Administrative Closure
Mental Health Provider Concerns at the
VA Central Iowa Health Care System
Des Moines Division (636A6)
Des Moines, Iowa
MCI# 2013-04594-HI-0490

The VA Office of Inspector General Office of Healthcare Inspections conducted a review in response to complaints regarding a provider's care at the Des Moines division of the VA Central Iowa Health Care System (facility). The purpose of the review was to determine the merits of the complaint. Specifically, the complainant alleged the provider:

> Without doing proper assessment/diligence, removed a patient's court-ordered commitment; did not assess a patient who came to the pain clinic after taking a week's dose of medication in a 24-hour period; inappropriately discharged a patient during inclement weather; did not discharge a locked MH unit patient timely; did not attend a patient's treatment meeting; and left "sticky notes" with patient personal information (PI) on doors and emailed patients' personal information.

The complainant further alleged that, after making a formal complaint to the facility leadership, a Summary Review Board (SRB) was convened but the staff appointed to the investigative board was biased and the investigative board's determination (b)(6) (b)(6).

We interviewed the complainant, and the facility's Director and Chief of Staff. We reviewed the electronic health records of the patients referred to us by the complainant. We also reviewed the facility's SRB's finding of facts and recommendations related to this complaint.

During our interview, the complainant recanted the allegation that the provider left "sticky notes" with patient PI on doors and emailed patients' PI.

Quality of Care and Patient Safety

We reviewed the electronic health records of the patients identified by the complainant and determined the following:

Court-ordered commitment: (b)(6), a court ordered that the patient be committed for facility MH outpatient treatment. (b)(6), the provider assessed the patient and reviewed neurological testing. After determining the patient had been stable for two years and agreed with the plan of care to continue MH outpatient treatment, the provider completed a form requesting termination of the court order. The patient's court-appointed advocate supported the termination and a judge later agreed to terminate the commitment order. We did not find that the patient was harmed by the provider's recommendation to terminate the commitment order.

Possible Overdose: The patient fell while he was in the waiting room of the MH clinic waiting area for his pharmacy refill. The MH primary care nurse note reported the patient told staff he took a week's worth of medication in 24 hours and that staff sent the patient to the emergency department. We determined the provider was not required to assess the patient because MH

nursing staff appropriately sent the patient to the emergency department and he was subsequently discharged.

Inclement Weather: (b)(6), the provider discharged this patient from the facility to the (b)(6) (b)(6). While documentation indicates the complainant and the provider's professional opinions differed regarding the patient's discharge, we found the (b)(6) (b)(6) staff transferred the patient and we determined the transfer occurred without incident.

Locked MH Unit Patient Discharge: We determined the patient wanted to leave the facility against medical advice and the provider was not available at the time the patient decided to leave.

Patient Treatment Meetings: During our interview, the complainant told us of one instance in which the provider declined attending a patient's treatment meeting because the provider had a prior engagement. We determined the patient was not harmed by the provider's failure to attend the meeting.

Summary Review Board

The complainant made the same allegations discussed above to facility leadership in (b)(6) (b)(6) The Director of Human Resources (b)(6) and the Chief of Staff recommended an SRB be convened to review the complainant's concerns.

We interviewed the Interim Director, who started at the facility in June. When the Interim Director arrived on station, he learned the SRB had not yet met and the provider was still on authorized absence. The Interim Director appointed three staff to conduct the review and ordered that the review occur as soon as possible. The SRB submitted their report in September.

Summary Review Board Bias: We determined the Interim Director's SRB staff member appointments ((b)(6) (b)(6)) were appropriate for the assigned task.

Provider's Return to Duty and Patient Safety: The SRB reviewed the following areas of concern related to this complaint – (1) relational concerns/accessibility, (2) tendency to avoid entrusted obligations of patient care by imposing responsibility of care onto other providers and/or ancillary staff, (3) faulty medical records review and inadequate documentation, and (4) deduction critical clinical judgment.

(b)(6)

Because the facility initiated appropriate actions prior to our review, we are administratively closing this case.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections 12/16/13