Department of Veterans Affairs

Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01104-134

Healthcare Inspection

Alleged Excessive Wait for Emergency Care and Staff Disrespect VA Southern Nevada Healthcare System Las Vegas, Nevada

April 30, 2014

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 request from the House Committee on Veterans' Affairs Chairman Jeff Miller and Congresswoman Dina Titus. The OIG evaluated the merit of allegations that a patient at the VA Southern Nevada Healthcare System (facility), Las Vegas, NV, experienced an excessive wait for emergency care and that staff repeatedly disrespected the patient.

We found that on October 22, 2013, an elderly patient spent 5 hours and 6 minutes in the facility's emergency department (ED), waiting 4 hours and 45 minutes to be evaluated by an ED physician.

We concluded that a wait of this length was, at a minimum, challenging for this patient. However, mitigating this long wait was the fact that numerous other patients who were assessed to be in more urgent need of attention were in the ED at the same time.

The facility's target is for less than 10 percent of its ED patients to experience a total ED length of stay of greater than 6 hours. This inspection revealed that the facility met this target on only 1 day during the week in which the patient visited the ED.

The purpose of triage in the ED is to prioritize incoming patients and to identify those who cannot wait to be seen. The patient's wait time to be triaged by a registered nurse was 63 minutes.

During the patient's multi-hour waiting period, there was no documentation of hourly nursing reassessments as required by local policy. We found no relationship between the length of the patient's ED wait and her subsequent clinical course.

We also found that instructions the patient received on October 22, which prompted her to report to the facility's Radiology Department prior to the ED visit, led to some confusion on the part of the patient and staff.

We did not substantiate the allegations of staff disrespect.

We recommended that the Facility Director ensure that action plans are developed and implemented to facilitate meeting and maintaining the facility's target of not more than 10 percent of ED patients' length of stay exceeding 6 hours and that the Facility Director ensure that nursing staff reassess ED patients according to facility policy.

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 14–17 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
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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection in response to a request from the House Committee on Veterans' Affairs Chairman Jeff Miller and Congresswoman Dina Titus. OHI evaluated the validity of the allegation that while at the emergency department (ED) of the VA Southern Nevada Healthcare System (facility), Las Vegas, NV, a patient experienced an excessively long wait for assessment and care. Additionally, OHI evaluated the allegation that facility staff were disrespectful to the patient.

Background

The facility is a 78-bed tertiary care medical center that provides primary, specialty, outpatient, medical, surgical, psychiatric, and rehabilitative care and serves a veteran population of approximately 235,000 in a primary service area that includes Clark, Lincoln, and Nye counties in Nevada.

The facility is part of Veterans Integrated Service Network (VISN) 22 and is one of the Veterans Health Administration's (VHA's) newest medical centers. It began admitting patients on April 15, 2013; although, the ED did not begin operations until July 1. Other operations were phased in over the next several months. Prior to April 15, outpatient care was delivered at the previous facility location and several clinical sites, and patients were provided with inpatient and emergency care at the Michael O'Callaghan Federal Hospital as well as several community hospitals.

The ED

The 6,900 square foot, 9-bed ED that became operational on July 1, 2013, is located on the ground floor in the rear of the facility and may be accessed by both ambulance and car, or a patient may walk in from other areas of the facility.

The ED evaluates and treats patients 24 hours a day, 7 days a week. Total ED staffing is 17 physicians, 8 nurse practitioners (NPs), 3 physician's assistants (PAs), 22 registered nurses (RNs), 3 nursing assistants (NAs), and several administrative staff. The ED operates on a "staggered shift" system.[1] On any single shift, there may be 1–2 physicians, 1–2 NPs, 4–7 RNs, 1 PA, and 1–2 NAs.

ED "triage" is the initial assessment, routing, and prioritization of all ED patients. Triage assessments are performed by an RN, "the triage nurse." At the facility, triage is accomplished in accordance with VHA policy, which prioritizes patients according to the Emergency Severity Index (ESI) rating, an instrument developed by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ). The ESI clinically stratifies patients into 5 groups ranging from Level 1 (most urgent) to Level 5 (least urgent). Overall, ED triage is governed by VHA Handbook 1101.05, *Emergency Medicine Handbook* and AHRQ's *Emergency Severity*

[1] Staggered shifts start at different times during the day such as 7:00 a.m. to 7:30 p.m. and 10:00 a.m. to 10:30 p.m.

Index Implementation Handbook. At this facility, ED triage is further governed by local policy.

ESI Level 1 patients require immediate physician involvement. For example, a patient presenting in cardiopulmonary arrest would be ESI Level 1. ESI Level 2 patients have acute emergencies with time sensitive conditions and require emergent care. Examples include a patient with acute chest pain for whom there is concern about a myocardial infarction (heart attack), a patient with unstable vital signs, or a patient who may be acutely suicidal or homicidal. Patients assigned ESI Levels 3 and 4 have lower acuity. Examples of ESI Level 3 patients include stable patients with abdominal pain, kidney stones, or non-cardiac chest pain. ESI Level 4 patients have non-urgent conditions such as sprains/strains or non-productive coughs. ESI Level 5 patients have lower acuity still and may not require emergency care but are seen due to hour of day and other circumstances.

While ESI levels quantify urgency, they do not mandate specific time requirements for evaluation. However, ESI Level 1 patients must be attended to upon arrival in the ED. ESI Level 2 patients should be taken to a treatment area immediately and the ED provider notified. ESI Level 3–5 patients are seen after ESI Level 1 and 2 patients, regardless of time of presentation. While there is no facility-wide policy dictating specific timeframes for the provider to evaluate the patient, the facility's nursing triage standard operating procedure states that ESI level 3 patients should be evaluated by a provider within 60 minutes.

Prior to the incident that prompted this inspection, facility management had ED patient flow concerns. Since the ED opened, staff have monitored patients' length of stay (LOS)[2] in the ED, patients who left without being seen (LWOBS) by a provider, and patients who left against medical advice (AMA). The patient flow data would enable the ED staff to better provide timely care and disposition for all ED patients. For LOS, the facility's target is for no more than 10 percent of patients to have an ED LOS greater than 6 hours. For patients who LWOBS and patients who leave AMA, the expectation is for the ED charge nurse or designee to follow up within 48 hours with the patient and to document this follow-up in the patient's electronic health record (EHR).

Following the initial triage assessment, within the context of the ESI level algorithm described above, the facility implemented reassessment guidance for nurses.[3] Standards were:

ESI Level 1:	Patients require continuous care.
ESI Level 2:	Patients require reassessment at least every 15 minutes.
ESI Level 3:	Patients require reassessment at least every 1 hour.
ESI Levels 4–5:	Patients require reassessments at least every 2 hours or more often if their conditions change.

[2] LOS is defined from the time of a patient's arrival to ED disposition, such as admission, transfer, or discharge and is used as a key indicator of adequate patient flow.
[3] VA Southern Nevada Healthcare System Inpatient Nursing Standard Operating Procedure 118-13-ED17, *Triage Practices and Procedures*, June 2013.

Allegations

On December 11, 2013, OIG received the following communication from Chairman Miller:

> *I am writing to refer an issue to you for investigation. According to an eyewitness account, an elderly, blind veteran [patient named] was made to wait six hours for emergency care and was repeatedly disrespected and mistreated by staff at the North Las Vegas VA Medical Center. [The patient], who was reportedly battling colon cancer and diabetes, died mere weeks after this incident. I respectfully request that you open an investigation into this matter and determine what further action should be taken.*

Scope and Methodology

We conducted a facility site visit December 17–18, 2013. We interviewed the ED physicians, nurses, and other clinical staff who had direct contact with the patient on October 22, 2013, the day of the ED visit in question. We also interviewed the patient's regular primary care provider (PCP), her endocrinologist, and the primary care nurse who cared for the patient on a routine basis. As other facility clinical and administrative staff had input into the patient's October 22 ED experience, including staff from Radiology, Pharmacy, and Security Services, we conducted additional interviews as appropriate. We also interviewed senior facility clinical and administrative staff, including the facility Director, Chief of Staff, Associate Director for Patient Care Services, Quality Manager, and Patient Advocate. We inspected the physical layout of the ED and the radiology and outpatient pharmacy reception areas.

To evaluate LOS in the ED and factors that might have influenced ED wait times, we examined the ED workload on October 22. We evaluated the acuity of the other patients who presented to the ED during the 24-hour period (midnight to midnight) centered around the time the case patient checked into the ED and performed a detailed analysis of the acuity of those patients. Additionally, we reviewed the ED workload for October 20–26, 2013, the week during which the patient presented to the ED, to further assess LOS in the ED during the week.

We reviewed the patient's EHR. In order to validate the facility's ESI assessments, we reviewed the EHRs of other October 22 ED patients. We reviewed paper copy/log book workload data for the time period under review because the facility did not begin entering information into the Emergency Department Integration Software (an automated program for collecting and reporting patient data) until November 2013.

We interviewed the patient's friend/caregiver who accompanied the patient to the facility's ED on October 22 and reviewed hard copies of text messages provided to the team by the friend/caregiver. The messages were between the patient's friend/caregiver and another individual involved in the patient's care at home and contemporaneously described the experience while waiting in the ED on October 22. Additionally, the messages described interactions with facility staff on October 24.

We reviewed VHA handbooks and directives, local policies, training program materials, medical records from two community hospitals (A and B), and other pertinent documents.

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 History

The patient was in her late seventies and had been followed long term at the facility. She had a history of brittle[4] insulin dependent diabetes mellitus, bilateral blindness related to the diabetes, and congestive heart failure. A pacemaker had been implanted in 2010 due to disturbances of her cardiac rhythm. The patient had been diagnosed and treated for colon cancer more than 14 years prior to the visit in question to the facility ED. The cancer treatments appeared to be curative as there was no evidence of cancer recurrence found during periodic follow-up in the early 2000s.

She was seen regularly by a VA primary care practitioner (PCP) and an endocrinologist. By October 22, 2013, the patient's PCP and endocrinologist had been treating the patient for several years and were actively involved in her care.

Between the time the patient was treated at the facility in the summer of 2013 and a follow-up evaluation in mid-October, she complained of increasing weakness and pain. It was observed that she was not eating. The patient's PCP noted that the patient was experiencing abdominal burning and would just sit and rock. A home health nurse suggested a referral to hospice which the PCP, and a facility social worker pursued with the patient but the patient declined. The patient also declined evaluation in the facility's ED and/or hospital admission in favor of additional home services.

Later in the month, however, on October 22, 2013, at approximately 3:40 pm., the patient, accompanied by a friend, presented to the facility's Radiology Department for a CT scan of the abdomen and chest x-ray. The Radiology Department was staffed by several employees at that time. A Radiology Department employee informed the patient that there was no physician's order for these tests. The patient's friend called the patient's home health nurse who, in turn, called the patient's endocrinologist. The order was placed at 4:08 p.m. As the radiology front desk closes at 4 p.m., the radiology front desk employee had reportedly left for the day. OHI learned that the radiographic tests were ordered as "routine" and thus, indeed, had to be pre-scheduled.

As best can be ascertained, a radiology technologist who was still present in the Radiology Department contacted the PCP. The patient was subsequently instructed by her PCP to go to the facility's ED. The chief radiology technologist on duty documented that the patient refused to leave the Radiology Department area and go to the ED.

[4] Brittle insulin dependent diabetes is diabetes that is difficult to control and may require frequent monitoring and adjustment to the patient's insulin regimen.

Radiology Department staff called facility security to inform them of the patient's presence in the adjacent hallway.

Ultimately, however, the patient did go to the facility's ED. The ED nursing triage note, recorded at 5:46 p.m., documented that the patient presented to the ED with a 10-day history of abdominal pain. This nurse wrote that the patient reported that a "CT scan was [supposed to be done] today and x-ray would not do it tonight, [the patient was] told to come to ED." Blood sugar Accuchecks® were low for the patient, and she was given orange juice. The nurse documented an initial blood glucose result of 64 milligrams/deciliter (mg/dl) (normal random blood glucose = 80–140 mg/dl). The triage nurse assigned the patient an ESI score of 3.

At 7:03 p.m., the ED's rapid medical evaluation nurse again checked the patient's blood glucose, and the result was within normal limits. At approximately 9:00 p.m., the patient was moved from the ED's waiting room to a secondary triage room also located within the ED complex. The patient was again assessed to be at ESI Level 3.

Soon thereafter, the ED physician saw the patient at which time she again related a 10-day history of epigastric (upper central) pain. She did not complain of fever, chills, nausea, vomiting, or bowel problems. However, while the patient related a 10-day history of abdominal pain, the friend accompanying the patient reported that the patient's abdominal discomfort had been present longer than 10 days. The friend also reported that the patient had lost 40 pounds in the previous 4 months. The physical examination was unremarkable.

An extended discussion ensued between the patient and the ED physician. The physician recommended that the patient have further blood work, a chest x-ray, and a CT scan of the abdomen and pelvis that evening. However, the patient refused the recommendation as she felt she could not undergo testing because of her diabetes. Instead, the patient opted to follow up with radiology the following morning.

The patient wanted to return home, and the ED physician discharged her "Against Medical Advice" (AMA). Despite leaving AMA, the patient was receptive to symptomatic treatment in the ED, which relieved her abdominal pain. Also, a prescription for pain medications was given to the patient before she left the ED. The patient agreed to have the recommended chest x-ray and CT scan the next morning.

After leaving the ED, the patient and her friend went to the outpatient pharmacy, where they waited for her pain medication prescription. The medication was dispensed at 10:36 pm.

The patient rested for a day, returned to the facility on the morning of October 24 and underwent the recommended testing. The test showed changes that could be consistent with a variety of conditions, including adenocarcinoma,[5] typhlitis,[6] perforated

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[5] Adenocarcinoma is cancer that begins in glandular cells. Most cancers of the colon are adenocarcinomas.
[6] Typhlitis is a life threatening, necrotizing enterocolitis occurring most commonly in patients with hematologic (blood) malignancies (e.g., leukemia).

appendicitis, and intestinal lymphoma.[7] The radiologist called the patient's endocrinologist with these results. Meanwhile, the patient and her friend had begun the trip home.

With the CT scan reading complete and the patient's endocrinologist informed, the facility's Radiology Department attempted to contact the patient with instructions to return to the facility. The patient's PCP and endocrinologist also contacted the patient regarding the results of the CT scan. However, the patient declined to return to the facility preferring to be seen elsewhere, and she went to a community hospital (Community Hospital A).

Later that day, the patient presented to the ED at Community Hospital A where she was admitted and treated for a presumed infection. Repeat testing to evaluate her abdominal pain was conducted a few days after admission. A number of consultants, including an infectious disease expert, evaluated the patient for medical problems other than her abdominal pathology including heart problems. The repeat testing showed an ill-defined mass-like area in the abdomen. Surgery was contemplated; however, it was determined that the patient could not tolerate an operation. The patient was discharged home with home health care 6 days after admission.

Two days later, November 1, the patient reported having no appetite and the presence of a bed sore on her coccyx. Her medications were adjusted and, and the patient was advised to follow up with the surgeon from Community Hospital A.

On November 3, the patient was admitted to a second community hospital (Community Hospital B) but was soon transferred to a community skilled nursing home. After a short stay at the nursing facility, she returned to Community Hospital B. On November 11, the patient was transferred to a non-VA inpatient hospice where she expired 4 days later.

[7] Cancer of the lymph system, a part of the body's immune system.

Inspection Results

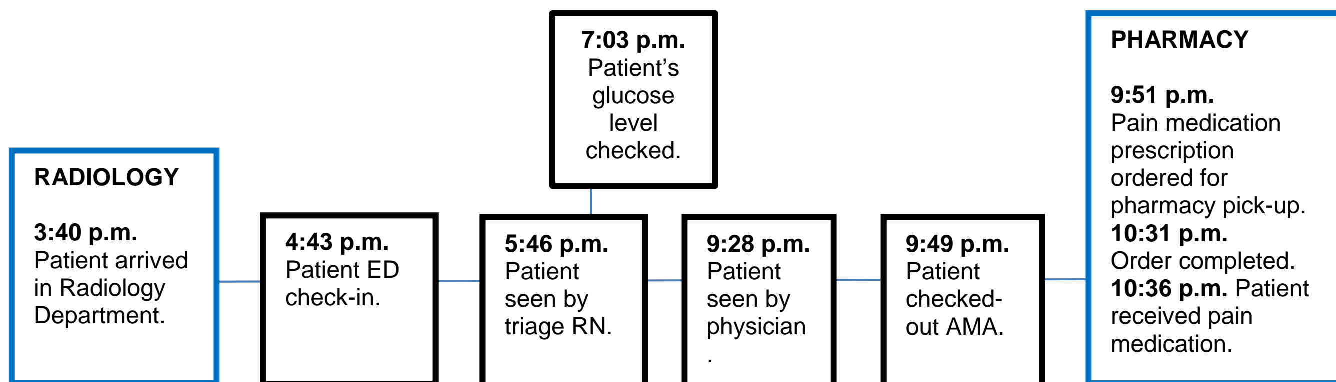
Issue 1: Excessive Wait for Emergency Care

We found that the patient's ED LOS was 5 hours and 6 minutes. Her wait time for a physician evaluation was 4 hours and 45 minutes.[8]

The patient presented to the ED on October 22, 2013, at 4:43 p.m. with non-emergent abdominal pain, was triaged within 63 minutes, and was classified as an ESI Level 3. She was evaluated by the ED physician at 9:28 p.m.

Figure 1 below depicts the chronology of the patient's experience in Radiology, the ED, and Pharmacy.

Figure 1: Chronology of Events on October 22



Source: OHI

As can be seen above, in addition to the ***5 hours and 6 minutes*** LOS in the ED, the patient's total LOS at the facility was approximately ***6 hours and 56 minutes***.

We found that when the patient checked in, there were nine patients with more emergent conditions (ESI Level 2) receiving care. We reviewed ED workload data for noon to midnight on October 22 and confirmed that patients whose ESI levels indicated more acute conditions and emergent needs were receiving care in the ED during the time that the patient was there. Table 1 on the next page shows the conditions of the ESI Level 2 patients being cared for by ED staff at the time the patient checked-in.

[8] Time interval between when the patient was checked in and when the patient was seen by the provider as defined by the American College of Emergency Physicians. This is also known as "door to doc time."

Table 1. ESI Level 2 Patients on October 22, 2013

Patient	Check-in Time	RN Triage Time	Physician Evaluation Time	Check-out Time	LOS (in hours)	Presentation
1	9:16 a.m.	10:59 a.m.	12:50 p.m.	5:10 p.m.	7:48	Abdominal pain with nausea
2	11:04 a.m.	11:23 a.m.	12:58 p.m.	4:47 p.m.	5:43	Left side chest pain
3	12:21 p.m.	2:45 p.m.	4:45 p.m.	6:33 p.m.	6:12	Anal fissure pain exacerbation, Left hip pain, UTI[9]
4	1:34 p.m.	2:28 p.m.	3:20 p.m.	7:15 p.m.	5:41	Suicidal ideation
5	1:39 p.m.	2:10 p.m.	4:10 p.m.	6:00 p.m.	4:17	Abdominal pain with constipation
6	2:19 p.m.	3:02 p.m.	5:58 p.m.	6:33 p.m.	4:14	High blood pressure
7	2:58 p.m.	3:52 p.m.	7:10 p.m.	1:55 a.m.	10:57	Abdominal pain with testicular pain
8	3:35 p.m.	4:12 p.m.	7:36 p.m.	9:15 p.m.	5:40	Blood in stool
9	4:31 p.m.	4:52 p.m.	7:30 p.m.	11:40 p.m.	7:09	Patient passed out while in clinic

Source: OHI

Patient-Specific ED Data for October 22, 2013

The purpose of triage in the ED is to prioritize incoming patients and identify those who cannot wait to be seen. The patient wait time for the triage RN was 63 minutes. Her chief complaint was abdominal pain of 10 days duration without nausea, vomiting, or diarrhea. The triage RN documented that the patient had a pain score of 9. Vital signs were stable. The triage RN also documented an initial blood glucose result of 64 mg/dl.

At 7:03 p.m., 77 minutes after the patient's initial contact with the triage RN, the rapid medical evaluation RN checked the patient's blood glucose, and the result was within normal limits. At approximately 9:00 p.m., she was moved from the waiting room to a secondary triage room. The patient was assessed to be ESI Level 3. Local policy requires that patients categorized as ESI Level 3 be reassessed by a nurse at least hourly.[10] Although staff told us that they periodically checked on the patient while she was in the waiting room, we found no evidence of nursing reassessment documented in the EHR from 7:03 p.m. until the patient was seen by the physician at 9:28 p.m. (2 hours and 25 minutes later).

After the physician evaluated the patient at 9:28 p.m., the patient received a non-narcotic medicine for abdominal pain. Additionally, laboratory tests, a CT scan of the abdomen and pelvis, and a chest x-ray were recommended. The physician documented that the patient refused to stay for the CT scan but that she would have the CT scan the next day. The patient left the ED AMA at 9:49 p.m.

[9] Urinary tract infection.
[10] Nursing Standard Operating Procedure 118-13-ED17.

General Patient ED Data for October 22, 2013

On October 22, there were a total (including the case patient) of 13 ESI Level 3—the ESI level of the case patient—patients who presented to the facility's ED. We reviewed the LOS of all 13 of these patients. Table 2 below summarizes this data.

Table 2. Summary of all October 22 ESI Level 3 Patients

Patient	Check-in Time	RN Triage Time	Physician Evaluation Time	Check-out Time	LOS (in hours)
1	1:02 a.m.	1:45 a.m.	2:22 a.m.	4:04 a.m.	3:02[11]
2	7:55 a.m.	8:09 a.m.	8:15 a.m.	9:42 a.m.	1:47
3	8:24 a.m.	9:03 a.m.	9:30 a.m.	9:50 a.m.	1:26
4	9:14 a.m.	10:02 a.m.	10:20 a.m.	2:10 p.m.	4:56
5	9:52 a.m.	10:05 a.m.	10:16 a.m.	3:16 p.m.	5:24
6	11:22 a.m.	12:44 p.m.	5:35 p.m.	10:55 p.m.	10:33[12]
7	11:22 a.m.	11:36 a.m.	1:00 p.m.	5:22 p.m.	6:00[13]
8	11:26 a.m.	11:49 a.m.	12:31 p.m.	6:45 p.m.	7:19
9	1:13 p.m.	1:29 p.m.	6:40 p.m.	10:31 p.m.	9:18[14]
10 (Case Patient)	4:43 p.m.	5:46 p.m.	9:28 p.m.	9:49 p.m.	5:06
11	5:00 p.m.	6:04 p.m.	10:50 p.m.	11:30 p.m.	6:30
12	6:44 p.m.	7:27 p.m.	LWOBS	9:00 p.m.	2:16 [15]
13	9:28 p.m.	9:41 p.m.	10:45 p.m.	11:50 p.m.	2:22

Source: OHI

Five of the above patients were admitted to the facility, transferred to another hospital, or LWOBS. Of the eight remaining patients, the LOS ranged from 1 hour and 26 minutes to 7 hours and 19 minutes (mean = 4 hours and 21 minutes, standard deviation = 2 hours and 13 minutes). In addition to the 63-minute wait for the patient to be seen by the triage nurse, there were two other patients whose check-in to RN triage times were more than 1 hour.

ED Workload Data for October 20–26, 2013

We reviewed ED workload data for October 20–26, the week during which the patient presented to the ED. We found that the facility did not meet its target of having less than 10 percent of patients experience a LOS greater than 6 hours. Our review of the ED workload showed that over this 7-day period, on all but 1 day, patient LOS exceeding 6 hours was greater than 10 percent of all patients seen that day.

[11] Transferred to a community hospital.
[12] Admitted to the facility.
[13] Admitted to the facility.
[14] Admitted to the facility.
[15] LWOBS by a provider.

Facility managers told us that the percentage of patients with LOS greater than 6 hours since the ED opened has improved and that it was approximately 14 percent as of the end of December 2013.

Although the patient volume and number of admissions on October 22 were similar to other days of the week, the number of patients requiring transfers was higher than normal. The ED manager told us that transferring patients to a non-VA facility generally requires more staff time to contact clinicians at the accepting hospital and complete the required paperwork for the inter-facility transfer. Table 3 below shows ED workload data for the week reviewed.

Table 3. ED Workload, October 20–26, 2013[16]

	Sun (Oct. 20)	Mon (Oct. 21)	Tue (Oct. 22)	Wed (Oct. 23)	Thu (Oct. 24)	Fri (Oct. 25)	Sat (Oct. 26)
Patient Volume	29	69	63	63	55	53	38
Left AMA	0	2	1	2	2	2	1
Admitted to the facility	8	8	9	17	9	10	7
Transferred to another hospital	1	1	9	1	4	2	4
LWOBS	1	3	4	4	3	1	0
(% LOS >6 Hours) Actual #s	(0%) 0	(24%) 17	(25%) 16	(25%) 16	(22%) 12	(16%) 14	(18%) 7

Source: OHI

ED Staffing on October 22, 2013

We reviewed staffing data for noon to midnight on October 22. VHA staffing guidelines recommend using 2.0 patients per hour as the baseline for emergency medicine physicians and 50 percent to 75 percent of the physician workload for mid-level providers (NPs and PAs). In addition, a minimum of two RNs must be available at all times.[17] We determined that staffing was consistent with the VHA recommended minimum guidelines during the time that the patient was in the ED. Table 4 on the next page shows ED staffing on October 22.

[16] Data extracted from the facility's daily ED administrative reports.
[17] VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.

Table 4: ED Staffing on October 22, 2013

Time period	Physicians	NPs/PAs	RNs
12:00 p.m.–1:00 p.m.	3	2 NPs	6
1:00 p.m.–2:00 p.m.	3	2 NPs	6
2:00 p.m.–3:00 p.m.	4	2 NPs	6
3:00 p.m.–4:00 p.m.	4	2 NPs	6
4:00 p.m.–5:00 p.m.	4	2 NPs	6
5:00 p.m.–6:00 p.m.	4	1 NP	6
6:00 p.m.–7: 00 p.m.	3	1 NP	6
7:00 p.m.–8:00 p.m.	3	1 NP	4
8:00 p.m.–9:00 p.m.	2	0	4
9:00 p.m.–10:00 p.m.	2	0	4
10:00 p.m.–11:00 p.m.	2	1 PA	3
11:00 p.m.–12:00 a.m.	2	1 PA	3

Source: OHI

Issue 2: Alleged Staff Disrespect

We did not substantiate the allegation that facility staff were disrespectful to the patient.

The patient's friend stated that facility staff were rude and cited instances where staff allegedly demonstrated unprofessional behavior. In an interview with OHI, the patient's friend reported that a Radiology Department staff member had "slammed" the reception window closed prior to leaving for the day.

We reviewed the written statements of several radiology staff members. The Radiology Department Registration staff did not remember the specific incident or the patient. The staff also noted that the roll up dividers at the registration window are heavy and hard to control and must be rolled down and shut with some force to lock properly and that this can sound as if the window is being slammed shut. During our onsite inspection, we verified that the registration window requires some force to lower and that it makes a loud noise when closed.

The Radiology Chief stated that a front desk clerk informed a radiology manager that the patient was in the waiting area for a CT. Two supervisory technologists spoke with the patient and her friend and explained that a routine CT exam had to be pre-scheduled. When the patient insisted she was to have a CT scan, the technologists called the patient's PCP. The technologists informed the patient of the PCP's desire for her to go to the ED for an evaluation.

We queried the facility's Patient Advocate for any complaints of staff disrespect[18] involving Radiology, Pharmacy, or ED staff. During the week of October 20–26, 2013, there were no staff courtesy complaints reported. From April 1 through October 20, there were four complaints for Pharmacy and none for Radiology. For the

[18] Reported in the Patient Advocate Tracking Package as Staff Courtesy (Code SC01) – *Patient is not treated with Dignity and Respect; there was perceived rudeness.*

ED, there were four complaints from July 1 through October 20. The Patient Advocate addressed the complaints, and all eight cases were resolved and subsequently closed.

We did find that the sequence of events surrounding the patient's presentation to the Radiology Department near the close of regular business hours led to some confusion on the part of the patient and staff. Nevertheless, we could not find additional evidence of intentional rudeness or unprofessional conduct on October 22. However, relating these encounters provides opportunities for the facility to develop and enhance additional quality improvement efforts focused on improving patient-centered and customer service practices.

Issue 3: Additional Concerns

The initial concern expressed by Congress focused on the patient's ED wait time. However, in the course of this inspection additional concerns arose.

It was reported that the patient was crying with pain, was pounding her cane on the floor, was "freezing" cold, and had been sitting in her wheelchair for 4–5 hours and that her friend had asked if the patient could use a double chair to lie down. We found that ED staff maintained that they neither saw the patient crying nor pounding her cane on the floor; they also maintained that the patient did not request to lie down on the chairs in the waiting room.

It was reported that once the patient left the ED and reached the outpatient pharmacy area, a pharmacy employee stated that they were busy with "someone upstairs" and that the patient would have to wait for her ED-prescribed pain medication. We found that it was possible that the patient waited until pharmacy staff became available because inpatients had priority over outpatients. The general process is for patients to wait in the ED waiting room until notified by the pharmacy that a medication order is completed. The patient is then instructed to go to the outpatient pharmacy. When the patient in this case left the ED AMA, she and her friend proceeded to the pharmacy where they waited until the prescription was completed.

Shortly after receiving requests in mid-December for an OIG inspection, we asked the facility to provide copies of available video footage for the ED, Radiology, and Pharmacy for October 22, 2013. VA police reported that the non-VA contractor "has reviewed the video footage from the main server and determined that no footage is available due to the 30 day lapse in time." We contacted a Police Chief at another VA medical center who confirmed erasing footage after 30 days was consistent with the practice at his facility.

We spoke with the non-VA contractor that provided the video equipment. The contractor informed us that they only provide the equipment and perform installation of the equipment but are not involved in maintenance of the video footage, which is under the VA's control. Prior to December, 30 days had already elapsed, and in response to our request for footage, the relevant video tapes were not available for OIG viewing.

Conclusions

On October 22, 2013, an elderly patient—the subject of this hotline inspection—waited 4 hours and 45 minutes to be evaluated by an ED physician. Additionally, her LOS in the ED was 5 hours and 6 minutes. We concluded that waits of this length were, at a minimum, challenging for this patient. However, mitigating these long waits was the fact that numerous other patients who were assessed to be in more urgent need of attention were in the ED at the same time.

The facility's target is for less than 10 percent of its ED patients to experience a total ED LOS of greater than 6 hours. This inspection revealed that the facility met this target on only 1 day during the week in which the patient visited the ED. We concluded that the facility's inability to meet its target warrants further management review and corrective actions.

In regard to the care of the specific patient discussed in this report, we found that there was no documentation of hourly nursing reassessments as required by local policy.

We did not substantiate the allegations that staff repeatedly disrespected the patient. However, the expression of these concerns provides opportunities for the facility to develop and enhance additional quality improvement efforts focused on improving patient-centered and customer service practices.

We concluded that the initial directions for the patient to report to the Radiology Department were poorly coordinated. This appeared, at least in part, due to the multiple communications by telephone and the late hour at which they occurred.

Finally, we found no relationship between the patient's wait in the facility's ED and her subsequent clinical course.

Recommendations

1. We recommended that the Facility Director ensure that action plans are developed and implemented to facilitate meeting and maintaining the facility's target of not more than 10 percent of emergency department patients should experience a length of stay exceeding 6 hours.

2. We recommended that the Facility Director ensure that nursing staff reassess emergency department patients according to facility policy.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 26, 2014

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **Draft Report**—Healthcare Inspection- Alleged Excessive Wait for Emergency Care and Staff Disrespect, VA Southern Nevada Healthcare System, Las Vegas, Nevada

To: Director, Regional Office of Healthcare Inspections (54LA)

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

1. I concur with the findings and recommendations in the report of the: Draft Report—Healthcare Inspection- Alleged Excessive Wait for Emergency Care and Staff Disrespect, VA Southern Nevada Healthcare System, Las Vegas, Nevada, recommendations 1 - 2.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

(*original signed by*:)

Stan Johnson, MHA, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 26, 2014

From: VA Southern Nevada Healthcare System Director

Subject: **Draft Report**—Healthcare Inspection- Alleged Excessive Wait for Emergency Care and Staff Disrespect, VA Southern Nevada Healthcare System, Las Vegas, Nevada

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. The attached Director's comments are submitted in response to the recommendations in the Office of Inspector General's Special Investigation Report.

2. Please contact me at (702) 791-9010, if you require further assistance.

(*original signed by*:)

Isabel Duff, MS

Attachments

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 action plans are developed and implemented to facilitate meeting and maintaining the facility's target of not more than 10 percent of emergency department patients should experience a length of stay exceeding 6 hours.

Concur

Target date for completion: September 30, 2014

Facility response: The following actions have been taken to address Emergency Department LOS > 6 hours since July 2013:

A systems redesign project was implemented to identify and address ED patient flow issues. Data collection and flow mapping was performed. Based on the data, the following changes were implemented:

- September 2013:

An additional shift (10 am – 8 pm) for providers/nursing staff was added to accommodate peak arrival times and ESI levels.

- October 2013:

An additional waiting area in the ED was created for non-acute patients with pending radiology tests and lab results enabling physicians to treat higher acuity patients in a timely manner.

- November 2013:

A Fast Track area was created in the ED by converting two office spaces.

Ancillary support services (pharmacy, lab and radiology) hours were extended to align with patient flow.

The Emergency Department Information System (EDIS) tracking system was implemented to help track patient status/flow.

- February 2014:

The Fast Track area was relocated to help decompress the main ED.

- March 2014:

Based on data, Fast Track hours were shifted to begin at 8am.
Outcomes:

As a result of the above interventions, EDIS data show a 6% decrease in wait times >6 hours

Action Plan:
ED performance metrics are being monitored daily in the leadership morning briefing. Monthly data is reported to Executive Leadership Board (ELB) by the Systems Redesign workgroup chairperson.

Additional actions and initiatives are being assessed by the Systems Redesign workgroup to assure compliance.

1. Full implementation of nursing protocols.
2. Formal rapid medical evaluation (RME) process.

Compliance with the target of less than 10% of patients waiting >6 hours for three consecutive months will be met by September 30, 2014. Metric will be calculated on a weekly average basis, based on the number of patients seen and those waiting greater than 6 hours.

Recommendation 2. We recommended that the Facility Director ensure that nursing staff reassess emergency department patients according to facility policy.

Concur

Target date for completion: July 15, 2014

Facility response:

ED patients will be reassessed in accordance with local policy. Triage Practices and Procedures policy was revised and approved by Nurse Executive Council (NEC) in March 2014 and will be effective April 14, 2014. The revised policy reflects best practices to include timeframes for assessment and reassessment of ED patients. The policy supports VHA guidelines, Emergency Nursing Association (ENA), Emergency Severity Index (ESI), national and community standards.

Actions:
Staff education on Triage Practices and Procedures policy and triage template will be completed and documented in the Talent Management System (TMS) by April 15, 2014.

Daily audits will be completed for the first 30 days to ensure 90% compliance for ESI level 3 patient assessment and reassessments. These audits will be completed weekly for three months to be completed by July 15, 2014. Audits will be reported to ELB through the Systems Redesign workgroup chairperson.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Michael Shepherd, MD Kathleen Shimoda, RN Daisy Arugay, MT Simonette Reyes, RN George Wesley, MD Jovie Yabes, RN Jackelinne Melendez, MPA

Appendix D

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