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Healthcare Inspection

Administrative Response to Deaths and Quality of Care Irregularities VA North Texas Health Care System Dallas, Texas

August 26, 2016

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to assess a complaint submitted by another Federal agency in 2014 alleging deaths and quality of care irregularities during calendar years 2011–2013 at the Dallas VA Medical Center (facility), part of the VA North Texas Health Care System (system). The allegations included that during 2011–2013, individuals died: (1) after being dropped in x-ray and bleeding (Patient A); (2) after being baptized in the spinal cord injury pool (Patient B); and (3) in a facility restroom (Patient C and Employee 1). Additional allegations included that: (4) a patient (Patient D) fell off a gurney and broke a nurse's foot (Employee 2) when staff attempted to move him from a small room to perform cardiopulmonary resuscitation; (5) wound care at the facility was poor; and (6) licensed vocational nurses were "pushing" intravenous medications against practice standards.

OIG confirmed that the allegations had merit and that system leadership was aware of the deaths and irregularities and had conducted quality reviews and pursued administrative actions, when indicated, to address the events and irregularities. OIG elected to review both the actual events that comprised the allegations as well as the system leadership's responses to those events.

We substantiated that in 2012, Patient A died after sustaining head trauma from a fall in the Radiology Department. We found that system leadership had investigated this incident and disclosed the details of the fall to Patient A's family. In our review of this event, we identified quality of care concerns related to the timely completion and interpretation of imaging study results for Patient A.

We substantiated that in 2011, Patient B died following baptism in a facility pool. We found that the system had conducted a review of this incident. However, we found that system leadership did not follow up on an ethics consultation recommendation resulting from the review. This recommendation was that the facility consider revising its "Do Not Resuscitate" policy to include re-addressing the status of Do Not Resuscitate orders with patients prior to any hospital procedures.

We substantiated that in 2012, facility Employee 1 died of an overdose, and Patient C died of a self-inflicted gunshot wound in facility restrooms. Related to the overdose death, we found that system leadership did not address a recommendation to improve employee drug testing procedures.

We substantiated that in 2013, Employee 2 was injured by a bed transport during the course of a cardiopulmonary resuscitative effort. We did not substantiate that the patient being resuscitated (Patient D) fell from a gurney during these resuscitative efforts. We found that system leadership was fully apprised of these events and, for each case, had conducted internal reviews and taken appropriate actions.

We did not substantiate poor wound care during our site visit. Nevertheless, in 2012, system staff identified an increase in pressure ulcer prevalence and implemented several new initiatives with resultant positive outcomes. We also found no evidence

that licensed vocational nurses were “pushing” (administering) intravenous medications at the time of the review.

We recommended that the System Director ensure that the care of Patient A is evaluated, including a review of computerized tomography scan orders and imaging study results, and take action if appropriate; consider revising the Do Not Resuscitate Policy to include re-addressing Do Not Resuscitate orders status with patients prior to any procedures in the hospital; and ensure timely compliance with all elements of the Drug-Free Workplace Program.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 14–17 for the Directors’ comments.) We consider Recommendations 1 and 2 closed. We will follow up on Recommendation 3 planned actions until they are completed.

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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to assess a complaint submitted by another Federal agency in 2014 alleging deaths and quality of care irregularities during calendar years 2011–2013 at the Dallas VA Medical Center (facility), part of the VA North Texas Health Care System (system). The purpose of the review was to assess the merit of the allegations and determine if system leadership took appropriate administrative actions, when indicated.

Background

System and Facility Information

The system, which is part of the Veterans Integrated Service Network (VISN) 17, comprises the facility and the Sam Rayburn Memorial Veterans Center in Bonham, TX. The system provides a broad range of inpatient and outpatient health care services to over 113,000 veterans in 38 counties in northern Texas and two counties in southern Oklahoma. The 853-bed system includes a Spinal Cord Injury Center, Domiciliary, a Community Living Center, and eight community based outpatient clinics.

Adverse Events

Since 1996, The Joint Commission has mandated that health care facilities conduct "investigation and analysis of Patient Safety Events (events not primarily related to the natural course of the patient's illness or underlying condition)."[1] The Joint Commission further defines some Patient Safety Events as:

- Sentinel[2]—event resulting in "death, permanent harm, severe temporary harm and intervention required to sustain life" and "they signal the need for immediate investigation and response"[3]
- Incident—unsafe event resulting in patient harm[4]
- Close call—event was unsafe, "but did not cause patient harm (also known as a "free lesson" or "near miss")[5]

The Veterans Health Administration (VHA) directs that system staff must report any unsafe conditions of which they are aware and that facilities have processes in place to

[1] http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/default.aspx, accessed August 19, 2015.
[2] According to VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011, VHA also uses the term "adverse" to include events with negative outcomes. This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 but has not yet been recertified.
[3] http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/default.aspx, accessed August 19, 2015.
[4] Human Factors Analysis in Patient Safety Systems, The Joint Commission The Source, April, Volume 13, Issue 4. Accessed August 19, 2015.
[5] Ibid.

determine whether an occurrence meets the definition of an adverse or sentinel event, and to follow up as required.[6] According to VHA, adverse or sentinel events signal the need for immediate investigation and response, which may result in initiating a(n):

- Root cause analysis (RCA), a review intended to focus on systems and processes versus individuals[7]
- Administrative Investigation Board (AIB), a review to identify and effectively correct individual and systemic deficiencies, such as in the case of an intentionally unsafe act[8,9]
- Disciplinary or other corrective action, taken whenever an employee's performance of duty or professional competence is determined to be unsatisfactory or when an employee's professional or personal conduct is not satisfactory, prompt and appropriate[10]

Peer Review

VHA utilizes an organized peer review process to evaluate the performance of a health care professional, which is conducted by a select committee or individual of health care professional(s). The intent is "…to promote confidential and non-punitive processes that consistently contribute to quality management efforts at the individual provider level." Peer reviews may be completed in cases where there is an unexpected or negative occurrence that may be related to care provided or suicide within 30-days of a clinical encounter.[11]

Disclosure

VHA outlines procedures to ensure consistent processes among VHA facilities in disclosing to patients, or to patients' personal representatives, the occurrence of adverse events related to patients' clinical care.[12] Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other VHA facility.[13]

[6] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
[7] Ibid.
[8] VA Directive 0700, Administrative Investigations, March 25, 2002.
[9] VA Handbook 0700, Administrative Investigations, July 31, 2002.
[10] VA Handbook 5021/5, *Employee Management Relations*, August 28, 2007.
[11] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This VHA Directive expired June 30, 2015, and has not been updated.
[12] VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012. VHA Handbook 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008, was current at the time of some of the events discussed in this report; it was rescinded with publication of the current Handbook in October 2012.
[13] Ibid. The current version and previous version of this Handbook contain the same definition of an adverse event.

VHA recognizes three types of disclosure: clinical,[14] institutional,[15] and large-scale.[16] Appropriate disclosure may include any or all types. Disclosure is warranted for adverse events that cause death or disability, lead to prolonged hospitalization, require life-sustaining intervention or intervention to prevent impairment or damage (or that are reasonably expected to result in death or serious and/or permanent disability), or that are sentinel events."[17]

Allegations

In 2014, another Federal agency submitted a complaint alleging deaths and quality of care irregularities at the facility. The allegations included that individuals died:

- After being dropped in x-ray and bleeding (Patient A)
- After being baptized in the spinal cord injury pool (Patient B)
- In a facility restroom (Employee 1 and Patient C)

The referral also included quality of care allegations that:

- A large patient fell off a gurney (Patient D) and broke a nurse's foot (Employee 2) when staff attempted to move him from a small room into a larger space to perform cardiopulmonary resuscitation.
- Wound care at the facility was poor.
- Licensed Vocational Nurses (LVNs) were "pushing" intravenous (IV) medications "against standards" for LVN practice.

Scope and Methodology

We conducted our review from May 2014 through December 2015, including a site visit to the facility from May 27 through May 29, 2014.

We interviewed select system leaders, managers, and other staff who were knowledgeable about the allegations and/or events. We reviewed relevant documents, including applicable regulations, policies, and guidance documents; AIB reports;

[14] A clinical disclosure is a process by which the patient's clinician informs the patient or the patient's personal representative as part of routine clinical care that a harmful or potentially harmful adverse event has occurred during the patient's care. VHA Handbook 1004.08; VHA 2008-002 contained a similar definition of clinical disclosure.
[15] An institutional disclosure is a formal process by which facility leaders together with clinicians and others, when appropriate, inform the patient or patient's representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury. The patient is also provided specific information about patients' rights and recourses. VHA Handbook 1004.08; VHA 2008-002 contained a similar definition of institutional disclosure.
[16] A large-scale disclosure is a formal process by which VHA officials assist with coordinating notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue. VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients,* October 2, 2012.
[17] VHA Handbook 1004.08. *Disclosure of Adverse Events to Patients,* October 2, 2012.

incident reports; issue briefs; performance improvement data; police reports; RCA reports; and applicable patient/resident electronic health records (EHRs).

The scope of review covered the period of the events reported in the allegations and actions taken to address the events, and included specific patient and employee safety practices related to chaplain activities, Radiology Service procedures, hospital acquired pressure ulcer and wound care management, LVN scope of practice, and incident-reporting procedures. We completed some of the work via secure data exchange, e-mail, and/or telephone.

Given the general nature of the allegation regarding poor wound care, we focused on hospital acquired pressure ulcers as an indicator of general wound care practice.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts shows the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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: Deaths

Patient A. We substantiated that Patient A fell while undergoing an x-ray, subsequently experienced bleeding (from an internal head injury), and died. We reviewed the system's reports and determined that the leadership in place at the time of this event completed some of the follow-up actions while current leadership took additional corrective actions following our site visit. We found that system leadership conducted an institutional disclosure to Patient A's family regarding the fall in x-ray. We identified quality of care concerns related to the timely completion and interpretation of imaging study results for Patient A.

Patient A was in his 70s and received care at the facility for multiple chronic medical conditions including atrial fibrillation (abnormal heart rhythm). In 2012 (Day 1), facility Emergency Department staff admitted Patient A to address complaints of acute problems including multiple recent falls and weakness. Nursing staff identified Patient A as a high fall risk.

On Day 9, Patient A fell and hit his head during a chest x-ray in the Radiology Department. At the time, the radiologic technologist who performed the x-ray did not report the fall and documented that Patient A returned to the unit "without incident." However, Patient A reported the fall to a nurse that same day, and a physician ordered a computerized tomography (CT) scan of the head that was completed shortly thereafter.[18] The interpreting radiologist documented that the CT scan did not show "…evidence of intracranial injury or skull fracture." The attending physician continued Patient A on anticoagulant medication[19] for atrial fibrillation.

In the morning of Day 14, staff members documented that Patient A was stable. That same afternoon, multiple staff members documented that Patient A's condition was deteriorating. Staff members initiated a series of actions, including a rapid response team consult. Besides respiratory distress, the physician noted that Patient A was lethargic although responsive, and ordered a "STAT"[20] CT scan of the head. For reasons that are not documented, the CT scan was not performed until the next day (Day 15).

[18] A CT Scan combines a series of x-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels and soft tissues inside of the body. Available at http://www.mayoclinic.org/tests-procedures/ct-scan/basics/definition/prc-20014610. Accessed on April 4, 2016

[19] Anticoagulant medication (referred to as blood thinner) lengthens the time it takes to form a blood clot. Available at https://www.nlm.nih.gov/medlineplus/bloodthinners.html. Accessed on November 9, 2015.

[20] "STAT studies should be performed immediately. Ordinarily a STAT study must also be interpreted within a short timeframe, unless the study will be preliminarily reviewed by the ordering physician." Radiology Service Policy and Procedure: NO. 114-7, VA North Texas Health Care System, Dallas, Texas, March 18, 2010.

The Day 15 CT scan report noted an interval increase in the size of a subdural hematoma.[21] Also on Day 15, a physician noted in reference to the Day 9 CT scan imaging study "…there was some evidence suggesting formation of hematoma..." Staff transferred Patient A to the Intensive Care Unit and he underwent emergency surgery. Patient A's condition continued to decline and he died on Day 35. The system completed two peer reviews.

On Day 119, Patient A's family member reported to the system's Risk Manager that the autopsy indicated blunt head injury was the cause of Patient A's death. Seven days later (Day 126), system leadership initiated an RCA. On Day 126, the radiologic technologist confirmed that Patient A fell during the x-ray on Day 9 and—at the time—he failed to seek immediate medical care for the patient or report the fall, as required by VHA.[22,23] System managers removed the radiologic technologist from patient care and took other appropriate action. Given the determination of the radiologic technologist's intentional unsafe act, system leadership discontinued the RCA. The VISN submitted an issue brief to VHA.

The Medical Examiner's report concluded that Patient A "…died as a result of blunt force head injuries. The subdural hemorrhage was likely exacerbated by anticoagulant therapy for atrial fibrillation."

On Day 155, system managers and leaders, including the Chief of Staff, Chief of Radiology, and Chief Technologist Radiology Supervisor, provided Patient A's family member with a formal institutional disclosure regarding the fall that occurred in x-ray.

VHA requires that facilities report any "…licensed health care professional whose behavior or clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients."[24] On June 4, 2014 (following our site visit), the current System Director formally notified The American Registry of Radiologic Technologists and the Medical Radiologic Technologist Certification Program (Texas Department of State Health Services) of the radiologic technologist's unethical actions and failure "to meet generally-accepted standards of clinical practice...."

Patient B. We substantiated that Patient B died following a baptism in the facility's spinal cord injury pool. We found that system managers did not follow up on all ethics and management review recommendations at the time of the event.

[21] A subdural hematoma is bleeding within the brain that compresses brain tissue and can lead to death; usually is caused by a head injury. Available at http://www.nlm.nih.gov/medlineplus/ency/article/000713.htm. Accessed June 26, 2014.
[22] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008. Rescinded October 2, 2012.
[23] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
[24] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. This Handbook expired December 31, 2010, and has not yet been updated. *See also* 38 CFR 47.2.

In 2011 (Day 1), Emergency Department staff admitted Patient B, who was in his 60s, for management of acute symptoms related to cancer. On Day 1, a Chaplain Service trainee visited the patient, but the patient was receiving nursing care so the trainee documented plans for a chaplain to return on Day 2. The chaplain did not follow up. Patient B verbalized a wish to be on Do Not Resuscitate (DNR)[25] status and reportedly signed an advance directive on Day 3. A physician entered a DNR order into the patient's EHR the same day.[26]

On Day 4, Patient B told a staff member that he wanted to be baptized by immersion. The chaplain told us that the staff member called Chaplain Services that day to inquire about a baptism, and the chaplain explained that the chaplain resident had until day 7 to see the patient. Patient B's physician knew about the request and on Day 5, the staff member documented that she informed Patient B's sister of the baptism request. The staff member and a nurse manager (who was also a non-VA minister by training) performed a full immersion baptism[27] in the facility's spinal cord injury pool without notifying Chaplain Service. Following the baptism, Patient B returned to his wheelchair. Staff spoke with Patient B and took photographs with him, and then Patient B became unresponsive "less than 5 minutes later." The staff did not perform resuscitation or airway management because of the DNR status and pronounced Patient B dead 10 minutes after the baptism.

Six days after Patient B's death (Day 11), the chaplain requested an ethics consult to determine if it is ethical for a service other than the Chaplain Service to baptize a patient. The Ethics consultant made the following recommendations.

- Religious activities in a health care system should remain under the Chaplain Service.
- Patient preferences should be honored when possible as long as considered safe and the appropriate providers are involved and precautions have been taken.
- Current guidelines require the System Director's permission for baptisms.
- Baptism is a complex patient decision and should be thoroughly assessed by all relevant parties.
- The safety of baptism (particularly by submersion) should be assessed and prior arrangements made for immediate problem management.
- DNR status should be re-addressed prior to any procedure in the hospital.

[25] "A do-not-resuscitate (DNR) order placed in a person's medical record by a doctor informs the medical staff that cardiopulmonary resuscitation should not be done." http://www.merckmanuals.com/home/fundamentals/legal-and-ethical-issues/do-not-resuscitate-dnr-orders, Accessed November 6, 2015.
[26] System policy states, "A "Do Not Resuscitate", or DNR order is a written order from the attending physician that resuscitation should not be attempted if a person suffers cardiac and/or respiratory arrest." VANTHCS Memorandum No. 11-06, July 9, 2008.
[27] Immersion is a "form of baptism in which part or the whole of a person's body is submerged in the water." http://dictionary.reference.com/browse.immersion?s=t, Accessed July 11, 2015.

System managers addressed the recommendations regarding religious activities but did not address the DNR status concern. Beginning in March 2012 through 2013, the system provided "Sensitivity to Diversity" training to all staff. In addition to overall cultural competency information, the training included specific information about the following system requirements: (1) Baptism is under the direction of Chaplain Service and requires approval from the System Director's office and (2) Staff (including non–VA Chaplain employees) are required to call Chaplain Service regarding patient spiritual care needs.

In April 2011, system leadership conducted a management review to evaluate the cause of death and the appropriateness of the baptism, staff actions, and the applicability of a DNR outside of the clinical area. Based on the management review recommendations, system managers requested a/an:

- AIB be convened
- Revision of Chaplain Service policy (specifically addressing the performance of religious activities)
- Review of the DNR policy by the Ethics Committee Chairperson

System leadership signed the AIB team report in July 2011. System managers completed actions on the following AIB recommendations to provide education for:

- Health care staff regarding their professional roles and limitations in assisting the chaplain in providing spiritual/pastoral care and counseling.[28]
- Providers regarding indications for reporting cases to the Medical Examiner.
- All staff on policy regarding photography on Federal grounds.[29]

As of October 8, 2015, system staff reported that no further baptisms had been conducted at the facility.

We found that the DNR policy in effect at the time of the event included the patient's option to suspend a DNR order during a surgical procedure but did not include other types of procedures. System managers did not produce evidence of a review of the recommendation that DNR status should be re-addressed prior to any procedure in the facility, and the November 2014 DNR policy update did not include revisions to this section.

Restroom Deaths. We substantiated the 2012 deaths of Employee 1 and Patient C that occurred in facility restrooms. We found that system managers did not address the Employee 1 AIB recommendation to improve timely employee drug testing procedures.

[28] The facility provided evidence of education of the social work staff only.
[29] The facility told us that at the time of the recommendation, the Medical Media Chief sent a memo to the Risk Manager identifying intent to take actions, however, the facility was unable to produce evidence of actions taken. In October 2015, the Interim Medical Media Chief disseminated educational information to Nurse Managers.

Employee 1. We substantiated that Employee 1 was a staff member who died from a drug overdose in a Community Living Center restroom in 2012. A nurse contacted the system police after hearing "unusual noises" coming from the locked restroom. The police unlocked the door and found Employee 1 unconscious with a pulse, irregular respiration, and evidence of drug use. Nursing staff initiated cardiopulmonary resuscitation and emergency code procedures, and the local police department responded. Life-saving and resuscitative efforts were unsuccessful.

The system's police informed the VA OIG Office of Investigations Criminal Division, which closed the case given the involvement of local police and the System Director's initiation of an AIB. The AIB determined that the patients in Employee 1's care that day received appropriate care. The AIB made recommendations regarding:

- Irregularities regarding Omnicell[30] usage and wastage records including that Pharmacy Service was "not actively reviewing processes and reports to look for drug diversion," as required.[31,32]
- Identifying and reporting impaired employees.
- Complex local process "for cause"[33] employee drug testing.

We found that system managers conducted an AIB consistent with VHA policies and procedures. We found that in 2013, system managers implemented specialized Omnicell software and processes to monitor drug diversion. However, a December 2014 OIG review found the system policy for safe use of automated dispensing machines did not include oversight of overrides, employee training, and minimum competency requirements for users.[34] We found that system leadership subsequently included this required information in an April 2015 policy.[35]

In March 2015, OIG Office of Audits and Evaluations recommended that the Deputy Assistant Secretary for Human Resources Management implement processes to ensure compliance with employee drug testing requirements.[36] System leadership implemented a training program for supervisory and frontline staff that was consistent with the VA Drug-Free Workplace Program.[37] System managers provided us with a

[30] An Omnicell is an automated medication-dispensing machine.
[31] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock,)*, November 16, 2010.
[32] VA North Texas Health Care System Memorandum No. 00-14, *Inspection of Controlled Substances, and Alcohols*, March 22, 2011.
[33] Reasonable Suspicion Testing of employees can only be initiated when there is suspicion of drug use based on criteria thereby identifying the testing "for cause."
[34] VA Office of Inspector General, Office of Healthcare Inspections, *Combined Assessment Program Review of the VA North Texas Health Care System*, Dallas, Texas, (Report No. 14-04223-100, February 5, 2015).
[35] VA North Texas Health Care System Memorandum 119-17, *Omnicell Automated Dispensing System*, April 17, 2015.
[36] VA Office of Inspector General, Office of Audits and Evaluations. *Audit of the Drug-Free Workplace Program*, (Report No. 14-02383-175, March 30, 2015).
[37] VA Handbook 5383/3, *VA Drug-Free Workplace Program*, December 1, 2008. This Handbook was in effect at the time of the event discussed in this report. VA Handbook 5383/5, *VA Drug-Free Workplace Program*, November 20, 2012 outlines current requirements.

description of a process for reasonable suspicion testing consistent with the VA Drug-Free Workplace Program. However, staff told us that inefficiencies in the process were ongoing including delays in obtaining drug test results. As of December 2015, the Drug Program Coordinator, Human Resource Officer, and System Director were aware of the issues and developing a strategic plan.

Patient C. Patient C was a male outpatient in his 60s who committed suicide in a facility restroom in 2012. He had been to the facility for a visit in 2002 and again in 2003. Patient C received private care for multiple chronic medical conditions.

In 2012 (Day 1), Patient C went to the facility to establish mental health treatment. In response to a psychiatrist's routine triage evaluation questions about safety, Patient C reported having access to firearms. The psychiatrist provided education on gun safety and limiting access to firearms and weapons. Based on his evaluation, the psychiatrist determined that Patient C was at low risk for harm to self or others and referred Patient C for mental health treatment. On Day 16, a social worker and a second psychiatrist each evaluated Patient C and both concluded that Patient C was at low risk for suicide. The social worker documented that the patient owned a gun and discussed gun safety and provided Patient C with information including the VA National Suicide Prevention Hotline number, mental health urgent care options, and VA and Community resources. The second psychiatrist referred the patient to psychology services for treatment.

Over the next 3 months, Patient C attended several appointments at the facility. During that time, the second psychiatrist completed a medication review and the psychologist provided psychoeducation regarding stress reduction and informed a social worker that Patient C wanted housing assistance to relocate.[38] Patient C had good insight and engaged in problem solving about his living and financial situations.

On Day 86, Patient C arrived at the facility—without an appointment—carrying a travel bag with a gun, entered a first floor pharmacy restroom, and committed suicide by self-inflicted gunshot. The patient had a suicide note with him at time of death. After a visitor found the patient, staff initiated emergency code procedures, and the local fire and police departments responded. Life-saving and resuscitative efforts were unsuccessful.

On the day of Patient C's death, the System Director and police contacted the VA OIG Office of Investigations. System managers also completed an incident report, issue brief, peer review, and an RCA. We reviewed these documents and determined that system leadership conducted the required reviews.

Issue 2: Quality of Care Irregularities

Patient D Fell From a Gurney and Injured Employee 2. We did not substantiate that Patient D fell from a gurney when staff attempted to move him from a small room into a

[38] On Day 69, the social worker left the patient a voice message requesting a call back to discuss housing.

larger space to perform cardiopulmonary resuscitation. However, we found that during staff transport of Patient D, the wheel of a bariatric hospital bed[39] rolled over and injured Employee 2's foot. We reviewed the system managers' follow-up and found that they conducted the required administrative and follow-up actions.

Patient D, a man in his 60s, was admitted to the facility through the Emergency Department in 2013 (Day 1), after suffering from complications of multiple chronic medical conditions. Patient D weighed over 350 pounds, and facility staff provided him with a bariatric hospital bed. On Day 5 of the patient's facility stay, he suffered a cardiac arrest, and staff performed successful cardiopulmonary resuscitation. During Patient D's transfer to the intensive care unit, the bariatric bed did not fit through the doorframe. In the process of attempting to get the bed through the doorway, it rolled over a nurse's foot, causing injury. The patient did not suffer harm.

System managers and staff filed relevant reports, including employee injury and incident reports. System managers provided education for nursing and bed management to ensure assignment of appropriately large rooms to patients in bariatric hospital beds.

Poor Wound Care. Based on interviews and system-provided wound-care data, we did not substantiate the allegation that wound care was poor during our site visit in May 2014. However, in 2013, system managers identified an increase in pressure ulcer prevalence and focused on facility prevalence compared to the VISN and National. Based on the data, system managers implemented an initiative at the beginning of calendar year 2013 that targeted wound assessments and management. This initiative included nurse education, training and designation of unit Wound Care Champions and Resource Nurses, and forming inter-professional workgroups. Nursing leadership also delegated basic wound care to unit nurses (rather than wound care specialists) to allow the specialists to focus on serious cases.

In February 2013, system managers noted an increase in wound prevalence rates and attributed the increase to the new initiatives and better assessment and reporting skills. National data indicated that the facility had lower rates of pressure ulcers over the 3-year period (June 2012–June 2015) as compared to the VISN or national rates.[40]

Nursing leadership identified two patient cases in which wound care management was substandard for the period of approximately 2 years prior to our site visit. Nursing leadership reported system managers took appropriate administrative action. In 2013, system managers discontinued individual unit tracking of pressure ulcers and initiated a centralized reporting procedure. The centralized report aggregated pressure ulcer data in order to track facility-wide trends and target performance improvements.

[39] A bariatric hospital bed is an oversized bed designed for larger patients.
[40] The Strategic and Analytics for Improvement and Learning (SAIL) includes a 3-year Patient Safety Index measure (PSI 3) that monitors pressure ulcer rates. http://www.va.gov/QUALITYOFCARE/measure-up/SAIL_definitions.asp, Accessed November 13, 2015.

The facility's Infection Prevention and Control Acting Program Director told us that the internal monitoring indicated that most wounds were not hospital acquired.[41] System policy provided clinical guidelines for post-surgical care of incision sites and Wound Care Team consultants are available.

LVNs Pushed IV Medication. Based on our interviews and documentation review, we did not find evidence that facility LVNs pushed IV medications.[42,43]

As required by VHA, an LVN Professional Standards Board at the system oversees LVN hiring, practice, and personnel actions.[44] According to the system's policy, LVNs who have demonstrated competency to administer IVs without additives and Pharmacy are allowed to prepare piggybacks[45] through an IV line already in place and running. However, only registered nurses can administer medication via the IV push method.[46] The system's LVN functional statement does not include the administration of antibiotics, blood products, or intravenously pushed medications. Unit nurse managers and staff articulated an understanding of LVN duties and could not identify any instances in which LVNs administered IV medications. We found that functional statements, position descriptions, and the system's drug policy and procedures were consistent with current practice.

Nursing staff (registered nurses and LVNs) who we interviewed consistently denied LVN administration of IV medication. Beginning in 2014, the Clinical Practice Committee proposed expanding LVN privileges to include administration of certain IV medications. This proposal was approved in July 2015. According to August 28, 2015 Nursing Leadership Council Minutes, the Nurse Executive Committee discussed "LVN training and preparation…to begin [IV and epidural] medication dispensing."

[41] CDC, Identifying Healthcare-associated Infections (HAI) for NHSN Surveillance, http://www.cdc.gov/nhsn/PDFs/pscManual/2PSC_IdentifyingHAIs_NHSNcurrent.pdf. Accessed November 18, 2015.
[42] Institute of Safe Medicine Practice. (2015). Safe Practice Guidelines for Adult IV Push Medications, page 19. "IV Push" is defined as "Direct manual administration of a medication using a syringe, usually under pressure, connected to an IV access device; this may include a manually administered IV "bolus" dose in an emergency." https://www.ismp.org/tools/guidelines/IVSummitPush/IVPushMedGuidelines.pdf Accessed November 18, 2015
[43] Healthline. (2013). Intravenous Medication Administration. "Sometimes, an IV medication is given as a "push" or "bolus" dose with a syringe directly into the vein. More often, an IV "line" or peripheral venous catheter (PVC) is inserted for quick and safe access over time http://www.healthline.com/health/intravenous-medication-administration#Definition1 Accessed November 18, 2015.
[44] VANTHCS System Memorandum No. 118A-05, *Appointment of Licensed Vocational Nurse (LVN) Professional Standards Board (PSB),* Accessed May 21, 2014.
[45] A piggyback is "a device [used in] the IV delivery of fluids and drugs being infused at different rates; in such devices, the reservoir and the valve controlling the rate of delivery are separate, while the delivery port—for example, an IV access line—is shared." http://medical-dictionary.thefreedictionary.com/piggyback+device. Accessed January 12, 2016.
[46] VANTHCS *Drug Policy and Procedures* 2013, §3(1-6). August 14, 2013.

Conclusions

We substantiated the 2012 death of Patient A after an unreported fall in x-ray and found that system managers disclosed the circumstances of the fall to the patient's family. We identified quality of care concerns related to the timely completion and interpretation of imaging study results for Patient A. We substantiated the 2011 death of Patient B following baptism in the spinal cord injury pool. We found that system leadership did not follow up on a review recommendation for the DNR policy to include re-addressing DNR status with a patient prior to any procedure in the hospital.

We also substantiated that in 2012, Employee 1 died by overdose and Patient C died by a self-inflicted gunshot wound in facility restrooms. We found that system leadership did not address a recommendation to improve timely employee drug testing procedures. We substantiated that Employee 2 was injured during a 2013 bed transport. However, we found that the system's leadership was aware of these events and, for each case, conducted internal reviews and took appropriate follow-up actions.

We did not substantiate the allegation that Patient D fell from a gurney in 2013. We did not substantiate that wound care was poor during our site visit in May 2014; however, facility staff identified an increase in pressure ulcer prevalence in 2012 and had since implemented several new initiatives in this area. We found no evidence that facility LVNs were pushing IV medications.

Recommendations

1. We recommended that the System Director ensure that the care of Patient A is evaluated, including a review of computerized tomography scan orders and imaging study results, and take action if appropriate.

2. We recommended that the System Director consider revising the Do Not Resuscitate Policy to include re-addressing Do Not Resuscitate orders status with patients prior to any procedures in the hospital.

3. We recommended that the System Director ensure timely compliance with all elements of the Drug-Free Workplace Program.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 11, 2016

From: Director, Veterans Integrated Service Network 17 (10N17)

Subj: Healthcare Inspection—Administrative Response to Deaths and Quality of Care Irregularities, VA North Texas Health Care Service, Dallas, Texas

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

Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings in this report.

2. Should you have any questions, please contact Deanna Boyer, Chief, Quality, Safety, & Value at (214) 857-0200.

Joseph Dalpiaz
Network Director, VISN 17

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: March 11, 2016

From: Director, VA North Texas Health Care System (549/00)

Subj: Healthcare Inspection— Administrative Response to Deaths and Quality of Care Irregularities, VA North Texas Health Care Service, Dallas, Texas

To: Director, VA Veterans Integrated Service Network 17 (10N17)

1. I have reviewed and concur with the findings in this report. Specific corrective actions have been provided for the recommendations.

2. Should you have any questions, please contact Deanna Boyer, Chief, Quality, Safety, & Value at (214) 857-0200.

(original signed by:)
Eric Jacobsen, FACHE, MHA
Acting Director

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 System Director ensure that the care of Patient A is evaluated, including a review of computerized tomography scan orders and imaging study results and take action if appropriate.

Concur

Target date for completion: April 13, 2016

Facility response: All elements of the case were reviewed by multiple different committees and groups. The reviews included scheduling, communication, and clinical care. Members of the disclosure panel state that all aspects of the case were appropriately discussed in the institutional disclosure with family members.

After this case, the Radiology service set expectations for the technicians to run reports identifying any pending STAT studies at the beginning and end of every shift in order to identify any STAT orders that may not have been communicated directly to the Radiology department. Facility discussions and education on provider expectations for STAT orders and consults have been ongoing and repeating. In addition, our next meeting of all medical staff will include our expectations that all inpatient STAT orders or consults are accompanied with direct communication to the service that would provide the procedure or care.

Recommendation 2. We recommended that the System Director consider revising the Do Not Resuscitate Policy to include re-addressing Do Not Resuscitate orders status with patients prior to any procedures in the hospital.

Concur

Target date for completion: March 11, 2016

Facility response: This case and our current policies were again reviewed. Our current policy does require a review of Do Not Resuscitate (DNR) orders prior to surgery or other significant procedures. Baptism was not considered to have a significant risk for injury, and the veteran was not questioned before the baptism about his prior choice to be DNR.

As a comparison, the risk of exercise in someone with a normal heart is considered to be a 1 out of 100,000 chance for heart attack, arrhythmia, stroke, death. For this patient, who has no record of a cardiac medical issue in our local chart, the baptism would have been less or equal stress to an episode of exercise, hence associated with 1 in 100,000 or less chance of an event. This patient's care has been reviewed multiple

times by various groups. In this terminal patient who had chosen to have a DNR order and had requested to be baptized before he died VANTHCS does not believe that a repeat discussion of his DNR status was necessary prior to his baptism.

Recommendation 3. We recommended that the System Director ensure timely compliance with all elements of the Drug-Free Workplace Program

Concur

Target date for completion: April 30, 2016[47]

Facility response: While working under the authority of VA Handbook 5383 Drug Fee Workplace, John Henderson, Chief of HR, attests to current compliance with reasonable suspicion protocol. In addition, Mr. Henderson will create a local policy and is pursuing a permanent designated HR specialist to serve as DFWP coordinator, in place of the temporary staff currently serving. Current action plan is to work with Ambulatory Care to hire a permanent occupational health provider who can also serve as the MRO. Consistency of processes and timeliness of results is the ultimate goal. Many of the duties to include Human Resources and Occupational Health have recently been covered by collateral or temporary duty personnel. The meeting with Ambulatory Care/Occupational Health is set for March 22, 2016 and the current processes of collecting drug testing samples and following the DFWP protocol will be reviewed and a forward looking action plan will be produced as initiated by Human Resources. HR Employee Relations currently provides guidance to supervisors on a just in time basis when reasonable suspicion is being considered. This process is working at this time.

[47] System leaders designated target dates for completion of proposed action plans at the time they submitted responses to the OIG draft report. OIG will monitor completion of the action(s) through its follow-up process.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Alison Loughran, JD, RN, Team Leader Jennifer Christensen, DPM, Team leader Terri Julian, PhD Melanie Oppat, LDN, MEd George Wesley, MD

Appendix D

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