Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care, Documentation, and Courtesy Issues
Hampton VA Medical Center
Hampton, Virginia

Report No. 09-00835-217 **September 18, 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

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Executive Summary

The purpose of the review was to evaluate allegations related to an Emergency Department (ED) visit at the Hampton VA Medical Center in Hampton, VA. We substantiated the allegation that the treating physician did not conduct an adequate work-up of the patient's stroke symptoms. In spite of fairly classic symptoms, the physician failed to follow American Heart Association guidelines as he did not order a computed axial tomography scan of the head, nor did he consult with a neurologist.

We also found that the ED physician improperly copied and pasted laboratory results from a patient he'd seen earlier in the ED into the medical record of the complainant. While this error did not result in patient harm, it could explain why the patient was allegedly told that his laboratory work was "good" when his blood glucose value was actually high. VHA requires monitoring of the copy and paste function; however, the medical center did not conduct this monitoring in accordance with guidelines. We also concluded that despite the patient's multiple efforts to have his complaints addressed and resolved, the patient advocate and other pertinent medical center staff did not promptly respond to his concerns.

We could not confirm the allegation that the patient's blood pressure was inaccurately recorded, nor could we validate that the physician was discourteous to the patient and his wife.

We made four recommendations to address the identified conditions. The VISN and Medical Center 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, VA Mid-Atlantic Health Care Network (10N6)

SUBJECT: Healthcare Inspection – Quality of Care, Documentation, and Courtesy Issues, Hampton VA Medical Center, Hampton, Virginia

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation related to a patient's Emergency Department (ED) visit at the Hampton VA Medical Center (the medical center). The complainant alleged that he presented to the ED with signs and symptoms of a stroke, yet the ED physician did not adequately evaluate and treat his condition. The complainant further alleged that documentation in his medical record was inaccurate, his ED physician was discourteous, and staff did not respond to his complaints. The purpose of this review was to determine whether the allegations had merit.

Background

The medical center provides primary, specialty, and long-term care services. The medical center has 177 hospital beds and 122 community living center (CLC) beds and serves a veteran population of about 220,000 throughout a 15-county region in eastern Virginia and northeastern North Carolina. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 6.

The ED is open 24-hours-per-day, 7-days-per-week and is staffed by contract physicians who work 12 hour shifts. The ED nurses utilize a triage algorithm called the Emergency Severity Index (ESI) which is designed to generate a disposition score by merging the patient's complaints with the nurse's clinical assessment. The ESI is comprised of five urgency levels ranging from "1" (requiring immediate clinical intervention) to "5" (requiring routine clinical intervention).

In mid December 2008, the complainant sent a letter to the Medical Center Director describing his displeasure with his ED visit in late November 2008. When he did not

receive acknowledgement, he contacted the OIG. Specifically, the complainant alleged that:

- Despite presenting with symptoms of a stroke, the ED physician failed to make this diagnosis.
- His blood pressure (BP) displayed on the monitor as 173/110 but was recorded in his medical record as 110/73.
- He was told his laboratory results were "good" but later learned that his blood glucose was high.
- The ED physician displayed a lack of courtesy by:
    - Giving the patient and his wife the perception that they were "wasting his time."
    - Hastily discharging the patient because he [the physician] needed to leave by 7:00 p.m. The complainant reported that he overheard the physician telling a nurse that he needed to leave. The patient also noted that the physician was wearing street attire when he (the patient) was discharged at 7:06 p.m.
- Responsible medical center staff including the patient advocate and Medical Center Director did not promptly and adequately respond to his complaints.

Scope and Methodology

We interviewed the complainant by phone. We conducted a site visit March 2–4, 2009, and interviewed the acting Medical Center Director, Chief of Staff, Chief of Primary Care, Risk Manager, patient safety officer, triage nurse, disposition nurse, a physician assigned to the ED, the acting Chief of Medical Service (who completed the clinical review), the Chief of Neurology, the laboratory technologist, the veteran's current nurse case manager, the patient advocate, the supervisory patient advocate, and the Chief of Laboratory Service. In addition, we interviewed by phone the subject ED physician. We reviewed the veteran's private hospital and VA medical records, and medical center and national policies associated with standards of care for the ED. We also evaluated the recommended national stroke assessment and treatment algorithms, medical record committee minutes, patient advocate tracking logs, reports of contact, credentialing and privileging minutes, clinical care review documents, and the medical center's contract for ED physician services.

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

Case Summary and Sequence of Events

The patient is a non service-connected male in his mid-50s. He received medical care both at private facilities and at the VA medical center in Salem, Virginia, until relocating to the Hampton, Virginia, area in November 2008. He has a significant medical history

that includes transient ischemic attacks (TIAs),[1] dysarthia,[2] hypertension, diabetes mellitus, hyperlipidemia,[3] and overactive bladder.

On a weekend day in late November 2008, the patient sought healthcare services at the medical center for the first time. The patient arrived at the ED accompanied by his wife. The initial nursing triage encounter stated that his assessment began at 5:28 p.m. and was completed by 5:39 p.m. The nurse documented the patient's chief complaint as "slurred speech left sided leg weakness." She recorded that he had experienced a stroke in 1991 and that he was allergic to insulin. The nurse obtained and recorded vital signs in the medical record as follows: temperature 98.1, pulse 68, respiration 18, BP 110/73, pulse oxygen level 100, and pain level "1." In addition, she recorded that the patient was alert; oriented to time, date, and place; respirations were even and unlabored; skin was warm and dry; extremity range of motion was within normal limits; and he was experiencing slurred speech. The nurse finalized her assessment and categorized the patient as a triage level "3," meaning a physician should evaluate him within 30 minutes. The nurse transferred the patient into an ED examining area and performed an electrocardiogram, the findings of which revealed normal sinus rhythm with left ventricular hypertrophy.[4]

At 5:45 p.m., the ED physician conducted a physical examination of the patient that consisted of a comprehensive body systems review. The physician recorded the patient's chief complaint as slurred speech, unsteady gait, left leg weakness, and a history of TIAs. He ordered laboratory tests which were completed and documented at 6:30 p.m. These results indicated that the patient's blood glucose value was high at 203 milligrams/deciliter (mg/dl) when compared to the local laboratory approved reference ranges of 76-99 mg/dl. The physician diagnosed demyelinating disease[5] and documented that the patient was stable for discharge. He scheduled a follow-up appointment in one month, for late December 2008, and signed the medical record at 7:02 p. m. The disposition nurse provided patient education and documented instructions to return to the emergency room if his condition worsened, take his medication as prescribed, and continue on hypertension, diabetes, and hyperlipidemia medications.

One day (Day 1) subsequent to the Hampton VA Medical Center ED visit, per hospital protocol, the nurse case manager called the patient at home to inquire about his health status. The case manager spoke to the wife, who informed her that the patient's condition did not improve and that she had taken him to a private-sector hospital ED where a computed axial tomography (CAT)[6] scan revealed that the patient had suffered a stroke.

[1] TIA is a "warning stroke" or "mini-stroke" that produces stroke-like symptoms but no lasting damage. Retrieved from www.americanheart.org on June 29, 2009.
[2] Dysarthia is difficulty in speech articulation caused by lack of muscle control resulting from damage to the central nervous system.
[3] An elevation of lipids (fats) in the bloodstream. Retrieved from www.americanheart.org on June 29, 2009.
[4] Thickening of the myocardium (muscle) of the heart's left ventricle. Hypertension is a cause of LVH.
[5] Demyelinating disease is a nervous system disorder that impairs the conduction of signals causing impairments in sensation, movement, cognition, or other functions depending on which nerves are affected.
[6] Computed Axial Tomography is an x-ray procedure that combines cross sectional pictures of the body.

The patient was admitted to the private-sector hospital, treated, and discharged home on Day 6 following his ED visit. The medical center transfer coordinator confirmed this information.

In early December, the patient and his sister-in-law visited the medical center's primary care clinic requesting that a provider fill prescriptions written by the private-sector hospital physician. They also met with the primary care case manager and recounted the ED visit in late November. The case manager contacted the patient advocate but that individual was unavailable to meet with the patient at that time. The case manager forwarded an electronic message to the patient advocate detailing the patient's complaints, and she told the patient to expect a phone call from the patient advocate the following day. The following day, the patient called the case manager to report additional complaints. The case manager forwarded the information to the patient advocate.

Since the initial incident in late November, the patient has experienced a second stroke for which he received rehabilitative services at the medical center. The ED physician's contract was not renewed.

Inspection Results

Issue 1: Quality of Care

We substantiated the allegation that the ED physician did not diagnose the patient's stroke. The patient presented with a history of TIAs, slurred speech, and left-sided weakness, which should have led the physician to suspect that the patient was experiencing a stroke.

The medical center did not have a clinical pathway[7] or other algorithm for the management of pre-stroke or stroke symptomatic patients; rather, ED staff were trained on and instructed to follow American Heart Association (AHA) guidelines on the assessment of stroke, which includes a CAT scan to confirm the diagnosis. In spite of fairly classic stroke symptoms, the physician failed to follow AHA guidelines as he did not order a CAT scan or consult with a neurologist.

The ED physician told us that his initial impression was stroke; however, his review of progress notes and a CAT scan from the Salem VA medical center led him to diagnose demyelinating disease and conclude that the slurred speech and weakness were residuals of previous TIAs. The ED physician said that while it is slightly inconvenient not to have on-site CAT scanning available on the weekends (because radiology services are closed), it is easy to secure a CAT scan through the contract provider. He told us that in his medical opinion, the patient's condition was not acute; thus, he did not order a CAT scan.

[7] A clinical pathway is a defined set of interventions and steps taken in assessing and caring for a specific medical condition.

The Chief of Neurology reviewed the patient's ED care and told healthcare inspectors that, regardless of the patient's medical history, clinical interventions should have included a CAT scan of the head and possible admission to the medical center.

Issue 2: Erroneous Documentation

We could not confirm or refute the allegations that the ED physician told the patient that his laboratory results were "good" when his blood glucose level was actually high. However, we did find a substantial documentation error which would explain the discrepancy. We found that the laboratory results included in the physician's assessment summary did not belong to the patient.

Laboratory Values

The patient's medical record contains two sets of blood chemistry results for his late November ED visit. The first results were entered at 4:38 p.m. and the second results at 6:30 p.m. As the patient was not triaged until 5:28 p.m., the first set of laboratory results could not have been his. We found that the laboratory results section of the patient's medical record contained the correct results, which matched both the ordering time by the provider and the blood draw time and reporting by the medical technologist. While the two sets of blood chemistry results were substantially different for several specific tests, including blood glucose, none of the laboratory values (from either set of results) would have prompted a clinical intervention or admission to the medical center.

The Chief of Laboratory Service conducted a review of the laboratory activities for the specific day in late November and confirmed that the lab results of the blood drawn at 4:38 p.m. were from an earlier patient, for whom the ED physician had ordered the same blood chemistry tests. He described that the provider utilized the "copy and paste" feature of the computerized patient record system (CPRS) when treating the first patient and failed to clear the memory prior to repeating the activity for the second patient.

The "copy and paste" function allows physicians to select data and text documented in the medical record during previous patient encounters and copy and paste into their current progress notes. "Copy and paste" is routinely used by physicians when information will not change from one visit to the next (e.g. when a patient had an appendectomy in 1981). However, if not used cautiously, copying and pasting could result in duplicative and confusing notes. Veterans Health Administration (VHA) requires monitoring of copying and pasting in the electronic medical record to assure that this function is used appropriately.[8] We found that this process was not monitored by the medical center.

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

Blood Pressure Reading

We could not substantiate or refute the allegation that the patient's BP in the ED in late November was 173/110 but was inaccurately recorded in the medical record as 110/73. The patient told us that he saw his BP, as displayed on the monitor, was 173/110. The triage nurse did not specifically recall the case; however, she stated that had his BP been that high, she would have initiated interventions to address the hypertension. The nurse believes that she accurately documented the patient's BP as 110/73, primarily because she did not take any actions to manage the patient's BP.

We were also unable to retrieve data from the BP monitor. BP monitors in the ED are high-use items that could be employed dozens of times daily. These monitors have limited memory capacity to store BP readings, and BP readings dating back to November 2008 were not available.

Issue 3: Lack of Courtesy

We could not confirm or refute the allegation that the physician displayed a lack of courtesy during the veteran's ED visit. In general, courtesy is a perception and cannot be validated.

The patient reported that the physician "made my wife and I feel like we were wasting his time." The physician told us he recalled that the patient and his wife appeared frustrated, but he was unaware that they were unhappy with the ED visit disposition. It was the physician's impression that their frustrations were related to his questions about medication compliance. We interviewed several ED staff members, all of whom reported that this physician is generally pleasant and courteous.

While the patient reported that he overheard the doctor telling the nurse he needed to leave by 7:00 p.m., and implied that this resulted in his hasty discharge, we could not find evidence to support this claim. Although the physician's shift ended at 7:00 p.m., the staff did not recall him indicating a need to leave the ED by 7:00 p.m. Physicians are not required to discharge a patient because their shift has ended; rather, there is a reporting process between the incoming and the departing physician to communicate relevant clinical information and to ensure continuity of patient care. The physician told us that the patient was stable for discharge; he advised that had the patient not been ready, his care would have been transferred to the incoming physician.

The physician reported that he always wears scrubs when treating patients and when his shift ends, he departs wearing the scrubs. The ED staff confirmed that the physician always wears scrubs when interacting with patients in the ED.

Issue 4: Response to Complaints

We could not confirm or refute the allegation that the patient advocate did not return calls to the complainant; however, we did determine that medical center staff did not promptly

respond to the patient's complaints. The patient provided us with documentation showing his repeated attempts to get resolution to his complaints.

We were informed that the patient advocate attempted to contact the patient after his early December 2008 visit to the primary care case manager. We found, however, that the first documented contact between the patient advocate and the patient was in late January 2009. During a 20-day period in the middle of December, the patient advocate was out of the office for 8 days but was on duty the remainder of the time. The patient advocate's supervisor, who would normally provide cross coverage during episodes of sick and annual leave, was unaware of the case until the supervisor was briefed in January 2009. The Risk Manager became aware of the case in late February 2009 and counseled the patient about his right to file a Tort claim the following day.

The patient told us that he sent a complaint letter to the Medical Center Director in mid December because he had not received a satisfactory response from the patient advocate. The Medical Center Director was in the process of transferring to another VA medical facility at the time and the complaint letter was never routed to an alternate official or processed accordingly. In fact, the acting Medical Center Director and other top managers were unaware of the patient's concerns until we contacted him about our site visit. We concluded that in spite of the patient's repeated contacts with medical center staff, there was not a prompt response to his complaints.

Conclusions

The medical center did not have a clinical pathway or other algorithm for the management of pre-stroke or stroke symptomatic patients. We determined that the ED physician did not conduct an adequate work-up of the patient's stroke symptoms as he did not order a CAT scan, nor did he consult a neurologist. We also found that the ED physician improperly pasted laboratory results from an earlier patient into the medical record of the complainant. While this error did not result in patient harm, it could explain why the patient was allegedly told that his laboratory work was "good" when, in fact, his blood glucose value was high. VHA requires monitoring of "copying and pasting" in the electronic medical record to assure that this function is used cautiously and appropriately; however, this monitoring was not being conducted.

We also concluded that despite the patient's multiple efforts to have his complaints addressed and resolved, the patient advocate and other pertinent medical center staff did not promptly respond to his concerns. While we were at the medical center, the Chief of Staff drafted a proposal that, when implemented, should improve the communication flow in the patient advocate program.

We could not confirm the allegations that the patient's blood pressure was inaccurately recorded, nor could we validate that the physician was discourteous to the patient and his wife.

Recommendations

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

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that ED staff receive education on the appropriate and acceptable use of the "copy and paste" function.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the Medical Record Committee to monitor the use of the "copy and paste" function in the electronic medical record.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director improves communication and cross coverage in the patient advocate's office to ensure that patient complaints are responded to in a timely manner.

Comments

The VISN and Medical Center Directors agreed with our findings and recommendations. A pre-stroke and stroke symptom clinical guideline has been developed and appropriate staff will receive training by September 30, 2009. In addition, staff have been educated about the use of 'cut and paste' in the medical record, and the Medical Records Committee has developed a tool and begun monitoring of this data, with quarterly reporting to the Medical Executive Board. The Customer Service patient advocates have been realigned under the Medical Center Director, and cross coverage backup system has been established. Patient complaint information is discussed daily in the Director's morning report, and a customer service supervisor provides a weekly report to senior leadership. 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:

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

Subject: **Healthcare Inspection – Quality of Care, Documentation, and Courtesy Issues, Hampton VA Medical Center, Hampton, Virginia**

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

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 18, 2009

From: Director, Hampton VA Medical Center (590/00)

Subject: **Healthcare Inspection – Quality of Care, Documentation, and Courtesy Issues, Hampton VA Medical Center, Hampton, Virginia**

To: Director, VA Mid-Atlantic Health Care Network (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 (757) 722-9961 extension 3100.

(original signed by:)

DEANNE M. SEEKINS

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 considers a plan for the development and implementation of an algorithm for ED patients with pre-stroke or stroke symptoms that is consistent with AHA guidelines.

Concur **Target Completion Date:** 8/31/2009

A Stroke work group was established for Hampton VAMC with the objective of developing stroke education plan and implementation. Chief Neurology section designated as the leader for the work group. The work group recommended that Hampton VA Medical Center follow ACLS stroke protocol as clinical guidelines for evaluation and management of any ED patient presenting with pre-stroke and stroke symptoms. All ED physicians are ACLS certified. A stroke nursing assessment progress note was implemented July 2009. An initial draft of the pre-stroke and stroke symptom clinical guideline for physicians and nurses was submitted to the Medical Executive Board (MEB) July 2009 and the MEB Chair reviewed. The final draft will be submitted for MEB approval August 2009. Once approved 100% of involved staff will receive education on the clinical guideline by September 30, 2009.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that ED staff receive education on the appropriate and acceptable use of the "copy and paste" function.

Concur **Target Completion Date:** 5/31/2009

Medical Center policy on copying and pasting was updated to align with VHA Directive. Chief of Medicine and ED Nurse Manager educated all ED providers and nursing staff about copying and pasting into medical records.

Health Administration Service developed a tool to monitor copying and pasting by providers. Medical Records Committee reviews this data, acts as needed, and reports to Medical Executive Board quarterly.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the Medical Record Committee to monitor the use of the "copy and paste" function in the electronic medical record.

Concur **Target Completion Date:** 7/31/2009

Health Administration Service developed a tool to monitor copying and pasting by providers. Health Administration began data collection of copying and pasting from April 2009. First quarterly report was reviewed by Medical Records Committee in July 2009.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director improves communication and cross coverage in the patient advocate's office to ensure that patient complaints are responded to in a timely manner.

Concur **Target Completion Date:** 8/10/09

Customer service patient advocates have been reassigned to Medical Center Director. Cross coverage of patient advocates was improved by establishing a backup system. Customer service supervisor attends daily report and informs leadership of significant and complex patient complaints for immediate action. Customer service supervisor provides weekly data of patient complaints to senior leadership. Appropriate administrative actions are being taken on the advocate who failed to follow the communications chain.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates Director, Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Nancy Albaladejo

Appendix D

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