Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00615-61

Healthcare Inspection

Alleged Quality of Care and Courtesy Issues at the Alamosa Community Based Outpatient Clinic Alamosa, Colorado

January 13, 2015

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 determine the validity of allegations of quality of care and lack of courtesy provided to a patient at the Alamosa Community Based Outpatient Clinic (CBOC) in Alamosa, CO. The CBOC is part of the VA Eastern Colorado Health Care System (facility) in Denver, CO.

The complainant alleged that a walk-in patient did not receive appropriate care during a CBOC encounter. Specifically, it was alleged that a nurse did not adequately assess and triage the patient because the patient had presented late on a Friday afternoon and treated the patient with disrespect, sarcasm, and lack of compassion. It was also alleged that, a few days after the visit, a CBOC staff member attempted to contact the patient through his brother instead of the emergency contact on file for the patient.

We did not substantiate the allegation that a nurse did not adequately assess the patient; however, we substantiated that the nurse did not appropriately triage the patient to a higher level provider based on that assessment. We were unable to determine if this occurred because the patient had presented to the CBOC late on a Friday afternoon. The nurse documented sufficient information in the patient assessment indicating that the patient needed to be triaged to a higher level of care. A CBOC physician later determined that the patient had not been appropriately triaged and took action to advise the patient to seek additional medical care. We determined that CBOC managers did not address the nurse's failure to appropriately triage the patient. We could not substantiate that the CBOC nurse was disrespectful, sarcastic, and uncompassionate to the patient. We could not substantiate that a CBOC staff member contacted the patient's brother instead of the emergency contact listed in the patient's electronic health record.

We recommended that the Facility Director implement CBOC triage guidelines and train staff on the guidelines. We also recommended that the Facility Director ensure that managers appropriately address CBOC staff who exhibit lapses in competency, when identified.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 7–9 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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations of quality of care and lack of courtesy provided to a patient at the Alamosa Community Based Outpatient Clinic (CBOC) in Alamosa, CO.

Background

The CBOC is part of the VA Eastern Colorado Health Care System (facility) and Veterans Integrated Service Network (VISN) 19. The facility provides primary, tertiary, and long-term care with a broad range of inpatient and outpatient health care services. The facility serves a veteran population of about 350,000 throughout the Front Range of Colorado and into Wyoming.

The CBOC provides outpatient health care including primary care, mental health, social work, and limited laboratory and pharmacy services to approximately 1,268 patients. The CBOC is one of nine CBOCs operated by the facility. Patients are generally seen at the CBOC by appointment only. The CBOC is open Monday through Friday, 8 a.m. to 4:30 p.m.

The CBOC is staffed with one physician and two nurses. The physician reserves each afternoon (beginning at approximately 3:30 p.m.) for office and administrative tasks, a time at which he, generally, does not see patients. At the end of May 2013, the two nurses retired from the CBOC. In June, Licensed Practical Nurses (LPNs) and a Registered Nurse (RN) from the facility's Pueblo and Salida CBOCs rotated to provide temporary coverage at the CBOC. In September and December, an RN and an LPN were hired to replace the retired nurses at the CBOC.

Allegations

In August 2013, the OIG Hotline Division received allegations concerning the quality of care and lack of courtesy provided to a walk-in patient at the CBOC. Specifically, it was alleged that a nurse:

- Did not adequately assess and triage[1] the patient because the patient had presented late on a Friday afternoon
- Treated the patient with disrespect, sarcasm, and lack of compassion

It was also alleged that, a few days after the visit, in an effort to contact the patient, a CBOC staff member called the patient's brother who was not the emergency contact on file for the patient.

[1] A clinical process where the nurse assesses the patient's current status and determines the priority level for intervention, if any is needed.

Scope and Methodology

In January 2014, we interviewed the complainant to clarify the allegations. We also interviewed the CBOC nurse manager and the CBOC staff who were on duty at the time of the patient's CBOC encounter including the physician, social worker, and medical support assistant. We were unable to interview the nurse because she no longer works for VA. We reviewed local and Veterans Health Administration (VHA) policies and procedures related to the evaluation, assessment, and scheduling of CBOC patients; complaints about the CBOC in calendar year 2013; and the patient's VA electronic health record (EHR) and non-VA medical records.

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 Summary

The patient is a male in his forties with a medical history of a chronic immune deficiency syndrome. The patient was enrolled in the VA health care system; however, due to a recent move to the area, he presented for the first time to the CBOC as a walk-in patient in July 2013 late on a Friday afternoon. The patient wanted to establish care and to receive treatment for his symptoms of dark urine and stools and an ingrown pubic hair.

An RN assessed the patient who reported that 2 weeks prior he was ill with a slight fever, chills, and diarrhea but had since regained the ability to eat solid foods. The patient denied frequent, painful urination, and reported he was emptying his bladder well. The RN took the patient's vital signs, which were unremarkable.[2] The RN noted that the patient's medications were current and that the patient had a sufficient supply until he could establish care with a CBOC provider. The nurse documented: "No further action needed at the time." The nurse advised the patient of the altitude adjustment [*sic* in Colorado] and instructed him to "triple" his fluid intake, avoid caffeinated beverages, and to schedule an appointment with a CBOC provider.

The following day, the patient felt worse and presented to a non-VA facility in New Mexico. Upon physical examination, the emergency department (ED) physician noted that the patient's eyes were jaundiced[3] and initially diagnosed him with liver failure and hepatitis. The physician discussed the need for hospital admission. The patient refused admission because he was a VA patient. He stated he would drive himself to a VA facility the following morning. The patient was discharged to home in fair condition.

Three days after the patient's CBOC visit, he was admitted to a VA medical center and treated for an acute liver infection. The patient was discharged to home 3 days after admission.

Inspection Results

Issue 1: Assessment and Triage

We did not substantiate the allegation that a nurse did not adequately assess the patient; however, we substantiated that the nurse did not appropriately triage the patient to a higher level provider based on that assessment. We were unable to determine that it was because the patient had presented late on a Friday afternoon. We found that CBOC managers did not address the nurse's failure to properly triage the patient to the on duty physician.

On the day in question, the nurse, who was providing temporary coverage at the CBOC, conducted the patient assessment but did not refer the patient to the on duty physician. The nurse sent a copy of the assessment to the physician and medical support

[2] According to the EHR, the patient's vital signs were: temperature 98.6 degrees Fahrenheit, pulse 75, respiration 15, blood pressure 136/87, pulse oximetry 94 percent, weight 167 pounds, and pain score of 0 out of 10. There was no mention of jaundice or dark urine in the assessment.
[3] Jaundice is the yellowish coloring of the white part of the eye, an indication of liver malfunction.

assistant. We found that the nurse assessed the patient and properly documented the results of the assessment; however, she did not recognize the seriousness of the symptoms in conjunction with the patient's history. Due to the nurse's lapse in competency, she did not appropriately refer the patient for a higher level of care. Triage decision making is an essential skill for CBOC nurses. Through initial assessment, a CBOC nurse prioritizes patient care on the basis of appropriate decision making.[4] The physician told us that when an unscheduled or walk-in patient presents to the CBOC, the nurse is expected to assess[5] and triage the patient. The physician further explained that, depending on the nurse's assessment, the nurse will advise the patient to make an appointment and return to the CBOC, triage the patient to the physician on duty (even if during the physician's administrative office hours), or refer the patient to a VA or non-VA ED.

Two days later, on Sunday, the physician reviewed the nurse's assessment of the patient in the EHR. The physician told us that based on the nurse's documented assessment of the patient—specifically, the patient's history and new reported symptom of dark urine—the nurse should have triaged the patient to him or referred the patient to an ED for treatment. The physician requested (in the EHR) that the nurse contact the patient and advise him to go to an ED for evaluation and treatment. The nurse acknowledged receipt of the physician's request on Monday. In the next and final EHR note, which was entered 7 days after the patient's CBOC visit, the nurse documented that the patient "…was going to establish care elsewhere. He did not indicate where. He did not leave a phone number or address."

Although the physician identified the error in not triaging this patient to a higher level of care and initiated appropriate action to contact the patient, we found that neither the CBOC physician nor the CBOC nurse manager addressed the nurse's failure to appropriately triage the patient in this case.

In October, facility managers implemented new processes and tools designed to enhance timely access to care and to formalize a triage process for walk-in patients. However, during our interviews with CBOC staff 3 months after the implementation, staff reported that they were unaware of formal policies or procedures for the triage of walk-in patients. In addition, each CBOC staff member interviewed verbalized a different procedure for triaging walk-in patients.

Issue 2: Courtesy

We could not substantiate that the nurse who assessed the patient treated the patient with disrespect, sarcasm, and lack of compassion. We were unable to interview the nurse because she no longer works for the VA. According to staff interviews, staff were either not present or could not recall the patient's encounter with the nurse. We

[4] Smith, A. & Cone, K. J. (2010). Triage Decision-Making Skills: A Necessity for all Nurses. *Journal for Nurses in Staff Development, 26 (1).* Retrieved from http://www.nursingcenter.com/lnc/static?pageid=1071278

[5] A patient assessment is an objective evaluation or appraisal of an individual's health status, including acute and chronic conditions. The assessment gathers information through collection of data, observation, and physical examination.

reviewed CBOC complaints that were received by the facility or the CBOC for calendar year 2013 and found no complaints related to this nurse.

We interviewed four CBOC staff members. One staff member told us that the nurse could be "rough around the edges" with CBOC patients and reported her to the nurse manager. The nurse manager recalled the complaint and reported that when she spoke to the nurse, the nurse cited that the CBOC was very busy—requiring her to multitask phone lines, perform blood draws, and handle many physician orders for diagnostics. The nurse manager told us that the nurse "tried" to improve her behavior.

Issue 3: Emergency Contact

We could not substantiate the allegation that, in an effort to contact the patient, a CBOC staff member called the patient's brother who was not the emergency contact on file for the patient.

After reviewing documentation of the patient's visit, the CBOC physician requested that the nurse who assessed the patient contact him. The nurse did not document the phone call or whom he/she attempted to contact only that the patient called and left a message about seeking care elsewhere.

The EHR reflects that the patient's brother was the first emergency contact for the patient; a friend of the patient was listed as the second emergency contact.

Conclusions

We substantiated the allegation that the nurse did not appropriately triage the patient to the on duty physician based on her assessment; however, we were unable to determine that it was because the patient had presented to the CBOC late on a Friday afternoon. We found that the nurse documented an adequate patient assessment which indicated that the patient needed to be triaged to a higher level of care. While CBOC physicians identified that the patient had not been appropriately triaged and took action to advise the patient to seek additional medical care, we found that CBOC managers did not address the nurse's failure to appropriately triage the patient at the time of the encounter.

We could not substantiate that the nurse treated the patient with disrespect, sarcasm, and lack of compassion. We were unable to interview the nurse and found that no witnesses were present during the patient's encounter with the nurse. We found no evidence to support that the nurse's behavior was inappropriate to the patient.

We did not substantiate that, in an effort to contact the patient, a CBOC staff member called the patient's brother who was not the emergency contact on file for the patient. We could not determine whom the staff member called and the brother was listed as emergency contact at the time of the subject encounter.

Recommendations

1. We recommended that the Facility Director implement the CBOC triage guidelines and train staff on the guidelines.

2. We recommended that the Facility Director ensure that managers appropriately address CBOC staff who exhibit lapses in competency, when identified.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 2, 2014

From: Director, Veterans Integrated Service Network (10N19)

Subject: Healthcare Inspection—Alleged Quality of Care and Courtesy Issues, Alamosa Community Based Outpatient Clinic, Alamosa, Colorado

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. We are submitting written comments in response to the Healthcare Inspection for the VA Eastern Colorado Healthcare System Alamosa Community Based Outpatient Clinic report received on November 12, 2014.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve the non-compliance areas cited. Network 19 concurs with the report.

3. If you have any questions regarding this response, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.

Ralph T. Gigliotti

Ralph T. Gigliotti, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 21, 2014

From: Director, VA Eastern Colorado Health Care System (554/00)

Subject: Healthcare Inspection—Alleged Quality of Care and Courtesy Issues, Alamosa Community Based Outpatient Clinic, Alamosa, Colorado

To: Director, Rocky Mountain Network (10N19)

1. We are submitting written comments in response to the Healthcare Inspection for the Alamosa Community Based Outpatient Clinic report received on November 12, 2014.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve the non-compliance areas cited. ECHCS Director concurs with the report.

3. If you have any questions regarding this response, please contact Mr. Keith Harmon at (303) 398-7469.

Lynette A. Roff

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director implement the CBOC triage guidelines and train staff on the guidelines.

Concur

Target date for completion: 2/28/2015

Facility response: CBOC triage guidelines are implemented in a template within the electronic medical record and staff training is completed by 2/28/2015.

Recommendation 2. We recommended that the Facility Director ensure that managers appropriately address CBOC staff who exhibit lapses in competency, when identified.

Concur

Target date for completion: 11/20/2014

Facility response: The Director has reinforced expectations to management. There are currently no lapses in competencies with the CBOC staff. Any lapses which occur in the future will be resolved within 10 business days.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Clarissa Reynolds, CNHA, MBA, Team Leader Michael Bishop, MSW Julie Kroviak, MD

Appendix E

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