

QUALITY CONCERN INQUIRY

Ahmed Nawaz, MD
1500 Forest Glen Road, Ground Floor
HCH - Hospitalists
Silver Spring, MD 20910

Date of Notice: April 3, 2006
Patient Name: Isreal Neustadter
MC #: 053247926A
Physician: Ahmed Nawaz, MD
Adm/Disch Dates: 3/10/03 - 3/27/03
Hospital: Holy Cross Hospital
Provider #: 210004
Medical Record #: 815510

Dear Doctor Nawaz:

The Delmarva Foundation (DF) is the Quality Improvement Organization (QIO) authorized by the Medicare Program to review inpatient services provided to Medicare patients in the State of Maryland. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our primary purpose is to identify potential areas where care can be improved and to provide this information to physicians and facilities. This peer review is intended to be a collegial interaction with the goal of improving patient care. We appreciate the time and effort involved in your cooperation with peer review activities.

A QIO physician reviewer has initially reviewed the care provided in the episode of care referenced above. Based on a careful review of a copy of the medical record provided by the facility, the physician advisor who reviewed this medical record has raised some concerns regarding the care provided during the above hospitalization.

Please provide any additional information regarding this/these potential quality concern(s).

As the QIO for Maryland, we are responsible to evaluate quality of care issues identified from random case review and from other sources.

The hospital record reviewed is that of Israel Neustadter who was hospitalized at Holy Cross Hospital between 3/10/03 through 3/27/03. It has been reviewed by a specialty-matched peer reviewer. The following are the initial results of the medical record review. Since the medical record may not always include all the pertinent information concerning the patient, please review the comments of our peer reviewer and provide relevant responses, if you feel the peer reviewer is incorrect, either by providing new information or referring to the medical record.

Mr. Neustadter is a 91 year-old who was admitted with diagnoses of sepsis, pneumonia, hypotension, and dementia.

- Delmarva asks all the right questions of Drs. Nawaz, Kariya and Weiner.
- Delmarva receives no response from the doctors or the hospital.
- Delmarva nonetheless finds that care met "professionally recognized standards."

Several issues exist that the peer-reviewer felt were quality issues.

- The DNR/resuscitation status upon hospital admission.

According to the History and Physical notes, "Had a very lengthy conversation with the patient's son...and if he wants the patient to be a full code." No resolution of this decision is documented. This note was dictated over 3 months after the admission on 3/10/03 i.e. 6/19/03. An additional History and Physical Examination was dictated 6/25/03, 6 days after the first History and Physical was dictated. The son apparently wanted "The patient to be a full code." It is not clear based on the information provided and documentation in the Medical Record on the next day why the orders on 3/10/03 included "DNR," in opposition to the son's wishes for this patient. Is it hospital policy when the decision has not yet been made for resuscitation status that the default code status is DNR?

A second opinion on 3/11/03 notes, "Intubate if necessary." The note on 3/25/03 from pulmonary and critical care documents, "Patient is more awake talking." On 3/26/03, the patient has respiratory distress that was not treated with replacement of an ET tube. The documentation notes, "I hope the pt's final days are peaceful as opposed to being suctioned/intubated or getting (?)." It is unclear from the actual documentation if the son's choice was to not suction or and not to intubate.¹

- Treatment of the patient's worsening pulmonary status.

On reviewing the patient's worsening pulmonary status, it is unclear why the choice of antibiotic was not changed.

- Intubation status.

Was intubation discussed with the family and when did they request comfort care only? This was not clearly documented in the medical record. In the record there are multiple documentation notes mentioning "D/W (discussed with) son," but there is no content of the discussion or the results of any decisions that may have been made.^{2, 3}

- Discrepancies between the orders on the order sheet and the progress notes.

A number of discrepancies are noted between the Progress Notes and the written orders

- The dosage of Levaquin is noted to be 500 mg in the chart vs. 250 mg in the orders.

- The DNR status is noted in the orders and Progress Note although based on documentation, the son did not approve of DNR at the time the DNR order was written and in effect.

Please provide your responses to these issues within the time frame noted in this letter.

We recognize that the medical record may not give a complete clinical picture and the source of a problem (whether the facility or the physician) may not be readily apparent. Therefore, we are sending this inquiry simultaneously to the Physician QIO Contact. While either a physician or a facility representative individually may respond to this inquiry, we strongly encourage you to coordinate the response.

We are providing you an opportunity to discuss this care. Your response must be received within 20 days from the date of this letter (**April 23, 2006**) in order for the information to be considered in our final determination. In addition, if you would like to discuss the care, or have any questions prior to your response, please call the Physician/Provider Contact at 1-800-999-3362 to make necessary arrangements for the discussion with a QIO physician. Please direct your correspondence to Delmarva Foundation; 9240 Centreville Road; Easton, MD 21601.

1. According to [Holy Cross Hospital brief](#) it was the doctors' unilateral choice not to intubate (intubation never "recommended" for my father). Dr. Kariya testified that intubation was *not needed* when he found his patient in respiratory distress and wrote the 3/26/03 documentation.
2. Record shows that family *never requested* and that hospital *never initiated* comfort care in days prior to death.
3. Dr. Shamim testified that he *did not discuss* intubation with son, despite writing "D/W (discussed with) son" in the record. Dr. Nawaz now admits intubation may *not have been discussed* with family.

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If the response is not received by the date specified above, a QIO physician reviewer will make a final determination regarding the concern(s) raised in this letter based on the information available in the medical record.

The information in this letter is confidential and may be redisclosed only in accordance with federal regulations found in 42 CFR 476.107-108.

Sincerely,

A handwritten signature in black ink that reads "Jeffrey M. Zale MD". The signature is fluid and cursive, with the letters "J" and "Z" being particularly prominent.

Jeffrey M. Zale, MD, MPH
Medical Director of Quality Assurance

JMZ/kcc
Attachment

cc: Administrator/CEO Contact: Kevin J. Sexton
DF Liaison: Judy Kluge-Taube
Compliance Officer: Fernando Fleitis
Physician QIO Contact: Elise Riley, MD

PLEASE PROVIDE YOUR RESPONSE ON THE ATTACHED FORM.

