N6)

SUBJECT: Healthcare Inspection – Quality of Care Issues, W. G. (Bill) Hefner VA Medical Center, Salisbury, NC

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding quality of care issues in the emergency department (ED) at W. G. (Bill) Hefner VA Medical Center (the medical center), Salisbury, North Carolina. The purpose of the review was to determine whether the allegations had merit.

Background

The medical center is a 484-bed tertiary care facility located in Salisbury, NC. Inpatient services are provided for acute medicine, cardiology, surgery, psychiatry, physical rehabilitation, sub-acute care, and extended care. Primary and specialized outpatient services are provided at the medical center and community-based outpatient clinics located in Charlotte, Hickory, and Winston-Salem, NC. The medical center's ED operates 24 hours-per-day, 7 days-per-week and has eight beds. The medical center is affiliated with Wake Forest University School of Medicine and is part of Veterans Integrated Service Network (VISN) 6.

In January 2009, a complainant contacted the OIG hotline and alleged that, in spite of stroke-like symptoms, a patient treated at the medical center ED in early November 2008 did not receive prompt care or a comprehensive assessment, and was improperly discharged. The complainant also alleged that the patient's symptoms worsened by the time he got home and an ambulance took him to a private-sector hospital where he died of a stroke.

Scope and Methodology

We conducted a site visit March 10–11, 2009, and toured the ED. Prior to our visit, we interviewed the complainant by telephone. We interviewed clinical care providers and

staff knowledgeable about ED services. We reviewed the patient's medical records from VA medical centers and the private-sector hospital where he died.

We also reviewed local policies and procedures, VHA directives, and other pertinent documents, and we reviewed ED staff credentialing and privileging documents, staffing schedules, and quality management documents (mortality and morbidity data, patient safety reports, and other performance management data).

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case Summary and Alleged Sequence of Events

On the morning of day 1, the patient in his mid-60s walked into the medical center accompanied by a relative, with complaints of headache, spots in his vision, and weakness. The complainant reported that although the patient and relative informed a clerk of his stroke-like symptoms, staff directed him to update his administrative paperwork and identification (ID) badge before going to the ED. The complainant said that the relative noticed worsening symptoms in the patient after completing the paperwork and alerted the ED nurses. The patient was then promptly taken to an ED exam room and, according to ED protocol, the relative was instructed to return to the waiting room and to limit visits with the patient to 5 minutes every hour.

The complainant said that the relative was not questioned or involved in the ED care despite asking to speak with the physician. As a result, the relative was unable to report that the patient fell earlier in the week, had mental status changes, was leery of doctors, and had neither seen a provider nor taken prescribed medication for years.

At 12:16 p.m., the ED nurse documented an assessment which noted that the patient had not taken his blood pressure (BP) medication for the past 5 years. His initial BP on assessment was 169/114; a repeat BP reading was 180/122. The ED physician examined the patient and found him to be alert and oriented, with no observed problems with speech, strength, coordination, or balance. The physician ordered further work-up including a computed tomography (CT) scan[1] of the head, laboratory studies, x-rays, an echocardiogram,[2] and a carotid ultrasound.[3] The patient also received medication to address his elevated BP.

The ED staff placed the patient on a heart monitor, treated his elevated blood pressure with intravenous medication, and monitored him for about 4 hours. The patient was also

[1] A CT scan uses x-rays to create cross-sectional pictures of tissues and organs.
[2] An echocardiogram is a test that uses sound waves to create a moving picture of the heart. The picture is more detailed than x-ray image and involves no radiation exposure.
[3] Carotid ultrasound is a test that uses sound waves to look for blood flow problems in the carotid arteries which are located in the neck and supply blood to the brain.

given pain medication for the headache and expressed total relief 3 hours later. The CT scan of the head revealed that the patient had had a recent stroke. Chest x-ray findings of a right lower lung nodule were noted but not confirmed later by a follow-up CT scan. Laboratory results did not suggest other problems such as a heart attack or diabetes. The patient's BP at about 3:00 p.m. was 142/78. By 4:07 p.m. on day 1, the patient was considered stable and discharged home with blood pressure medication, baby aspirin, and instructions to return for additional tests and a primary care visit.

The complainant alleged that the patient was discharged because it was closing time for the ED. The complaint also said that later on day 1, on the way home, the patient developed confusion, slurred speech, nausea, and vomiting, and was taken by ambulance to a private-sector hospital where he was admitted for further evaluation and treatment of stroke.

The private-sector hospital physician documented that the patient likely suffered a sub-acute stroke within the previous 24 hours. The patient's physical and mental status deteriorated quickly, and a magnetic resonance imaging (MRI)[4] study of the brain completed on day 2 revealed significant brain death. On day 4, the patient died at the private-sector hospital.

Inspection Results

Issue 1: Delayed Treatment

We could not confirm or refute the allegation that the patient's treatment was delayed. The medical record shows that the patient completed a means test and obtained a new photo ID badge approximately 30 minutes before being evaluated by the ED. Since this patient was last seen at the medical center in early March 2005, steps to update his administrative information would be part of standard procedure.

We interviewed the clerk who completed the patient's means test and were told that it takes about 30 minutes to complete and requires the patient be able to accurately answer questions regarding personal finances, insurances, and other information. She indicated that a patient with urgent symptoms is sent directly to the ED for care before completing paperwork or obtaining an ID badge.

Although the patient complained of symptoms related to vision and headache, he was able to walk independently and interact with people during this visit. The physician's evaluation indicated no problems with balance, speech, or other symptoms that might have prompted staff to send the patient for immediate attention.

[4] A MRI study uses magnets and radio waves to create pictures of body tissues and organs.

Of issue is whether, and to what extent, the patient or his relative reported his medical symptoms to the clerk or other medical center employees. In this case, we were unable to confirm that the patient or his relative related his symptoms to the clerk or that he appeared to be in acute distress.

Issue 2: Lack of Comprehensive Assessment

We did not substantiate the allegation that the patient did not receive a comprehensive assessment because staff did not talk to the relative about the patient's condition. Assessments begin with a report of symptoms, typically gathered directly from the patient, but may also be taken from family members or other individuals. The decision to discuss a patient's care with others depends upon the patient's ability to independently provide accurate information, as well as the patient's privacy preferences. This patient was found to be alert, oriented, and capable of self-reporting. Further, the relative was neither an immediate family member nor listed as his emergency contact. Although the complainant was displeased that the relative was not questioned or involved in the ED care, this may have been an appropriate decision based on the patient's wishes and instructions.

We found that the clinical assessment and treatment decisions made for this patient were reasonable. The assessment included a physical examination, imaging study of the brain, and other tests. We found the interventions to treat the patient's headache and blood pressure, as well as the prescribed medications, were appropriate and effective in relieving symptoms.

Issue 3: Improper Discharge

We partially substantiated the allegation that the patient was improperly discharged to home from the ED. The complainant presented two primary complaints in support of the allegation.

Complaint (a): The patient was told to return for more tests because it was closing time for the ED.

We could not confirm complaint (a). The ED physician told us that he ordered additional tests, such as a carotid ultrasound, because he believed they would be useful. He did not believe these tests were emergent, and could therefore be followed-up by a primary care provider. Thus, the patient was scheduled to return on different days for these appointments.

We also verified that the medical center ED is open 24-hours-per-day, 7-days-per-week, as required by VHA regulations.[5]

Complaint (b): The patient's symptoms worsened by the time he got home and an ambulance took him to a private-sector hospital where he died of a stroke.

We confirmed complaint (b). Records reflected that within a few hours of leaving the medical center's ED, the patient was admitted to a private-sector hospital with a stroke diagnosis where he died within 3 days of admission.

The patient's symptoms of moving spots in his visual field suggested that the stroke was not stable or not complete, and the imaging study suggested that the stroke was recent. It would have been prudent to observe the patient for a longer period of time in the VA ED or to admit him to the medical center. One of these actions would have allowed a more continuous assessment of his cerebral circulation, thus permitting his providers to determine the most effective means to reduce his risk for a recurrent stroke or cardiac event.

The medical center did not have a standard of care protocol, clinical pathway,[6] or other algorithm for the management of pre-stroke or stroke symptomatic patients. Although algorithms are not required, there are benefits of such. For example, treatment practices are standardized and up-to-date when created with research and evidence-based information. We were told that the medical center staff planned to develop a critical pathway on stroke.

Conclusions

We could not confirm or refute that treatment was delayed for this patient, as we could not verify that the relative reported an emergent situation or that the patient appeared in distress. We did not substantiate the allegation that the ED staff did not complete a comprehensive assessment. We found that the clinical assessment was reasonable, and that based on the available clinical information, the treatment was appropriate. The patient's symptoms improved prior to discharge. However, we did conclude that it would have been prudent to observe the patient longer or admit him.

We substantiated that the patient was improperly discharged to home from the ED. Admission or further observation could have enabled a continuous assessment of the patient's condition and potentially reduced the risk for another stroke. We concluded that

[5] VHA Directive 2006-051, *Standards for Nomenclature and Operations in VHA Facility Emergency Departments*, September 15, 2006.
[6] A clinical pathway is a defined set of interventions and steps taken in assessing and caring for a specific medical condition.

the implementation of an algorithm, as planned by the medical center staff, would be a reasonable step to address this issue.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director completes the plan for development and implementation of an algorithm for ED patients with pre-stroke or stroke symptoms.

Comments

The VISN and Medical Center Directors agreed with our findings and recommendation. The Medical Center Director reported that a protocol which includes an algorithm for the management of ED patients with pre-stroke or stroke symptoms has been developed and approved by the Medical Staff, and staff training will be conducted. We will follow up until the planned actions 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: August 5, 2009

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Healthcare Inspection – Quality of Care Issues, W. G. (Bill) Hefner VA Medical Center, Salisbury, NC**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Office (10B5)

I concur with the response by the Medical Center Director and with the recommendation for improvement identified in the report.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 5, 2009

From: Director, Salisbury VA Medical Center (00)

Subject: **Healthcare Inspection – Quality of Care Issues, W. G. (Bill) Hefner VA Medical Center, Salisbury, NC**

To: Network Director, VISN 6 (10N6)

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Healthcare Inspection – Quality of Care Issues draft report. I concur with the recommendation for improvement identified in the report.

2. The response and action plan for the recommendation is enclosed.

3. Should you have any questions regarding the comments or implementation plan, please contact me at (704) 638-9000 extension 3344.

(original signed by:)

CAROLYN L. ADAMS

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 VISN Director ensure that the Medical Center Director completes the plan for development and implementation of an algorithm for ED patients with pre-stroke or stroke symptoms.

Concur **Target Completion Date:** October 1, 2009

A protocol which includes an algorithm for the management of ED patients with pre-stroke or stroke symptoms has been developed and approved by the Medical Staff. The protocol will be fully implemented upon completion of staff education/training. Evaluation of the protocol will be provided to the Clinical Executive Board.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates Director, Atlanta Office of Healthcare Inspections (404) 929-5962
Acknowledgments	Melanie Cool Toni Woodard

Appendix D

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