Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Medication Overdose and Poor Communication
VA Boston Healthcare System
Boston, Massachusetts

Report No. 08-01777-163 **July 10, 2008**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The VA Office of Inspector General received a Congressional inquiry concerning the quality of care and lack of communication at the VA Boston Healthcare System. The purpose of the inspection was to determine the validity of the following allegations:

- Nurses administered an overdose of prescribed pain medications, and this caused the complainant (the patient) to collapse.
- The patient advocate refused to review the patient's record.
- Senior managers were unresponsive to the patient's concerns.

We did not substantiate the allegations. Our review showed that the patient received pain and all other medications as prescribed; that the patient advocate managed the patient's complaint appropriately; and that at the request from the Chief of Surgery's office, the Chief of Neurosurgery reviewed the patient's medical record and medication administration history relative to the admission in question. The Chief of Neurosurgery spoke by telephone with the patient regarding the conclusion that the patient might have suffered an exaggerated response to narcotic medications.

We concluded that the quality of care and communication with the patient was appropriate, and we made no recommendations.

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

TO: Acting Director, New England Healthcare System (10N1)

SUBJECT: Healthcare Inspection – Alleged Medication Overdose and Poor Communication, VA Boston Healthcare System, Boston, Massachusetts

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) reviewed allegations concerning quality of care and communication issues at the VA Boston Healthcare System's (the system) West Roxbury division. The purpose of this inspection was to determine the validity of the following allegations:

- Nurses administered an overdose of prescribed pain medications, and this caused the patient to collapse.
- The patient advocate refused to review the patient's record.
- Senior managers were unresponsive to the patient's concerns.

Background

The system is comprised of three divisions. Jamaica Plain provides primary care services, West Roxbury provides acute inpatient medical and surgical services and primary care services, and Brockton provides long-term care and primary care services. Academic affiliations include Harvard Medical School and the Boston University School of Medicine.

OIG received a Congressional inquiry requesting a review of quality of care concerns on behalf of a constituent. According to the letter, the complainant (the patient) was an inpatient at the West Roxbury division in January 2008. The patient alleged that during that admission, nursing personnel administered an overdose of prescribed pain medication; and the overdose caused the patient to collapse. The patient alleged that the computer system did not keep an accurate record of the narcotics administered to the patient, and it did not alert nurses when doses of medications approached critical levels. In addition, the patient alleged that the patient advocate was "too busy" to review the medical record, and facility administrators were unresponsive to the patient's concerns.

Scope and Methodology

We interviewed the patient by telephone and reviewed portions of the patient's medical record pertinent to the admission in question. We reviewed computer generated medication administration records, narcotic inventories for the inpatient unit, and other pertinent documentation. We conducted a site visit on May 13, 2008, to discuss the patient's concerns with the patient's attending surgeon, the nurse manager from the inpatient unit, and other personnel with related information. We conducted telephone interviews with the facility's patient advocate (who was unavailable during the site visit) and the Director's secretary on May 15, 2008.

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

Case Summary

The patient presented to West Roxbury in January 2008 for elective surgery for a history of intractable neck pain and right upper extremity weakness and initially did well postoperatively. The attending surgeon prescribed a patient controlled analgesia[1] (PCA) pump containing Dilaudid®[2] for post-surgical pain relief. A nursing note recorded in the patient's medical record at 0400 on the first postoperative day (POD1) reflects that the patient was still "in a lot of pain," and the nurse increased the dose of pain medication per the surgeon's orders with moderate effect. At 0715, a physician assistant (PA) from neurosurgery assessed the patient and documented that the PCA pump controlled the patient's pain; however, the PA documented that the patient continued to complain of some soreness in the neck. The patient received an intramuscular injection of a non-narcotic pain reliever at 0930 and a scheduled dose of clonazepam.[3] In preparation for the patient's discharge, clinicians discontinued the Dilaudid® PCA, and nursing staff removed the pump at 0950. A physical therapist evaluated the patient and documented at 1017 that the patient was "independent with all mobility without a device." Nursing documentation completed at 1146 indicated that the patient was "alert X 3,"[4] and the patient was determined to be ready for discharge. However, at approximately 1430

[1] Patients recovering from surgery often are equipped with patient controlled analgesia (PCA) pumps. PCA is a method of pain control that gives the patient the power to control their pain. In PCA, a computerized pump containing a syringe of pain medication, as prescribed by a doctor, is connected directly to a patient's intravenous (IV) line. In some cases, the pump is set to deliver a small, constant flow of pain medication known as the basal rate with additional doses of medication self-administered as needed by the having the patient press a button. Other times, a patient can control when he or she receives pain medication and does not receive a constant flow.
[2] Dilaudid® is the brand name of the drug hydromorphone, a narcotic analgesic prescribed to patients with acute or chronic pain.
[3] Clonazepam is a controlled substance medication in the drug class of benzodiazepines. Doctors may prescribe a benzodiazepine for many common conditions such as anxiety, insomnia or seizure control.
[4] Medical shorthand indicating that a patient is in a cogent state and aware of their surroundings; alert x3 means the patient is aware of person, place, and time.

documentation shows that the patient complained of increased pain and a headache and received two Percocet®[5] tablets per physician's orders. Approximately 10 minutes later, the patient's wife came from the patient's room and told nurses that the patient needed help.

According to the attending physician's documentation, the patient had an episode of dizziness, focal weakness,[6] and somnolence after taking the Percocet® tablets. Medical record documentation indicated that the patient did not lose consciousness. The nurse performed a finger stick glucose test at the bedside, which ruled out hypoglycemia as a cause for the episode. A computed tomography scan of the brain done at approximately 1500 ruled out a stroke or intracranial bleeding.

During our interview, the attending surgeon related that the patient continued to have symptoms or weakness and somnolence, and the surgeon decided to order Narcan® by intravenous injection, which the patient received at 1700. Narcan® prevents or reverses the effects of opioid narcotics, including respiratory depression and sedation. According to nursing and physician documentation, the patient responded with increased wakefulness within minutes of administration. At 2146, a medical neurologist evaluated the patient because of the focal weakness noted during the episode of somnolence. The neurologist's assessment was that the symptoms may have reflected an exaggerated response to narcotics and the resolution of symptoms following Narcan® supported this.

The neurosurgeon who performed the patient's surgery, who is also the Chief of Neurosurgery, reviewed the patient's medical record and medication administration history at the request of the Chief of Surgery's office in February 2008. In addition, the surgeon spoke with the patient by telephone on February 18, 2008, regarding the surgeon's assessment and conclusion that the patient suffered an exaggerated response to narcotic medications.

Inspection Results

Issue 1: The Patient Received an Overdose of Prescribed Pain Medications.

We did not substantiate this allegation. A medical doctor and a doctor of pharmacy from OHI reviewed the pertinent portions of the patient's medical record and medication administration history. The patient told us that during the inpatient stay, nursing personnel did not administer routine medications on the same schedule that the patient had established at home. However, our review determined that the difference in the schedules was not contributory to the patient's episode of dizziness, weakness, and somnolence. Based on our review, we found that the patient did not receive an overdose of pain medication. We also found that bar code medication administration software

[5] Percocet is a brand name for oxycodone/acetaminophen – a narcotic analgesic.
[6] Refers to weakness confined to a portion of the body, such as a limb, not generalized to the entire body.

recorded all medications administered to the patient, and the unit maintained accurate inventories of the narcotics in question. Medical record documentation and interviews with nurses and the attending surgeon confirm that clinicians responded appropriately to the episode of weakness, dizziness, and somnolence and cancelled the patient's discharge for that day. After ruling out other causes and given the patient's response to Narcan®, they concluded that the patient might have had sensitivity to Percocet®.

Issue 2: The Patient Advocate Refused to Review the Medical Record.

We did not substantiate this allegation. We reviewed the patient advocate's report of contact (ROC) of the patient's telephone call dated February 7, 2008. The ROC relates that the patient asked the patient advocate to read all the pertinent notes in the medical record over the telephone. However, the patient advocate informed the patient that it would be inappropriate to do so because the patient advocate was not a physician and could not help the patient interpret the notes. In addition, the ROC relates that the patient advocate advised the patient to obtain a copy of the medical record. According to the ROC, the patient's response was to ask to speak with "administration."

We interviewed the patient advocate by telephone on May 15, 2008. The patient advocate recalled speaking with the patient and related that the telephone contact with the patient was brief and was accurately reflected in the ROC. The patient advocate transferred the patient's telephone call to the Director's office at the patient's request.

We interviewed the Director's secretary who did not specifically recall a conversation with this patient. However, she told us that it would be common practice to obtain a complainant's contact information and as much information about the complaint as possible in order to ascertain who would be best suited to resolve the complaint; and refer the complaint to that person or service for resolution.

Issue 3: Senior Managers Were Unresponsive to the Patient's Concerns.

We did not substantiate this allegation. The patient reported sending an electronic mail message to "the head of the hospital" and got no response from that contact; however, the patient could not provide a copy of the message. Neither the Director nor Director's secretary recalled receiving the message. Interviews with other personnel established that the Chief of Surgery's office requested that the Chief of Neurosurgery review the patient's medical record and medication administration history relative to the January 2008 admission. The Chief of Neurosurgery conducted the reviews and spoke with the patient by telephone regarding the conclusions of the review.

Conclusions

We concluded that the patient did not receive an overdose of pain medication and that the system investigated the patient's episode of dizziness, weakness, and somnolence appropriately. We also concluded that the patient advocate managed the patient's complaint appropriately, and that clinical managers communicated pertinent clinical information to the patient. Further review of this case is unwarranted, and we made no recommendations.

Comments

The VISN Director and System Director agreed with the findings and conclusions. (See Appendixes A and B for the Directors' comments).

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 3, 2008

From: Acting Director, New England Healthcare System

Subject: **Healthcare Inspection – Alleged Medication Overdose and Poor Communication, VA Boston Healthcare System, Boston, MA**

To: Assistant Inspector General for Healthcare Inspections

We concur with the findings and that there are no recommendations.

Should you have any questions or concerns, please contact VISN 1 Quality Management Officer.

(original signed by:)

TAMMY FOLLENSBEE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 3, 2008

From: System Director

Subject: **Healthcare Inspection – Alleged Medication Overdose and Poor Communication, VA Boston Healthcare System, Boston, MA**

To: Assistant Inspector General for Healthcare Inspections

We concur with the findings and that there are no recommendations.

Should you have any questions or concerns, please contact VA Boston Healthcare System, Quality Management Director.

(original signed by:)

Michael Lawson

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Jeanne Martin, Pharm.D. Bedford Office of Healthcare Inspections (603) 222-5872
Acknowledgments	Andrea Buck M.D., J.D., Medical Consultant Katherine Owens, MSN

Appendix D

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