Administrative Closure
Alleged Quality of Care Issues
Captain James A. Lovell Federal Health Care Center
North Chicago, Illinois
MCI# 2013-00448-HI-0329

On December 22, 2011, the VA Office of Inspector General Office of Healthcare Inspections received an anonymous complaint alleging quality of care issues at the Captain James A. Lovell Federal Health Care Center (facility). Specifically, the complainant alleged a patient experienced a delayed cancer diagnosis in 2010. On January 13, 2012, the Office of Inspector General, Hotline Division, requested that the facility determine the merits of the complainant's allegation. On March 9, 2012, the facility managers responded to the request. On November 6, 2012, the Chicago Office of Healthcare Inspections was asked to review the facility's findings to determine if the complainant's allegations were adequately addressed.

In response to the complainant's allegations, the facility conducted an electronic health record review. The facility found that on March 5, 2010, the patient, a 67 year old male, presented to the mental health clinic at the facility. The mental health clinic staff escorted the patient to the facility's emergency department (ED) because the patient had a low a blood pressure (63/43). While being treated in the ED, the patient received a chest radiograph (CXR) which revealed a lung tumor. The radiologist interpreting the CXR results activated the facility's "view alert system", notifying the patient's primary care physician and the ED physician of the CXR results. The radiologist recommended that the patient undergo a computed tomography scan of the chest. The patient was discharged from the ED without receiving a computed tomography scan of the chest or being informed of the CXR results. According to the facility's documentation, the results of the CXR and the radiologist's recommendation were not acted on by the patient's primary care physician and the ED physician until July 20, 2010. On July 23, 2010, the patient underwent a biopsy of the lung tumor, which revealed non-small cell carcinoma.

The facility completed peer reviews addressing the delayed diagnosis. [redacted]. The patient expired on July 6, 2012.

We concur with the facility's actions and make no recommendations.

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