3/15/11
Approved
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Memorandum to the File
Administrative Closure

Healthcare Inspection – Alleged Emergency Department Safety Issues
Durham VA Medical Center, Durham, North Carolina
MCI # 2011-00374-HL-0237
2011-00374-HI-0059

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an oversight review of the Durham VA Medical Center's (medical center) response to allegations made by a confidential complainant. The complainant alleged that security and staffing issues within the Emergency Department (ED) jeopardize the safety of patients and staff. Specifically,

- The ED has insufficient staffing which results in an unsafe working environment for staff and patients.
- The ED lacks metal detectors and has limited police presence. Patients can approach the ED window and verbally abuse and threaten staff.
- On September 2, 2010, two registered nurses were on duty when a violent, non-compliant and destructive psychiatric patient escaped through an open ED door, was pursued, forcibly restrained and pepper sprayed, and later held in the ED with high acuity medical patients and three other psychiatric patients.

We received the complaint on January 11, 2011, and planned an on-site visit January 19–21. On January 13, the Medical Center Director (Director) told us that OIG Hotline Division had previously tasked the complaint to the medical center. Medical center staff conducted an internal review of the allegations and responded to OIG Hotline Division in a memorandum dated December 16, 2010. We received a copy of the medical center's memorandum on January 13.

According to the medical center's memorandum, the medical center followed VHA standards [VHA Directive 2010-010 (*Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*)]. In addition, medical center management was responsive to the needs of ED and had addressed issues appropriately. Ongoing redesign plans for the ED are in progress and renovations will include a locked perimeter, a police dispatch station at the ED entrance, a secure psychiatric suite with seclusion capabilities, and a room for police searches of high-risk patients. Additionally, an ED staffing model was developed that includes an increase in registered nurses and medical support assistants. We found that the medical center's review and subsequent responses were appropriate.

We made no recommendations.

11-18

Summary of the Medical Center's review

Issue 1: Staffing

The allegation that the ED has insufficient staffing which results in an unsafe working environment for staff and patients was unsubstantiated.

The ED maintains staffing levels that ensure safe working conditions. The ED adjusts staffing periodically, according to census. The ED developed a staffing model and matrix—that supports hours per patient visit standards recommended by the Emergency Nurses Association—in September 2010. This has resulted in the approval of six additional registered nurses (RN), which brings the RN full-time employee equivalent (FTE) to 29.3. Five of the six RN positions are filled and the new staff will start by January 2011.

The ED also maintains two licensed practical nurse and two psychiatric nursing assistant FTEs. Additionally, the ED uses agency contract sitters on a one-to-one staff to patient basis to supervise high-risk patients.

Issue 2: Safety Issues

The allegations that the ED lacks metal detectors and has limited police presence, and that patients can approach the ED window and verbally abuse and threaten staff were unsubstantiated.

A triage nurse asks all patients who present to the ED if they have contraband, such as weapons, knives, or medications. The triage nurse asks patients with contraband to relinquish the items and then notifies VA police, who secure the items until the patient is discharged. In addition, high-risk patients are clothed in hospital attire, and staff remove and secure their belongings.

VA police patrol the ED hourly. VA police increase the frequency of rounds or remain present when indicated or required. VA police respond to calls for assistance within a "couple of minutes" and remain in the ED until medical staff determines the situation is safe.

In September 2010, a request for 3.5 additional medical support assistants (MSAs) was approved and the additional MSAs are expected to begin work by March 2011. Using television monitors, the MSAs will visually screen individuals as they approach the ED and will have the ability to control access to the ED. The ED MSAs will control access to the clinical environment to eliminate unauthorized personnel to access the clinical environment and staff as appropriate so that all patients requiring emergency services are immediately recognized and treated.

During the past year, ongoing design plans and strategies for the ED have been underway. Construction is scheduled to begin during the Spring of 2011. Renovations will include a locked perimeter, a police dispatch station at the ED entrance, a secure psychiatric suite with seclusion capabilities, and a room for police to search high-risk patients.

Issue 3: ED Incident

The allegation that on September 2, 2010, a violent non-compliant and destructive psychiatric patient escaped through the open door, was pursued, forcibly restrained and pepper sprayed, and later held in the ED with high acuity medical patients, three other psychiatric patients, and only two registered nurses on duty was partially substantiated. The facility did not substantiate the use of pepper spray during the incident.

We found the alleged incident involving a psychiatric patient did occur. A patient, with a history of violence, eloped from the ED through a door that had "lockdown" capability[1]. The lockdown mechanism has a 30-second delay between the time of activation and actual locking of the door. During the time interval between staff calling an alert, and the activation of the lockdown, the patient was able to leave the ED. Staff notified VA police, ED staff, and a psychiatrist. VA police located the patient, and calmly escorted him back to the ED. VA police, and psychiatry and nursing staff, then escorted the patient to a seclusion room on the locked psychiatric unit, where the patient received further psychiatric evaluation and treatment.

As a result of this incident, the ED implemented several changes. A former office space was renovated and is now a designated "safe room". The room is used for psychiatric patients at risk for violent and/or psychotic behavior. When a high-risk patient presents to the ED, the patient is assigned to an area within the ED where a one-to-one staff to patient supervision is assigned. Additionally, the ED now has a top-priority designation for the allocation of staff assigned to maintain one-to-one staff to patient observation.

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[1] Staff have the ability to electronically activate the door locking mechanism when necessary.

Approved by: _____ 3/15/11

Pat Christ, Deputy Assistant IG for Healthcare Inspections