



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues and Communication Lapses Washington DC VA Medical Center, Washington, DC

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to determine the validity of allegations regarding a patient's quality of care and communication between professional staff and a patient's family at the Washington DC VA Medical Center. The complainant alleged that treatment of the patient's urinary tract infection was delayed; that the facility did not tell the family the patient had a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection; that the patient was released from outpatient care despite the MRSA infection; and that communication with the family about all of the patient's conditions was poor.

We substantiated that management of the MRSA urinary tract infection was not timely instituted. When the providers were informed that a large quantity of MRSA was detected in the patient's urine, and antibiotic susceptibilities were known, no management changes were made. Within 72 hours of the positive MRSA result, the patient was hospitalized with MRSA sepsis. We found that the facility did not conduct a Quality Review for the outpatient MRSA management issue.

We substantiated that the patient and family were not timely notified of the patient's MRSA infection while he was an outpatient. However, following admission to the hospital several days later, the patient and family were informed of the MRSA infection. We did not substantiate the allegation that the facility lacked professionalism in relating to the patient's family. The nursing staff and physicians we interviewed stated they explained the patient's clinical course to the family throughout the hospitalization. There were no formal complaints made to the patient advocate or the leadership team alleging poor communication while the patient was hospitalized.

We recommended that the facility Director, in accordance with VHA Handbook 1004.08, consult with Regional Counsel regarding institutional disclosure to the patient's family; ensure that a quality of care review is conducted with specific attention to deficiencies identified in this report; and monitor providers' documentation to ensure compliance with VHA policies on information management and health records.

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Washington DC Veterans Healthcare Network (10N5)

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues and Communication Lapses, Washington DC VA Medical Center, Washington, DC

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding a patient's quality of care and communication lapses with the patient's family at the Washington DC VA Medical Center (facility).

Background

The facility is part of Veterans Integrated Service Network (VISN) 5 and serves veterans from surrounding Virginia, Maryland, and the District of Columbia. The facility provides medical and surgical care, inpatient and outpatient mental health services, and primary care. The facility has a community living center, which provides long term, hospice, and palliative care.

Allegations

A complainant contacted the OIG's Hotline Division with allegations regarding a patient's quality of care and ineffective communication with the patient's family.

The complainant alleged that:

- Mistakes were made in the patient's treatment during November 2010.
- The facility failed to notify the patient and family of the development of a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection¹.

¹ Methicillin-Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that is resistant to treatment with many commonly used antibiotics. Where a patient's immune response is compromised, MRSA may evolve into a serious and potentially life-threatening infection. MRSA is not a risk to otherwise healthy individuals. Among the strategies to limit the impact of MRSA infections is prompt and effective treatment relying on antibiotic susceptibility testing when available.

- The patient was discharged prematurely from outpatient care despite his diagnosis of a MRSA urinary tract infection in November 2010.
- There was poor communication between the facility and the family as to the patient's overall care.

Scope and Methodology

We reviewed the patient's VA medical records, local and Veterans Health Administration (VHA) policies and procedures, clinical practice guidelines and quality management documents. In addition, we interviewed the complainant on March 7, 2012 and conducted a site visit on May 8-9, 2012. We interviewed facility leadership, physicians, a physician assistant, nursing personnel, supervisory staff, and administrative staff. We also reviewed patient advocate reports.

We conducted the inspection in accordance with the *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient was a man in his seventies with a history of chronic medical conditions, which included multiple myeloma that was treated with chemotherapy and corticosteroids,² prostate enlargement with urinary obstruction, end-stage renal disease (ESRD),³ and orthostatic hypotension.⁴ The patient experienced recurrent urinary tract infections (UTI)⁵ with the predisposing factors of urinary outflow obstruction, periods of indwelling urinary catheterization⁶, and an immune-compromised state.⁷

In June and July 2010, the patient was seen in the Emergency Department (ED) several times for UTIs, and treated with catheterization and antibiotic therapy, which was confirmed as effective by antibiotic susceptibility test results. In August, the patient started kidney dialysis treatments for ESRD 3 times a week. In mid-October, the patient was assigned a new primary care physician (PCP).

² Multiple myeloma is a cancer of plasma cells, a type of white blood cell, which produces a specific antibody as part of the body's immune system.

³ End-stage renal disease is the complete, or almost complete, failure of the kidneys to function.

⁴ Orthostatic hypotension is a condition where a person develops low blood pressure within seconds to minutes of standing upright.

⁵ A urinary tract infection is an infection that involves any part of the urinary tract system (i.e., kidney, ureters, bladder, or urethra).

⁶ A urinary catheter is a flexible tube passed through the urethra and into the bladder to allow urine to drain into a collection bag.

⁷ Immune-compromised or immunodeficiency is a state in which the immune system's ability to fight infectious disease is compromised or entirely absent.

In early November, the patient presented to the ED with findings to include fatigue, generalized weakness, poor appetite, urinary retention, and orthostasis. His previously placed urinary catheter had been removed weeks earlier. A urinary catheter was inserted and the bladder was drained. The urine was tested and the results showed bacteria and a high number of urinary white blood cells, consistent with another UTI. While awaiting culture and sensitivity results, empiric⁸ antibiotic coverage was started. The ED staff consulted the urology service and arrangements were made for the patient to be seen in clinic within a few days. The purpose of the urology visit was to follow up on the patient's urine function and the results of the urine culture obtained in the ED.

Three days later, at 9:10 a.m., the patient was seen in the Urology Clinic by a physician assistant (PA)⁹ and noted to have "blood-tinged sedimentitious urine." However, there was no documentation of follow-up on the urine culture taken in the ED. The patient continued to receive the empiric antibiotic regimen started in the ED.

At 10 a.m., the PCP was notified by the laboratory that the urine culture obtained 3 days earlier was growing a large quantity of MRSA, which was not sensitive to the antibiotic regimen the patient was on. The infection control nurse promptly documented the newly diagnosed MRSA UTI in the Electronic Health Record (EHR). The PCP telephoned the patient's family member explaining that the empiric antibiotic would be changed based on the additional information.

The PCP then discussed, by telephone, the case with the PA in the Urology Clinic who had seen the patient 2 hours earlier. The PCP notified the PA that the urine culture result was positive for MRSA. The PA informed the PCP that based upon the PA's interaction during the urology appointment earlier in the day, the patient seemed to be doing well. The PA offered an opinion to the PCP that the reported culture result for MRSA may not reflect actual MRSA infection but, rather, a urine contaminant,¹⁰ as the patient had been previously catheterized to maintain urinary flow. The PA did not inform the supervising urologist of the reported MRSA UTI on November 5. The PCP accepted the PA's recommendation to continue the empiric antibiotic instead of tailoring the choice of treatment based on the laboratory's MRSA antibiotic susceptibility data. The PCP then telephoned the family member a second time and left a message to continue with the previously prescribed empiric regimen.

At 1 p.m., the patient underwent a previously scheduled surgical procedure for replacement of the dialysis catheter¹¹. The patient tolerated the procedure well and was discharged home.

⁸ Empiric-therapy refers to initiating an antibiotic for a presumed infection pending identification of a specific microorganism.

⁹ A physician assistant is a mid-level medical practitioner, who works under the supervision of a licensed physician.

¹⁰ Urine contaminated with bacteria other than from the bladder, such as from unsterile insertion of a catheter.

¹¹ A dialysis catheter is used for exchanging the patient's blood between the hemodialysis machine and the patient.

Two days later, the patient returned to the ED complaining of confusion, fever, rapid heart rate, cough, and difficulty breathing. He was admitted to the Medical Intensive Care Unit with a diagnosis of MRSA urosepsis.¹² During the patient's 3-week hospitalization, he experienced persistent MRSA bacteremia¹³ and additional MRSA complications of endocarditis,¹⁴ septic brain emboli,¹⁵ and abscesses of the liver and muscle.¹⁶ The patient continued to decline and he died November 30, 2010, of cardiac arrest.

Inspection Results

Issue 1: Patient Management

We substantiated that the patient did not receive timely modification of his antibiotic treatment following the confirmation of MRSA UTI data. Neither the PA nor the PCP modified UTI management based on the confirmed identification of a large growth of MRSA in the setting of numerous urinary white blood cells and with specific antibiotic susceptibility data available. Clinical standard of care requires modification of empiric antibiotic treatment in an immune compromised patient with a documented MRSA UTI. Failure to timely modify the treatment may have resulted in a more complex clinical course for this patient, who went on to experience multisystem infectious complications of MRSA and progressive clinical decline.

Issue 2: Failure to Notify Family of MRSA Infection

We substantiated the allegation that there was poor communication between the facility and family regarding the MRSA infection in the outpatient setting when the patient was initially diagnosed. However, we did not substantiate that there were communication lapses with the patient's family during the subsequent hospital admission.

The ED staff did inform the patient and his family that he "was found to have a UTI" and would be seen in the Urology Clinic for his follow-up appointment within a few days. During the follow-up visit three days later, the PA examined the urinary catheter and noted the "urine was clear with intermittent blood tinge" in the urinary catheter bag, but did not follow up on the urine culture as requested by the ED. However, within an hour of the urology visit the laboratory notified the PCP and the PA of the positive MRSA culture. The PCP and PA conferred as to the laboratory significance of the finding but made no changes in antibiotic management.

¹² MRSA urosepsis is an infection previously localized to the urinary tract that enters the bloodstream and causes a systemic infection.

¹³ Bacteremia is the presence of bacteria in the bloodstream.

¹⁴ Endocarditis is the inflammation of the inside lining of the heart chambers and heart valves.

¹⁵ Septic brain emboli are the bacterial infection of the brain with blood clots.

¹⁶ Abscess-a collection of pus usually caused by bacterial infection.

The patient and family were not initially informed that laboratory tests performed in the ED were positive for MRSA. However, infection control personnel told us that it is facility policy to inform patients as soon as practical and feasible when they become either colonized,¹⁷ or infected, with MRSA. Forty-eight hours later the patient was admitted with a diagnosis of MRSA sepsis. We reviewed documentation that the admitting nurse noted the MRSA infection, initiated isolation precautions, and educated the patient on MRSA protocols. The hospitalist we interviewed told us that they spoke with the complainant on the day following admission and told the patient he had a MRSA infection. The complainant, however, claimed to be uninformed as to the finding of a MRSA infection until 2 weeks after admission, when the staff responded to a family member's specific question.

VHA policy requires that the facility's infection control nurse place a clinical warning in the EHR when a patient is determined to have a positive MRSA culture. In addition, the laboratory is required to telephone the ordering provider to notify them of the positive MRSA culture. In this case, the laboratory did notify the patient's provider. We found that the facility had complied with VHA policy.¹⁸

We could not substantiate nor refute the allegations that the facility acted unprofessionally toward the patient or the patient's family during his admission.

Issue 3: Release from Outpatient Care

We did not substantiate the allegations that the patient was released early from the outpatient setting following the insertion of a catheter for venous access for dialysis. The patient was stable prior to as well as after the procedure, and discharged from surgery in the care of a family member.

Issue 4: Peer Review

We found that the facility did not conduct peer review of the care provided the patient in early November – the MRSA management issue in the outpatient setting.

Peer review is a non-punitive, confidential process used to evaluate care provided to patients by individual providers. According to VHA policy, the formal process of peer review involves evaluation of specific episodes of care, determination of necessary specific actions based on evaluations, confidential communication with providers, and identification of systems and process issues that may require special actions.¹⁹ The facility's Peer Review Committee is responsible for overseeing the process by

¹⁷ Colonized-MRSA bacteria - can live normally on human skin surfaces, and, especially, in the nose and throat, without likely causing symptoms in an immunologically intact person; 5-10% of the general population carries MRSA but without active infection.

¹⁸ VHA Directive 2010-006, *Methicillin-Resistant Staphylococcus Aureus (MRSA) Prevention Initiative*, February 3, 2010.

¹⁹ VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

designating peer reviewers and monitoring the completion of actions.²⁰ Based on VHA and internal peer review policies, the MRSA management issue warranted peer review.

Conclusions

We substantiated that the facility failed to timely notify the patient and the family of the positive MRSA culture when it was verified in the outpatient setting.

We did not substantiate the allegation of failure of the facility to communicate with the family during the patient's hospitalization in November 2010.

We found that the PA failed to discuss the laboratory finding of a MRSA UTI in an immune compromised patient with the supervisory urologist.

In the course of reviewing the patient's overall clinical care, we found the outpatient management of the patient's MRSA UTI, to be substandard.

At the time of our site visit, the facility had not conducted a quality of care review on this case and we have not been informed of any subsequent processes.

Recommendations

Recommendation 1. We recommended that the Medical Center Director consult with Regional Counsel regarding possible institutional disclosure to the patient's family for whom quality of care concerns were identified.

Recommendation 2. We recommended that the Medical Center Director take action to improve oversight of PA practice activities in the urology clinic.

Recommendation 3. We recommended that the Medical Center Director conduct a peer review of the care identified in this report.

²⁰ VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–10 for the Directors’ comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 14, 2013

From: VISN Director, VA Capitol Health Care Network (10N5)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues and Communication Lapses, Washington DC VA Medical Center, Washington, DC**

To: Director, Washington DC Office of Healthcare Inspections (54DC)

Thank you for conducting this Healthcare Inspection. We concur with your recommendations and appreciate your work to improve the care to our Veterans.

(original signed by:)

Fernando O. Rivera, FACHE
Network Director, VISN 5
VA Capitol Health Care Network

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 11, 2013

From: Director, Washington DC VA Medical Center (688/00)

Subject: **Alleged Quality of Care Issues and Communication Lapses,
Washington DC VA Medical Center, Washington, DC**

To: VA Capitol Health Care Network (10N5)

Thank you for conducting this Healthcare Inspection. We concur with your recommendations and appreciate your work to improve the care to our Veterans.

(original signed by:)

Brian A. Hawkins, MHA
Medical Center Director

**Director's Comments
to Office of Inspector General's Report**

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director consult with Regional Counsel regarding possible institutional disclosure to the patient's family for whom quality of care concerns were identified.

Concur **Target Completion Date: January 10, 2013**

Facility's Response: The Washington DC VAMC has consulted with the Regional Counsel. The Chief of Staff and Risk Manager continue to work with that office to ensure appropriate actions occur. The final decision for Institutional Disclosure will be made after the Peer Review and Infectious Disease consult are completed.

Status: Open

Recommendation 2. We recommended that the Medical Center Director take action to improve oversight of PA practice activities in the urology clinic.

Concur **Target Completion Date: February 1, 2013**

Facility's Response: The Medical Center Director has requested a full review of the oversight of PA practice in the Urology clinic. The Chief of Surgery and Urology along with Quality Management will conduct a comparison of level 1a and 1b PA practices.

Status: Open

Recommendation 3. We recommended that the Medical Center Director conduct a peer review of the care identified in this report.

Concur **Target Completion Date: February 7, 2013**

Facility's Response: A peer review was initiated January 10, 2013 and will be discussed in the February 4 Peer Review Committee meeting. The Chief of Staff has also requested that Chief of Infectious Disease review the case and make recommendations.

Status: Open

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Randall Snow, JD, Project Leader Myra Conway, RN, Team Leader Bruce Barnes Thomas Jamieson, MD

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