DEPARTMENT OF VETERANS AFFAIRS

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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center

New York

HEALTHCARE INSPECTION | REPORT # 17-03347-285 | SEPTEMBER 18, 2018

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations made regarding patient abuse and neglect in a community living center (CLC) at the Northport VA Medical Center (Facility), New York. The complainant made the following allegations.

- A patient died at one of the Facility's four CLCs (CLC 3) due to patient abuse and neglect:
  - The patient fell while wearing improper shoes and required surgery [to repair a hip fracture sustained in fall].
  - The patient failed to receive medication to prevent blood clots.
  - A nursing assistant (NA) who was assigned to provide one-to-one (1:1) observation failed to provide proper observation during the shift when the patient had a medical emergency and died.
- Facility managers failed to respond to reported issues on the unit:
  - A Nurse Manager received complaints about staff behaviors that negatively impacted patient care and failed to take corrective actions.
  - Managers tried to cover up the circumstances surrounding the patient's death.

The OIG substantiated that a patient died at the Facility. The Suffolk County Medical Examiner determined that the patient died as a result of high blood pressure and heart disease, complicated by a hip fracture from a fall.

The OIG substantiated that the patient fell while living in CLC 3 and required surgery due to a hip fracture sustained during the fall. The OIG did not substantiate that the patient's fall was caused by lack of appropriate fall precautions. Facility staff assessed the patient's fall risk upon admission to the CLC and at each subsequent reassessment point and assigned a level three fall risk, which indicated a high risk for falls. The Facility had the proper fall risk precautions in place and the patient was wearing non-slip footwear at the time of his fall. Therefore, the OIG did not substantiate that the patient's death was caused by abuse or neglect.

The OIG substantiated that the patient did not receive anticoagulation injections to prevent blood clots following surgery for hip fracture per Facility protocol. The OIG did not substantiate that the failure to receive three of the four doses of anticoagulation medication during the hospital stay contributed to the patient's death. Because the patient did not die of a blood clot, which may have been prevented by anticoagulation, the missed doses likely had no impact on the patient's death.

The OIG team determined that the patient missed three of the four doses of the anticoagulation medication during the hospital stay—one dose due to the order being auto-discontinued during a unit transfer and not reordered by the provider and two doses due to the patient declining the injection. The auto-discontinuation rules in place at the time required Orthopedic Service providers to rewrite their own orders with each patient transfer. This increased the potential for human error, such as omitting the rewriting of a necessary order. The Facility has since added Orthopedic Service to the exemption list for the auto-discontinuation rule that now allows orders to remain active during transitions in care from the operating room to the Intensive Care Unit and the Intensive Care Unit back to Orthopedic Service.

The OIG was unable to substantiate or not substantiate that an NA assigned to perform 1:1 observation failed to provide proper observation during the shift when the patient died, because the OIG team was unable to resolve discrepancies between Facility documentation and interviews. The NA reported remaining at the patient's bedside within arm's length and observing the patient the entire shift except for two breaks and a 30-minute meal; however, the NA's 24-Hour Observation Flow Sheet documentation does not support this statement. The registered nurse working the night shift at the time of the incident stated there was no evidence of inattention on the part of the NA.

A review of literature indicates concern that working extra hours with double shifts could lead to staff becoming tired and less vigilant. The NA assigned to 1:1 observation for the patient during the shift when the patient died was working a double shift (16 hours) for the sixth consecutive day. Colleagues with a history of working with the NA expressed no concerns about the NA's alertness while working extra shifts. The extensive hours worked by a single employee assigned to 1:1 observation was identified by the Facility as a concern. As a result, a change in practice was implemented which limited the number of consecutive hours any one employee may be assigned to perform 1:1 observation.

The OIG did not substantiate that the CLC 3 Nurse Manager received complaints about staff behaviors that negatively impacted patient care or that the Nurse Manager failed to take corrective action. The Nurse Manager denied awareness of staff behavior issues that could negatively impact patient care, such as sleeping or using personal devices while providing 1:1 observation. A review of emails found no evidence that management received written complaints of staff behaviors that compromised patient care. However, a nursing supervisor stated that some issues may go unreported in part because staff were reluctant to complete a report of contact documenting an incident.

The OIG did not substantiate that Facility leaders or managers tried to cover up the circumstances surrounding the patient's death. The Facility quality management staff performed reviews of the patient's care as required by VHA policy. However, the OIG team's study of the facts of the patient's case indicates that the missed anticoagulation injection doses were not

addressed in the Facility's quality management review. The treating physicians provided briefings to the patient's family during the course of the patient's care.

The Facility has a new Director, acting Chief of Staff, and acting Nurse Executive. During discussions of the patient's case, Facility leaders shared their goals of increasing transparency and the visibility of leadership, rebuilding trust, and encouraging a culture where staff feel comfortable sharing their concerns with their immediate managers.

The OIG made three recommendations related to reviewing the accuracy of 24-Hour Observation Flow Sheets, conducting an updated quality management review of the patient's case, and consulting the Office of General Counsel about missed anticoagulation doses and institutional disclosure to the patient's family.

Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 19–22, for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

ADL	activities of daily living
CLC	community living center
CPR	cardiopulmonary resuscitation
ED	Emergency Department
EHR	electronic health record
ERT	Emergency Response Team
FY	fiscal year
ICU	Intensive Care Unit
M&M	Mortality and Morbidity
NA	nursing assistant
OIG	Office of Inspector General
PM&R	Physical Medicine and Rehabilitation
RN	registered nurse
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding patient abuse and neglect in one of the community living centers (CLC) at the Northport VA Medical Center (Facility), New York.

Background

The Facility is part of Veterans Integrated Service Network (VISN) 2 and provides medical, surgical, psychiatric, rehabilitative, and long-term care. In fiscal year 2016, the Facility served more than 31,000 patients and had a total of 381 operating beds, including 173 inpatient beds (12 of which are Intensive Care Unit (ICU) beds), 38 domiciliary beds, and 170 CLC beds. The Facility is affiliated with the Stony Brook School of Medicine in Stony Brook, New York, and maintains fully integrated residency programs in general medicine, surgery, anesthesiology, dermatology, pathology, and rehabilitation medicine.

CLCs

The Facility CLCs provide short to long term care to patients with a variety of medical conditions who need assistance with activities of daily living (ADL)[1] and/or skilled nursing or medical care. The Facility has four CLCs, and patients[2] are assigned to each CLC based on their medical condition and individual care needs. CLC 3 is a specialized locked unit for patients who wander, exhibit aggressive behaviors, present elopement risks, and/or show significant cognitive impairment that places them at risk of injury. CLC 3 has a maximum capacity of 30 patients.

Special Status Observation

Facility policy defines Special Status as "A status of intensive, continuous observation of a patient by an exclusively designated properly trained nursing staff member." There are varying levels of increased monitoring, ranging from checking on a patient at 15-minute intervals, to continuous visual observation by staff, to trained nursing personnel remaining within close

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[1] VHA Handbook 1142.01. *Criteria and Standards for VA Community Living Centers (CLC).* August 13, 2008. This handbook was scheduled for re-certification on or before the last working day of August 2013 but has not been re-certified. "ADLs include: grooming, bathing, dressing, personal hygiene, toileting, eating, and mobility. This may also include transfers from one location to another (moving in bed, sitting, and standing)."

[2] All veterans who reside in a CLC are typically referred to as residents. However, since this report will be discussing patient care provided by Medicine and Surgery resident doctors, to avoid confusion, the term "patient" will be used to describe CLC patients and the term "resident" will be used to describe resident doctors.

proximity to the patient. One-to-one (1:1) observation is often used for patients presenting with potentially dangerous behaviors, such as suicidality, wandering or elopement risk, aggressive behaviors, high agitation, or interfering with medical therapies (such as pulling out lines or tubes).[3] Additionally, 1:1 observation may be used for patients who are at risk for failing to adhere to postsurgical precautions, such as movement restrictions, particularly when coupled with factors such as confusion, delirium, or dementia, which may limit patients' awareness of their physical limitations, thus increasing their risk for accidental injury.[4]

Anticoagulation Medications

Anticoagulation medications are a class of drugs that work to prevent the clotting of blood. Providers use anticoagulation medications for the treatment and prevention of cardiac disease, cerebrovascular accidents (strokes), and blood clots in both inpatient and outpatient settings. Blood clots can form in the deep veins of individuals who have certain medical conditions, surgical procedures, or long periods of immobility. Clots may dislodge from deep veins and travel to the lungs. Blockage of blood flow in the lungs by a detached blood clot is known as pulmonary embolism. Small clots may cause lung damage and symptoms such as shortness of breath or chest pain, while larger clots can be fatal.

The American Academy of Orthopaedic Surgeons evidence-based guidelines recommend the use of anticoagulation medications for preventing blood clots in patients who undergo hip and knee surgery.[5] Starting blood thinners, such as enoxaparin anticoagulation injection, early in postoperative patients has been associated with significant reductions in blood clot formation and reduced risk for pulmonary embolism.[6] Missed doses in a planned anticoagulation medication regimen are common in the hospital setting.[7] Review of literature suggests that approximately

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[3] Rochefort, C.M., Ward L., et al., Patient and nurse staffing characteristics associated with high sitter use costs. *J Adv Nurs.* 2012 Aug;68(8):1758-67. https://www.ncbi.nlm.nih.gov/pubmed/22050594. (The website was accessed on November 20, 2017.)

[4] Rochefort, et al; Nadler-Moodie, et al; Laws, D. & Crawford, C. Alternative Strategies to Constant Patient Observation and Sitters. *J Nurs Adm*. 2013 Oct;43(10):497-501. https://www.ncbi.nlm.nih.gov/pubmed/24061581. (The website was accessed on November 20, 2017.)

[5] American Academy of Orthopaedic Surgeons. Preventing Venous Thromboembolic Disease in Patients Undergoing Elective Hip and Knee Arthroplasty. Evidence-Based Guideline and Evidence Report. 2011.

[6] Agaba, Kildow, et al., Comparison of postoperative complications after total hip arthroplasty among patients receiving aspirin, enoxaparin, warfarin, and factor Xa inhibitors. *J Orthop*. 2017 Aug 14;14(4):537-543. https://www.ncbi.nlm.nih.gov/pubmed/28878512. (The website was accessed on December 2017.)

[7] Louis, Sato, et al., Correlation of missed doses of enoxaparin with increased incidence of deep vein thrombosis in trauma and general surgery patients. *JAMA Surg*. 2014 Apr;149(4):365-70. https://www.ncbi.nlm.nih.gov/pubmed/24577627. Connelly, Van, et al., Thrombelastography-Based Dosing of Enoxaparin for Thromboprophylaxis in Trauma and Surgical Patients: A Randomized Clinical Trial. *JAMA Surg*. 2016 Oct 19;151(10):e162069. https://www.ncbi.nlm.nih.gov/pubmed/27487253. (The websites were accessed on June 25, 2018.)

half of patients who are prescribed anticoagulation medications miss at least one dose. Patient medication refusal is a leading cause[8] of missed doses of anticoagulation medication in inpatients, and missed doses significantly increase risk for blood clots.[9]

Medication Reconciliation at Transitions in Care

"Medication reconciliation identifies and resolves unintentional discrepancies between patients' medication lists across transitions in care."[10] Medication discrepancies are common. While research suggests that the majority of patients experience no significant harm as a result, the potential for harm exists, and the process of medication reconciliation is widely endorsed and mandated by healthcare accreditation bodies in the U.S. that include the World Health Organization and The Joint Commission.

VHA's directive on medication reconciliation outlines expectations to ensure accurate, safe, effective, and patient centered medication information achieved through the communication of relevant medication information to and between members of the VA healthcare team.[11]

At a minimum, medication reconciliation at transitions in care for inpatients should involve provider review of all medications in use prior to transfer and the correction of any discrepancies between the patient's previous medication list and the proposed medication orders. Enhanced medication reconciliation may include provider collaboration between sending and receiving physicians, nursing or pharmacy staff integration of medication lists into discharge summaries and prescriptions, and the provision of medication counseling to the patient or patient's family.

Auto-Discontinuation of Orders

Auto-discontinuation of orders is an electronic process that involves the automatic discontinuation (cancellation) of orders for a patient once that patient is transferred from one location to another or from one level of care to another. The Facility Clinical Executive Board determines which orders are subject to auto-discontinuation and which transfers of care

[8] Patients miss doses for various reasons, including preoperative interruption, patient refusal, and provider errors.

[9] Haac, Bryce et al., Patient Preferences for Venous Thromboembolism Prophylaxis After Injury: a Discrete Choice Experiment. *BLM Open* 2017, 7:e016676. https://www.ncbi.nlm.nih.gov/pubmed/28801426. (The website was accessed on December 11, 2017.)

[10] "Transitions in care include admission, transfers between services and discharge from the hospital." Kwan, MD Janice L. et al., Medication Reconciliation During Transitions of Care as a Patient Safety Strategy. *Annals of Internal Medicine* 2013; 158:397-403. https://www.ncbi.nlm.nih.gov/pubmed/23460096. (The website was accessed on December 7, 2017.)

[11] VHA Directive 2011-012, *Medication Reconciliation,* March 9, 2011. This directive expired March 31, 2016, and has not been replaced.

trigger the process. There are exclusions, and certain orders, such as Do Not Resuscitate orders,[12] may follow the patients throughout their continuum of care regardless of transfers.

Following inpatient transfers, the auto-discontinuation of medication orders requires the receiving provider to assess the patient, determine which medications are needed, and write new orders that are appropriate for the patient's continuing care. While this step introduces the possibility of human error, such as attention or memory failure causing a provider to miss writing or rewriting an order, auto-discontinuation reduces the likelihood of continuing a medication that is no longer warranted and shifts responsibility for orders to the receiving provider during transitions in care.

Fall Risk Assessment

Falls that result in injury are a prevalent patient safety problem.[13] The National Council on Aging says, "Patient falls are the leading cause of fatal injury and the most common cause of nonfatal, trauma-related hospital admissions among older adults."[14]

The Facility's Nursing Service Memo[15] Fall Prevention/Reduction Policy states that "The veteran is assessed upon admission utilizing the Morse Fall Scale Assessment Tool to determine possible risk for falls." It further states, "[t]he veteran is reassessed [utilizing the Morse Fall Scale Assessment Tool] upon any significant change in condition, transfer, or following the occurrence of a fall."[16] The Morse Fall Scale Assessment Tool assigns a point value[17] for each of several risk factors or diagnoses.[18] The total score is used to assign a Fall Prevention Care Level for the patient. Level one reflects low-risk for falls, while level three reflects high-risk for falls. Precautions for a patient identified with level three fall risk in the CLCs include use of non-slip

[12] A "Do Not Resuscitate" order is a medical order written by the provider instructing the care team of the patient's wishes to have no cardiopulmonary resuscitation if the patient stops breathing or if the patient's heart stops beating. https://medlineplus.gov/ency/patientinstructions/000473. (This website was accessed on June 5, 2018.)

[13] The Joint Commission Sentinel Event Alert, Issue 55, September 28, 2015.

[14] National Council on Aging, *Falls Prevention Facts*. https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/. (The website was accessed on June 5, 2017.)

[15] Facility Nursing Service Memo C-5, *Fall Prevention/Reduction Policy,* October 3, 2014.

[16] The Morse Fall Scale Assessment Tool is a template found in the patient's EHR that is used to determine the fall risk category for each patient upon admission, on any transfer from one unit to another within the Facility, upon any change in the patient's status, or following a fall.

[17] Numerical scores starting at 0 are given based on a number of variables that are used to determine the fall risk category for each patient. Depending on the number of qualifying criteria, a patient may be assigned a score of 0-150.

[18] Risk factors that can affect score include: history of falling; use of cane, walker, or crutches; and weakness. Diagnoses that can affect score include: dementia; postsurgical status; postural hypotension; seizure disorder; and certain medications that may cause dizziness or unsteady gait.

footwear, lowered bed position, assistance from nursing staff for transfers and ambulation as needed via a bedside call bell, and periodic observation by staff for patient comfort rounds.

Allegations

The OIG received allegations from an anonymous complainant[19] who identified the patient of interest.

- A patient died at the Facility's CLC 3 due to patient abuse and neglect:
  - The patient fell while wearing improper shoes and required surgery [to repair a hip fracture sustained in the fall].
  - The patient failed to receive medication to prevent blood clots.
  - A nursing assistant (NA) assigned to provide 1:1 observation failed to provide proper observation during the shift when the patient had a medical emergency and died.
- Facility managers failed to respond to reported issues on the unit:
  - A Nurse Manager received complaints by staff about staff behaviors that could negatively impact patient care and failed to take corrective action.
  - Facility managers tried to cover up the circumstances of the patient's death.

[19] The complainant was anonymous. As such, some aspects of these allegations were limited by the Team's inability to clarify the complainant's intent or request additional information.

Scope and Methodology

The OIG initiated a healthcare inspection on September 27, 2017, and conducted a site visit October 16–20, 2017.

The OIG team (Team) reviewed the identified patient's electronic health record (EHR) from admission to the CLC to the date of death, with particular focus placed on the care provided in summer 2017. The Team reviewed relevant medical literature, The Joint Commission standards, VHA and Facility policies, nurse staffing schedules and assignments, and internal reviews. The Team also reviewed the patient's Medical Examiner's Report.

The OIG reviewed over 8,600 emails of relevant management staff for a nine-month period in 2017, using key terms, such as "sleeping," "asleep," "phone," "personal devices," "overtime," and specific staff names.

The Team interviewed staff members, including physician and nursing staff, who provided care in the CLC, Emergency Department (ED), operating room (OR), and Psychiatry, Orthopedic, and Physical Medicine and Rehabilitation (PM&R) Services. The Team interviewed members of the Emergency Response Team (ERT) who responded to the code in the CLC. The Team also interviewed Facility staff from Health Informatics Management Service, Pharmacy, and Health Administration Service to gain an understanding of the processes and practices governing provider orders, particularly those related to medications, during transitions of care. The Team held discussions with representatives from VA's National Center for Patient Safety, Office of Health Informatics, and Pharmacy Benefits Management Service to gain an understanding of national guidance related to medication reconciliation and auto-discontinuation of medication during transitions of care.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to substantiate or not substantiate an allegation when the available evidence is insufficient to determine whether or not an alleged event or action took place.

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

Case Summary

A mid-60s patient, with a history of psychiatric issues including dementia and specific medical conditions was admitted to CLC 3 in 2016. The patient met the criteria for CLC 3 due to a diagnosis of dementia. The patient had an unsteady gait and was on medications that predisposed falling, and the patient ambulated by wheelchair most of the time. The CLC staff had implemented fall interventions as the patient was assessed to be at high-risk for falls.

On a morning in summer 2017 (Day 1), the patient was transported by the ERT to the ED for evaluation of chest pain. The ED physician diagnosed the patient with pleurisy (inflammation of the lung lining) after obtaining a chest x-ray, laboratory tests, and an electrocardiogram. The patient returned to CLC 3. Around mid-afternoon, an NA found the patient on the floor. The patient was unable to stand and had low blood pressure.

The ERT transported the patient back to the ED for an evaluation after the fall. However, the patient declined a hip x-ray. A psychiatrist evaluated the patient and deemed that the patient lacked understanding of the circumstances. Therefore, the patient had no capacity to refuse the x-ray, and the x-ray was performed. The ED physician diagnosed the patient with a hip fracture and documented that there might have been an infection that contributed to the fall.[20] The patient was admitted to the Facility under the care of the inpatient Medicine Service providers for preoperative evaluation on a medicine unit, with plans for surgery the next day.

On Day 2, staff transferred the patient from the Medicine Service to the OR for surgery. While the patient was in the OR, the Orthopedic Service surgery resident[21] entered the original order for anticoagulation[22] medication to start on Day 3. Following surgery, the patient was transferred from the OR to the ICU. During this transfer, all orders, including the original anticoagulation order, were auto-discontinued. The Orthopedic Service surgery resident re-entered the orders but did not re-order the anticoagulation medication.

On Day 3, there was no active order for anticoagulation medication in the ICU, and the patient did not receive anticoagulation medication. On the same day, the patient was transferred from the ICU to a medical/surgical unit and continued to be followed by Orthopedic Service providers. Orders were once again auto-discontinued and rewritten by the Orthopedic Service surgery resident. Anticoagulation medication was not included in these orders.

[20] Infection may lead to dehydration which may predispose patients to falls.

[21] Residents are physicians who have graduated from medical school and finished at least one year of post-graduate training, but who are still in residency training.

[22] Patients are at increased risk of developing blood clots after surgery, especially if they are bed bound. Anticoagulation with medication that thins the blood can lower the risk of patients developing a clot.

On Day 4, early in the morning, the Orthopedic Service surgery resident added an order for daily anticoagulation medication. The patient was transferred from the Orthopedic Service to the PM&R Service on the same unit. The patient continued to have an active order for anticoagulation medication given by injection. On Day 4, a nurse attempted to administer the anticoagulation medication injection, but the patient declined the injection. The nurse notified the PM&R physician.

On Day 5, a nurse attempted to administer the anticoagulation medication and the patient again declined the injection. The PM&R physician was notified of the patient's refusal. In the afternoon, staff transferred the patient back to CLC 3 due to an inability to tolerate the intensity of inpatient rehabilitation. The orders were discontinued and rewritten by the CLC 3 provider. The CLC 3 provider reordered the anticoagulation injections. The provider also ordered 1:1 observation for adherence to postoperative precautions.

On the patient's first full day back at CLC 3 (Day 6), the patient received the first dose of anticoagulation injection. Due to concerns of possible infections, antibiotic medication orders were continued.[23] There were multiple attempts made to place an IV for delivery of the antibiotic medication. The patient received most of the antibiotic medication before the IV stopped working. Although the EHR stated that the patient did not seem to understand the need for the antibiotics, the patient did not wish to receive any more "pokes." The ED physician called the Infectious Disease physician, who recommended discontinuing antibiotics because the bacteria found in the blood culture was likely a contaminant.[24]

That same evening, the patient returned to CLC 3 and declined the meal. At 9:48 p.m., the patient received oral pain medication. The 24-Hour Observation Flow Sheet (flow sheet) completed by the NA assigned to 1:1 observation noted that the patient slept or rested throughout the night, and the NA repositioned the patient at 4:45 a.m. The registered nurse (RN) noted that at 5:55 a.m., the NA informed the RN that the patient had stopped breathing. The nursing staff initiated resuscitation and called for ERT. Five minutes later, the ERT arrived at CLC 3.

[23] The patient received one dose of antibiotics while in the ICU due to concerns about an infection causing the fall. However, the physician documented that the positive blood cultures drawn in the ED might have been contaminated and recommended holding further antibiotics and repeating blood cultures on Day 3. The repeat blood cultures became positive (showed presence of bacteria) on the patient's first day back in the CLC. The infectious disease physician recommended placing an IV and starting antibiotics.

[24] A blood culture contaminant is a bacterial organism that may not have been present in the patient's bloodstream but was introduced into the culture during the process of obtaining the culture leading to a false positive. Common causes for blood culture contaminants include: lack of sterility of technique while obtaining the blood specimen; site from which blood is taken (directly from a vein or from an IV site); and type of blood culture systems used. Common contaminants are organisms that are normally occurring on the skin.

At 6:07 a.m., the ERT transported the patient to the ED, where staff continued resuscitation efforts. The patient was successfully intubated at 6:15 a.m. Resuscitation efforts continued until 6:42 a.m., when the ED physician pronounced the patient dead.

Inspection Results

Issue 1: Patient's Fall and Facility's Fall Precautions

The OIG substantiated that the patient fell while living in CLC 3 and required surgery due to a hip fracture sustained as a result of the fall. However, the OIG did not substantiate that the patient's fall was caused by the Facility's lack of appropriate fall precautions. Documentation in the EHR indicates that Facility staff had the proper fall precautions in place prior to the patient's fall. The patient was wearing non-slip footwear, and there were no clinical indications at that time to necessitate 1:1 observation. Therefore, the OIG did not substantiate that the patient's death was caused by abuse or neglect.

Nursing staff assigned the patient a level three fall risk when assessed upon the admission to the CLC and at each subsequent reassessment point. The Team's EHR review and staff interviews corroborated the presence of multiple elements which could increase the patient's risk for falls, including unsteady gait and the use of a wheelchair for ambulation. Staff reported that the patient moved around the unit most often by propelling forward while sitting in the wheelchair, although the patient would sometimes walk behind it using the wheelchair for support.[25] The patient's confusion, history of seizure, and the use of certain medications also contributed to the fall risk.

Issue 2: Anticoagulation Medication Following Surgery

The OIG substantiated that the patient did not receive anticoagulation injections to prevent blood clots per Facility protocol following surgery for a hip fracture. The OIG did not substantiate that the failure to receive three of the four doses of anticoagulation medication during the hospital stay contributed to the patient's death. The Suffolk County Medical Examiner determined that the patient died as a result of high blood pressure and heart disease, complicated by a hip fracture from a fall. Because the patient did not die of a blood clot, which may have been prevented by anticoagulation medication, the missed doses likely had no impact on the patient's death. Medication orders and physician documentation in the EHR outlined a plan for the patient to receive anticoagulation medication by injection daily for a period of 30 days starting on the day following the surgery (Day 3). However, the medication administration records show the patient did not receive the first three doses. The Team determined that the patient missed one dose due

[25] EHR documentation and staff reports confirmed that prior to the fall in summer 2017, the patient had no history of falls during the stay on CLC 3.

to provider error and two doses due to the patient declining the injection. If the patient had received these intended doses, the risk of pulmonary embolism could have been decreased.[26]

Patients admitted for the treatment of a hip fracture are co-managed by providers in Orthopedic, Medicine, and PM&R Services. The patient's course of care began with the patient on Medicine Service for a preoperative evaluation. Orthopedic Service performed the surgery, and the patient was admitted to the ICU then to the inpatient Orthopedic Service. The Orthopedic Service surgery resident was responsible for writing all preoperative and postoperative orders related to the hip fracture and rehabilitation, including orders for anticoagulation medication to prevent blood clots. At each of these service transfers, auto-discontinuation of orders occurred and the orders needed to be rewritten by the Orthopedic Service surgery resident. The patient was transferred to PM&R for rehabilitation. Upon transfer to PM&R, orders were auto-discontinued. Conducting medication reconciliation[27] and writing of new orders were assumed by the PM&R physician. The patient remained in the care of PM&R until discharge from the facility. During the course of the five-day inpatient admission for the treatment of the hip fracture, the patient followed the expected course of care and was transferred[28] between services five times.[29]

OIG staff reviewed the patient's EHR and determined that the Orthopedic Service surgery resident wrote all of the initial postoperative orders while the patient was in the OR area, prior to the patient's transfer to the ICU. The orders specified that the first dose of anticoagulation injection should be given on Day 3 (postoperative day 1). Upon transfer from the OR to the ICU, the orders were auto-discontinued. The Orthopedic Service surgery resident re-entered the postoperative orders but omitted the anticoagulation injection; therefore, the patient did not receive the intended dose on Day 3.

On the evening of Day 3, the patient was transferred from the ICU to the Orthopedic Service. Because of the transfer, the patient's orders were auto-discontinued and the Orthopedic Service surgery resident wrote a new set of orders for the patient without an anticoagulation injection

[26] A patient's risk factors for pulmonary embolism include: age greater than 60 years; history of blood clots; limited mobility or bedridden; having surgery; broken bones; and history of smoking.

[27] Facility Memorandum 11-230, *Medication Reconciliation*, March 2, 2012 states "Patient medications will be reconciled in all outpatient clinics, on admission, in the Emergency Department, on transfer to an alternate level of care, and at discharge." It is the responsibility of the receiving medical provider to assess the patient, review prior medications, and ensure medication and treatment orders specific to the patient's current needs are in place upon patient transfer from another inpatient unit to a new level of care or care team.

[28] When patients are transferred from CLC 3 to the Facility, a physical transfer occurs. Administratively, the patient transfer is recorded as movement of the patient from CLC 3 to Absent Sick in Hospital to Facility Ward or Service. A discharge summary is required. When patients are transferred from the Facility Ward or Service back to CLC 3, it is recorded as Service to Absent Sick in Hospital to CLC 3. A discharge summary is required.

[29] Transfers were from CLC 3 to ED, ED to Medicine, Medicine to the operating room, operating room to ICU, ICU to Orthopedics, Orthopedics to PM&R, and discharged from PM&R to CLC 3.

order. On the morning of Day 4, the Orthopedic Service surgery resident wrote an order for daily anticoagulation injection to be given starting that morning. Within two hours of the new order, the patient was deemed stable and transferred to the PM&R Service. The PM&R physician wrote a new set of orders on Day 4 that included an order for anticoagulation injection, but the anticoagulation injection order was auto-discontinued. The PM&R physician wrote an order for the anticoagulation injection again on Day 5 but it was again discontinued, this time by pharmacy staff as a duplicate order.

The Team asked Facility staff to review the patient's auto-discontinuation process. The Facility responded that the patient transfer, which occurred two hours after the anticoagulation injection order was written by the Orthopedic Service surgery resident, was entered incorrectly by the ward clerk, and resulted in an auto-discontinuation of the anticoagulation medication. However, the ward clerk identified the patient transfer error shortly after it occurred. The transfer was canceled and corrected by the ward clerk, and the order was reinstated within minutes of the auto-discontinuation. The orders written by the Orthopedic Service surgery resident remained active until the patient was transferred back to CLC 3 on the morning of Day 5. Because the reinstated order written by the Orthopedic Service surgery resident remained active and was not discontinued until Day 5, the PM&R physician's orders were discontinued as duplicate orders when reviewed by pharmacy as part of their medication reconciliation process. These events did not adversely impact nursing staff's attempts to administer the anticoagulation injections as intended on Day 4 and Day 5.

A PM&R nurse attempted to administer the scheduled injection on Day 4 and again on Day 5 per the active order from the Orthopedic Service surgery resident, but the patient declined the medication on both days. The nurse notified the PM&R physician that the patient declined the anticoagulation injections on both occasions. The PM&R physician described the patient as agitated, combative, and refusing all treatment attempts. The patient, who had dementia, was also confused postoperatively, and the PM&R physician identified the patient's lack of familiarity with the inpatient staff and surroundings as a possible factor in the patient's behavior. The PM&R physician recommended a transfer of the patient back to CLC 3, where the staff and environment were familiar. The transfer was discussed with the patient's daughter, who concurred. Staff noted that the patient became less agitated and combative after learning of the return to CLC 3. The patient transferred back to CLC 3 on the morning of Day 5. The patient received the first dose of anticoagulation injection in CLC 3 on the following day.

The course of care for patients with hip fractures involves multiple patient transfers. The auto-discontinuation rules in place at the time of the OIG site visit required Orthopedic Service providers to rewrite their own orders with each patient transfer, which sometimes occurred the same day. This increased opportunities for human error, such as omitting the re-writing of a necessary order. In November 2017, the Facility added Orthopedic Service to the exemption list

for the auto-discontinuation rule, which allowed orders to remain active during transitions in care from the OR to the ICU and the ICU back to the Orthopedic Service.

Issue 3: One-to-One Observation of the Patient

The OIG was unable to substantiate or not substantiate that an NA assigned to provide 1:1 observation failed to provide proper observation during the shift when the patient became unresponsive and died; the Team was unable to reconcile discrepancies between Facility documentation and interviews.

When the patient returned to CLC 3, 1:1 observation was ordered by the CLC provider to ensure adherence to postsurgical precautions. Facility policy requires that the staff member who is assigned to 1:1 observation maintain continuous observation and remain within an arm's length of the patient at all times.[30] NAs are required to complete an ADL note[31] to document the care provided to the patient throughout the shift for each patient for whom they provide care. In addition to the ADL note, staff members assigned to 1:1 observation are required to document using codes specific to behavioral observations and interventions and to document patient status and care provided at 15-minute intervals on the flow sheet and initial each line of documentation. When relieving 1:1 observation staff for breaks, the relieving staff members are expected to complete and initial the flow sheet for the time period specific to when they are observing the patient. The RN on the shift assesses the patient's needs and formulates a plan of care; supervises the staff member assigned to 1:1 observation; initiates the flow sheet; and writes a Special Observation Shift Note. The RN also signs the flow sheet at the end of the shift, which documents supervision of 1:1 observation staff and the RN's assessment of the patient every two hours.

The NA, who was assigned to perform 1:1 observation for the patient during the shift when the patient died, was working a double shift (16 hours). The NA reported remaining at the patient's bedside within an arm's length and observing the patient the entire shift, with the exception of two breaks and a 30-minute meal. The NA self-described as being used to working lots of overtime shifts. The RN working at the time of the incident reported usually performing hourly rounds and had no concerns of inattention on the part of the NA that night. Colleagues who had a history of working with the NA described the NA as very energetic, and they expressed no concerns about alertness while working extra shifts. The Nurse Manager also reported that the

[30] Facility Memorandum 116A-14, *Intensive Psychiatric Observation of Patients Judged Dangerous to Self or Others*, November 4, 2015; Center Memorandum 118-04, *Continuous Visual Observation of Patients by Nursing Service Personnel*, April 9, 2015.
[31] An ADL note documents patient's disposition, fall risk, mobility/activity level, percentage meal consumption, and bowel movements. It also documents the patient care provided during that shift, including grooming, bathing, dressing, personal hygiene, and transfers from one location to another (moving in bed, sitting, and standing).

NA was accustomed to working overtime hours and extra shifts per week and had no concerns that the NA may have failed to perform proper observation during those shifts.

During the Team's review, several discrepancies were noted between the flow sheet intended to document staff observation of the patient and staff recollections of events. The day prior to the patient's death, the patient was transported to the ED on three occasions, and the NA reported accompanying the patient. However, these transports to the ED were not documented on the flow sheet. Although the NA reported being with the patient the entire shift, except for two breaks and a 30-minute meal, the NA's initials were entered across all 15-minute periods in the shift flow sheet, and there was no documentation by a second staff member to indicate the NA was gone for the reported breaks. The Team found a similar documentation pattern for three other shifts where the NA provided 1:1 observation of the patient. On the morning of the incident, the flow sheet noted that the NA assisted the patient to the bathroom at 2:30 a.m.; however, the NA recalled the activity taking place 15 minutes later. Both timelines were inconsistent with a statement written by the Nurse Manager, who documented that the NA had a one-hour break from 2:00 a.m. to 3:00 a.m. The NA stated that at 5:45 a.m. the NA repositioned the patient. The behavioral observation code documented on the flow sheet for 5:45 a.m. noted that the patient was sleeping without an intervention/care code for repositioning documented. The NA stated that at 5:55 a.m. the NA heard the patient gasp, checked for breathing, and, finding none, called for help. Cardiopulmonary resuscitation (CPR) was initiated by the nursing staff and continued until arrival of the ERT; the patient was transferred to the ED. The last behavioral observation documented on the flow sheet was at 5:45 a.m., with an additional note indicating "0610 to ER."

The RN working at the time of the incident reported usually performing hourly rounds and had no concerns of inattention on the part of the NA. However, the RN did not document a Special Observation Shift note that confirmed rounds were completed. The RN stated that the note was not completed due to the patient transfer to the ED. The RN completed two nursing notes following the patient's transfer to the ED. The notes documented the CLC staff's initiation of CPR, the call for ERT in response to the patient being unresponsive, and the patient's transfer to the ED.

In response to the documentation concerns identified through the Team's review, the Nurse Manager met with the NA and staff member who covered during the NA's breaks and provided re-education on the appropriate completion of the flow sheets.

A review of literature indicates concern that working extra hours with double shifts could lead to staff becoming tired and less vigilant.[32] The NA had worked double shifts for six consecutive days. At the time of the patient's death, the NA was 14 hours into a double shift. Following the incident, the lengthy hours worked by a single employee assigned to 1:1 observation were identified by Facility leaders as a concern. As a result, a change in practice was implemented that limited the number of consecutive hours any one employee may be assigned to 1:1 observation.

Because of the Facility staff's incomplete documentation and a lack of video evidence, the OIG was unable to corroborate verbal accounts of employee attentiveness and the events that took place on this shift.

Issue 4: Management Responses to Concerns about Staff Behaviors

The OIG did not substantiate that the CLC 3 Nurse Manager received complaints about staff behaviors that could negatively impact patient care and failed to take corrective action.

The Nurse Manager for CLC 3 denied awareness of staff behavior issues that could negatively impact patient care, such as staff sleeping or using personal devices while providing 1:1 observation. The Nurse Manager told the Team that if reports were received of concerns, such as staff falling asleep, it would have been reported. When asked how the Nurse Manager ensured that staff were ready for work, the Nurse Manager looked at staff appearance and behavior to determine fitness for duty using indicators such as obvious fatigue, disheveled appearance, or the smell of alcohol on their breath.

A nursing supervisor acknowledged that some instances of staff who fell asleep while assigned to work 1:1 observation went unreported because staff were reluctant to complete a report of contact documenting the incident.

To evaluate the possibility that complaints of staff behavior had not been addressed, the Team reviewed emails identified using specific search terms[33] for a nine-month period in 2017 and found no evidence that Facility managers received written complaints of staff behaviors that compromised patient care.

[32] Griffiths, Peter, RN, PhD; Dall'Ora, Chiara, MSc; Simon, Michael, RN, PhD; Ball, Jane, RN, MSc; Lindqvist, Rikard, RN, PhD; Rafferty, Anne-Marie, RN, DPhil; Schoonhoven, Lisette, RN, PhD; Tishelman, Carol, RN, PhD; Aiken, Linda H., RN, PhD. Nurses Shift Length and Overtime Working in 12 European Countries. *Medical Care*, November 2014; 52: 975-981.

[33] The Team reviewed Facility leaders' emails by using specific key word search terms such as "sleeping" and "personal devices."

Issue 5: Alleged Cover-up of Circumstances Surrounding the Patient's Death

The OIG did not substantiate that Facility leaders or managers tried to cover up the circumstances surrounding the patient's death. The treating physicians provided briefings to the patient's family. A Facility Quality Management staff member prepared an Issue Brief and conducted a Root Cause Analysis (RCA) related to the patient's fall.

Facility Quality Management staff also completed a fact-finding review of the patient's care from the fall through the patient's death which was reviewed by Facility managers. The Issue Brief completed after the patient's fall documented that a clinical disclosure[34] of the patient's fall would be required and that an institutional disclosure[35] was not warranted for the fall. The Orthopedic Service surgery resident performed clinical disclosure to the patient's daughter of the patient's fall, injury, and subsequent needs for medical and surgical care.

VHA Handbook 1050.01 states "An RCA is a specific type of focused review that is used for all adverse events or close calls requiring analysis."[36] VHA's National Patient Safety Handbook[37] states that an RCA must be completed within 45 days of the Facility becoming aware that an RCA is required. An RCA must be done for a patient fall with major injury. The Facility Quality Management staff performed an RCA focusing on the patient's fall that resulted in his hip fracture. The RCA studied factors leading up to the patient's fall and mitigation of fall risks and did not, per the scope of the RCA, include a review of the patient's care after the fall.

VHA Directive 2010-025[38] requires that cases involving a patient death during or within 30 days of a surgical procedure be referred for peer review for quality management. The Facility complied with this requirement, and the Chief of Orthopedic Service performed a protected peer review for quality management due to surgical morbidity. The Surgery Service also presented the case at the Mortality and Morbidity (M&M) conference.

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[34] VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients,* October 2, 2012. This handbook was due for recertification on October 31, 2017, but has not yet been recertified or replaced. "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 course of care."

[35] Institutional Disclosure of adverse events is a formal process by which Facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal 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.

[36] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was due for recertification March 31, 2016, and has not yet been recertified or replaced.

[37] VHA Handbook 1050.01.

[38] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This directive expired June 30, 2015, and has not been replaced.

The Facility's quality management reviews did not document relevant medication management facts throughout the inpatient admission. As of May 2018, no further reviews of the patient's case have been completed.

The Facility has a new Director, acting Chief of Staff, and acting Nurse Executive. During discussions of the patient's case, Facility leaders shared their goals of increasing transparency and the visibility of leadership, rebuilding trust, and encouraging a culture where staff feel comfortable sharing their concerns with their immediate managers.

Conclusion

The OIG substantiated that a patient died at the Facility. The Suffolk County Medical Examiner determined that the patient died as a result of high blood pressure and heart disease, complicated by a hip fracture from a fall.

The OIG substantiated that the patient fell while living in CLC 3 and required surgery due to a hip fracture sustained during the fall. The OIG did not substantiate that the patient's fall was caused by lack of appropriate fall precautions. The patient's fall risk was assessed upon admission to the CLC and at each subsequent reassessment point, and the patient was assigned a level three fall risk, which indicated a high-risk for falls. During the review of the patient's care prior to the fall, the Team found that the Facility had the proper fall precautions in place and the patient was wearing non-slip footwear at the time of the fall. Therefore, the OIG did not substantiate that the patient's death was caused by abuse or neglect.

The OIG substantiated that the patient did not receive anticoagulation injections to prevent blood clots per Facility protocol following surgery for hip fracture. The OIG did not substantiate that the failure to receive three of the four doses of anticoagulation medication during the hospital stay contributed to the patient's death. Because the patient did not die of a blood clot, which may have been prevented by anticoagulation, the missed doses likely had no impact on the patient's death.

The Team determined that the patient missed three of the four doses of anticoagulation medication during the hospital stay; one dose due to the order being auto-discontinued during a unit transfer and not reordered by the provider and two doses due to the patient declining the injection. The auto-discontinuation rules in place at the time required Orthopedic Service providers to rewrite their own orders with each patient transfer, which sometimes occurred the same day. This increased the potential for human error, such as omitting the re-writing of a necessary order. The Facility has since added Orthopedic Service to the exemption list for the auto-discontinuation rule, allowing orders to remain active during some transitions in care, specifically from OR to ICU and ICU back to the Orthopedic Service.

The OIG was unable to substantiate or not substantiate that an NA assigned to provide 1:1 observation failed to provide proper observation during the shift when the patient had a medical emergency and died. The Team lacked sufficient evidence to resolve discrepancies between the records intended to document staff observations of the patient and staff testimonial statements. The 1:1 observation documentation did not accurately record evidence of staff breaks or the care of the patient as reported by the NA.

A review of literature indicates that working extra hours with double shifts could lead to staff becoming tired and less vigilant. The NA assigned to 1:1 observation for the patient during the shift when the patient died was working a double shift (16 hours) for the sixth consecutive day. Colleagues with a history of working with the NA expressed no concerns about the NA's

alertness while working extra shifts. The extensive hours worked by a single employee assigned to 1:1 observation was identified by the Facility as a concern. As a result, a change in practice was implemented that limited the number of consecutive hours any one employee may be assigned to 1:1 observation.

The OIG did not substantiate that the CLC 3 Nurse Manager received complaints about staff behaviors that negatively impacted patient care and failed to take corrective action. The Nurse Manager denied awareness of staff behavior issues that could negatively impact patient care, such as sleeping or using personal devices while providing 1:1 observation. A review of emails found no evidence that management had received written complaints of staff behaviors which might compromise patient care. A nursing supervisor acknowledged that some issues may go unreported in part because staff were reluctant to complete a report of contact documenting the incident.

The OIG did not substantiate that Facility managers tried to cover up the circumstances surrounding the patient's death. The treating physicians provided briefings to the patient's family. The Facility quality management staff performed reviews of the patient's care as required by VHA policy. However, the Team's study of the facts of the patient's case indicates that the missed anticoagulation injection doses were not addressed in the Facility's quality management review.

The Facility has a new Director, acting Chief of Staff, and acting Nurse Executive. During discussions of the patient's case, Facility leaders shared their goals of increasing transparency and the visibility of leadership, rebuilding trust, and encouraging a culture where staff feel comfortable sharing their concerns with their immediate managers.

The OIG made three recommendations.

Recommendations 1–3

1. The Northport VA Medical Center Director ensures a review of Community Living Center 3's 24-Hour Observation Flow Sheets is completed to determine the accuracy of documentation entered by all shifts for the past three months, beginning with the date of receipt of this report, and initiates an action plan to correct identified deficiencies.

2. The Northport VA Medical Center Director makes certain that an updated quality management review is completed, to include evaluation of medication management throughout the discussed patient's admission, and disseminates findings to staff and service lines involved in the care of the patient.

3. The Northport VA Medical Center Director ensures that the Office of General Counsel is consulted regarding the patient's missed anticoagulation doses to determine if institutional disclosure to the patient's family is appropriate per Veterans Health Administration Handbook 1004.08, *Disclosure of Adverse Events to Patients*.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 26, 2018

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: Healthcare Inspection—Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with the findings and recommendations in the OIG report, Healthcare Inspection—Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York, and the responses and actions initiated by the Northport VA Medical Center.

(Original signed by:)
Joan E. McInerney, MD, MBA, MA, FACEP
Network Director

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 25, 2018

From: Interim Director, Northport VA Medical Center (632/00)

Subj: Healthcare Inspection—Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York

To: Director, New York/New Jersey VA Health Care Network (10N2)

I have reviewed and concur with the Office of Inspector General's findings and recommendations and the responses and actions initiated by Northport VAMC. Thank you for the opportunity to review our processes and ensure that we continue to provide exceptional care for our Veterans.

(Original signed by:)
Dr. Cathy Cruise
Interim Medical Center Director
VAMC Northport, New York

Comments to OIG's Report

Recommendation 1

The Northport VA Medical Center Director ensures a review of Community Living Center 3's 24-Hour Observation Flow Sheets is completed to determine the accuracy of documentation entered by all shifts for the past three months, beginning with the date of receipt of this report, and initiates an action plan to correct identified deficiencies.

Concur.

Target Date for Completion: January 1, 2019

Director Comments

A 100% review of Community Living Center (CLC) 3's 24-hour observation flow sheets were conducted for all three shifts for dates April 12, 2018–July 12, 2018. A total of ninety 24-hour observation flow sheets was reviewed; based on this review an action plan has been developed in which Nursing Service will review and revise the 24-hour observation flow sheet to accurately reflect the care that was rendered.

Continuation of 100% review of the 24-hour observation flow sheets on CLC 3 for completeness of documentation until 90% compliance for four consecutive months is achieved; this will include random weekly observations of care rendered and review of the corresponding documentation to verify accuracy on the CLC 3 24-hour observation flow sheet until 90% compliance for four consecutive months is achieved.

Recommendation 2

The Northport VA Medical Center Director makes certain that an updated quality management review is completed, to include evaluation of medication management throughout the discussed patient's admission, and disseminates findings to staff and service lines involved in the care of the patient.

Concur.

Target Date for Completion: December 2018

Director Comments

A full review of the patient's medical record was conducted including medication management. The Designated Education Officer (DEO) will develop and implement an educational process to educate all Physician Residents on the tools available for ensuring orders are accurate at points of transition across the continuum of care. The education will include discussions surrounding this event and examples of available tools to prevent recurrence. Compliance will be reported as

a semiannual agenda item for the Clinical Executive Board (CEB) meeting to ensure all clinical leadership is aware and compliance is maintained.

Recommendation 3

The Northport VA Medical Center Director ensures that the Office of General Counsel is consulted regarding the patient's missed anticoagulation doses to determine if institutional disclosure to the patient's family is appropriate per Veterans Health Administration Handbook 1004.08, *Disclosure of Adverse Events to Patients*.

Concur.

Target date for completion: September 1, 2018

Director Comments

Northport has consulted with and is waiting for a response from General Counsel for guidance to determine if an Institutional Disclosure is warranted.

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OIG Contact and Staff Acknowledgments

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