Administrative Closure

Fayetteville, NC VA Medical Center
MCI #2008-00777-HI-0211

PURPOSE

On August 28, 2008, the complainant sent a letter to Representative. Robin Hayes (R–NC) alleging that over the past 10 years (b)(6) endured multiple episodes of improper care, unsanitary conditions, and discourteous communications while a patient at the VA Medical Center (the medical center) in Fayetteville, NC. The complainant reported that he brought his concerns to the attention of managers on numerous occasions, but corrective actions were not taken.

BACKGROUND

The medical center provides general medical, surgical, and mental health services. It operates 90 hospital beds and 69 nursing home beds at its primary site in Fayetteville, NC., and also provides care at two community based outpatient clinics located in Jacksonville and Wilmington, NC. The medical center has affiliation agreements with several educational institutions covering 24 different areas of study. The medical center is part of Veterans Integreted Service Network (VISN) 6.

METHODOLOGY

We reviewed the patient's medical records from both the medical center and the Charleston VAMC. We also reviewed incident reports, patient complaints, and the medical center's response to previous complaints by the patient and her husband. We interviewed staff knowledgeable about the case.

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

Brief Case Summary

The patient is a frequent user of medical center services. To promote clarity and readability, we did not present an exhaustive medical history; rather, we explained the patient's medical situation as it specifically related to the allegation at the time.

The patient is a (b)(3):38 U.S.C. 5701 veteran with a primary medical history that includes hypertension, hyperlipidemia, asthma, atrial fibrillation, myocardial infarction (b)(6) irritable bowel syndrome (IBS), chronic diarrhea, and overactive bladder. Past procedures include cardiac catheterization (b)(6) several esophagogastroduodenoscopies[1]

[1] Diagnostic endoscopic examination of the upper part of the gastrointestinal tract.

(EGDs), colonoscopy (b)(6) lumboperitoneal (LP) shunt placement (b)(6) and removal (b)(6) and rectocele[2] repair (b)(6) The patient has been routinely followed by the Women's Health Clinic, and she has had regular appointments in the Urology, Neurology, Eye, Visual Impairment, Podiatry, and Nephrology clinics.

The patient and her husband have been receiving care at the medical center since (b)(6) In (b)(6) a medical center committee met to develop healthcare contracts for both the patient and (b)(6) this action was taken in response to the (b)(6) negative and disrespectful communications with medical center staff. In September 2003, the patient signed a "Healthcare Agreement" which outlined her responsibility to conduct herself "appropriately." (b)(6) refused to sign a similar agreement as it required him to "check in" with medical center police prior to each healthcare appointment.

In (b)(6) the patient became angry after she was discharged from a 23-hour observation admission. A "Code Green"[3] was called to manage the patient's disruptive behavior. After this event, the patient's "Healthcare Agreement" was rescinded, and she transferred her care to the Charleston VA Medical Center (VAMC). At Charleston, providers removed her LP shunt in (b)(6) In (b)(6) she applied for, and received, approval to return to the medical center for health care services. The patient has been seen in the medical center's emergency room (ER) 20 times since (b)(6) Several progress notes reflect providers' perceptions of somatization.

REPORT FINDINGS

In his letter, the complainant described multiple events that he believed reflected improper care or other substandard conditions. During the course of our review, however, we found that, in general, the complainant's allegations either could not be substantiated or were directly refuted by documentation in the medical record. While we determined that some of the allegations were technically accurate, we did not substantiate the implied inappropriateness of the conditions. In other cases, we could not confirm or refute the complaint as the alleged event took place anywhere from several months to several years ago and did not always include names or dates. Without detailed information, it is often difficult to determine with certainty what happened on a specific date in the remote past.

Allegations

1. For nearly 10 years, (b)(6) has been misdiagnosed at least twice. (b)(6) repeatedly went to the medical center's emergency room (ER) with severe stomach pain (b)(6) kept telling her she had gastritis.

We did not substantiate the allegation that the patient was misdiagnosed. The notes do not show that (b)(6) repeatedly told the patient that she had gastritis. The medical

[2] Condition that occurs when rectal tissue bulges into the vagina through a tear in the rectovaginal septum.
[3] An interdisciplinary team, including medical center police officers, respond when a patient becomes disruptive.

record reflects that (b)(6) an ER physician, saw the patient on the following dates for the noted reasons:

(b)(6) – chest pain. (b)(6) cosigned the note of another ER physician – he did not make the initial diagnosis.
(b)(6) – chest pain (b)(6) admitted the patient to an observation bed with a diagnosis of gastritis and anxiety. The admission orders reflect the gastritis diagnosis; however, the progress note does not. (b)(6) – for sinusitis.
(b)(6) – for unresolved right forearm pain.
(b)(6) – for urinary frequency and chest pain.

Other than the (b)(6) admission orders, we found no other reference to gastritis written by (b)(6)

As the complainant may have confused (b)(6) for another ER physician, we reviewed the patient's ER progress notes for the year immediately preceding the LP shunt removal in (b)(6) to determine if anyone repeatedly told her she had gastritis. Of the seven ER visits during that time (excluding the ER visit that prompted the (b)(6) admission), only one ER note, dated (b)(6) and completed by (b)(6) references gastritis. This note states :

> D/D [differential diagnosis]: EPIGASTRIC PAIN & TENDERNESS MOST LIKELY DUE TO GASTRITIS, POSSIBLE H.PYLORI INFECTION.

(b)(6) ordered a gastroenterology (GI) consult for endoscopy, and prescribed antibiotics, pain medication, and Prilosec.™ The patient had an EGD on (b)(6) the diagnosis was gastric retention and gastritis.

The next mention of gastritis is around (b)(6) when (b)(6) treated her in the ER and admitted her to the hospital with a diagnosis of gastroenteritis. She was hospitalized (b)(6) Notes by multiple physicians reflect this diagnosis and further detail the patient's explanation that she had eaten at a local fast-food restaurant and gotten sick. One note documents that the patient's (b)(6) said he contacted the health department who reported that three other people had gotten sick after eating at this restaurant.

2. (b)(6) put her in the hospital overnight.

This is an accurate statement. (b)(6) admitted the patient to an observation bed secondary to reports of chest pain. The admitting orders, however, reflected diagnoses of gastritis and anxiety.

3. No physician came to see the patient for 22 hours.

During the (b)(6) admission, the patient was in an observation status. The physician saw her about 22 hours after admission, noted that she was stable, and ordered her discharge.

4. The patient was immediately discharged in severe pain.

The documentation does not support this allegation. Progress notes from (b)(6) (b)(6) reflect the following:

(b)(6) – *Pt.* [patient] C/O [complaining of] pain 8/10 on pain scale in back. Pt. medicated with PRN [as needed] Hydrocodone 5mg/500mg x1 tab per orders. Spouse remains at bedside. Will continue to monitor.
(b)(6) – *Pt.* resting quietly in bed with eyes closed. No signs of pain or discomfort noted. Will continue to monitor.
(b)(6) – Witnessed pt. attempting to remove IV in right hand. Writer able to remove IV with catheter intact. 2x2 applied.
(b)(6) – Pt. noted walking by nursing station with bags refusing to sign discharge paperwork or to sign out AMA [against medical advice]. Nurse manager walking with pt at this time.
(b)(6) – Code GREEN activated, pt was upset and crying @ the elevator. PT left without signing discharge observation note.

At (b)(6) the patient was observed to be stable with no signs of pain or discomfort. The physician reexamined the patient and reviewed her laboratory results, then ordered her discharge at (b)(6) We saw no documented evidence that she was discharged in severe pain.

5. Because the patient refused to sign the discharge papers, the Chief of Staff banned her from the hospital for 1 year.

The patient was discharged on (b)(6) As a result of her apparent disruptive behavior that prompted a police response, her "Healthcare Agreement" was revoked. The patient transferred her care to the Charleston VAMC, where she had been a patient in the past. She received care at Charleston from (b)(6) The patient then transferred her care back to the medical center.

6. At this new VA (referring to Charleston), staff immediately knew the patient was in severe pain and noted she had a 10-year old shunt in her stomach. Staff ordered a STAT myelogram.

Based on the medical record, it does not appear that the patient was in severe pain when she first sought care at the Charleston VAMC. After her move to Charleston, the patient was first seen on (b)(6) The History & Physical documents, "Chief Complaint: Here for history and physical. Patient states that she would like to get

established at the Charleston VA. [Patient] has many medical problems and states that her main complaint today is her heel spurs that are causing her pain..." The attending physician also documented "Denies...abdominal pain..."

She was subsequently seen on the following dates for the noted reasons:

(b)(6) – ER visit for rectal bleeding and pain times 3 weeks.
– GI consult – reports 40 lb. weight loss "food goes right through." No complaints of abdominal pain. Assessment: IBS exacerbation.
(b)(6) – GI consult – presented for colonoscopy for 3 year history of diarrhea and pain; colonoscopy cancelled due to discomfort and need for anesthesia.
(b)(6) – Computed tomography (CT) of the abdomen with contrast– possible ovarian cyst. No obstruction.
(b)(6) – ER visit for abdominal pain – ordered CT, but no etiology found.
– Magnetic Resonance Image (MRI) of the lumbar spine completed.
– Colonoscopy and EGD completed – findings were within normal limits.
– Neurosurgery (NS) consult – ordered myelogram to correlate clinical findings. The myelogram was not a STAT order.
(b)(6) – X-ray of the abdomen – notes shunt tubing but no clinical findings.
– ER visit. The physician documented, "In truth I explained to the patient and her husband that I could not think of any further imaging, referrals, analysis that could be done to better explain these symptoms." "Patient and husband did not take this news very well and despite my attempts to offer reassurance, they seemed convinced that not enough testing was being done."

It does not appear that the patient initially presented to the Charleston VA with severe pain. About 2 months after her initial presentation, it appears that staff began a work-up for abdominal pain and that the myelogram was part of this work-up.

7. The myelogram showed that the LP shunt was a problem and the patient went for immediate surgery to remove the shunt.

Progress notes and consults reflect the following:

(b)(6) – Myelogram completed. Findings reflect "some clumping of nerve roots below this level suggesting the possibility of arachnoiditis."[4]
(b)(6) – NS note (no visit – just phone call) – The primary neurosurgeon conferred with another neurosurgeon and consideration was given as to whether the LP shunt may be contributory to pain. The plan was to discuss in NS conference.
(b)(6) – The neurosurgeon documents "MRI and CT myelogram show multilevel degenerative changes – shunt catheter coiled in the lumbar thecal sac. No obvious root compression is seen... that would explain her radicular pain."
(b)(6) – LP shunt removed.

[4] Inflammation of the arachnoid lining that surrounds the brain and spinal cord. The inflammation causes constant irritation, stinging, and pain in the lower back and lower limbs.

The myelogram showed that the LP shunt may have contributed to the problem. Neurosurgeons debated whether to remove it and ultimately decided to do so because it could be causing problems. After the myelogram findings, surgery to remove the shunt occurred more than a month later, not immediately as alleged.

8. The patient has had no abdominal pain since.

The patient has had abdominal pain since as evidenced by her admission for gastroenteritis in (b)(6) However, it may be true that she has not had the same type of pain in the same location after removal of the shunt. The medical record does not specifically comment on this distinction.

9. (b)(6) made the patient suffer for nearly a year and never looked at the records to see she had a shunt.

(b)(6) saw the patient only two times in the year preceding the LP shunt removal in (b)(6) On both occasions, the patient complained primarily of chest pain.

10. On (b)(6) the patient fell and injured her wrist. (b)(6) was working in the ER and told her she had not fractured her wrist; he just wrapped it in an ace bandage.

The patient was seen in the ER on (b)(6) by (b)(6) An x-ray was completed during the visit. The radiology report reflects "Bony structures of the right wrist are intact with no evidence of fracture or dislocation." Treatment provided in the ER included an ace bandage wrap and Ultram (pain killer), with instructions to follow up with the Primary Care Provider (PCP).

11. On (b)(6) the patient returned to the ER complaining of wrist pain. (b)(6) refused to x-ray it and refused to remove the ace bandage.

After the (b)(6) visit, the patient was next seen by (b)(6) in the ER on (b)(6) for a primary complaint related to congestion and sinus drainage. There is no documented complaint of wrist pain. Treatment provided was for the sinus condition.

On (b)(6) did see the patient in the ER for unresolved right forearm pain. His note reflects that the wrist/hand x-rays completed on (b)(6) were within normal limits. (b)(6) documented that the patient said her pain killer (Darvon) was not working. (b)(6) prescribed three Percocet tablets and noted that the patient had a pain contract. He referred the patient to her PCP for follow up. (b)(6) wrote an addendum noting that the patient was crying and had accused him of refusing to provide the required treatment.

We found that the treatment provided by (b)(6) on (b)(6) was reasonable given the patient's history and what appeared to be a normal x-ray from (b)(6)

12. The patient went to Primary Care where they removed the ace bandage and immediately sent her to x-ray. The x-ray showed a fracture, and orthopedics followed the patient for a year.

This appears to be an accurate statement. A new x-ray completed on (b)(6) showed "questionable nondisplaced cortical fractures of the distal radius." An x-ray completed on (b)(6) confirmed "a nondisplaced transverse torus type fracture of the distal radius." The patient was followed by orthopedics for about 1 year.

13. Over the years, the patient has been dispensed the wrong medications.

Without specific information related to the dates, medications, and dosages, we had no way to evaluate this complaint.

14. On one admission, a male attendant entered the patient's shower area when she was naked but the Medical Center Director did not allow anyone to write an incident report.

The complainant did not provide enough details about the alleged event for us to adequately evaluate the complaint.

15. There are multiple medical errors throughout her records. For example, (b)(6) (b)(6) had a rectocele surgery on (b)(6) This statement is not true; the patient never had a surgery at the Fayetteville VA medical center.

While it is unclear which progress note the complainant is referring to, the patient did have a rectocele repair at the Charleston VAMC on (b)(6) It appears that the provider correctly documented the month and day of the procedure, but erroneously documented the year.

16. Another example of a medical record error: The patient "had a cystocele surgery in Charleston." This statement is not true; she has never had a cystocele surgery in her life.

A (b)(6) Urology note does erroneously refer to a cystocele (fallen bladder) repair completed at the Charleston VAMC. Later in this same note, the urologist documents, "I have suggested that cystocele repair is not indicated and often worsens irritability symptoms." This additional statement suggests that the writer knows the patient has not had a cystocele repair and that it is not recommended in her case. Other notes correctly refer to the procedure as a rectocele repair completed on (b)(6)

17. In (b)(6) the patient was admitted for atrial fibrillation. The nurse did not wash her hands during an exam and the patient got MRSA [methicillin-resistant staph aureus] "in her nose."

The patient checked into the ER and was seen by a triage nurse at (b)(6). MRSA testing was ordered at (b)(6) and completed at (b)(6) Testing revealed that MRSA had colonized in the patient's nose. A staff nurse using unsanitary procedures on (b)(6) would not result in a patient testing MRSA positive less than 10 hours later.

18. When the patient was admitted to the hospital in (b)(6) there was an oxygen line left open in the room and there were EKG leads and clumps of hair on the shower floor.

We cannot confirm or refute this allegation. The medical center could not provide terminal cleaning records for the patient's room.

19. A consultation report reads "Consultation terminated because he [complainant] stated he was contacting his senator."

It is unclear which consultation report the complainant is referring to. The complainant specifically mentioned a urologist by name, and also referred to an orthopedist (no name provided) alleging that they recently told him to leave the office when he said he was writing to Senator Edwards. We reviewed Urology and Orthopedics progress notes and consultations from (b)(6) to (b)(6) but found no documentation reflecting the above statement.

20. The Patient Advocate made an offensive remark.

We could not confirm or refute this statement. We interviewed the patient advocate who did not have any recall of a negative interaction with the complainant. We found no documentation (reports of contact or patient advocate reports) regarding this complaint.

21. The Chief of Staff "kicked the patient out" of the medical center in (b)(6) because she was crying and refused to sign the discharge papers.

The patient was admitted to a 23-hour observation unit on (b)(6) The patient was discharged the following day in stable condition. Records reflect that the patient became angry and disruptive, and a "Code Green" was called. This event prompted the medical center's decision (which was supported by the VISN), to revoke her "Healthcare Agreement." The patient was duly advised of this decision in a letter dated (b)(6) and a follow up letter dated (b)(6) the patient was subsequently seen at the medical center multiple times in (b)(6) before moving to Charleston.

22. The patient was talked to "like a dog" by (b)(6) in Urology. He told her to use a measuring cup from the kitchen to measure her urine output, and then told her she was not being truthful about the output (called her a liar).

A (b)(6) Urology note reflects that the urologist was skeptical about the nightly urine output totals. An addendum dated (b)(6) reflects that the urologist used an "erroneous conversion factor" and he changed the output amounts accordingly. A Urology note dated (b)(6) shows the urologist was skeptical about the amount of nighttime voiding with reported "minimal fluid intake." We interviewed the urologist who told us that in order to get a precise measure of intake and output, he suggested the patient catalogue all of her nightly fluid intake and output in a log. He reported that he told her she could use any container with measurement markings to calculate her output. He denied telling her to use a standard measuring cup from her kitchen.

23. The patient was admitted to a room in (b)(6) that had baby roaches. The nurse told her, "A place like this will have roaches."

The (b)(6) pest control log shows that a room on the medical floor was treated for pests; we believe this to be the patient's assigned room. We can't confirm or refute that a nurse made the above statement.

24. The patient is getting weaker and rapidly losing weight because of a bladder problem, but they are not doing anything to find the problem.

The patient's recent weights are as follows:

(b)(6)

215 lbs.
210 lbs.
205 lbs.

In (b)(6) staff documented that they discussed weight management with the patient. A loss of 10 lbs. over 3 months was a healthy improvement and not indicative of "rapid" weight loss. The patient has a long-standing and well documented history of overactive bladder and voiding problems "resistant to therapy." The medical record is replete with evidence of ongoing efforts to address the patient's condition, symptoms, and frustrations.

25. Medical center Urology staff never scoped her bladder.

This appears to be an accurate statement. We found no indication in the medical record that she had a cystoscopy or that the urologist had every suggested/planned cystoscopy for the patient.

26. Three years ago another VA [Charleston] found an abrasion in her bladder.

Providers at the Charleston VAMC completed a workup for the patient's bladder issues, the results of which were "normal." They did note a non-contributory bladder lesion.

CONCLUSION

We did not substantiate that the patient received improper care at the medical center. Managers provided documentation of their attempts to manage the (b)(6) ongoing complaints, disruptive conduct, and inappropriate communications. Since the patient's (b)(6) admission, the (b)(6) has sent seven complaint letters; none of these were responded to per the instructions of the VISN 6 Public Affairs Officer. The medical center did respond to another congressional office on (b)(6) regarding the (b)(6) admission and the fractured wrist event.

The patient's medical record reflects reasonable and ongoing efforts to address and manage the patient's multiple medical conditions. We could not confirm unsanitary conditions or discourteous communications. We made no recommendations.

/es/
VICTORIA H. COATES
Director
Atlanta Office of Healthcare Inspections

October 31, 2008