



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

Office of Healthcare Inspections

Report No. 14-03212-295

Healthcare Inspection

Emergency Department Concerns Dwight D. Eisenhower VA Medical Center Leavenworth, Kansas

October 2, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office (OIG) Office of Healthcare Inspections conducted an inspection to assess the validity of an allegation concerning the Dwight D. Eisenhower VA Medical Center (VAMC) Emergency Department (ED), Leavenworth, Kansas, part of the Eastern Kansas Health Care System, Topeka, Kansas.

We substantiated the allegation that some patients who sought care at the Leavenworth VAMC ED did not receive a required medical screening examination to determine whether an emergency medical condition existed.

Leavenworth VAMC ED staff sent 112 (10 percent) of the 1,120 unique patients who sought emergency care March 26–May 23, 2014, to the Leavenworth VAMC Primary Care Clinic without ensuring the patients received a required medical screening examination. Of the 112 patients sent to the Primary Care Clinic, 50 (45 percent) were not examined by a physician, nurse practitioner, or physician assistant that day. We also determined Leavenworth VAMC ED registered nurse triage staff did not always use required ED documentation templates, and ED and Primary Care Clinic nursing staff did not consistently document required assessments.

We recommended that the Eastern Kansas Health Care System Director ensure that all patients who present to the Leavenworth VAMC ED requesting an examination or treatment receive a medical screening examination, that Leavenworth VAMC ED and Primary Care Clinic nursing staff document required assessments, and that compliance be monitored.

Comments

The Veterans Integrated Service Network and Eastern Kansas Health Care System Directors concurred with the findings and recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 7–9 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 Office (OIG) Office of Healthcare Inspections conducted an inspection to assess the validity of an allegation concerning the Dwight D. Eisenhower VA Medical Center (VAMC) Emergency Department (ED), Leavenworth, KS.

Background

VA Eastern Kansas Health Care System (HCS) comprises two VAMCs—the Dwight D. Eisenhower VAMC (Leavenworth VAMC) in Leavenworth, KS, and the Colmery-O’Neil VAMC (Topeka VAMC) in Topeka, KS. The HCS is part of Veterans Integrated Service Network (VISN) 15.

At the time of this review, the Leavenworth VAMC operated a dedicated ED, and the Topeka VAMC operated an Urgent Care Clinic (UCC) 24 hours per day, 7 days per week.¹ Veterans Health Administration (VHA) requires² that a registered nurse (RN) triage all patients who present to the ED and assign acuity levels based on the Emergency Severity Index (ESI).³ The ESI is a five-level algorithm that categorizes acuity and expected resource needs into priority groups from 1 (requires immediate, life-saving intervention) to 5 (non-urgent). HCS local policy requires that patients who present to a UCC also receive an RN triage.

Although VA is not technically subject to the Emergency Medical Treatment and Active Labor Act (EMTALA),⁴ VHA Handbook 1101.05 states that the practice of VHA emergency medicine includes evaluation and emergency care that is compliant with EMTALA.

EMTALA requires that hospitals with a dedicated ED provide a medical screening examination (MSE) to any individual who comes to the ED and requests an examination or treatment. The Act requires that a person specifically determined to be a qualified medical provider conducts the MSE. VHA Handbook 1101.05 specifies that physicians, nurse practitioners (NP), and physician assistants (PA) are qualified to conduct the MSE. Even when an ED is on diversion, VHA requires that patients receive an MSE prior to being referred to a clinic for further evaluation and treatment if deemed appropriate.⁵ EMTALA imposes no further obligations if the qualified medical person determines the patient does not have an emergency medical condition.

¹ On January 31, 2014, Eastern Kansas Health Care System leadership temporarily changed the status of the Topeka Emergency Department to a 24/7 Urgent Care Clinic due to reported physician staffing challenges.

² VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.

³ Gilboy N, Tanabe T, Travers D, Rosenau AM, Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4: Implementation Handbook 2012 Edition, AHRQ Publication No. 12-0014, Rockville, MD, Agency for Healthcare Research and Quality, November 2011.

⁴ 42 U.S.C. §1395dd.

⁵ VHA Directive 2009-069, *VHA Medical Facility Emergency Department Diversion Policy*, December 16, 2009.

Centers for Medicare and Medicaid Services (CMS), the Federal entity tasked to enforce EMTALA, has issued guidelines to assist with EMTALA interpretation.⁶ The guidance states: “An MSE is a process required to reach, within reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC [emergency medical condition] or not...It is an ongoing process that begins, but typically does not end, with triage.” The guidance notes that not all screenings must be equally extensive. “If the nature of the individual’s request makes clear that the medical condition is not of an emergency nature, the MSE is reflective of the individual presenting complaints or symptoms.” The guidance states that not all individuals who present to the ED trigger EMTALA obligations. For example, an individual who presents to the ED and requests a preventative care service such as an immunization or flu shot does not trigger an MSE.

Eastern Kansas HCS local policy⁷ requires that ED and UCC staff document patient care on an “EK-10:10”⁸ template note, even if the patient is not seen by a provider. Required note content includes vital signs (temperature, pulse, respiration, blood pressure (BP), and pain).

OIG conducted an Employee Assessment Review Survey of Eastern Kansas HCS staff April 7–28, 2014.⁹ The survey responses included a concern that patients were at risk because Leavenworth VAMC ED triage nursing staff sometimes sent patients seeking ED care to the Leavenworth VAMC Primary Care Clinic (PCC). According to the survey, those patients received a brief triage and ESI level assignment in the ED, referred to as “First Look,”¹⁰ but did not receive an MSE in the ED and some of those patients were sent home from the PCC without receiving an examination by a physician, NP, or PA.

Scope and Methodology

We conducted site visits at the Leavenworth and Topeka VAMCs on May 22, 2014. We interviewed ED and UCC physicians, RNs, and nurse managers; PCC RNs; and other clinical staff. We also requested that the Eastern Kansas HCS Director immediately ensure that all individuals who came to the Leavenworth VAMC ED and Topeka VAMC UCC requesting an examination or treatment, received an MSE performed by a physician, NP, or PA.

We reviewed facility policies, VA and VHA handbooks and directives, and other related documents. We reviewed the electronic health records (EHRs) of the 112 patients who presented to the Leavenworth VAMC ED March 25–May 23, 2014, and were referred to

⁶ Centers for Medicare and Medicaid Services, State Operations Manual, Appendix V, *Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines*, July 16, 2010.

⁷ VA Eastern Kansas Health Care System, *Nursing Standard of Practice, Nursing Process and Documentation in Emergency Room/Urgent Care*, February 25, 2014.

⁸ Eastern Kansas HCS ED electronic medical record documentation template note.

⁹ The Employee Assessment Review survey is a short, confidential survey that invites all facility employees to share quality of care and safety observations with OIG staff prior to a Combined Assessment Program Review.

¹⁰ We did not find guidelines outlining a “First Look” ED process in VA, VHA or Eastern Kansas HCS policies.

the PCC without a documented MSE. We also reviewed the EHRs of selected patients who sought care March 25–May 23, 2014, at the Topeka VAMC UCC.

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

Inspection Results

Issue 1: Medical Screening Examination

We substantiated that some patients who sought care at the Leavenworth VAMC ED did not receive an MSE as required. The Leavenworth VAMC ED manager and ED RN triage staff told us that, during the PCC's operating hours and when the ED was busy, an RN was assigned to briefly assess patients who presented to the ED. The assessment was termed "First Look."

The RN assigned to conduct the First Look assessment (First Look RN) was tasked to document the patient's chief complaint, a short history, and vital signs in an EHR template note titled "EK-Nursing First Look." The RN also determined the patient's ESI level and, if the ESI was a Level 4 or 5 and the RN determined that the patient did not require ED services, the RN would communicate the patient's complaint to PCC staff and direct the patient to the PCC. Patients sent to the PCC by the First Look RN did not receive MSEs in the ED and were not escorted by staff to the PCC.

We determined 112 (10 percent) of the 1,120 patients who presented to the Leavenworth VAMC ED March 25–May 23, 2014, were directed to the PCC via the First Look process.¹¹ However, three patients were returned to the ED and received treatment after PCC staff determined they could not meet the patients' needs. Of the 112 patients referred to the PCC, 50 (45 percent) were not examined by a physician, NP, or PA, and 12 of those patients did not receive an assessment that included a complete set of vital signs.

Case Reviews. The following cases are examples of individuals whose EHRs indicated they presented to the Leavenworth VAMC ED March 25–May 23 requesting examination or treatment but did not contain evidence of required ED documentation and/or that an MSE was performed on their initial presentation.

Case 1 – A man in his 80s with a known history of mitral valve replacement and coronary artery disease with a stent¹² placement presented to the Leavenworth VAMC ED in the morning. An ED RN documented in the "EK-Nursing First Look" template that the patient complained of sinus and chest congestion, and a cough for 5 days. The RN assigned the patient an ESI level 4. The RN did not document a physical assessment or the patient's vital signs. The RN documented referring the patient to the PCC and giving a hand-off report to a Licensed Practical Nurse (LPN). The patient received a chest x-ray before arriving at the PCC.

Almost an hour later, an LPN documented the patient was a PCC "walk in." The LPN noted the patient complained of "cold symptoms," a productive cough, and had been in

¹¹ Although on May 22, 2014, we directed the EKHCS Director to ensure Leavenworth VAMC ED and Topeka VAMC UCC patients received medical examination screens, one Leavenworth VAMC ED patient was directed to the PCC without receiving a medical examination screen on May 23, 2013.

¹² A mesh tube placed inside a coronary artery to prevent blocked or damaged arteries from closing.

bed for 3 days. The LPN documented the following vital signs: temperature 97.1 degrees, pulse 77 beats per minute, respirations 20 breaths per minute, BP 87/62 mm Hg,¹³ and blood oxygen saturation 98 percent. The patient's reported throat pain was a 4 on a scale of 1–10.

Two hours later, a PCC provider noted, "Best for ED to assess patient ...BP is too low..." The patient was immediately returned to the ED by wheelchair, and an ED RN used the required EK-10:10 documentation template and assigned the patient an ESI level 3. An ED provider examined the patient, and the patient received intravenous fluids and a respiratory treatment. The patient was discharged home with the following diagnoses: symptomatic hypotension (low B/P), mildly elevated blood urea nitrogen and creatinine levels,¹⁴ acute bronchitis, and suspected influenza.

Case 2 – A man in his 60s with a known history of diabetes¹⁵ presented to the Leavenworth VAMC ED in the morning. An ED RN documented in the "EK-Nursing First Look" template that the patient fell a "couple weeks ago" against a gas pump and complained of left side rib and back pain and cough. The RN noted the patient denied difficulty breathing and rated his pain a 3 (1–10 scale). The RN did not document the patient's vital signs. Soon after the patient's arrival, the RN assigned him an ESI level 4 and documented referring the patient to the PCC and giving a hand-off report to an RN.

Shortly thereafter, the patient presented to the PCC with rib pain and a burn on his lower right leg. An RN documented the patient had been riding a motorcycle, fallen into a gas pump, and complained of sharp and stabbing pain upon movement or deep breaths. The RN also noted a 1.5 inch by 1.5 inch burn on the patient's right lower leg and that the wound appeared red with some crusting. The RN placed a consult request for a wound specialist and noted the wound was red and warm to touch.

There was no evidence a physician, PA, or NP examined the patient that day, that ED or PCC staff treated his burn, or that his vital signs were obtained as a part of his ED assessment. The following day, a wound care specialist examined the patient, diagnosed a second degree burn to his right lower leg, and treated the wound.

Case 3 – A man in his 80s with a known history of diabetes and long-term anticoagulation therapy presented to the Leavenworth VAMC ED mid-morning. An ED RN documented in the "EK-Nursing First Look" template that the patient had "ripped" a toenail off and that the patient stated the bleeding had slowed down on his way to the ED. He rated his pain a 2 (1–10 scale). The RN assigned the patient an ESI level 4 and documented his vital signs, which were normal. The RN also documented referring the patient to the PCC and giving a report to an RN.

The EHR contained no further documentation on the day the patient presented to the ED. There was no evidence a physician, PA, or NP examined the patient that day or

¹³ Blood pressure, recorded in "millimeters of mercury" (mm Hg), is a measure of the pressure of blood on the vessels when the heart beats. Normal blood pressure values range approximately from 100–135/60–90.

¹⁴ A possible cause of elevated creatinine and blood urea nitrogen is dehydration.

¹⁵ Patients with diabetes are more prone to leg infections, which are a frequent cause of lower leg amputation.

that ED or PCC staff assessed the patient's toe or amount of blood loss, treated the wound, or drew blood samples to assess the patient's anticoagulation status.

Topeka VAMC Urgent Care Clinic (UCC): We did not find evidence that Topeka VAMC UCC staff directed patients to the PCC without an MSE. Although some PCC staff believed UCC staff directed patients to the PCC without receiving an MSE, the staff did not provide specific patient information for us to review. To identify possible patients who did not receive an MSE as required, we reviewed Patient Advocate complaint data and did not find relevant complaints.

Conclusions

We substantiated the allegation that some patients who requested an examination or treatment at the Leavenworth VAMC ED did not receive an MSE as required.

Leavenworth VAMC ED staff sent 10 percent of the patients who sought ED care March 26–May 23, 2014, to the PCC without ensuring the patients received a required MSE. We determined that 45 percent of the patients sent to the PCC were not examined by a physician, NP, or PA on the day they sought ED care. We also determined Leavenworth VAMC ED RN staff did not always use required ED documentation templates, and ED and PCC nursing staff did not consistently document required assessments.

Recommendations

1. We recommended that the Eastern Kansas Health Care System Director ensure that all patients who present to the Eastern Kansas Health Care System Emergency Department requesting an examination or treatment receive a medical screening examination and that compliance is monitored.
2. We recommended that the Eastern Kansas Health Care System Director ensure Leavenworth VAMC Emergency Department and Primary Care Clinic nursing staff document required assessments and that compliance is monitored.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 25, 2014

From: Director, VA Heartland Network (10N15)

Subj: **Draft Report** – Healthcare Inspection—Emergency Department Concerns, Dwight D. Eisenhower VAMC, Leavenworth, Kansas

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

Attached, please find the initial status response for the Healthcare Inspection—Emergency Department Concerns, Dwight D. Eisenhower VAMC, Leavenworth, Kansas (Conducted on May 22, 2014).

I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity to focus on continuous performance improvement.

For additional questions, please feel free to contact Mary O'Shea, VISN 15 Quality Management Officer at 816-701-3000.

(original signed by:)

WILLIAM P. PATTERSON, MD, MSS

Network Director

VA Heartland Network (VISN 15)

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 21, 2014

From: Director, VA Eastern Kansas Health Care System (589A6/00)

Subj: **Draft Report** – Healthcare Inspection—Emergency Department Concerns, Dwight D. Eisenhower VAMC, Leavenworth, Kansas

To: Director, VA Heartland Network (10N15)

Eastern Kansas VA Medical Center concurs with the findings brought forth in this report. Specific corrective actions have been provided for the recommendations.

Should you have any questions, please contact Mary Weier, Chief, Quality Management, at (913) 682-2000 ext 52146.

(original signed by.)

A. RUDY KLOPFER, FACHE, VHA-CM

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 Eastern Kansas Health Care System Director ensure that all patients who present to the Eastern Kansas Health Care System Emergency Department requesting an examination or treatment receive a medical screening examination and that compliance is monitored.

Concur

Target date for completion: October 31, 2014

Facility response:

1. Non-compliant practice was stopped immediately. An email was sent to all staff stating that all patients presenting in Emergency Department will have a medical screening examination completed. A sample of 150 Emergency Department cases in July 2014 were reviewed. All of them had a medical screening examination completed.
2. Continued review of records to validate compliance will occur and be reported monthly to the Emergency Department Committee.

Recommendation 2. We recommended that the Eastern Kansas Health Care System Director ensure Leavenworth VAMC Emergency Department and Primary Care Clinic nursing staff document required assessments and that compliance is monitored.

Concur

Target date for completion: October 31, 2014

Facility response:

1. All Leavenworth nursing staff will review/read Nursing Process & Documentation Policy and Nursing Process and Documentation in the Emergency Department/Urgent Care Policy.
2. Designated nursing staff will review random sample patient records. Compliance will be reported to Nursing Operations Committee monthly.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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