Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care, Customer Service, and Environment of Care, VA Western New York Healthcare System, Buffalo, New York

Report No. 05-02118-201 **September 19, 2005**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Western New York Healthcare System (528/00)

SUBJECT: Healthcare Inspection – Quality of Care, Customer Service, and Environment of Care, VA Western New York Healthcare System, Buffalo, New York, Project Number: 2005-02118-HI-0226

1. Purpose

The Department of Veteran Affairs Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) reviewed allegations that a patient received poor quality of care, experienced poor customer service, and was exposed to unclean environmental conditions at the Buffalo Division of the VA Western New York Healthcare System (the system). The purpose of this inspection was to determine the validity of the allegations.

2. Background

The system consists of two divisions located in Buffalo and Batavia, New York. The Buffalo Division provides inpatient and outpatient medical, surgical, mental health, and long-term care services. The Batavia Division provides long term care and primary care services. The system is academically affiliated with the State University of New York (SUNY) at Buffalo School of Medicine and is accredited by the American College of Surgeons for cancer treatment.

On May 16, 2005, OHI received a copy of a letter written by a complainant on behalf of the aforementioned patient, dated February 5, 2005, and sent to the Director of the system. A courtesy copy of the letter was also sent to Senator Daniel K. Akaka, Ranking Member of the Senate Veterans' Affairs Committee. The complainant and/or patient alleged that:

- The patient received poor quality of care in the Urology and Oncology Clinics. He allegedly experienced a 6 month delay in the diagnosis of bladder carcinoma, a delay in treatment after the initial diagnosis was made, and did not receive his final dose of chemotherapy.
- The communication between the patient and his providers was poor. The patient alleged that he did not receive a response to a letter he had sent to his oncologist

regarding his care. Also, the patient alleged that there was an inability to see the same provider in the Urology Clinic and to communicate with the Chief, Urology Service, about his care.

- The patient experienced poor customer service: waiting times in Urology Clinic were excessive; he was not allowed to check into the Urology Clinic until 15 minutes prior to his appointments; and he waited 2 to 4 hours after his blood was drawn before he received his chemotherapy treatment. Additionally, the patient was allegedly treated rudely by a clerk in the Urology Clinic, and a laboratory employee gave system employees preference over patients. This employee also allegedly told the patient that employees would always be taken before veterans.
- The Oncology Clinic's patient lunch area was not clean, and the patient saw bloodstains on the walls in the Oncology Clinic treatment room.

3. Scope and Methodology

We interviewed the complainant and the patient. We reviewed the patient's medical records and other pertinent documents. We visited the system's Buffalo Division on May 31 to June 2, 2005, and interviewed the patient's attending physicians and other employees who were familiar with the patient's care. We also interviewed Urology Clinic patients and patients waiting to have blood tests completed in the laboratory. Additionally, we observed employees' behavior in these areas. We inspected the Oncology Clinic treatment room and the lunch area used by ambulatory chemotherapy patients to assess environmental conditions.

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

4. Inspection Results

The patient was a 60-year-old veteran with a history of multiple chronic medical conditions. On September 24, 2001, the patient was seen in Primary Care at the Buffalo Division with a complaint of hematuria (blood in the urine). The provider ordered blood tests and a urinalysis and sent a consult to Urology Service. The urinalysis was positive for blood, and the patient was seen in the Urology Clinic on October 24. On November 9, the patient had an intravenous pyelogram (IVP), which is a bladder imaging examination; and on November 13, a cystoscopy[1] was performed. Bladder tumors were identified. On November 21, a transurethral resection of the bladder tumors (TURBT)[2] with biopsies of the tumors was performed. The pathology report showed a high grade transitional cell carcinoma[3] with no invasion into the adjacent bladder muscle. On

[1] Cystoscopy: A scope is inserted through the urethra into the bladder for inspection of the interior of the bladder.
[2] TURBT: Bladder surgery to remove tumors.
[3] High-grade transitional cell carcinoma: Tumor confined to the bladder cavity's first layer of cell structures and is a precursor to invasive cancer to the second layer and the bladder muscle.

December 21, the patient was seen by Oncology Service. However, the patient elected to receive his cancer treatment and care at a community hospital. At the community facility, from December 2001 through January 2004, the patient underwent chemotherapy treatments, multiple cystoscopies, and another TURBT was performed on January 20, 2004.

On February 18, 2004, the patient returned to the Buffalo Division for his cancer treatment and was seen in the Urology Clinic. The urologist recommended that the patient undergo another 6 week course of chemotherapy treatments followed by a cystoscopy. The plan was that if the bladder tumors recurred, a radical cystectomy (removal of the bladder) would be considered. The patient completed the 6 week course of chemotherapy treatments on April 6. On July 13, the patient had a follow-up cystoscopy and due to recurrence of bladder tumors, underwent a TURBT on August 10.

The patient requested a consult to Oncology Service to discuss the possibility of receiving another series of chemotherapy treatments. The consult was ordered on September 9, and he was seen by Oncology Service on September 21. The oncologist recommended a repeat cystoscopy in 3 months and documented that while another series of chemotherapy would not harm the patient, it was highly probable that the bladder tumors would return. The oncologist also documented that it would be reasonable for the patient to consider a cystectomy.

On September 28, the patient requested a second opinion regarding his treatment. On October 21, he was seen by a Syracuse, New York, VA Medical Center (VAMC) urologist. The urologist ordered blood and urine tests, an IVP, and a cystoscopy. On December 28, the Syracuse VAMC urologist advised the patient to consider a cystectomy. The patient agreed to the procedure, and the surgery was performed at the Syracuse VAMC on March 25, 2005. The patient's bladder, prostate, and appendix were removed, and a new bladder was reconstructed from a portion of the small intestine. The patient's hospital course was uncomplicated. He left the Syracuse VAMC against medical advice on April 9. However, he had follow-up appointments to monitor his condition scheduled in the Syracuse VAMC Genitourinary Clinic. At the time of our review, the patient told us that he continued to receive his urology care at Syracuse VAMC.

Issue 1: Quality of Care

Delay in diagnosis and treatment: We did not substantiate that there was a delay in diagnosis and treatment of the patient's bladder cancer.

The patient was assigned to the same Buffalo Division primary care provider (PCP) from May 1999 to September 12, 2001. The patient alleged that in March 2001 he told his PCP that he had hematuria. Medical record documentation for that period does not support that he complained of hematuria. Also, the PCP told us that he could not recall

that the patient ever complained of hematuria. The PCP ordered a routine urinalysis in September 1999 that was negative for hematuria.

On September 24, 2001, the patient was seen by another PCP, and medical record documentation shows at that time the patient did complain of hematuria. The PCP ordered a urinalysis that was positive for blood. A consult requesting further evaluation was sent to Urology Service. The patient was seen in the Urology Clinic on October 24. He had an IVP on November 9 and a cystoscopy on November 13, and bladder tumors were identified. On November 21, the patient underwent a TURBT. The pathology report showed a high grade transitional cell carcinoma with no invasion into the adjacent bladder muscle. On December 21 the patient was seen by Oncology Service.

Overall, we found that after the patient complained to his PCP of hematuria, a methodical evaluative process occurred that included obtaining a urologic consultation, followed by performance of diagnostic tests (IVP and cystoscopy), and the performance of an operation with tissue obtained during this procedure. This process took less than 60 days.

Chemotherapy dosage: We did not substantiate that the patient did not receive his full dose of chemotherapy treatment at his last session on April 2004.

Medical record documentation indicates that the patient received the full prescribed dosage of chemotherapy medication at all six sessions. Also, the oncology nurse who administered the last chemotherapy treatment told us that the patient received his full prescribed amount of medication.

Communication: We did not substantiate the complainant's allegation that the oncologist did not respond to the patient's September 23, 2004, letter regarding his treatment.

The patient told us that he had never written a letter to his oncologist. He thought that if a letter was sent to the oncologist, it must have been sent by the complainant. The oncologist told us that she did not recall receiving a letter from either the patient or the complainant. The oncologist also told us that the patient could have contacted her at any time if he had questions about his care.

The complainant and the patient also alleged that the patient never saw the same provider in Urology Clinic and never talked to the Chief, Urology Service.

There is no documentation that the patient talked to the Chief, Urology Service, at the Buffalo Division. However, there is no requirement that this need occur. Additionally, the Chief, Urology Service, was present during the patient's cystoscopies and TURBT procedures. With regard to the providers that the patient did see, medical record documentation shows that the patient saw the same resident during two of his five Urology Clinic visits. The system is a teaching institution and supports urology residents from SUNY at Buffalo School of Medicine.

Issue 1: Customer Service

Clinic Waiting Times: We substantiated that prior to our inspection there were long waiting times in the Urology Clinic. However, the Buffalo Division and Veterans Integrated System Network (VISN) 2 managers recognized that patients reporting to the Urology Clinic for scheduled appointments sometimes had extended waiting times. Managers also knew that the clinic was frequently over-booked (two or more appointments scheduled for the same time slot). The Buffalo Division and VISN managers conducted a Specialty Care Site Review in April 2005. Based on their findings from the review, managers developed and implemented an action plan prior the OIG inspection to alleviate these conditions.

Additionally, we interviewed 10 patients in the Urology Clinic: 7 patients said that on the average they were seen within 30 minutes or less of their scheduled appointment, 1 patient responded that he could not remember how long the waiting times were, and 2 patients said they may have had to wait for an hour or more.

Clinic Check-in Process: We substantiated that prior to our inspection veterans were not allowed to check-in for Urology Clinic appointments until 15 minutes before their scheduled time and that this was the process at the time referenced by the complainant.

In the course of the inspection, we learned this process was changed due to the complainant's letter to the system Director on February 5, 2005. Currently, patients can check in anytime before their appointments. Buffalo Division managers were responsive to the patient's concerns and changed the check-process prior to the OIG inspection

Chemotherapy Treatment Delays: We substantiated that patients wait from 2 to 4 hours after having their blood drawn until initiation of their chemotherapy treatments the same day.

Providers need to see patients' blood test results before they can prescribe chemotherapy treatments. The oncology nurse told us that this process can take 2 hours or longer depending on laboratory and pharmacy workload. She told us that patients are informed of this possibility prior to their first chemotherapy treatment, and patients are not required to remain in the treatment area during this necessary waiting period.

We suggested that clinical managers consider the possibility of offering patients the option of having their blood drawn the day before they are scheduled to come to the clinic for chemotherapy treatment, in an effort to decrease waiting times. Clinical managers agreed to consider this suggestion.

Employee Behavior: We could neither substantiate nor refute that the patient was treated rudely by a Urology Clinic clerk. While the complainant provided us with an employee name in reference to this complaint, we were told that no one by that name ever worked

in the Urology Clinic. We observed several different clinic clerks during our site visit and noted them to be very helpful to patients during the check-in process. All clinic clerks were observed to treat patients with courtesy. The 10 Urology Clinic patients we interviewed all stated that the clerks treated them with dignity and respect.

Also, we could neither substantiate nor refute that a laboratory employee gave priority treatment to system employees over patients, or that this employee told the patient that system employees are always given priority over other patients. The laboratory employee in question could not remember the alleged incident. Our observation of the laboratory check-in process and employees' behavior did not identify any issues. We interviewed five patients waiting to have their blood drawn. They all stated that laboratory testing was timely and employees were always courteous.

Issue 2: Environment of Care

Patient Lunch Area: We could neither substantiate nor refute that the Oncology Clinic patient lunch area was unclean at the time referred to by the complainant. However, in the course of our inspection and site visit, we inspected this area and found it to be clean.

A Patient Advocate report dated March 26, 2004, shows that the patient advocate received a complaint on behalf of the patient regarding dust accumulation in the Oncology Clinic patient lunch area. The patient advocate notified Environmental Management Service (EMS) mangers, and the area was cleaned immediately. EMS managers told us that after they were made aware of the situation, the requirement for regular cleaning was reinforced with housekeeping employees. Additionally, supervisors make daily rounds to ensure that cleaning assignments are completed.

The complainant also alleged that the stereo equipment in the lunch area was not in working condition. We could neither substantiate nor refute that was the case at the time referred to by the complainant. At the time of our visit, the equipment was functioning.

Blood Stained Walls: We could neither substantiate nor refute the allegation that there were bloodstains on the walls in the chemotherapy treatment area at the time referred to by the complainant. Medical center employees told us that there were iodine stains on the wall after one of the patient's treatments. A nursing employee told us the iodine spattered on the walls when iodine pads were placed into the trash. According to the nurse, housekeeping was notified after the patient brought the stains to the nurse's attention, and the wall was cleaned. The March 26, 2004, patient advocate report showed that a call was made to the patient advocate regarding this same issue. According to the report, the area was inspected by nursing managers the same day, and there was no evidence of stains on the wall. During our site visit, we inspected the area and found no evidence of bloodstains or any other stains on the walls.

5. Conclusions

We concluded that the patient received quality and timely evaluation and care for bladder cancer. We also found that the patient's care was consistent with the guidelines published by the American College of Surgeons, the American Urological Association, and the American Cancer Society. The patient requested and received a second opinion, and that opinion and treatment was consistent with the recommendations made by the clinicians at the Buffalo Division.

We concluded that the complainant raised several legitimate and important customer service issues. We found that system managers had adequately addressed these issues prior to our inspection.

Several issues could be neither substantiated nor refuted due to the passage of time. However, the issues referred to in the complaints no longer appeared current (for example, whether or not there were bloodstains on the walls in the chemotherapy treatment area at the time referred to by the patient). We found that no such situation presently existed.

Medical center managers agreed to consider the suggestion of allowing patients to have their blood work completed the day before scheduled chemotherapy treatments. Based on our observations in the Urology Clinic and the laboratory, as well as through interviews with patients waiting in these areas, we concluded that patients were treated with dignity and respect.

We concluded that system managers adequately addressed the complainant's and the patient's environmental concerns prior to the OIG inspection. Our inspection of the areas found no adverse environmental conditions.

Further review of this case is not warranted, and we will make no recommendations.

OIG Comments

The Healthcare System Director agreed with the report findings and conclusions. (See Appendix A, page 9, for the Director's comments.)

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

Appendix A

Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 23, 2005

From: Director, VA Western New York Healthcare System

Subject: **Quality of Care, Customer Service, and Environment of Care, VA Western New York Healthcare System, Buffalo, New York**

To: Assistant Inspector General for Healthcare Inspections.

We concur with your findings and conclusions.

(original signed by:)

Michael S. Finegan, Medical Center Director

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Hotline Call Center (800) 488-8244
Acknowledgments	Annette Acosta Jeanne Martin Hope Watt

Appendix C

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