

Administrative Closure
Tucson VA, Anthem CBOC, and Phoenix VA in Arizona
MCI# 2011-00446-HI-0033

We recommend administrative closure of this inspection for the following reason: Tort claim.

On November 4, 2010, a confidential complainant contacted the OIG hotline with the following allegations:

Tucson VA

- The patient was discharged home after open heart surgery without referrals for home health, cardiac rehabilitation or a referral to a cardiologist in the Phoenix area near his home.
- The patient did not receive a prescription for furosemide¹ at discharge.

Anthem CBOC

- The primary care physician (PCP) failed to follow up appropriately on the patient's urinary tract infection (UTI).
- The PCP instructed the patient to stop taking furosemide and did not document the instructions in the medical record.

Phoenix VA

- The medical staff failed to diagnose and treat the patient's UTI.
- Staff in the Emergency Department (ED) and cardiac telemetry unit communicated inappropriately with the patient and family.

We substantiated the allegation that the patient was discharged from the Tucson VA without orders for home healthcare or cardiac rehabilitation; however, we found that these actions were appropriate. The patient did not meet criteria for home healthcare, and the PCP at the Anthem CBOC ordered cardiac rehabilitation. Although we substantiated the allegation that the patient was discharged without an order for furosemide, we determined that furosemide was not warranted at that time.

We did not substantiate the allegation that the PCP at the Anthem CBOC instructed the patient to stop taking furosemide. We found that the PCP instructed the patient to change the furosemide dosage. We did substantiate that the PCP did not document the adjusted dose and discussion in the patient's medical record. During our review, we also found that the PCP did not reconcile medications prior to the completion of the patient's clinic visits as required by local policy.

¹ Lasix increases the amount of urine produced and excreted, and removes excessive water.

We did not substantiate the allegation that the patient was discharged from the Tucson VA without a referral to a Phoenix area cardiologist or that the PCP at the Anthem CBOC failed to follow up appropriately on the patient's urinary tract infection (UTI). We not substantiate the allegation that the Phoenix VA staff failed to diagnose and appropriately treat the patient's UTI. We could not confirm or refute the complainant's allegation that the staff in the Emergency Department and cardiac telemetry unit communicated inappropriately with the patient and his family.

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D." in a cursive script.

John D. Daigh, JR., M.D.
Assistant Inspector General for
Healthcare Inspections