



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 13-00488-26

Healthcare Inspection

Alleged Chemotherapy Delay and Excessive Emergency Department Length of Stay Jesse Brown VA Medical Center Chicago, Illinois

December 9, 2013

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to a complainant's allegations of a delay in chemotherapy treatment, excessive length of stay (LOS) in the Emergency Department (ED), and failure to perform a kidney ultrasound at the Jesse Brown VA Medical Center (the facility) in Chicago, IL.

We substantiated a delay in chemotherapy treatment, that the patient experienced excessive LOS in the ED on two occasions while awaiting admission, and that an inpatient kidney ultrasound was ordered but not performed. However, on both ED visits, the patient was promptly triaged and treated. We could not substantiate that the patient suffered any adverse medical outcomes as a result of these delays.

We found that there was no clearly defined process for monitoring oncology clinic patients awaiting inpatient beds after hours and that there was inconsistent patient handoff communication between oncology clinic staff and the ED triage nurses.

We also identified problems in the Patient Flow Committee structure, membership, and communication of patient flow initiatives to the frontline staff.

We recommended that the Facility Director:

- Ensure that LOS in the ED is reviewed, and that action plans are developed to address excessive LOS, and that action plans are implemented and monitored for compliance.
- Ensure that the Patient Flow Committee meets as required by local policy, reviews membership to ensure inclusion of frontline staff, that follow-up reports are submitted, and that identified improvement processes are monitored and communicated to all involved staff.
- Ensure that action plans addressing the monitoring and handoff communication of oncology clinic patients waiting for after-hours admission are communicated to involved staff, implemented, and monitored for compliance.

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 7–10 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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to a complainant's allegations of a delay in chemotherapy treatment, excessive length of stay (LOS) in the Emergency Department (ED), and failure to perform a kidney ultrasound at the Jesse Brown VA Medical Center (the facility) in Chicago, IL. The purpose of the review was to determine if the allegations had merit.

Background

The facility is a tertiary care medical center with 210 inpatient beds in Veterans Integrated Service Network (VISN) 12. The facility provides a broad range of inpatient and outpatient healthcare services to 58,000 veterans in Chicago and 6 counties in Northwestern Indiana.

Excessive ED LOS

The facility ED provides initial evaluation and treatment for a broad spectrum of illness, injuries, and psychiatric disorders 24 hours a day, 7 days a week. The ED also provides resuscitative therapy and stabilization in life-threatening situations. In FY 2012, the facility temporarily closed beds for renovation of an inpatient unit, leading to increased LOS in the ED. Patients who present to the ED are admitted, discharged home, or transferred to other facilities. The Joint Commission considers ED stays excessive if they exceed 4 hours from the time a decision for hospital admission occurs. The practice of holding patients beyond this time while waiting for an available bed is called "boarding" and presents patient safety and quality of care concerns.¹

Clinic Admission Process

The clinic physician initiates the admission process by submitting an order in the Electronic Health Record (EHR) and calling the admissions clerk. The bed control coordinator checks the Bed Management System and assigns the patient to the bed. When a bed is available, the bed control coordinator calls the clinic, who in turn notifies the patient. The patient reports to admissions and is escorted to the bed, completing the admitting process. If the clinic closes before the bed becomes available, clinic staff escort the patient to the Admissions/ED/Transportation waiting room and the admissions clerk notifies the patient when the bed becomes available and escorts the patient to their room.

¹Joint Commission LD.04.03.11. VHA recently codified this standard in VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, (August 28, 2013); requiring that patients kept in the ED for 4 hours or more after admission orders are placed must be designated as boarders and ED providers must provide acute emergency care while the patient is in the ED.

Chemotherapy

Chemotherapy is the use of medication to treat cancer. There are many medications that can be combined during chemotherapy, which can be administered along with surgery or radiation treatment.² Depending on the type and stage of cancer and the specific medication used, chemotherapy may be given orally or intravenously (into the patient's vein) as inpatient or outpatient treatment. Patients may develop side effects from chemotherapy such as acute kidney injury, hair loss, gastric upset, and weakened immune system.

Scope and Methodology

We conducted a site visit January 7-9, 2013. Prior to our visit we interviewed the complainant via telephone. We reviewed the EHR, Emergency Department Integrated Software (EDIS) facility data, Veterans Health Administration (VHA) directives and handbooks, Joint Commission guidelines, facility clinical practice guidelines, patient flow committee meeting minutes, and quality management documents.

While on site we interviewed facility leadership, medicine, primary care and intensive care service chiefs, pharmacy managers, ED, medicine, and oncology providers, oncology clinic staff and others involved in the patient's care. We also interviewed the patient advocate and admissions personnel, and toured the ED, Admission/ED/Transportation waiting area, and the oncology clinic.

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

Case Summary

The patient, a man in his early 60's, had a history of prostate cancer diagnosed in June 2003. In August 2008, he was diagnosed with lymphoma – a cancer that begins in the lymphocytes of the immune system and presents as a solid tumor³ - and in January 2009 he received chemotherapy at a non-VA facility. Thereafter, the patient sought his care at the VA facility.

²American Cancer Society website, <http://www.cancer.org/treatment/treatmentsandsideeffects/index>, accessed August 27, 2013

³Cancer Council website, cancer of the lymphatic system. <http://www.cancercouncil.com.au/19924/cc-publications/understanding-ca.ncer-series/understanding-hodgkin-lymphoma/understanding-hodgkins-lymphoma-the-lymphatic-system/?pp=19924>, accessed August 27, 2013

There was no evidence of cancer recurrence until the summer of 2012 when an enlarged groin lymph node was discovered. On September 25, 2012, the site was biopsied and he was diagnosed with diffuse large B-cell lymphoma. His oncologist told him that he would start inpatient chemotherapy the following week.

On October 1, in preparation for the patient's admission, the oncologist submitted an order in the EHR for chemotherapy. The following morning the oncologist saw the patient in the clinic, cleared him for admission, and notified the bed clerk that the patient was awaiting admission. The patient was escorted to the oncology clinic waiting room to wait for an inpatient bed. When the clinic closed 8 hours later, an oncology nurse escorted the patient to the Admission/ED/Transportation waiting area, where he waited for 4 hours before being admitted. According to the patient, while waiting, he began to feel dizzy and weak. An ED triage nurse spoke with the patient and escorted him back to the ED and allowed him to rest in a bed. Although not admitted to the ED, he was allowed to stay there until an admission bed was available. The initiation of his chemotherapy was delayed until 10:00 a.m. the following morning.

The patient completed his chemotherapy on October 6, and expected to be discharged. However, he was informed that his treatment required an additional day for intravenous hydration in order to prevent possible chemotherapy-induced kidney injury. The patient refused the additional hydration and insisted on leaving the facility against medical advice. Prior to leaving, he was instructed to drink one liter of water or Gatorade® the following day, and a follow-up oncology appointment was scheduled for October 9.

The patient returned to the facility, as scheduled, for laboratory testing. That afternoon the oncologist called the patient and told him to go to the ED for evaluation because the laboratory tests showed low potassium and possible chemotherapy-induced kidney injury. The patient reported to the ED and was promptly triaged and treatment was initiated. He was told he needed to be admitted but there were no beds available at the facility. The treating physician offered to transfer him to a non-VA facility with available beds to continue treatment but the patient refused the transfer. The patient continued treatment overnight in the ED while awaiting admission. In the morning, an ED physician and an oncologist evaluated the patient and noted that his condition had improved and he could be discharged. He was discharged with instructions to return to the facility 3 days later for laboratory testing.

On October 13, the patient reported to the facility for laboratory testing. Later that day, the oncologist received the test results, which indicated a decrease in kidney function, called the patient, and instructed him to go to the ED immediately. Upon arriving at the ED, the patient was promptly triaged and treatment was initiated. Eight hours later he was admitted to the acute care unit.

The day after admission, the patient was evaluated by a nephrologist who recommended a kidney ultrasound and a routine order (within 72 hours) was placed. The following day, while awaiting the ultrasound and a blood transfusion, the patient requested discharge. The medical resident discussed the pending ultrasound with the oncologist and received approval to reschedule the test so that the patient could be

discharged. The resident called radiology clinic to schedule the ultrasound, but was told it could not be scheduled until 15 days later. The resident then spoke with the patient, who was very upset, but agreed to stay until the next morning in order to get the ultrasound completed. The ultrasound was not performed the following morning and the patient insisted on being discharged. Upon discharge, the patient went to his oncologist and expressed his dissatisfaction with the admission process, the inpatient experience, and the failure to obtain the ultrasound.

The following week the patient returned to the facility for repeat laboratory tests and examination by his oncologist, who noted improved kidney function. The patient continues to receive his treatment at the facility and is participating in autologous stem cell transplant.⁴

Inspection Results

Issue 1: Treatment Delays

We substantiated the allegation that there was a delay in initiating the patient's chemotherapy and that the facility failed to perform the inpatient kidney ultrasound. However, we could not substantiate that the patient suffered any adverse medical outcomes as a result.

The October 1 admission was followed by approximately 12 hour wait from the time the patient was evaluated by the oncologist in the oncology clinic and the time the patient was admitted. The chemotherapy was delayed until the following day. The kidney ultrasound was never performed; however, the week after it was ordered the patient saw his oncologist who noted that the patient's kidney function had improved.

We further substantiated that the patient had excessive LOS in the ED. On October 9, the patient remained in the ED overnight. When the decision to admit was made the physician caring for the patient advised the patient of the lack of inpatient beds and offered to transfer him to a non-VA facility for care. The patient declined the transfer and was treated overnight in the ED. He was re-evaluated in the morning and deemed stable for discharge. On October 13, before being transferred to an inpatient unit, the patient was held and treated in the ED for 8 hours after the physician made the decision to admit him.

Issue 2: Patient Flow

We identified opportunities for improvement in the Patient Flow Committee and communication of patient flow initiatives to the front line staff.

⁴<http://www.mayoclinic.com/health/stem-cell-transplant/MY00089>. Stem cell transplant is the infusion of healthy stem cells to help the body make enough healthy white blood cells, red blood cells, or platelets.

Facility policy requires that the patient flow committee meet monthly to review diverse patient flow issues such as ED LOS over 4 hours and long wait times for inpatient beds. When the committee identifies a problem, the policy directs that a work group is assembled to review current practices and identify patient flow improvements.

We found that during Fiscal Years 2011 and 2012, the facility Patient Flow Committee did not meet monthly as required, and when they did meet, meeting minutes reflected problems in getting project follow-up data from committee members. Frontline staff told us that they were frequently unaware of the process improvements identified by the committee for implementation in their areas.

Issue 3: Handoff Communication

In the patient flow committee meeting minutes, issues were identified regarding clinic patients, including those from oncology, who wait after clinic hours for admission. In response, the committee developed a new standard of practice that requires oncology clinic patients waiting after hours admission be escorted by an oncology clinic nurse to the Admission/ED/Transportation waiting area. The clinic nurse is required to handoff the patient to the ED triage nurse. Handoff communication from the clinic nurse to the triage nurse should include any medications the patient may need, and other issues the triage nurse should be aware of while the patient is in the waiting area. Oncology clinic nursing staff and ED triage nurses we interviewed told us that the handoff occurred inconsistently. In addition, the triage nurses we spoke with told us they had not been included in the development of the new standard of practice.

We toured the Admission/ED/Transportation waiting area at different times during day and evening shifts and each time there were many patients in the area. The waiting area is a large open space with limited visibility because of a large pillar in the center of the room and a partition screening an area for the ED admissions clerk. In addition, there are cubicles along one wall for the admissions and transportation staff. The triage area is located near the entrance to the ED. The triage nurses we interviewed told us that it is very difficult to see all the patients in the room from the triage area. The triage nurse is also occupied with assessing patients for admission to the ED. While we were in the room we noted that the triage nurses were busy with ED patients and did not have time between patients to walk through the waiting area to monitor clinic patients they could not easily see. As a result, clinic patients waiting for admission might not be monitored from the time of arrival in the area until admitted to a bed.

Conclusions

We substantiated allegations of a chemotherapy delay and failure to perform an inpatient kidney ultrasound. However, we could not substantiate that the patient suffered any adverse medical outcomes as a result of these delays.

We substantiated that the patient experienced excessive LOS in the ED on two different occasions. On both occasions, the patient was triaged promptly and treated

appropriately. On one occasion, when an extended LOS in the ED was anticipated, the facility offered to transfer the patient to a non-VA facility however, the patient refused.

We identified opportunities for improvement in the facility patient flow process to include; frequency of committee meetings, membership, and communication of process improvements to the frontline staff.

We determined that Oncology clinic staff and ED triage nurses had varying levels of understanding regarding the standard of practice for how patients are admitted from ambulatory to inpatient units, which led to inconsistent handoff communication and failure to monitor those oncology patients in the Admission/ED/Transportation waiting area.

Recommendations

1. We recommended that the Facility Director ensure that length of stay in the emergency department is reviewed, and that action plans are developed to address excessive length of stay, and that action plans are implemented and monitored for compliance.
2. We recommended that the Facility Director ensure that the Patient Flow Committee meets as required by local policy, reviews membership to ensure inclusion of frontline staff, that follow-up reports are submitted, and that identified improvement processes are monitored and communicated to all involved staff.
3. We recommended that the Facility Director ensure that action plans addressing the monitoring and handoff communication of oncology clinic patients waiting for after-hours admission are communicated to involved staff, implemented, and monitored for compliance.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 24, 2013

From: Director, VA Great Lakes Health Care System (10N12)

Subject: Healthcare Inspection – Alleged Chemotherapy Delay and Excessive ED LOS, Jesse Brown VA Medical Center, Chicago, IL

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

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the draft report and I concur with the Office of Healthcare Inspections recommendations as well as the corrective action plans developed by the Jesse Brown VA Medical Center.
2. Thank you for the opportunity to review the findings enclosed in this report.

(original signed by:)

Jeffrey A. Murawsky, M.D.

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 17, 2013

From: Acting Director, Jesse Brown VA Medical Center (537/00)

Subject: Healthcare Inspection – Alleged Chemotherapy Delay and Excessive ED LOS, Jesse Brown VA Medical Center, Chicago, IL

To: Director, VA Great Lakes Health Care System (10N12)

1. I would like to express my appreciation to the Office of Inspector (OIG) Health Care team for their professional and comprehensive health care review conducted January 7-9, 2013.
2. I have reviewed the draft report for the Jesse Brown VA Medical Center and action plans are provided for the recommendations.
3. I appreciate the opportunity to submit this response in support of continuous improvement in the health care services provided to our Veterans

(original signed by:)

Judy K. McKee, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that length of stay in the emergency department is reviewed, and that action plans are developed to address excessive length of stay, and that action plans are implemented and monitored for compliance.

Concur

Target date for completion: September 3, 2013

Facility response: Length of stay in the Emergency Department and reasons for LOS exceeding 6 hours is monitored daily and reviewed monthly at the facility Patient Flow Committee. Data from FY 13 EDIS report indicates an average of 15 % patients stay longer than 6 hours. Action plans have been developed to address the excessive length of stay; the main reason is the unavailability of beds. An analysis of diversion and utilization data was conducted and demonstrated that there is a need to increase the number of current telemetry beds. Senior Leadership is currently reviewing a proposal to increase the number of telemetry beds.

Additionally, the Medical Center's Transformational Plan of Care (TPOC) identified Patient Flow as the #1 Value Stream. Since March 2013, two Rapid Process Improvement Workshops (RPIWs) have been conducted with a third planned for the last week of September. Each RPIW is working to improve a portion of the patient flow from ED to discharge from the medical center. Currently there are over 25 tests of change being processed for improvements. Action plans addressing patient flow initiatives are tracked at the Patient Flow Committee to assure completion and compliance.

Recommendation 2. We recommended that the Facility Director ensure that the Patient Flow Committee meets as required by local policy, reviews membership to ensure inclusion of frontline staff, that follow-up reports are submitted, and that identified improvement processes are monitored and communicated to all involved staff.

Concur

Target date for completion: September 3, 2013

Facility response: Review of the current membership was completed and front line staff representatives comprise 60% of the committee membership. During FY 2013 the Patient Flow Committee met 11/12 months. Patient Flow Committee reports to Quality Leadership Council quarterly where all action plans are monitored to ensure that improvement processes are communicated to involved staff and tracked until resolution.

Meeting minutes from the Patient Flow Committee and Quality Leadership Council are audited to assure the minutes include documentation of actions.

Recommendation 3. We recommended that the Facility Director ensure that the action plans addressing the monitoring and handoff communication of oncology clinic patients waiting for after-hours admission are communicated to involved staff, implemented, and monitored for compliance.

Concur

Target date for completion: December 16, 2013

Facility response: The Admission from Outpatient Clinics to Inpatient Units Medical Center Memorandum 11-96-16 was revised and signed February 19, 2013 to include handoff communication requirements for all admissions from outpatient clinics including oncology patients. The Medical Center Memorandum was discussed and distributed to all users including service chiefs for distribution. This process is monitored on a daily basis by the Bed coordinators on the day and evening shifts through tracking on the Bed Management System (BMS). All patients planned for admission are added to the BMS admission wait list and can clearly be identified as clinic admissions, when applicable. Medical record audits will be conducted monthly to assure that there is appropriate hand off communication documentation between the outpatient clinics, the inpatient admissions service and the ED triage nurses.

OIG Contact and Staff Acknowledgments

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