Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Misdiagnosis and Alleged Lapses in Courtesy
Fayetteville VA Medical Center
Fayetteville, North Carolina

Report No. 12-00002-199

July 17, 2012

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 an evaluation in response to allegations of misdiagnosis and courtesy lapses in the Emergency Department (ED) at the VA Medical Center (the medical center) in Fayetteville, North Carolina. The purpose of this inspection was to determine the validity of the allegations.

We substantiated that the patient did not receive an accurate diagnosis during his ED visit in mid-June 2011. An ED physician did not complete a comprehensive evaluation and was unaware that the patient had a low sodium level and was being treated with antibiotics for a surgical site infection. The medical center conducted quality of care reviews, but those reviews did not address the deficiencies in this report.

The ED physician failed to review recent and readily available medical records or ask the patient about current medications. The physician had a history of performance deficiencies in these areas, but we found no evidence that deficiencies were addressed or corrective actions taken. Further, the Service Chief and the Professional Standards Board did not follow policy when they renewed the physician's clinical privileges.

We could not confirm or refute the allegation that the ED physician was rude during the patient's ED visit.

We recommended that the Medical Center Director ensure actions are taken to improve this provider's medication reconciliation practices, processes for renewal of clinical privileges comply with Veterans Health Administration guidelines, and a quality of care review is conducted with specific attention to the deficiencies identified in this report.

The Veterans Integrated Service Network 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 – Misdiagnosis and Alleged Lapses in Courtesy, VA Medical Center, Fayetteville, North Carolina

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to allegations of misdiagnosis and courtesy lapses in the Emergency Department (ED) at the VA Medical Center (the medical center) in Fayetteville, North Carolina. The purpose of this inspection was to determine the validity of the allegations.

Background

The medical center provides general medical, surgical, and mental health services to more than 157,000 veterans living in a 21-county area of North Carolina and South Carolina. It operates 90 hospital beds and 69 community living center beds at its primary site in Fayetteville, North Carolina, and also provides care at two community based outpatient clinics located in Jacksonville and Wilmington, North Carolina. The medical center is part of Veterans Integrated Service Network (VISN) 6.

A complainant (the patient) contacted the OIG's Hotline Division and alleged that during an ED visit in mid-June 2011, an ED physician:

- Misdiagnosed his condition and, as a result, he was subsequently hospitalized at a private-sector facility for 8 days.
- Was loud and extremely rude.

Scope and Methodology

We conducted telephone interviews with the complainant, the ED physician, and ED nursing staff. We reviewed the patient's VA and non-VA medical records, local and Veterans Health Administration (VHA) policies, quality management information,

credentialing and privileging information, patient advocate reports, and other documents that addressed these allegations.

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

Case Summary

The patient is a man in his sixties with a history of insulin-dependent diabetes mellitus, chronic kidney disease, hypertension, high cholesterol, acid reflux, and osteoarthritis. He has been followed by medical center providers, primarily for routine diabetes and osteoarthritis care.

In April 2011, the patient was evaluated for benign cysts on the left buttock and a similar cyst of the posterior neck region. In early May, a medical center general surgeon removed both cysts. At the 2-week postoperative follow-up visit, the surgeon documented that both surgical sites were healing well with "faint redness" to the left buttock area. Twenty-four days later, the patient presented for an unscheduled general surgery visit for "redness and drainage" from the buttock incision site. The surgeon obtained cultures from the incision site and started the patient on a 10-day course of two oral antibiotics (cephalexin and trimethoprim/sulfamethoxazole) for a presumed wound infection. Five days later, the wound culture results showed "heavy growth of staphylococcus aureus"[1] which was sensitive to trimethoprim/sulfamethoxazole.

Two days later at 11:40 a.m., the patient presented to the medical center's ED accompanied by a friend. He complained of "feeling flushed, [with a] headache, abdominal discomfort, [and] chest pain" and reported that "nothing is right from the stomach to head." The ED physician documented that "the patient complains of cough, denies sputum production." There was no reference to, or acknowledgement of, the ongoing antibiotic treatment (i.e., the patient was on day 7 of a 10-day antibiotic regimen) or the reason it was ordered.

The ED physician documented the vital signs to include a rapid heart rate of 127 beats per minute (normal range is 60 to 100 beats per minute) and a fever of 100.6 F. An abbreviated physical examination did not include the abdomen or skin. An electrocardiogram confirmed an increase in heart rate but reflected no other changes. Laboratory results included a low plasma sodium level (131 mmol/l, normal range 136-145) and white blood cells with a slight predominance of polynuclear forms (a type of cell often seen with infections). Blood cultures obtained on this date ultimately showed "no growth." A chest x-ray was interpreted as showing no active disease process. The

[1] Staphylococcus aureus is a common bacterial inhabitant of the skin that may become pathogenic and can result in mild, localized, to severe systemic infections.

patient was given acetaminophen and two liters of normal saline intravenously. At approximately 5:00 p.m., the patient's temperature was 98.6 F, and his heart rate had decreased to 106 beats per minute. The ED physician discharged the patient at approximately 6:00 p.m., noting that the "patient felt better." He listed the assessment as "fever/chills, possible heat exhaustion" and documented the patient's condition as "stable."

The complainant told us that, at the time of discharge, he "felt worse" and "was shaking," and that 2 days following his ED visit, he was "feeling weaker and more uncomfortable." He phoned the medical center to ask for guidance twice that day, but reported that he "got a recording" each time, so he sought care at a local private-sector hospital. According to the complainant, the local hospital transferred him to another non-VA facility via emergency ambulance. Within 24 hours, his condition required activation of a "rapid response team" due to "low blood pressure" and admission to the intensive care unit. He was discharged after an 8-day hospitalization. Diagnoses listed at discharge included pneumonia, acute respiratory failure, congestive heart failure, and uncontrolled diabetes. At this time, the patient is clinically stable and is being followed again for routine maintenance care at the medical center.

Inspection Results

Issue 1: Quality of Care

We substantiated that the patient did not receive an accurate diagnosis. The ED physician did not complete an appropriate assessment or acknowledge abnormal laboratory data and, as a result, did not consider relevant diagnostic possibilities.

Upon presentation to the ED, the patient had a fever (100.6 F), rapid heart rate (127 beats per minute), and an infection under current treatment. Therefore, the patient's overall clinical state met defined criteria for "systemic inflammatory response syndrome" (SIRS), a condition often associated with infection. The ED physician told us that he was familiar with the general concept of SIRS and its significance as a marker for developing sepsis. However, the ED physician did not perform an appropriate evaluation and did not examine the patient's skin. The record of his assessment and actions indicated that he was unaware that the patient had a low blood sodium level and had been recently treated with antibiotics for a surgical site infection, although the patient's medical record, available to the physician in mid-June 2011, documented the recent skin infection, ongoing antibiotic treatment, and low sodium.

The ED physician's overall clinical impression was of "fever/chills, possible heat exhaustion,"[2] and he treated the patient with acetaminophen for his fever and two liters of

[2] Heat exhaustion is caused by an increase in the core body temperature and is usually associated with fluid loss (dehydration).

saline intravenously for dehydration. Had the physician completed an examination and considered all laboratory data and other available information, he would have gained a more accurate view of the patient's potential for systemic illness. However, we could not confirm that these lapses caused the patient's deterioration over the next 48 hours and led to his subsequent non-VA hospitalization.

The medical center completed two reviews evaluating the quality of care this patient received in the ED in mid-June. However, neither review addressed the deficiencies described in this report.

Issue 2: Courtesy Issues

We could not confirm or refute the allegation that the ED physician was rude during the patient's ED visit. We did confirm, however, that the ED physician typically speaks in a loud tone of voice, sometimes perceived by others as "too loud."

Two registered nurses (RNs) who cared for the patient during his time in the ED could not recall any overt rudeness or negative interactions between the patient and the ED physician. Both RNs stated that English is not the ED physician's first language and that he often speaks loudly, saying "that's just him."

The patient also reported that, as he was leaving the ED, he was "shaking uncontrollably." The patient reported that the ED physician asked the patient's friend whether he (the patient) was "a drinking man." The patient denied this, and told us that he was embarrassed and humiliated by the question, especially in the presence of his friend. The RN who discharged the patient did not recall this exchange and told us that the patient left the ED with a steady gait.

Patient advocate reports did not reflect any trends related to lapses in courtesy by the ED physician.

Issue 3: Medication Reconciliation and Renewal of Clinical Privileges

Medication Reconciliation

During the course of our review, we noted that the ED physician did not obtain medication information from the patient to complete medication reconciliation. The medication reconciliation process seeks to maintain and communicate accurate patient medication information. VHA and local policy requires the provider to review the current list and verify the patient's medication regimen and compliance, and to document "medication changes made, concurrence and/or consultation to Pharmacy."[3]

[3] MCM 11-83, *Reconciling Medications*, May 12, 2010.

We found that documentation of current medications and medication reconciliation was an ongoing issue with the subject ED physician. During a two year period, his clinical supervisor completed 140 medical record reviews of the subject ED physician's cases to evaluate compliance with professional practice standards and documentation requirements. Of the 140 records reviewed, 78 (56 percent) did not contain a complete medication reconciliation note and 36 (26 percent) did not contain evidence that the ED physician asked about current medications or medication allergies. Review of patients' medications is critical to appropriate evaluation, treatment planning, and safety.

The physician's supervisor reported that he had addressed deficiencies in medication reconciliation with the physician, but we found no documentation that this was addressed or that corrective actions were taken.

Reprivileging

Clinical leaders did not follow established procedures[4] for renewing the ED physician's clinical privileges.

The ED physician was reprivileged in early 2011, but we found no evidence that any of his provider-specific performance improvement data (including medication awareness and reconciliation) was discussed or considered by either the Service chief or the Professional Standards Board (PSB) during the reprivileging process. Neither listed the documentation reviewed or the rationale for the conclusions as required. Further, the Service chief had not developed criteria that would define acceptable versus unacceptable performance in relation to medication awareness and medication reconciliation. (For example, the Service chief might establish an 80 percent compliance target, and if the provider fails to meet the target over a specified date range, this would trigger a more in-depth review of a provider's performance in relation to that performance element.) Because the Service chief had not defined the triggers, we could not determine whether the ED physician's ongoing lapses in these areas would have been enough to prompt a monitoring plan in conjunction with his renewed privileges.

Conclusions

We substantiated that the patient did not receive an accurate diagnosis during his ED visit in mid-June 2011. The ED physician did not complete a comprehensive evaluation and was unaware that the patient had a low sodium level and was being treated with antibiotics for a surgical site infection. As a result, the ED physician did not consider relevant diagnostic possibilities. However, we could not confirm that these lapses caused the patient's clinical deterioration over the next 48 hours and led to his subsequent non-VA hospitalization. Two quality of care reviews were conducted, but neither addressed the deficiencies described in this report.

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

The ED physician failed to review recent and readily available medical records or ask the patient about current medications. The physician had a history of performance deficiencies in these areas, but we found no evidence that deficiencies were addressed or corrective actions taken. Further, the Service chief and the Professional Standards Board did not follow policy when they renewed the physician's clinical privileges.

We could not confirm or refute the allegation that the ED physician was rude during the patient's ED visit.

Recommendations

Recommendation 1. We recommended that the Medical Center Director take action to improve this provider's compliance with medication reconciliation requirements.

Recommendation 2. We recommended that the Medical Center Director ensure that processes for renewal of clinical privileges comply with VHA guidelines.

Recommendation 3. We recommended that the Medical Center Director ensure that a quality of care review is conducted with specific attention to the deficiencies identified in this report.

Comments

The Veterans Integrated Service Network and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 7-10, for the Directors' comments.) We will follow up on the planned actions for recommendations 1 and 2 until they are completed, and we consider recommendation 3 closed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 1, 2012

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

Subject: **Healthcare Inspection –** Misdiagnosis and Alleged Lapses in Courtesy, VA Medical Center, Fayetteville, NC

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

Director, Management Review Service (10A4A4)

1. The attached subject report is forwarded for your review. I have reviewed the facility's responses and concur.

2. Please contact Lisa Shear, Quality Management Officer, at 919-956-5541, if you have further questions.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 1, 2012

From: Medical Center Director (565/00)

Subject: **Healthcare Inspection –** Misdiagnosis and Alleged Lapses in Courtesy, VA Medical Center, Fayetteville, NC

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

1. We have reviewed the recommendations of the Misdiagnosis and Alleged Lapses in Courtesy, at the VA Medical Center, Fayetteville, NC.

2. We concur with the recommended improvements brought forth in the report.

3. Should you have any questions, please contact Damaris Reyes, Performance Improvement Coordinator, at 910-822-7091.

(original signed by:)

ELIZABETH GOOLSBY

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 Medical Center Director take action to improve this provider's compliance with medication reconciliation requirements.

Concur **Target Completion Date: May 1, 2012**

Facility Response:

This case and its findings were reviewed and discussed with the provider in question. He verbalized understanding and will improve his compliance with medication reconciliation requirements.

To ensure facility-wide compliance, the Medical Executive Board recommended the addition of medication reconciliation process to the core elements of the medical record review. The Medical Records Committee discussed this at their April 26, 2012, meeting.

Status: Complete

Recommendation 2. We recommended that the Medical Center Director ensure that processes for renewal of clinical privileges comply with VHA guidelines.

Concur **Target Completion Date: June 4, 2012**

Fayetteville VAMC complies with VHA guidelines and policies concerning privileging. However, the facility has recognized the need for strengthening the FPPE/OPPE processes. As a result, effective April 1, 2012 the Medical Executive Board standardized the privileging, OPPE and FPPE processes throughout the facility. These changes include a tool that facilitates the collection, viewing, and trending of data over time to facilitate and ensure ongoing analysis. Service specific triggers were identified and included in this process.

Status: Complete

Recommendation 3. We recommended that the Medical Center Director ensure that a quality of care review is conducted with specific attention to the deficiencies identified in this report.

Concur **Target Completion Date: May 1, 2012**

Facility Response:

The care of the Veteran during the referenced visit underwent three independent reviews. All the reviews were consistent and concluded that the standard of care was met.

Status: Complete

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	Audrey Collins-Mack, RN, Project Leader Victoria Coates, LICSW, MBA Thomas Jamieson, MD

Appendix D

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