Administrative Closure

Healthcare Inspection – Alleged Patient Confidentiality, CBOC Staffing and Clinic Workload Issues, Ashtabula Community Based Outpatient Clinic, Ashtabula, Ohio (562/00)

MCI# 2010-02487-HI-0301

Purpose

The VA Office of Inspector General Office of Healthcare Inspections (OHI) reviewed allegations that there was a potential for compromise of patient confidentiality and that understaffing and over scheduling of patients at the Ashtabula community based outpatient clinic (CBOC) resulted in omissions in patient care.

Background

The Ashtabula CBOC is one of five CBOCs operated by Erie VA Medical Center (medical center), Erie, PA, which is part of Veterans Integrated Service Network 4. The CBOC opened in May 2004 and is located approximately 52 miles from the medical center. The CBOC provides primary care (PC), and ancillary and behavioral health (BH) services. Since opening the 3550 square-foot clinic, the CBOC's patient population has grown from 1569 to 2465. In addition, the number of CBOC ancillary staff increased from 3.9 to 5.9 full time employee equivalents and from 1 to 3.6 providers.

We conducted a site visit on May 14, 2010, to inspect the physical clinic space and on October 13 to interview CBOC staff. We reviewed selected patients' medical records for the period March 2009 to July 2010. Additionally, we reviewed applicable medical center and national policies and procedures, as well as provider workload and patient visit data.

Issue 1: Patient Confidentiality

Because of limited space, and at the time of the complaint, a part-time (PT) BH social worker used a supply closet for an office. The supply closet abutted the patient waiting area and allowed some spoken words to be heard through the wall. However, we found that words from the supply closet could not be heard when the waiting room television and/or noise machine were operating. There were no reported patient complaints related to breach of confidentiality while the supply closet was in use.

Following our initial site visit inspection, medical center leaders instructed the CBOC staff to stop using the supply closet for patient care. The PT BH social worker subsequently moved patient visits to any available space within the clinic, including the CBOC conference room. However, during our site visit, we observed that:

- Staff occasionally interrupted BH appointments to retrieve supplies from the conference room closets.

- Conference room video teleconferencing (V-tel) equipment signage warned that, "Confidentiality cannot be assured due to the presence of V-tel equipment."
- The PT BH social worker's email encryption was not properly set up for use on the shared computer in the conference room.

VHA requires facilities to protect confidentiality of patient information from unnecessary disclosure.[1] Failure to provide privacy and confidentiality in the provision of patient care is a breach of patient rights.

We found potential for compromised patient confidentiality in the CBOC conference room when it was used for patient appointments. However, medical center managers and staff said that they would address these issues by retrieving supplies and unplugging the V-tel equipment before patient appointments, as well as resolving email encryption issues. Additionally, the Patient Aligned Care Team (PACT) model renovations planned for the clinic are expected to improve the flow, soundproofing, and other safety issues (including a staff-distress alarm system). Leadership plans to continue monitoring the success of the renovations in addressing these issues.

Issue 2: CBOC Staffing and Clinic Workload

Staff expressed anxiety over the potential for medical errors or omissions in care related to the alleged chronic understaffing and over-scheduling of patients. We reviewed the medical records of two CBOC patients that staff reported as examples of unintentional medical errors related to these allegations.

Case Study #1:

In March 2009, a CBOC PC provider ordered a screening thyroid-stimulating hormone (TSH) laboratory test for a patient. Although the TSH test result was highly elevated at more than 100 (normal 0.34–5.6) International Units/milliliter, the ordering PC provider did not treat the elevated TSH. More than a year later, during a non-VA hospitalization, the patient was diagnosed with hypothyroidism and started on appropriate treatment. When the patient returned to the CBOC for care, the PC provider appropriately treated and monitored the patient's TSH.

We are unable to confirm or refute that understaffing or over-scheduling of patients contributed to the ordering provider not becoming aware of the TSH test result earlier. Overall, no harm resulted from the delay in the provider's awareness of the test result.

[1] VHA Handbook 1605.03, *Privacy Compliance Assurance Program and Privacy Compliance Monitoring,* April 13, 2009.

Case Study #2:

In November 2009, a CBOC PC provider saw the patient for the first time. The patient told the provider that he had not taken blood pressure medications for approximately 2 years. On examination, the patient's blood pressure was elevated at 174/108 millimeters of mercury (mm Hg). The PC provider also noted that the patient had symptoms of congestive heart failure, including difficulty breathing upon exertion, nighttime urination, and edema.

The provider ordered an electrocardiogram, echocardiogram, and x-rays to evaluate the patient's cardiovascular symptoms, and prescribed lisinopril to treat the blood pressure. On December 10, the echocardiogram was performed. Later that week, another CBOC PC provider sent the patient a letter stating that his echocardiogram was "stable." On May 28, 2010, the original provider again saw the patient and, because the provider noted the echocardiogram results, he stopped the lisinopril and prescribed metoprolol. When the patient's blood pressure remained elevated, the provider increased the metoprolol and, later added lisinopril back to the patient's regimen.

We are unable to confirm or refute that understaffing or over-scheduling of patients contributed to the ordering provider not becoming aware of the echocardiogram results earlier. Overall, no harm resulted from the delay in the provider's awareness of the echocardiogram result.

Additionally, we found that in the last 2 months, there were no documented patient complaints or incident reports related to CBOC medical errors or omissions in care.

Conclusion

We found potential for compromised patient confidentiality in the conference room when used for appointments at the CBOC. However, medical center leadership addressed the immediate concern and has plans for PACT renovations of the CBOC.

Although we found that a CBOC PC provider was not timely in addressing a patient's abnormal TSH laboratory value and in adjusting another patient's medication, we were unable to substantiate that either medical error was related to staffing or over-scheduling of patients. We also found no evidence of resulting patient harm; therefore, we make no recommendations and consider the case closed.

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