DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System

California

HEALTHCARE INSPECTION | REPORT #17-02186-114 | MAY 6, 2019

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Loma Linda Healthcare System (system), California, to evaluate allegations that were initially received in 2016, related to nurse staffing:

I. Several deaths resulted because patients were not transferred timely to units that could have provided a more intensive level of care.

II. Beds in certain units were blocked (closed) due to low nurse staffing levels.

III. With the nurse staffing ratios, the system would only allow a certain number of patients per nurse even if beds for additional patients were available.

The OIG initially sent a request to the system to review the allegations along with seven patient names submitted by the complainant. The system responded and provided the OIG with five additional names (one was a duplicate) of patients who died in the Emergency Department (ED) between summer 2016 and spring 2017. The system response prompted this inspection. The OIG identified concerns related to an additional two patients who had injuries after a fall (total of 13 patients) and conducted an unannounced site visit to the system in June 2017.

Following the June 2017 site visit, the OIG Hotline received additional anonymous allegations. Two months later, the OIG conducted an announced site visit to evaluate the additional allegations:

IV. The work environment was unsafe due to nurses having to take up to 15 patients.

V. Insufficient staffing led to an increase in patient falls, rapid responses, code blues, and sentinel events.[1]

VI. There were inadequate supplies, including linens.

The OIG also identified concerns related to patients boarded in the ED, quality of care of patients boarded in the ED who were reviewed by the OIG team, the coordination of care between the system and the Robley Rex VA Medical Center for a traveling patient, and an ED safety issue related to camera surveillance.

[1] System Policy 11-66, *Rapid Response Team for Non- Code Blue Emergencies*, January 26, 2017, "A *rapid response team* is a group of specially trained individuals who bring critical care expertise to the patient's bedside to address changes in patient status before a serious event occurs;" System Policy 11-12, *CPR or Code Blue Procedure*, November 3, 2016, "A *code blue* is an event when a patient is in respiratory and/or cardiac arrest that requires cardiopulmonary resuscitation;" VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, "A *sentinel event* is a type of adverse event that is unexpected and involves death, serious physical or psychological injury, or risk thereof."

The OIG reviewed nurse staffing within the context of allegations I–V: patient deaths allegedly occurring because patients were not timely transferred from the ED, the blocking of beds, restricted nurse-patient ratios, unsafe working conditions related to high patient-nurse ratios, and an increase in the number of adverse events. The OIG had difficulty making an accurate assessment of real-time nurse staffing on some units as a variety of staffing documents were provided that included conflicting or incomplete information. The OIG was unable to find specific guidance regarding standardized tools for documentation and retention of historical staffing records.

Allegation I. Several Deaths Allegedly Resulted when ED Patients were Not Timely Transferred

The OIG did not substantiate the allegation that several deaths occurred in the ED as a result of patients not being transferred timely to units because of insufficient staffing. The OIG medical consultant physician reviewed the 13 patients at issue. Eight of the 13 patients had died, five in the ED and three after transfer to other locations. While the OIG identified some quality of care concerns for some of the patients (details regarding these patients [Patients A–H] are included in the patient case summaries in Appendix A and throughout the report under identified issues), the concerns could not be attributed to insufficient staffing.

Staffing information for the ED was provided to the OIG by the system in the initial response and appeared to show a sufficient number of nurses on duty when the five patients (C, F, I, J, and K) died in the ED between summer 2016 and spring 2017. None of these five patients were delayed in the ED. Patient F had admission orders but could not be transferred due to clinical instability after a rapid decline in the patient's condition.[2]

For one patient, (Patient B) who died after transfer from the ED, the OIG was unable to determine that staffing on the two days at issue played a role in a delay of transfer to the intensive care unit (ICU); however, the OIG identified quality of ED care issues. For two of the three patients (G and H) who died after transfer from the ED, the OIG did not identify a delay in transfer.

Allegation II. Blocked Beds

The OIG substantiated that beds in certain units were blocked due to low nurse staffing levels. In its response to initial allegations, the system reported that beds were closed due to low staffing levels. System policy stated that taking a bed out of service for any reason must be done with the concurrence of the nurse manager and the Associate Director of Patient Care Services (ADPCS)

[2] The admission order was initially for a step-down unit with cardiac monitoring capability; that order was subsequently changed to an ICU admission.

or designee. When a staffing shortage existed that could not be modified with a simple shift of personnel from one work area to the affected work area, a bed would be taken out of service and reported to the Veterans Integrated Service Network (VISN) daily.[3] VISN leaders were not notified of bed "holds" or "closures" from October 1, 2015, through September 30, 2017. The VISN Quality Management Officer informed the OIG team that the VISN would not be notified unless the bed closure was sustained due to construction or discontinuation of service, which was not consistent with the system's policy.[4]

Allegation III. Restricted Nurse-Patient Ratio

While the OIG substantiated that the system allowed a certain number of patients per nurse even if beds were available, the OIG did not substantiate the implied inappropriateness of this action. Per VHA Directive 2010-034 on staffing methodology, system leaders and the ADPCS had discretion to make decisions regarding staffing requirements and allocation of resources.[5]

Allegation IV. Alleged Unsafe Work Environment Related to High Patient-Nurse Ratios

Due to insufficient evidence, the OIG was unable to determine whether there was an unsafe work environment related to nurses having to take up to 15 patients. A nursing leader denied registered nurses (RNs) were assigned up to 15 patients and staff did not mention this concern. According to the second set of allegations from an anonymous complainant, nurses were completing and submitting Staffing Objections forms to notify management about unsafe assignments of up to 15 patients per nurse. However, a system leader explained that the objection form was not a Veterans Health Administration (VHA) approved form, completed forms were not maintained, and neither the system nor the employees' union aggregated the data.[6] During their review of the identified patients' electronic health records (EHRs), OIG inspectors did not find gaps in patient care that may have reflected insufficient staffing.

Allegation V. Alleged Increase in Select Adverse Events

The OIG was unable to determine whether insufficient staffing contributed to an alleged increase in patient falls, rapid responses, code blues, and sentinel events. The OIG did not find an increase

[3] System Policy 11-51. *Bed Management Solution Policy,* September 5, 2016. The Bed Management Solution electronic bed board is the system's primary bed tracking tool. It provides a real-time, user-friendly web-based VistA interface to track patient movement and determine bed availability while also providing concurrent and retrospective performance feedback information that drives processes to expedite patient flow within, and between VA medical centers. System Policy 11-50, *Patient Flow Process Policy,* March 24, 2017.

[4] System Policy 11-50, System Policy 11-51.

[5] VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel, July 19, 2010.

[6] As the system did not collect and maintain the forms, only a blank form was available for the OIG's review. The OIG was not provided with completed forms that contained statements that up to 15 patients were assigned to RNs.

in the number of patient falls, rapid responses, code blues, or sentinel events from winter 2016 through late spring 2017 and was not able to make a correlation between the adverse events that did occur and staffing issues.

The system provided the OIG a list of patients with falls that occurred between winter 2016 and late spring 2017. The system identified patient falls in the Acute Psychiatric Unit (APU) as an area of concern and had developed an action plan. The OIG reviewed the EHRs of 50 APU patients with a total of 86 falls from the list provided by the system. The OIG determined that fall risk scores had been assigned to most of the patients on APU, fall prevention education was provided unless the patient refused, and examples of interventions were documented in the EHR. An APU patient's risk for falling may be increased due to the use of certain medications such as analgesics, hypnotics, psychotropics, and sedatives.

During the review, the OIG determined that two patients had falls with an injury. Patient G had a hip fracture after a fall and Patient H died because of intracranial hemorrhaging (bleeding in the brain) after a fall. The OIG reviewed staffing sheets for the two medical units where the falls occurred and determined the staffing for Patient G's inpatient medical unit and Patient H's Community Living Center unit on the days of their falls appeared adequate; however, the OIG noted discrepancies in the data on the staffing sheets provided.[7] According to the OIG team's EHR review, nursing staff assessed documented fall risks and implemented interventions accordingly.[8]

The OIG reviewed rapid response team (RRT) logs that contained the reasons for RRT calls. Incidents were recorded that did not meet the definition of an RRT call, such as insertion of an intravenous catheter or patient transports without a deterioration in the patient's condition. Nursing leaders agreed the data did not accurately reflect RRT events and in FY 2016, they provided staff education regarding the appropriate use of an RRT.

The OIG reviewed the code blue data by unit and found the highest number of code blues (seven) occurred in spring 2017. Three of the seven code blues occurred on an acute medicine unit; the OIG did not attribute them to inadequate staffing. The OIG reviewed the EHRs of the three acute medicine patients and found nursing staff assessed the patients' conditions and made appropriate interventions. The remaining four patients with code blues were single events in other areas of the system.

While the OIG did not find an increase in the number of sentinel events, the OIG determined that Patient G's and H's falls met the definition of a sentinel event and did not find evidence of complete administrative action required after a sentinel event. VHA Handbook 1050.01, the *VHA National Patient Safety Improvement Handbook*, requires that all sentinel events, such as those

[7] The various documents contained contradictory information regarding the staff who were working on the days at issue and could not be readily reconciled.

[8] Documenting fall risk and actions taken based on the fall risk are indicators of appropriate nursing care.

resulting in unanticipated death, have "immediate investigation and response." Immediate investigations may be a root cause analysis (RCA) or in the case of an intentionally unsafe act, administrative action.

The system conducted an RCA to investigate Patient G's fall and hip fracture. The system did not conduct an RCA to investigate Patient H's fall and death. In addition, VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients,* October 2, 2012, states

> Institutional disclosure of adverse events is a formal process by which facility leader(s) together with clinicians and others, as appropriate, 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, and provide specific information about the patient's rights and recourse.[9]

The OIG team determined that the system did not make institutional disclosures to the families or patients who had falls with injuries.

Allegation VI. Alleged Inadequate Supplies and Linens

The OIG substantiated that the system had inadequate supplies including needles, vacutainers, wound care supplies, and urinals.[10] Staff reported concerns related to inadequate supplies and that they borrowed from other units. According to information received after the OIG's June 2017 visit, it was alleged that nursing staff reported purchasing supplies for patients (for example, toothpaste).

Staff also reported the system implemented measures to improve communication and availability regarding supplies. These measures included a Logistics Management Response Team, a dedicated email address, and a discussion of supplies in morning huddles. The Chief of Logistics acknowledged meeting with the ADPCS twice a month to discuss issues. Due to actions taken and noted improvements, the OIG did not make a recommendation related to inadequate supplies.

The OIG did not substantiate linens were inadequate or unavailable at the time of the August 2017 site visit. The OIG staff inspected the linen storage carts on the acute care units and determined they were fully stocked.

[9] The 2012 handbook was rescinded and replaced by VHA Directive 1004.08. *Disclosure of Adverse Events to Patients,* October 31, 2018, that contains the same or similar language for the definition of an institutional disclosure.

[10] The OIG team determined that the causes for reported supply shortages were multifactorial and included logistics staffing issues, changes in the contracting process, and hoarding of items.

Other Finding: Boarding Issues in ED

The OIG found 35 percent of ED patients admitted to the system between summer 2016 and late spring 2017 waited for four hours or more (ED boarders) before transfer to an inpatient unit. The OIG determined that information entered in the system's Emergency Department Integration Software (EDIS) that reflected boarding data was inconsistent with information documented in the patients' EHRs. The OIG determined that without accurate documentation of patients' key EDIS boarding metrics (Time In, Disposition, Time Out, and Time In to Decision to Admit), system leaders did not have factually correct information to make key decisions for operational improvements of patient flow. Factors contributing to boarding at the system included blocked or unavailable beds, and restricted nurse-patient ratios (allegations II and III). Other factors that contributed to the boarding of patients in the ED included capping, ED space limitations until new construction was completed, time of patient discharge, telemetry availability, and availability of non-VA mental health beds.

Other Finding: Quality of Care Issues for Patients Boarded in the ED

The OIG identified quality of care concerns for five patients (Patients A, B, D, E, and F) who were boarded in the ED awaiting beds on the inpatient units. Three of the five patients (Patients A, B, and F) did not receive the acute care they required. Patients A, B, and F exhibited signs of infection and/or sepsis that may have been treated more appropriately had their symptoms been recognized earlier.[11] The OIG determined Patients D and E did not receive the level of mental health care in the ED that they would have received on the APU. Patient D was boarded in the ED approximately four days, according to the EHR, and did not have a nursing assessment completed within 24 hours of admission. Patient E, who was actively suicidal and not considered "safe" for the secured APU, was boarded in the ED for two days. Although Patients D and E had group therapy ordered, a review of the patients' EHRs did not indicate that they participated in groups. VHA Directive 1101.05 (2) states that the standard of care must be upheld for a patient admitted to an inpatient area who is held in a temporary bed location, such as an ED.[12]

Staff told the OIG that mental health providers were unlikely to come see an ED patient during the night and would wait until morning, usually around 5:00 a.m. From 9:00 p.m. to 7:00 a.m., psychiatric residents covered three facilities: the VA, Loma Linda University Medical Center, and another psychiatric hospital.

[11] Patient A did not undergo neurological checks as ordered; Patient B's vital signs (such as blood pressure) were not taken as frequently as ordered; and Patient F did not receive antibiotics and fluid resuscitation in an optimal time frame. The OIG was unable to determine the causes for deficiencies in care.

[12] VHA Directive 1101.05 (2). *Emergency Medicine*. September 2, 2016, amended March 7, 2017.

Other Finding: Coordination of Care Issue

The OIG identified deficiencies in a patient's coordination of care (Patient C) between the Robley Rex VA Medical Center in Louisville, Kentucky, (Louisville VAMC) and the system.

Patient C was treated at the system ED in summer 2016 for left shoulder osteoarthritis with pain medication and a steroid injection. Four days later, the patient presented to the Louisville VAMC, was admitted, and found to have a shoulder and knee infection that was going to require six weeks of antibiotic therapy. To facilitate the long-term antibiotic treatment, a peripherally-inserted central catheter line was placed in Patient C's arm.[13] Patient C wanted to be discharged and return to California.

VHA requires that veterans on extended travel have their anticipated or unexpected medical needs coordinated, through shared responsibility, by their preferred facility and the alternate facility to prevent disruption in care. Nine days after admission to the Louisville VAMC, a case manager contacted a Patient Aligned Care Team (PACT) social worker at the system inquiring about how best to continue the patient's care upon return to the system. Documentation in the EHR was incomplete regarding where the patient should go upon return to the system and did not contain documentation that indicated the PACT social worker contacted the system ED staff or the patient's primary care physician.

Three weeks after admission, Patient C's Louisville VAMC attending physician documented that the patient was cleared for discharge. Patient C was discharged with the peripherally-inserted central catheter line in place and traveled to California accompanied by a family member on an early afternoon flight.

The next day, the patient presented to the system ED in the morning. requesting continued antibiotics. No one in the ED appeared to be expecting the patient or to be aware of transfer arrangements in relation to the Louisville VAMC. After being triaged by an ED nurse, the patient was sent back to the waiting room.[14] A little over an hour later, the family took the patient to the infectious diseases clinic before the patient was seen by an ED physician. Approximately an hour later, the infectious diseases clinic intake nurse found that the patient had a very low blood pressure and was slow to respond to verbal commands. The nurse called for an RRT and the patient was transported to the ED.

The patient was immediately placed in an ED bed, rapidly declined, and suffered a cardiac arrest. Despite the ED staff's resuscitation attempts, the patient died. The death certificate listed cardiac

[13] A peripherally-inserted central catheter line is a catheter that is inserted through a peripheral vein in the arm and threaded into the superior vena cava, the large central vein close to the heart.

[14] Triage is the sorting of patients (as in an ED) according to the urgency of their need for care. https://www.merriam-webster.com/dictionary/triage. (The website was accessed on October 24, 2017.)

arrest, bradycardia (slow pulse), high potassium, and diabetes as the causes of death. An autopsy was not performed.

Other Finding: ED Safety Issue

The OIG identified a deficiency related to camera surveillance in the ED that could negatively impact patient and employee safety. The camera system that monitored the four locked acute psychiatric rooms in the ED was not fully functional. Staff reported cameras were not working; therefore, the video monitor did not properly transmit images to the VA Police observation station. A member of the executive leadership team had witnessed and reported to the contractor, a transmission delay of 15–20 seconds approximately two weeks prior to the OIG site visit. In January 2018, the OIG followed up with a system leader and found no reported instances of camera failure or systems issues in the ED from October 1, 2017, through December 31, 2017, except for one incident in the VA Police office on December 5, 2017, which was resolved the same day.

The OIG made 10 recommendations to the System Director related to ED patient flow, accuracy of ED data, the reporting of closed beds, provision of the same level of care in the ED as the units to which the patients are assigned, the care of sepsis patients in the ED, psychiatrist response times to evaluate ED patients, coordination of care for traveling patients, root cause analyses, and reviewing specific patients discussed in the report.

Comments

The Veterans Integrated Service Network and System Directors concurred with the recommendations and provided an acceptable action plan. (See Appendixes C and D, pages 37–44 for the Directors' comments.). The OIG considers all recommendations open and will follow up on planned and recently implemented actions to ensure that they have been effective and sustained.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

ADPCS	Associate Director of Patient Care Services
APU	Acute Psychiatric Unit
CLC	Community Living Center
ED	Emergency Department
EDIS	Emergency Department Integration Software
EHR	electronic health record
EMMT	Emergency Medicine Management Tool
FCLO	Facility Chief Logistics Officer
FY	fiscal year
ICU	intensive care unit
OIG	Office of Inspector General
PACT	Patient Aligned Care Team
PICC	peripherally inserted central catheter
RN	registered nurse
RRT	rapid response team
RCA	root cause analysis
UCC	Urgent Care Center
VHA	Veterans Health Administration
VSSC	VHA Support Service Center

VA

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Loma Linda Healthcare System (system), California, to evaluate allegations that several deaths resulted from an inability to transfer patients timely to units that could have provided a more intensive level of care and that nurse staffing issues were causing bed management issues. The OIG conducted a second site visit to evaluate three additional allegations that the work environment was unsafe due to nurses having to take up to 15 patients, insufficient nurse staffing was contributing to adverse patient events, and that supplies, including linens, were inadequate.

Background

The system, part of Veterans Integrated Service Network (VISN) 22, includes an Ambulatory Care Center and six community based outpatient clinics. It provides inpatient medicine, surgery, and behavioral health care for over 72,000 veterans. The system has 269 total operating beds; 159 are acute hospital beds, with the remaining 110 beds assigned to the system's Community Living Center (CLC). According to a Veterans Health Administration (VHA) End of Year 2018 bed report, 34 of the 159 acute hospital beds were designated for Acute Psychiatric Unit (APU) patients. The OIG observed that four of the 34 APU beds were reserved for geropsychiatric patients (geriatric patients with mental health issues). The CLC provides short- and long-term stay services for skilled nursing care. The system is affiliated with Loma Linda University.

Nurse Staffing

To establish safe and effective nurse staffing levels to meet all direct patient care responsibilities and demands, VHA directed nursing leadership at each facility to implement a nationally standardized staffing methodology no later than September 30, 2011.[15] The methodology was based on an analysis of multiple variables, including patient needs, direct care staffing responsibilities, environmental support, and professional judgment. These variables were to be taken into consideration when recommending nurse staffing targets to provide nursing hours per patient day.

At the system, a unit-based expert panel made nurse staffing recommendations for minimum and maximum targets for nursing hours per patient day. The system also had a system-based expert

[15] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This directive was rescinded and replaced by VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017. The major changes in the 2017 directive were an increased emphasis on veterans' access to care, and updated responsibilities for facility leaders related to implementation and support of the methodology.

panel responsible for reviewing, revising, reconciling, and consolidating the recommendations from the unit-based panel.[16]

System ED

An ED is a 24-hour/seven-day per week emergency service unit for patients requiring attention for urgent or life-threatening problems, and is staffed by physicians, nurse practitioners, registered nurses (RNs), and support staff.[17] The system ED is an 18-bed unit comprised of 14 acute patient beds, and four mental health patient beds located in a separate, locked area. The system ED nursing staff included eight RNs, and four Licensed Vocational Nurses/Health Technicians per shift.

The OIG team was informed that depending on the number of mental health patients, two ED staff would be assigned to the locked mental health area located within the ED. As a safety measure, cameras were installed that continuously monitored staff and patients in the locked area. The camera feeds were monitored by staff located in the non-locked area of the ED and by police at the VA police observation station, which was located near the ED.

ED Processes

When a patient arrives at the ED, an RN performs a triage assessment and assigns the patient an acuity level using a tool called an Emergency Severity Index.[18] Five Emergency Severity Index levels are defined by system policy:

- Level 1: Resuscitation (immediate, life threatening)
- Level 2: Emergent (care within 5–15 minutes)
- Level 3: Urgent (care within two hours)
- Level 4: Semi-Urgent (care within three hours)
- Level 5: Non-Urgent (care within four hours)

[16] VHA Directive 2010-034. "A unit-based expert panel is an advisory group comprised of nursing staff that work on the designated unit and are representative of all nursing roles on the unit in consultation with the unit's nurse manager. A facility-based expert panel is an advisory group that supports the ADPCS who is ultimately responsible for the provision of nursing care."

[17] VHA Directive 1101.05 (2), *Emergency Medicine,* September 2, 2016, amended March 7, 2017.

[18] Triage is the sorting of patients (as in an Emergency Department) according to the urgency of their need for care. https://www.merriam-webster.com/dictionary/triage. (The website was accessed on October 24, 2017.)

The OIG found that patient vital signs and complaints were entered into the electronic health record (EHR). Following triage, patient wait times for ED beds depended on the Emergency Severity Index level and ED bed availability.[19]

Emergency Department Integration Software

VHA requires that all VA EDs fully implement and utilize the Emergency Department Integration Software (EDIS) tracking program for recording and managing the delivery of care to patients in the ED. In addition, all providers selected to practice in the ED/Urgent Care Clinics (UCC) were to be provided a proctored orientation program that included instruction on the proper utilization of the EDIS package.[20]

Emergency Medicine Management Tool

The Emergency Medicine Management Tool (EMMT) is a VHA performance analysis and reporting tool that provides information about the operational performance of VA EDs and UCCs. EDIS and EMMT support several key improvement objectives associated with VHA's Emergency Medicine Improvement initiative, a system-wide effort whose objectives include

- Improvement of patient flow through the ED/UCC,
- Improvement of the productivity of ED resources, and
- Increase standardization of operations in VHA ED/UCCs.[21]

The primary data used in EMMT are derived from EDIS and are a key tool for operational improved decision-making to meet the Emergency Medicine Improvement Initiative's local and national objectives.[22] EMMT utilizes data from EDIS to generate daily patient flow and productivity metrics for each of VHA's ED/UCCs, and provides access to those metrics through standard reports, improvement dashboards, and a process analysis tool.[23]

[19] System Nursing Service Memorandum 118-D-22, *Triage in Emergency Department*, October 24, 2016; Facility *Triage SOP Emergency and Ambulatory Care Department.* November 1, 2012.

[20] VHA Directive 1101.05 (2).

[21] VHA Support Service Center (VSSC), Emergency Medicine Management Tool (EMMT). *EMMT V2 User Manual.* November 19, 2015.

[22] VHA Office of System Redesign and Improvement, *FY 16 VHA Patient Flow Coordination Collaborative Guidebook*, January 4, 2016.

[23] VHA Support Service Center (VSSC), Emergency Medicine Management Tool (EMMT).

Boarding

Successful administration of healthcare delivery systems involves ensuring that the flow of patients matches supply and demand.[24] Competition for resources between scheduled admissions and patients who arrive through the ED may result in overcrowding and boarding of patients waiting for admission. These unplanned admissions from the ED to receiving units lead to staff overload and understaffing.

VHA defines an overflow patient (boarder) as

> a patient who *requires inpatient care* due to a medical, surgical, or psychiatric condition but whom the facility is unable to accept on the designated unit due to a lack of available beds. An overflow patient may be held in a temporary bed location or be temporarily placed in a different level of care. Patients who wait in the ED or the UCC for an inpatient bed for 4 or more hours after the decision to admit is made are called "boarders" by current Centers for Medicare and Medicaid Services (CMS) definition.[25]

Studies have shown that patients boarded in the ED are at higher risk for negative outcomes than patients who are sent to the appropriate inpatient units within two hours of admission.[26] Boarded patients experience a higher rate of morbidity, mortality, and a greater length of stay.[27] In the 2016 VHA Patient Flow Coordination Collaborative Guidebook, VHA recognized that ED crowding is a hospital-wide problem involving patient flow, and is not just an ED problem.[28]

Supply Chain and Textile (Linen) Inventory Management

VHA requires mandatory procedures, and operational requirements for implementing the physical inventory of stocked supplies and equipment necessary to provide patient treatment and care.[29] The Facility Chief Logistics Officer (FCLO) represents the medical facility on all topics

---

[24] VHA Office of System Redesign and Improvement, *VHA Patient Flow Coordination Collaborative Guidebook FY 16*. January 4, 2016; VHA Directive 1117, *Utilization Management Program,* July 9, 2014.

[25] VHA Directive 1101.05 (2).

[26] VHA Directive 1101.05 (2).

[27] Singer AJ, Thode HC Jr, Viccellio P, et al. The Association between Length of Emergency Department Boarding and Mortality. (Patient Safety LLSA Study Guide). *Acad Emerg Med.* 2011;18(12):1324–1329; "Morbidity is the incidence of disease." https://www.merriam-webster.com/dictionary/morbidity. (The website was accessed on August 24, 2017.); "Mortality is the proportion of deaths to a population." https://www.merriam-webster.com/dictionary/mortality. (The website was accessed on August 24, 2017.)

[28] VHA Office of Systems Redesign and Improvement. *VHA Patient Flow Coordination Collaborative Guidebook*: *FY 16*. January 4, 2016.

[29] VHA Directive 1761 (1), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018.

related to supply chain management. The FCLO assists in establishing a Clinical Products Review Committee to ensure that supplies are compatible with medical facility requirements, and completing a Logistics staffing level review as program responsibilities change, promoting efficient utilization of supplies by ensuring inventory levels of appropriate supplies are maintained, and provides education for supply chain management staff.[30] The OIG was told the system utilized an Automated Supply Dispensing Cabinet—Omnicell®. The Omnicell® was used to maintain automated inventories and dispense individual medical supplies.[31]

Textiles include linens such as sheets, pillows, and blankets, as well as other reusable material essentials. Par levels, the term used to describe the quantity of each textile item needed in circulation for a 24-hour period, are established to ensure adequate linens are available. Each VA medical facility is expected to ensure adequate textile resources are available, as well as appropriately sanitized and stored.[32]

Allegations

The OIG evaluated the following allegations initially received in 2016 related to nurse staffing:

I. Several deaths resulted because patients were not transferred timely to units that could have provided a more intensive level of care.

II. Beds in certain units were blocked (closed) due to low staffing levels.

III. With the nurse staffing ratios, the system would only allow a certain number of patients per nurse even if beds for additional patients were available.

The OIG sent a request to the system to review the allegations along with seven patient names submitted by the complainant. The system response included reviews of the seven patients, and five additional patients (one was a duplicate of complainant's list) of patients who died in the ED between summer 2016 and spring 2017. The system response prompted this inspection. The OIG identified concerns related to two additional patients who had injuries after a fall (total of 13 patients) and conducted an unannounced site visit to the system in June 2017.

Following the June 2017 site visit, the OIG Hotline received three additional anonymous allegations; the OIG conducted an announced site visit in August 2017 to evaluate the additional allegations:

[30]VHA Directive 1761 (1).

[31] VHA Directive 1761 (1).

[32] VHA Directive 1850.03. *Textile Care Management,* March 25, 2010. This directive was in effect for a portion of the timeframe of the events discussed in this report; it was rescinded and replaced by VHA Directive 1850.03, *Textile Care Management,* April 4, 2017.

IV. The work environment was unsafe due to nurses having to take up to 15 patients.[33]
V. An increase in patient falls,[34] rapid responses,[35] code blues,[36] and sentinel events,[37] resulted from insufficient staffing.[38]
VI. There were inadequate supplies, including linens.

The OIG also identified concerns related to patient boarders in the ED, quality of care issues for patient boarders in the ED, a coordination of care issue for a traveling patient, and an ED safety issue related to camera surveillance.

[33] As this allegation concerns nurse staffing, the OIG discusses it with other allegations related to nurse staffing submitted with the original complaint in Inspection Results - Nurse Staffing.

[34] The Agency for Healthcare Research and Quality defines patient falls as "unplanned descent to the floor with or without injury to the patient." "A fall may result in fractures, lacerations, or internal bleeding, leading to increased health care utilization." Ganz DA, Huang C, Saliba D, et al. Preventing falls in hospitals: a toolkit for improving quality of care. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHSA290201000017I TO #1.) Rockville, MD: Agency for Healthcare Research and Quality; January 2013. AHRQ /Publication No. 13-0015-EF.

[35] System Policy 11-66, *Rapid Response Team for Non-Code Blue Emergencies*, January 26, 2017. "A rapid response team is a group of specially trained individuals who bring critical care expertise to the patient's bedside to address changes in patient status before a serious event occurs."

[36] System Policy 11-12, *CPR or Code Blue Procedure*, November 3, 2016. "A code blue is an event when a patient is in respiratory and/or cardiac arrest that requires cardiopulmonary resuscitation."

[37] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. "Sentinel events are a type of adverse event defined by the Joint Commission as unexpected occurrences involving death, serious physical or psychological injury, or risk thereof."

[38] As this allegation concerns nurse staffing, the OIG discusses it with other allegations related to nurse staffing submitted with the original complaint in Inspection Results—Nurse Staffing.

Scope and Methodology

The OIG initiated the inspection on June 5, 2017, conducted an unannounced site visit to the system in June 2017, and conducted an announced site visit in August 2017.

The OIG team interviewed the National Consultant for Emergency Medicine, the VA Central Office Chief of Specialty Care, and the Associate Director of Patient Care Services (ADPCS) and Nursing Services/Chief Nursing Officer. The OIG team interviewed the system executive leadership team, the Chiefs of Medicine, Emergency Medicine, Mental Health, and Quality Management. In addition, the OIG team interviewed nurse managers and assistant nurse managers for patient care units including the ED, critical care, medical, surgical, and the APU. The OIG team also interviewed the Risk Manager, Patient Safety Manager as well as staff and consultants who were knowledgeable about the issues.

The confidential complainant submitted seven patient names to the OIG related to the initial allegations. These patient names were submitted to the system for review. The system responded and provided the OIG with an additional five names of patients who died in the ED between summer 2016 and spring 2017 (one of the names was a duplicate from the complainant's list). In response to the second set of allegations, the OIG expanded the scope of the review to include summer 2016 through late spring 2017 system fall data and identified two patients with quality of care concerns. The OIG team reviewed rapid responses, code blues, and sentinel event information provided by the system. The OIG team made observations of supplies and linens, and the camera system used to monitor the ED's locked mental health area.

The OIG medical consultant physician reviewed 13 patients (Patients A–M):

- Seven patients identified by the complainant,
- Four of the five patients identified by the system (the fifth patient was a duplicate from the complainant's list), and
- Two patients identified by the OIG during its review of system fall data.

The OIG team reviewed system boarding data from EDIS for patients who were admitted to inpatient status between summer 2016 and late spring 2017. The OIG team also reviewed relevant VHA, The Joint Commission, and system requirements; system policies and procedures; medical literature; staff schedules, and nursing hours per patient day for individual patient care units; and meeting minutes for the Peer Review, Medical Executive Board, and Quality, Safety and Value Committees.

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 determine whether an alleged event or action took place when there is insufficient evidence.

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.

Inspection Results

1. Nurse Staffing (Allegations I–V)

The OIG reviewed several aspects of nurse staffing in relation to allegations regarding patient deaths when patients were not timely transferred from the ED, the blocking of beds, restricted nurse-patient ratios, high patient-nurse ratios, and an increased number of adverse events.

Allegation I. Several Deaths Allegedly Resulted when ED Patients were Not Timely Transferred

The OIG did not substantiate that several deaths occurred in the ED as a result of patients not being transferred timely to units because of insufficient staffing. The OIG reviewed the identified 13 patients and determined that five of the eight patients died in the ED, while the other three patients died after transferring out of the ED. Case summaries for the eight patients are provided in Appendix A (Patients A–H). For the five patients who died in the ED, the OIG did not find delays in transfer (boarding) or that their deaths were a result of insufficient staffing.[39]

Deaths in the ED

Staffing information for the ED was provided to the OIG by the system in the initial response and appeared to show a sufficient number of nurses on duty when the five patients died in the ED between summer 2016 and spring 2017 (C, F, I, J, and K). Patient F initially had admission orders to a step-down unit but could not be transferred due to clinical instability after a rapid decline in the patient's condition. The admission orders were changed from a step-down unit to ICU. None of these five patients were delayed in the ED.

The OIG received a variety of documents related to staffing on the receiving units that were difficult to interpret because they included conflicting or incomplete information that did not allow for an accurate evaluation of nurse staffing. The OIG was unable to find specific guidance regarding standardized tools for documentation and retention of historical staffing records. The OIG looked at Nurse of the Day sheets, 24-hour staffing reports, individual unit census and assignments, and actual documentation in the EHR to determine if insufficient nurse staffing on the receiving units contributed to a delay in transfers out of the ED. The OIG reviewed staffing documents and found discrepancies in the number of nursing staff provided for each day. Intensive care unit (ICU) assignment sheets appeared to reflect an adequate number of nurses to care for the patients in the ICU but the information did not answer questions regarding

[39] OIG considered Patient F a boarder because being in the ED for more than 4 hours technically met the definition of a boarder; however, the time in the ED included a rapid decline in clinical status that required a change in the level of care needed from the originally ordered step-down unit to an ICU.

availability to accept additional patients. A system leader had previously requested an electronic staffing program during the budgeting process and the request was denied.

Deaths After Transfer from the ED

Three patients (B, G, and H) died outside of the ED between simmer 2016, and mid-spring 2017:

- Patient B in the system's surgical intensive care unit,
- Patient G in a community nursing home, and
- Patient H in a non-VA hospice unit.

Patient B was evaluated by an ICU physician approximately two hours after arriving in the ED. The record reflects Patient B had impending septic shock and ICU admission orders were entered into the EHR. Patient B remained in the ED for approximately 25 hours. The OIG was unable to determine from reviewing EHR documentation as to why the patient was boarded such a long time in the ED prior to transfer to the ICU. The system provided the OIG a brief summary of patient care, but the summary did not address the delay in transfer to ICU. The OIG was unable to determine if the receiving unit staffing for the 25 hours at issue played a role in the delay of transfer to the ICU. The OIG describes quality of ED care issues provided to patient B later in this report.

Patient G was admitted to the system from the ED with a hip fracture; however, due to other medical issues, it was determined that Patient G was not a surgical candidate. Patient G was transferred to a nursing home and died approximately one month later.

Patient H was an elderly, frail patient who fell at the VA CLC. Patient H was taken to the ED for evaluation, underwent imaging studies, and was diagnosed with intracranial hemorrhaging (bleeding in the brain). After a neurosurgeon determined Patient H was not a surgical candidate, Patient H was admitted to hospice.

The OIG determined that neither Patient G nor H experienced a delay in transfer from the system ED.

Allegation II. Blocked Beds

The OIG substantiated that beds in certain units were blocked (closed) due to low nurse staffing levels. The system response to initial allegations indicated that beds were closed due to low staffing levels.

During an interview, a staff member confirmed that beds were closed incrementally, shift by shift as needed. System policy stated that taking a bed out of service for any reason must be done with the concurrence of the nurse manager and the ADPCS or designee, and when a staffing shortage exists that cannot be modified with a simple shift of personnel from one work area to

the affected work area, a bed will be taken out of service.[40] According to system policy, bed closures must be reported to the VISN on the daily Bed Management Service call.[41]

VISN leaders were not notified of bed "holds" or "closures" from October 1, 2015, through September 30, 2017. Additionally, the VISN Quality Management Officer informed the OIG team that the VISN would not be notified unless the bed closure was sustained due to construction or discontinuation of service, which was not consistent with the system's policy.

Nurse-Patient Ratios

In the initial set of allegations, the complainant stated there were a certain number of patients per nurse even if beds were available while in the second set of allegations, the complainant stated the work environment was unsafe due to nurses having to take up to 15 patients.

Allegation III. Restricted Nurse-Patient Ratio

While the OIG substantiated that the system allowed a certain number of patients per nurse even if beds were available for additional patients, the OIG did not substantiate the implied inappropriateness of this action. System leaders advised the OIG that they were complying with VHA Directive 2010-034, which was current at the time of the events discussed in the report.[42] Per the 2010-034 Directive, nurses participated in committees to identify staffing requirements for their units. Final decisions regarding staffing requirements and allocation of resources were made by system leaders. The VHA Directive stated the ADPCS may evaluate staffing frequently if needed.

Allegation IV. Alleged Unsafe Work Environment Related to High Patient-Nurse Ratio

The OIG was unable to determine whether there was an unsafe work environment related to nurses having to take up to 15 patients due to insufficient evidence. A nursing leader denied RNs were assigned up to 15 patients and staff did not mention this concern. According to the second set of allegations from an anonymous complainant, nurses were completing and submitting Staffing Objections forms to notify management about unsafe assignments of up to 15 patients per nurse. However, a system leader explained that the objection form was not a VHA-approved form, completed forms were not maintained, and neither the system nor the employees' union aggregated the data. As the system did not collect and maintain the forms, only a blank form was available for the OIG's review. The OIG was not provided with

[40] System Policy 11-50, *Patient Flow Process Policy*. March 24, 2017; System Policy 11-51, *Bed Management Solution Policy.* September 5, 2013.

[41] System Policy 11-51.

[42] VHA Directive 2010-034.

completed forms that contained statements that up to 15 patients were assigned to RNs. During their review of the identified patients' EHRs, OIG inspectors did not find gaps in patient care that may have reflected insufficient staffing.

Allegation V. Alleged Increase in Select Adverse Events

The OIG was unable to determine that insufficient staffing contributed to an alleged increase in patient falls, rapid responses, code blues, and sentinel events. VHA delineates what types of patient safety events are considered within the patient safety program and how events need to be addressed. Identifying patient safety-related incidents, broadly evaluating the actual and potential contributory factors, and analyzing, trending, and reporting near misses and actual incidents are keys to preventing future occurrences of similar events.[43]

The OIG did not find an increase in the number of patient falls, rapid responses, code blues, or sentinel events between winter 2016 and late spring 2017, and was not able to make a correlation between the adverse events that did occur and staffing issues. As stated previously, the OIG found a variety of nurse staffing sheets with discrepancies regarding the number of nursing staff available on the inpatient units. Therefore, the OIG was unable to accurately evaluate whether nurse staffing contributed to an alleged increase in patient falls, rapid responses, code blues, and sentinel events.[44]

Falls

The system provided the OIG a list of patients with falls that occurred between winter 2016 and late spring 2017. The OIG noted that the system identified patient falls in APU as an area of concern and had developed an action plan. The OIG reviewed the EHRs of 50 of the APU patients with falls (total of 86 falls) from the list the system had provided. The OIG determined that fall risk scores had been assigned to most of the patients on the APU. The OIG determined fall prevention education was provided unless a patient refused, and examples of interventions were documented in EHRs, such as call lights within reach, placement of patients closer to nurses' stations, non-skid slippers, and every 15-minute surveillance rounds if indicated. One factor that can increase an APU patient's risk for falling is the prescribing of any of the following medications such as analgesics, antihypertensives, hypnotics, psychotropics, and sedatives.

[43]VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was scheduled for recertification on or before the last working date of March 2016 but has not been recertified.

[44] Similarly, nursing researchers have faced two fundamental problems when designing staffing studies that included identifying "suitable data sources and measures for staffing and patient outcomes and linking the two types of variables to reach valid conclusions." Clarke SP, Donaldson NE. Nurse Staffing and Patient Care Quality and Safety. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Vol. 2, Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 25.

The OIG determined that two patients had falls with an injury (not in the APU). Patient G had a hip fracture after a fall and Patient H died because of intracranial hemorrhaging (bleeding in the brain) after a fall. The OIG reviewed staffing sheets for the two medical units where the falls occurred and determined the staffing for Patient G's inpatient medical unit and Patient H's CLC unit on the days of their falls appeared adequate; however, the OIG noted discrepancies in the data on the staffing sheets provided. According to the OIG team's EHR review, nursing staff assessed, documented fall risks, and implemented interventions (indicators of appropriate nursing care) for these two patients.

Rapid Response Calls

The OIG reviewed rapid response team (RRT) logs that contained the reasons for the RRT calls. Incidents were recorded regarding RRTs that did not meet the definition of an RRT, such as a request to insert a catheter for intravenous infusions or patient transports without a deterioration in the patient's condition. Nursing leaders agreed the data did not consistently reflect RRT events and in FY 2016 and indicated that they provided staff education regarding the appropriate use of an RRT.

Code Blues

The OIG reviewed the code blue data by unit and found the highest number of code blues (seven) occurred in spring 2017. Three of these seven code blues occurred on an acute medicine unit, and the OIG did not attribute them to inadequate staffing. The OIG reviewed the EHRs of the three acute medicine patients and found nursing staff assessed the patients' conditions and made appropriate interventions. The remaining four patients with code blues were single events in other areas of the hospital.

Sentinel Events

While OIG did not find an increase in the number of sentinel events, OIG determined that Patient G and H's falls met the definition of a sentinel event but did not find evidence of actions that are warranted after a sentinel event.

VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, requires that all sentinel events, such as those resulting in unanticipated death, have "immediate investigation and response."[45] Immediate investigations may be a root cause analysis (RCA) or in the case of an intentionally unsafe act, administrative action.[46] The Acting Chief Officer for the National Center for Patient Safety informed the OIG that an RCA should be conducted within 45-days of

[45] VHA Handbook 1050.01.

[46] An RCA is a specific type of focused review that is used for all adverse events or close calls requiring analysis.

a sentinel event. The system did not conduct an RCA to investigate Patient G's fall and hip fracture. The system did conduct an RCA to investigate Patient H's fall and death.

The OIG team also determined that the system did not make institutional disclosures to the families or patients who had falls with injuries.

VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients,* October 2, 2012 states

> Institutional disclosure of adverse events is a formal process by which facility leader(s) together with clinicians and others, as appropriate, 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, and provide specific information about the patient's rights and recourse.[47]

The Directive further states that

> Serious injury may include significant or permanent disability, injury that leads to prolonged hospitalization, injury requiring life-sustaining intervention, or intervention to prevent impairment or damage…[s]uch adverse events require institutional disclosure regardless of whether they resulted from an error.[48]

2. Inadequate Supplies and Linens (Allegation VI)

Supplies

The OIG substantiated that the system had inadequate supplies including needles, vacutainers, wound care supplies, and urinals. Staff reported concerns related to inadequate supplies and the borrowing of supplies from other units. The second set of allegations included a statement that nursing staff reported purchasing toothpaste for patients when supplies ran out. A staff member told the OIG they were now getting personal care products from the Logistics Service.

VHA requires mandatory procedures, and operational requirements for implementing the physical inventory of stocked supplies and equipment necessary to provide patient treatment and care.[49] The FCLO told the OIG that the system used an Omnicell® system that allowed staff to remove more than one of the same supply item from the cabinet once it was opened. This automated point-of-use system included locked cabinets for each unit that required a user to input a user code, a supply code, quantity dispensed, and a patient identifier into a computerized panel to open and retrieve the required supply item. The FCLO also told the OIG that a report

[47] VHA Handbook 1004.08. *Disclosure of Adverse Events to Patients,* October 2, 2012. The 2012 handbook was rescinded and replaced by VHA Directive 1004.08. *Disclosure of Adverse Events to Patients,* October 31, 2018, and contains the same or similar language for the definition of an institutional disclosure.

[48] VHA Handbook 1004.08, 2012; VHA Directive 1004.08, 2018.

[49] VHA Directive 1761(1).

was automatically generated to the Logistics Service on a regular predetermined schedule to allow for optimal restocking of the supplies used. Inventory reports were also generated on an as-needed basis.

Staff told the OIG they removed more than one supply item at a time because of a concern of running out of a specific supply when needed. The OIG team determined that this practice did not correctly amend the inventory and resulted in inaccurate inventory reports being sent to Logistics Service and, consequently, inaccurate restocking of supplies.

Staff reported the system implemented measures to improve communication and availability of supplies. These measures included a Logistics Management Response Team, a dedicated email address, and a discussion of supplies in morning huddles. The Chief of Logistics stated he and the ADPCS were meeting twice a month to discuss issues.

The national roll out of VHA's Medical Surgical Prime Vendor–Next Generation Program in March 2017, required system managers to change the way they ordered and received medical supplies. The FCLO shared that the National Program changes were resulting in significant adjustments to the management of supplies, such as using alternative types of similar supplies or special ordering for specific supply brands, and the FCLO had provided training and communication to system staff about the requirements.

The FCLO informed the OIG that when the VA Loma Linda Ambulatory Care Center opened, (located approximately two miles from the system), there was an increase in Logistics Service staff workload without the addition of new employees. The OIG found that multiple disciplines, including the FCLO, had identified and implemented solutions for supply management.

Due to actions taken and noted improvements, the OIG did not make a recommendation related to inadequate supplies.

Linens

The OIG did not substantiate linens were inadequate or unavailable at the time of the August 2017 site visit. When interviewed in August 2017, a staff member acknowledged consistently running out of linens, especially on weekends and evenings, and reported the need to borrow from other units. The OIG was also told some nurses stockpiled linens to increase availability. The OIG inspected the linen storage carts on the acute care units and determined they were fully stocked.

VHA requires mandatory procedures and operational requirements for implementing an effective textile distribution system, which includes the requisitioning, repair, replacement, and distribution of textiles.[50] A system leader reported the system had previously contracted with

[50] VHA Directive 1850.03.

another VA healthcare system to provide textile supplies; however, the contract was discontinued due to suboptimal service. A new contract with a local vendor was implemented.

The ADPCS, with assistance from staff, developed an action plan and responded with appropriate interventions to solve concerns related to linens. In November 2017, the OIG followed up with the ADPCS who reported that a quality assurance program for monitoring linens had been implemented. The program outcomes resulted in improved par levels (the quantity of each textile item needed in circulation for a 24-hour period), assessment of current and needed linens inventory and cost, purchase of high-quality linens for patient comfort, and increased service reliability including faster emergency response for linens. In addition, an emergency linen cart was available for afterhours use.

3. Other Finding: Boarding in the ED

Boarding Metrics

The OIG found that 35 percent of ED patients who were admitted to the system between summer 2016 and late spring 2017 waited for four or more hours before transfer to an inpatient unit. The OIG determined the system did not meet the national target of less than or equal to 10 percent of patients in the ED for greater than four hours.[51]

The OIG determined that information entered into the system EDIS reflected boarding data that were inconsistent with information documented in the patients' EHRs.[52] In some cases, the Admission Disposition Time/Decision to Admit Time (used as the starting point of boarding time) was not documented or was inaccurate.[53]

A staff member informed the OIG team that all nurses were trained by a preceptor on EDIS, but the OIG did not find that the system had EDIS training procedures. The OIG was told that all staff were trained by a preceptor on EDIS, but no evidence of annual training as required by system policy was found.[54]

The OIG determined that without accurate documentation of patients' key EDIS boarding metrics (Time In, Disposition, Time Out, and Time In to Decision to Admit), system leaders did

[51] The boarding time was calculated by Time Out minus Disposition Time.

[52] Information in EDIS was obtained from the VSSC EMMT Activity Reports and data extracted from EDIS. The OIG utilized documentation in the EHR from the ED Worksheet, ED/Physician Note, and ED/Nursing Note; the OIG compared the fields defined in EDIS and EHR: Patient =Name/SS/Pt ID fields, Check In Time=Time In field, Decision to Admit=Disposition DateTime field, Patient Transferred to Inpatient Ward Time=Time_Out field, ED LOS (Hours)=Elapsed field calculated by Time In to Time Out, Elapsed time from check in to decision to admit =Admission_Decision field calculated by Time in to Disposition, and the Boarding Time (Hours) =Calculated from Decision to Admit to Time Out (Elapsed minus Admission Decision).

[53] The Decision to Admit Time is captured as the Disposition Date Time EDIS field.

[54] System Policy 11-51.

not have factually correct information to make key decisions for operational improvements of patient flow.

Identified Patients Who were Boarded in the ED

The OIG determined that five of the 13 patients who were identified and reviewed were boarded, Patients A, B, D, E, and F. Four patients (A, B, D, and E) had boarding times in the ED over 15 hours. The fifth patient (Patient F) met the four-hour time frame to qualify as a boarder; however, Patient F's clinical status had rapidly declined, became too unstable for transfer, and had an overall time in the ED of less than eight hours. Patient D was noted to have the most significant boarding time (three days per EDIS, or four days per the EHR).

Factors Contributing to Boarding

Two factors contributing to boarding at the system are discussed in Section 1 in relation to allegations related to blocked beds and restricted nurse-patient ratios. Other contributing factors that OIG identified included capping, space limitations of ED until new construction was completed, team time of discharge, telemetry availability, and availability of mental health beds in the community. The Chief of Staff informed the OIG that one identified factor, the lack of resources for patients who required transitional care, has been addressed by the system.

Capping

Staff described times when "capping," the inability of a receiving medical team to take admissions due to exceeding the number of patients allowed by the Accreditation Council for Graduate Medical Education added to the delay in admitting patients to the units.[55] This issue was discussed with the Chief of Staff and the Chief of Medicine. The OIG received conflicting answers as to whether capping applied to all hospitalists' admissions. The OIG determined there was a discrepancy in the application of capping.

VHA adheres to the institutional requirements of the Accreditation Council for Graduate Medical Education.[56] The 2016 Accreditation Council for Graduate Medical Education Program Requirements for Graduate Medical Education in Internal Medicine required a sponsoring institution such as the system to assume responsibility for inpatient assignments to residents on rotations with specific requirements:

- Internal medicine residents are limited to an 80-hour work week.

[55] The Accreditation Council for Graduate Medical Education is the accrediting body that https://www.acgme.org/What-We-Do/Overview. (The website was accessed on March 17, 2019.)

[56] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. This handbook was due for recertification on or before December 29, 2017, and has not been recertified or replaced.

- A first-year resident must not be assigned more than five new patients per admitting day.
- A first-year resident must not be responsible for the ongoing care of more than 10 patients.
- A supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period.

Patient flow between and among the ED and units can be impacted when the number of admissions exceeds the limits ("caps") for interns and residents, set by the accrediting body. Interns and residents were members of an assigned team that accepted, declined, and facilitated admissions, discharges, and continued stays on several units within the system.

Limited Beds in the ED

The OIG determined the system followed a local county policy, that did not allow medical facilities in the county to divert arriving ambulances except under specific guidelines; therefore, patients could continue to arrive by ambulance to the system ED regardless of bed availability.[57] During interviews, staff told the OIG that ED bed limitations were being addressed through construction of a new ED that will increase the number of available ED beds.[58]

Time of Discharge

At the system, medical teams made rounds in the morning or afternoon. According to the ADPCS, there was not a set schedule. During rounds, teams generally make decisions about patients' treatment and progress, including discharges. A staff member told the OIG that inpatient medical team members often wrote orders at the end of the day. Patients could not be discharged until orders were entered into the EHR. Orders written at the end of the day contributed to delayed discharges and admissions, thus impacting patient flow.

[57] Inland Counties Emergency Medical Agency. *Requests for Hospital Diversion Policy (San Bernardino County Only).* Reference 8060. April 1, 2013; VHA Directive 1101.05(2). VHA defines diversion as the inability to accept patients for admission and evaluation "because the appropriate beds are not available, needed services cannot be provided, staffing is inadequate, acceptance of another patient would jeopardize the ability to properly care for those already at the facility, or disaster has disrupted normal operations."

[58] The number of beds available at the time of the OIG's on-site visit was 18; the reported increase in beds varied according to interviewees from 20 to 24 beds.

Decreased Availability of Telemetry

Staff informed the OIG that the availability of telemetry monitors and trained step-down telemetry staff had been a concern; however, the system had recently recommended increasing the availability of telemetry monitors for existing beds and provided corresponding staff training.[59] In addition, the number of beds available for stepdown patients had increased, with a goal of increasing the availability of ICU beds.[60]

Limited Mental Health Beds and Community Coverage

The OIG determined there were delays in system mental health admissions and transfers. Mental health admissions were delayed because psychiatry residents were on-call at night for two other hospitals (Loma Linda University Medical Center and another non-VA hospital). Additionally, the non-VA hospitals in the community and other VA facilities in the region had limited capacity for accepting mental health and geropsychiatric transfers.

The system had 34 APU beds available; four were geropsychiatric beds. The Chief of Mental Health informed the OIG that the ED had social workers in the mental health area of the ED and implemented a team that was available during the day and part of the evening shift for additional coverage. Staff told the OIG that mental health providers were unlikely to evaluate an ED patient during the night and would wait until morning, usually around 5:00 a.m. From 9:00 p.m. to 7:00 a.m., the psychiatric residents covered three facilities that included the system, Loma Linda University Medical Center, and another non-VA psychiatric hospital. The mental health provider acknowledged in an interview that travel time among the three facilities was significant.

The Chief of Psychiatry reported that there were not enough beds in the community and other VA facilities in the region had limited capacity for accepting mental health and geropsychiatric transfers. In addition, the Chief of Psychiatry told OIG that San Bernardino and surrounding counties have the lowest number of psychiatrists and primary care physicians in the country. The OIG's research showed that San Bernardino and Riverside counties together had the lowest ratio of behavioral health/mental health professionals, particularly psychiatrists, relative to other regions.[61]

[59] Telemetry is an electronic transmission of dynamic images of the patient's cardiac waveform to a central monitor without limiting the patient's mobility. It may also refer to a specific unit of a hospital where patients are monitored.

[60] A stepdown unit is an area of the hospital that cares for patient requiring additional monitoring but not to the level of an intensive care patient.

[61] J Coffman, T Bates, I Geyn, J Spetz, *California's Current and Future Behavioral Health Workforce*, Healthforce Center at UCSF (University of California, San Francisco), February 12, 2018.

Limited Resources for Patients Who Needed Transitional Care

The Chief of Staff reported that a committee evaluated patient flow and recognized there were limited resources for patients who needed transitional care. According to the Chief of Staff, a reallocation of CLC beds improved the delays for acute care admissions and discharges.

4. Other Finding: Quality of Care Issues

The OIG determined that five patients who were boarders in the ED did not receive the level of care they required (as discussed below) although a review of the number of ED staff provided to the OIG from the system appeared adequate for the days in question.[62] The OIG's concerns about the coordination of care for Patient C is discussed in Section 5.

VHA Directive 1101.05 (2) states that the standard of care must be upheld for a patient admitted to an inpatient area in all temporary bed locations. The directive further notes that

> When a patient requires admission to a critical care unit and no Intensive Care Unit (ICU) bed is available, it is an absolute requirement that the patient receive ICU-level care in an alternative location including monitoring, staffing, and treatment consistent with ICU standards.[63]

According to the system *Continuum of Care* policy, once the decision has been made to admit, the same standard/level of care for boarded patients in the ED will apply as on the admitting unit, including medicine, psychiatry, surgical, telemetry, and critical care.[64] The system *Assessment of Patients* policy required nursing staff to complete a general admission assessment with interdisciplinary screening within 24 hours of admission, and a physical assessment within 15 minutes of an ICU admission, and two hours for an acute care admission. Reassessments must occur at regular intervals and should include pertinent areas based on the patient's individual needs, change in level of care, diagnosis, and response to care. Patient assessments should occur at least every four hours.[65]

Required Acute Care Not Provided to ED Patients

Patients A, B, and F did not receive the level of acute care required in the ED. In summer 2016, Patient A arrived by ambulance complaining of weakness and had physician orders for admission to a telemetry unit for confusion that was thought to be secondary to a shingles infection. Patient A remained in the ED as a boarded patient and was admitted to the ICU the

[62] The five patients were A, B, and F, who received acute care, and D and E, who received mental health care. The OIG did not identify quality of care concerns for the remaining three boarder patients (I, J, K).

[63] VHA Directive 1101.05(2).

[64] System Policy 11-67, *Continuum of Care*. June 30, 2014.

[65] System Policy 11-30, *Assessment of Patients.* February 19, 2016.

next day. The medicine team ordered neurological checks every four hours. However, the ED nursing staff did not complete the neurological checks as ordered.

The system ICU physician evaluated Patient B in the ED and documented that the patient had impending septic shock. Patient B had physician orders for admission and was admitted to the surgical intensive care unit the next day. Vital signs were ordered to be done every hour in the ED, but vital signs were not documented on Day 2 from 6:00 a.m. to 6:00 p.m.[66] The night shift nurse documented that Patient B had low blood pressure between 6:35 p.m. and 7:00 p.m. and became pulseless about two hours and 30 minutes later. A code blue was called. Patient B was successfully resuscitated and transferred to the ICU but died the next day.

VHA Directive 2008-063 states that prevention of cardiac arrest may have the greatest impact on mortality and that "almost half of all patients who die in acute care hospitals have serious, yet potentially reversible, abnormalities in their vital signs in the 24 hours before death."[67] Had hourly vital signs been done as ordered, an instability in Patient B's condition signaling a deterioration in clinical status (sepsis) might have been detected earlier and might have changed the outcome.

Patient F, who developed septic shock, experienced a delay in receiving intravenous fluids and antibiotics. Patient F did not receive intravenous fluids until four hours after initial presentation.[68] The International Guidelines for Management of Sepsis and Septic Shock (Guideline) recommends giving intravenous fluids within three hours. In addition, about an hour and a half elapsed before Patient F received an antibiotic.[69] The Guideline strongly recommends that intravenous antibiotics start as soon as possible after recognition of sepsis (and within one hour as a minimum target), because each hour of delay is associated with an increase in mortality.[70] The delay in administering intravenous fluids (fluid resuscitation) and antibiotics might have contributed to Patient F's progression to septic shock in the ED.

The Guideline states that hospitals with a performance improvement program for sepsis have been associated with improved patient outcomes.[71] Hospitals in the state of New York mandate

---

[66] The day shift RN documented that the patient had "continuous" cardiac monitoring; vital signs are the signs of life, specifically includes the pulse rate, respiratory rate, temperature, and blood pressure of a person. https://www.merriam-webster.com/dictionary/vital%20signs. (The website was accessed on March 22, 2018.)

[67] VHA Directive 2008-063. *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008. This VHA directive expired October 31, 2013, and was rescinded and replaced by VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

[68] Sepsis can progress to septic shock when the patient's circulatory system becomes overwhelmed leading to a drop in blood pressure and increased risk of death. Singer M, Deutschman CS, Seymour CW, et al. The Third International Consensus Definitions for Sepsis and Septic Shock. *JAMA*. 2016; 315 (8) 801-810.

[69] The recommended dose is 30 mL/kg. The patient weighed 182 kg and would have needed about five liters within the first three hours based on this recommendation.

[70] Rhodes, A, Evans LE, Alhazzani W, et al. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016.

[71] Rhodes, A, Evans LE, Alhazzani W, et al.

the use of sepsis treatment protocols to improve timeliness to diagnosis and treatment. Although not required by VHA, the system did not have standardized sepsis treatment protocols. The OIG confirmed with VHA senior leaders that VHA had not adopted sepsis protocol requirements; instead, they utilize an individualized approach and assist medical facilities that are experiencing high mortality or complications. VHA will be offering an educational virtual series on sepsis with the National Center for Patient Safety.

Required Mental Health Care Not Provided to ED Patients

The OIG determined that Patients D and E did not receive the level of mental health care in the ED that they would have received on the APU. Patient D was boarded in the ED approximately four days according to the EHR and did not have a nursing assessment completed within 24 hours of admission. Inpatient mental health patients are required to have a nursing assessment within 24 hours, as well as a lethality scale assessment.[72] Additionally, a physical assessment is required within two hours of a patient's arrival on unit. The OIG interpreted "on unit" to include any patient for whom the decision had been made to admit so the same standard/level of care is applied.[73]

Patient E was actively suicidal and was boarded in the ED for two days after not being considered "safe" for the secured APU. The system provided information related to Patient E with its initial response to OIG in 2017 that included a statement that the APU had "high acuity with volatile patients" on the day at issue so it was an "unsafe milieu for an actively suicidal patient. Patient-centered care was considered, and to assure the patient's continued safety, [the patient] remained in the ED 'serenity area…with a 1:1 sitter.'"

The psychiatrist for Patients D and E had requested group therapy according to documentation in the EHRs, during their admissions to the psychiatry unit. However, a review of the patients' EHRs did not indicate that they participated in groups. In addition, both patients were moved several times during their ED stays, from the ED psychiatric area to other beds in the main ED. An ED staff member told OIG inspectors that patient moves occurred often for staffing convenience.

5. Other Finding: Coordination of Care Concerns

The OIG identified deficiencies in a patient's coordination of care (Patient C) between the Robley Rex VAMC in Louisville, Kentucky, (Louisville VAMC) and the system. In summer 2016, Patient C was seen in the system ED for left shoulder pain. The patient was diagnosed with

[72] System Policy 11-30, *Assessment of Patients,* February 19, 2016.
[73] System Policy 11-67.

osteoarthritis. Patient C was given pain medication and a steroid (Kenalog) injection and discharged.[74]

Four days later, after travelling, Patient C presented to the Louisville VAMC complaining of severe left shoulder pain after a fall as well as increasing right knee pain. Patient C was found to have a low serum sodium level and admitted to the Louisville VAMC for further treatment.

During the hospitalization, Patient C was diagnosed with a shoulder and knee infection which would require six weeks of intravenous antibiotic therapy. To facilitate this long-term antibiotic treatment, a peripherally-inserted central catheter (PICC) was placed in Patient C's arm.[75]

Patient C's hospitalization at the Louisville VAMC was complicated by the development of bleeding intestinal ulcers and episodes of high blood pressure. Patient C wanted to be discharged from the Louisville VAMC and return to California.

VHA states that "coordination and continuity of care are core features of high-quality primary care."[76] VHA requires that veterans on extended travel have their anticipated or unexpected medical needs coordinated, through shared responsibility, by their preferred medical facility and the alternate medical facility to prevent any disruption in their care.[77]

Nine days after admission, Patient C's Louisville VAMC case manager contacted a Patient Aligned Care Team (PACT)[78] social worker at the system inquiring about how best to continue the patient's care upon return to California. There was incomplete documentation as to where the patient should go upon return to the system. The EHR did not have documentation that indicated the system PACT social worker contacted the system ED staff or the patient's California primary care physician.

Three weeks after admission, the patient's Louisville VAMC attending physician documented that the patient was cleared for discharge. Patient C was discharged from the Louisville VAMC with the PICC in place and traveled to California accompanied by a family member on an early afternoon flight.

---

[74] Immunosuppression medications treat rheumatoid arthritis by stopping the inflammatory response in the body. However, these medications also increase the risk of infections because the body's natural immune system may become compromised.

[75] A PICC is inserted in a peripheral vein in the arm and threaded into the superior vena cava, the large central vein close to the heart. This allows medications to be delivered to the central circulation. A PICC can remain in place for a longer duration than a regular peripheral intravenous catheter.

[76] VHA Directive 2009-038, *National Dual Care Policy*. Aug 25, 2009.

[77] VHA Handbook 1101.11(3), *Coordinated Care for Traveling Veterans*, April 22, 2015. "Extended travel is a type of travel in which a veteran travels away from the preferred facility and requires coordinated care with an alternate facility. This need for coordinated care is typically due to either complex clinical needs and/or a prolonged period away from the veteran's principal residence."

[78] The Patient Aligned Care Team (PACT) is a team of health care professionals including a physician, nurse, and administrative support staff who work together to manage and coordinate the primary care needs of patients.

The next day, the patient presented to the system ED in the morning requesting continued antibiotics. No one in the ED appeared to be expecting the patient or to be aware of transfer arrangements in relation to the Louisville VAMC. An ED nurse triaged the patient, assigned an ESI Level 3, and the patient returned to the waiting room. An hour later, the family took Patient C to the Infectious Diseases Clinic before being evaluated by an ED physician. Approximately an hour later, the Infectious Diseases Clinic intake nurse found that Patient C had a very low blood pressure and was slow to respond to verbal commands. The nurse called for an RRT and the patient was transported to the ED.

Patient C was immediately placed in an ED bed, rapidly declined, and suffered a cardiac arrest. Despite the ED staff's resuscitation attempts, Patient C died. The death certificate listed cardiac arrest, bradycardia (slow pulse), high potassium, and diabetes as the causes of death. An autopsy was not performed.

The OIG interviewed the system Traveling Veterans Coordinator who was also the Transfer Coordinator. The OIG team did not find a VHA directive that outlined follow-up after inpatient care; the Traveling Veterans Coordinator stated there was no specific guidance. The Traveling Veterans Coordinator described the expected process for coordination and communication:

- Coordination and communication between the system and Louisville VAMC Traveling Veterans Coordinators and discharge planners
- Consults placed with specialty and PACT for necessary medications and tests
- Coordination with the system PACT instead of the ED

The OIG found incomplete coordination and communication processes occurred for Patient C.

6. Other Finding: ED Safety Issue

VHA allows the use of cameras for patient safety purposes to protect patients from immediate harm.[79] Images from at least two cameras in each of four locked psychiatric rooms were displayed on monitors in the ED and depicted a view of each of the beds from various angles so patients could not be out of view of the camera. While touring the ED, the OIG identified a deficiency related to camera surveillance in the ED that could negatively impact patient and employee safety. During the first OIG site visit, cameras were not working; therefore, the video monitor did not properly transmit images to the VA Police observation station. Multiple staff had also reported the cameras were not working consistently. A member of the executive leadership team had witnessed the problem and reported to the contractor a transmission delay of 15–20 seconds approximately two weeks prior to the OIG site visit.

[79] VHA Directive 1078(1) Privacy of Persons Regarding Photography, Digital Images, and Video or Audio Recordings, November 4, 2014, amended November 19, 2014.

The OIG discussed the deficient cameras with system leaders who reported issues had occurred with the camera and surveillance system procurement and installation for two to three years. VA Police, the system Management Service, and the Office of Information and Technology had difficulty with the coordination of equipment and repairs. System leaders decided to upgrade the system and a contractor began part of the installation in June 2017.

In January 2018, the OIG followed up with a system leader and found no reported instances of camera failure or systems issues in the ED from October 1, 2017, through December 31, 2017, except for one incident in the VA Police office on December 5, 2017, which was resolved the same day.

Conclusion

The OIG did not substantiate that several deaths resulted in the ED when patients were not transferred timely to units because of insufficient staffing. The OIG medical consultant physician reviewed the EHRs of 13 patients and determined that five of the eight patients who had died, expired in the ED while the other three patients expired after transferring out of the ED. The OIG did not find a delay in transfer for the five patients who died in the ED, and staffing information provided by the system appeared to show a sufficient number of nurses on duty at the time of the patients' deaths. One of the three patients, (Patient B) who died after transfer, had a delay in transfer from the ED. While the OIG was unable to determine whether inadequate staffing was related to the delay, the OIG identified quality of care issues for Patient B.

The OIG substantiated that beds in certain units were blocked due to low nurse staffing levels. According to system policy, a bed may be taken out of service with the concurrence of the nurse manager and the ADPCS or designee and, when a staffing shortage exists that cannot be modified with a simple shift of personnel from one work area to the affected work area, a bed will be taken out of service. The OIG determined that system managers did not inform VISN staff of the bed closures as required by system policy.

While the OIG substantiated that the system allowed a certain number of patients per nurse even if beds were available, the OIG did not substantiate the implied inappropriateness of this action.

The OIG was unable to determine whether there was an unsafe work environment related to nurses having to take up to 15 patients due to insufficient evidence. A nursing leader denied RNs were assigned up to 15 patients and staff did not mention this concern. OIG inspectors did not find gaps in patient care that may have reflected insufficient staffing.

The OIG was unable to determine that insufficient staffing contributed to an alleged increase in patient falls, rapid responses, code blues, and sentinel events. The OIG did not find an increase in the number of patient falls, rapid responses, code blues, or sentinel events between winter 2016 and late spring 2017 and was not able to make a correlation between the adverse events that did occur and staffing issues. The OIG reviewed the EHRs of 50 patients with a total of 87 falls on

the APU. The OIG found fall risk scores were assigned to most of the patients on APU, fall prevention education was provided unless the patient refused, and examples of interventions were documented.

The OIG identified two patients who had falls with an injury. Patient G had a hip fracture after a fall and Patient H died because of intracranial hemorrhaging (bleeding in the brain) after a fall. Staffing for Patient G's inpatient medical unit and Patient H's CLC unit on the days of their falls appeared adequate; however, the OIG noted discrepancies in the data on the staffing sheets provided. According to the OIG team's EHR review, documentation indicated appropriate nursing care for these two patients. The system conducted an RCA to investigate Patient G's fall and hip fracture. The system did not conduct an RCA to investigate Patient H's fall and death. In addition, the OIG determined that the system did not complete institutional disclosures for Patients G and H.

The OIG substantiated that the system had inadequate supplies including needles, vacutainers, wound care supplies, and urinals. Staff reported concerns related to inadequate supplies and that they borrowed from other units. Due to actions taken and noted improvements, OIG did not make a recommendation related to inadequate supplies.

The OIG did not substantiate linens were inadequate or unavailable at the time of the August 2017 site visit. The OIG staff inspected the linen storage carts on the acute care units and determined they were fully stocked.

The OIG found 35 percent of ED patients admitted to the system between summer 2016 and late spring 2017 waited for four hours or more (boarders) before transfer to an inpatient unit. Factors that OIG identified as contributing to the boarding of patients in the ED included capping, space limitations of the ED until new construction was completed, time of discharge, telemetry availability, and availability of mental health beds in the community.

The OIG identified quality of care concerns for five patients (A, B, D, E, and F) who were boarded in the ED awaiting beds on the inpatient units. Three of the five patients (A, B, and F) did not receive the acute care they required. Patients A, B, and F exhibited signs of infection and/or sepsis that may have been treated more appropriately had their symptoms been recognized earlier. The OIG determined the remaining two patients (Patients D and E) did not receive the mental health care they required. Patient D was boarded in the ED for approximately four days and did not have a nursing assessment completed within 24 hours of admission. Patient E, who was actively suicidal and not considered "safe" for the secured APU, was boarded in the ED for two days. Neither patient participated in group therapy as ordered. VHA Directive 1101.05 (2) states that the standard of care is upheld for a patient admitted to an inpatient area who is held in any temporary bed locations, such as an ED.

The OIG identified deficiencies in the coordination of Patient C's care between the Louisville VAMC and the system. Patient C traveled to Kentucky in summer 2016 shortly after receiving treatment for left shoulder osteoarthritis at the system ED.

While travelling, Patient C was admitted to the Louisville VAMC for treatment of a shoulder and knee infection that would require six weeks of intravenous antibiotic therapy. To facilitate long-term antibiotic treatment, a PICC was placed in Patient C's arm.

Approximately three weeks after admission, Patient C was discharged with the PICC in place and returned to California the same day by plane. The patient's Louisville VAMC case manager had contacted a system Patient Aligned Care Team (PACT) social worker to discuss discharge and continuation of the patient's care upon return to Loma Linda VAMC but the EHR documentation was incomplete about the specifics of care upon the patient's return to California.

When Patient C presented to the system ED one day after discharge from the Louisville VAMC, no one in the ED appeared to be expecting the patient or to be aware of transfer arrangements in relation to the Louisville VAMC. Within three hours of arrival to the system, Patient C rapidly declined, suffered a cardiac arrest, and could not be resuscitated.

The OIG identified a deficiency related to camera surveillance in the ED that could negatively impact patient and employee safety; the video monitor did not properly transmit images to the VA Police observation station. In January 2018, the OIG followed up with a system leader and found no reported instances of camera failure or systems issues in the ED from October 1, 2017, through December 31, 2017, except for one incident in the VA Police office on December 5, 2017, which was resolved the same day.

Recommendations 1–10

1. The VA Loma Linda Healthcare System Director defines goals, implements measures, and monitors outcomes to improve the flow of patients throughout the hospital, including the Emergency Department, inpatient medical and surgical units, mental health units, and the Community Living Center.

2. The VA Loma Linda Healthcare System Director conducts a review to evaluate the accuracy of data entered in Emergency Department Integration Software and takes action to ensure that the data collection tool may be used for operational improvement.

3. The VA Loma Linda Healthcare System Director ensures that patients admitted to a unit where there is no bed available receive the same level of care that is provided in the unit to which they are assigned.

4. The VA Loma Linda Healthcare System Director ensures that bed closures are reported to the Veterans Integrated Service Network as required by VA Loma Linda Healthcare System policy.

5. The VA Loma Linda Healthcare System Director evaluates the care of patients with sepsis in the Emergency Department, identifies opportunities for improvement, and takes actions to improve care.

6. The VA Loma Linda Healthcare System Director evaluates the response time of psychiatrists consulted for the care of mental health patients in the Emergency Department and takes action if required.

7. The VA Loma Linda Healthcare System Director conducts an evaluation of Patient C's 2016 coordination of care, discharge planning, and transfer of care, including but not limited to, conferring with the Director of the Robley Rex Veterans Affairs Medical Center, Louisville, Kentucky, and takes action as necessary.

8. The VA Loma Linda Healthcare System evaluates, develops, and implements processes for veterans who have anticipated or unexpected medical needs coordinated by their preferred medical facility and an alternate medical facility.

9. The VA Loma Linda Healthcare System Director evaluates and ensures that root cause analyses are completed in accordance with Veterans Health Administration directives.

10. The VA Loma Linda Healthcare System Director reviews the care of the two fall patients with injuries discussed in this report, adheres to Veterans Health Administration policies, and takes action as appropriate.

Appendix A: Patient Case Summaries

Patient A

The patient, who was in his/her late 60s, had a history of polycystic kidney disease and renal failure on dialysis.[80] The patient was seen at a non-VA facility and diagnosed with shingles (reactivation of the chickenpox virus) in summer 2016.[81] Patient A then presented to the system ED with complaints of weakness and burning on urination.[82] The ED physician performed an evaluation and ordered intravenous fluids. Patient A was discharged home after receiving the intravenous fluids. The next day, the patient returned to the system ED by ambulance complaining of weakness. The medicine resident admitted the patient for confusion, which was thought to be secondary to a shingles infection.

About three hours after the patient presented to the ED, the admitting physician wrote orders for admission, but Patient A stayed in the ED overnight because of the lack of an inpatient bed. At approximately 2:30 p.m. the next day, an ED nurse found the patient in an unresponsive state with a slow heart rate. The patient had a low blood sugar; the ED physician ordered glucose, calcium, and atropine.[83] The patient's heart rate and blood sugar improved with these measures. Patient A woke up but fell asleep again. The patient was transferred to the Intensive Care Unit (ICU) shortly after the event.

During the admission, Patient A was diagnosed with a brain infection likely from the shingles virus and contracted an antibiotic-associated diarrhea. Both were treated successfully. After 18 days, Patient A was discharged to a non-VA nursing home.

Concerns: Boarding, Level of Critical Care in ED.

Patient B

The patient, who was in his/her late 60s, had a history of chronic lung disease, hypertension, and high cholesterol. In summer 2016, Patient B was admitted for a week to a non-VA hospital with pneumonia. The pneumonia was of sufficient severity that intubation and mechanical ventilation was required. After the seven-day stay in the non-VA hospital, the patient was discharged to a non-VA nursing home for rehabilitation and stayed at that facility for a month.

Shortly after discharge from the non-VA nursing home, Patient B presented to the system ED for medication refills. Two days later, Patient B returned to the ED complaining of shortness of

[80] The OIG uses "his/her" to protect patients' privacy; patients with polycystic kidney disease develop cysts which could destroy the function of the kidneys.

[81] Shingles is a reactivation of chicken pox which occurs when a patient's immunity decreases with age.

[82] This was the patient's first system encounter in about 10 years.

[83] Atropine is a medication that raises the heart rate.

breath of one-day's duration and diarrhea/vomiting of one-week's duration. The patient's oxygenation on room air was low and the blood pressure was very low. The system ED physician diagnosed pneumonia, acute kidney injury, and a possible blood clot in the lungs. After receiving four liters of intravenous fluids and two antibiotics within three hours of arrival, Patient B's blood pressure normalized.

Two hours after Patient B's arrival to the ED, the ED physician placed an order for the patient to be admitted to the ICU. However, Patient B was not transferred to ICU that day. The system's ICU physician evaluated the patient in the ED 30 minutes later; documentation was not entered until the next day that Patient B had impending septic shock.[84] While in the ED, Patient B received medications for treatment of a possible blood clot and antibiotic-associated diarrhea (*Clostridium difficile* colitis).[85]

The next day, at approximately 9:30 p.m., while still in the ED, Patient B's stopped breathing and became pulseless. A code blue was called. ED staff intubated and successfully resuscitated Patient B. Transfer to the system's ICU occurred approximately a half hour later.

While an inpatient, Patient B suffered two more code blue events and required four medications to support low blood pressures. A system surgeon and gastroenterologist determined that Patient B was not a candidate for any procedures. Patient B's brother arrived at the hospital and ultimately elected to halt aggressive care measures, which included taking the patient off life support. The patient died the day after transfer to the ICU.

Concerns: Death in Hospital, Boarding, Level of Critical Care in ED

Patient C

The patient, who was in his/her mid-40s, had a history of diabetes and hypertension, and was taking immunosuppression medications for rheumatoid arthritis.[86] In summer 2016, Patient C was seen in the system ED for left shoulder pain. After obtaining an x-ray of the left shoulder,

[84] Septic shock refers to the body's response to an overwhelming infection. Symptoms may include low blood pressure, low oxygenation, fast breathing, and confusion. Rapid recognition of septic shock and treatment with IV fluids antibiotics is crucial for patient survival.

[85] "*Clostridium difficile* is a bacterium that causes inflammation of the colon, known as colitis." Centers for Disease Control and Prevention. Healthcare-associated Infections. https://www.cdc.gov/hai/organisms/cdiff/cdiff-patient.html. (The website was accessed on December 4, 2017.)

[86] Immunosuppression medications treat rheumatoid arthritis by stopping the inflammatory response in the body. However, these medications also increase the risk of infections because the body's natural immune system may become compromised.

the ED physician diagnosed the patient with osteoarthritis, Patient C was given pain medication and a steroid (Kenalog®) medication by injection, and was discharged.[87]

Four days later, Patient C was travelling and presented to the Louisville VAMC complaining of severe left shoulder pain after a fall, as well as increasing right knee pain. Patient C was found to have a low serum sodium level and was admitted to the Louisville VAMC for further treatment.

During the hospitalization, Patient C was diagnosed with a shoulder and knee infection which would require six weeks of intravenous antibiotic therapy. To facilitate long-term antibiotic treatment, a peripherally-inserted central catheter (PICC) was placed.

Patient C's hospitalization at the Louisville VAMC was complicated by the development of bleeding intestinal ulcers and high blood pressures. Patient C wanted to be discharged from the Louisville VAMC and return to California.

Nine days after admission, a Louisville VAMC case manager contacted a system Patient Aligned Care Team (PACT) social worker inquiring about how best to continue Patient C's care upon return to California.[88] The PACT social worker advised that the patient should report to the system ED so that the ED physician could write new intravenous antibiotic and home health orders. The PACT social worker documented that the patient would be set up to see the PACT primary care physician after being evaluated at the system's ED. The EHR did not have other documentation that indicated the PACT social worker contacted the system ED staff or the patient's primary care physician in California.

Three weeks after admission to the Louisville VAMC, an attending physician documented that Patient C was cleared for discharge. On the day of discharge, Patient C, with the PICC in place, traveled to California with a family member on an early afternoon flight.

The next day, Patient C presented to the system ED in the morning requesting continued antibiotics. No one in the ED appeared to be expecting Patient C or to be aware of transfer arrangements in relation to the Louisville VAMC. An ED triage nurse noted an elevated blood pressure and rapid pulse, and assigned the patient an ESI Level 3. An hour later, Patient C went to the Infectious Diseases Clinic without waiting to be seen by an ED physician. Approximately an hour later, the Infectious Diseases Clinic intake nurse found that Patient C had a very low blood pressure and was slow to respond to verbal commands. The nurse called for an RRT, who transported Patient C to the ED.

---

[87] "Osteoarthritis occurs when cartilage, the tissue that cushions the ends of the bones within the joints, breaks down and wear away." National Institute on Aging https://www.nia.nih.gov/health/osteoarthritis (The website was accessed on December 4, 2017.)

[88] The PACT is a team of health care professionals including a physician, nurse, and administrative support staff who work together to manage and coordinate the primary care needs of patients.

Patient C was immediately placed in an ED bed, rapidly declined, and suffered a cardiac arrest.[89] Despite the ED staff's resuscitation attempts, Patient C died. The death certificate listed cardiac arrest, bradycardia (slow pulse), high potassium, and diabetes as the causes of death. An autopsy was not performed.

Concerns: Death in ED, Coordination of Care

Patient D

The patient, who was in his/her late 70s had a history of psychiatric illness, dementia, and chronic kidney disease. Patient D presented to the system ED in late summer 2016 and complained of low back pain to the ED triage nurse. After informing the nurse of being homeless, the triage nurse contacted a social worker to address the homelessness issue.

The social worker discovered that Patient D had been living in a nursing home until the day prior to presenting to the ED and had been discharged to a board and care home.[90] The board and care home staff informed the social worker that the patient was "mad and yelling this morning," refused to eat or take medications, and elected to leave the home.

In the ED, a psychiatric resident who evaluated Patient D ordered admission to the APU for stabilization and placement. Both the psychiatric resident's and attending physician's notes documented that Patient D would be engaged in the unit milieu and supportive group therapy.

However, the system had no available APU geropsychiatric beds. Patient D remained in the ED for four days before being transferred to the CLC.[91]

Concerns: Boarding, Level of Mental Health Care in the ED

Patient E

The patient, who was in his/her mid-30s, had a history of psychiatric illnesses, alcohol abuse, and homelessness. Patient E was brought to the system ED by a sibling in late summer 2016, at 3:20 p.m. because the patient had suicidal ideation. Patient E was not a veteran and had not previously been seen in the system ED.

The ED social worker, physician, and psychiatry resident evaluated the patient and determined that Patient E needed admission. The social worker placed the patient on an involuntary hold at

[89] Patients in cardiac arrest have no pulse and therefore do not have enough circulation to oxygenate the cells of the body.

[90] A board and care home, or residential care facility, provides nonmedical custodial care in a single family residence. Skilled nursing services are not provided but assistance with all daily living activities such as bathing and dressing are allowed.

[91] The patient used a walker, which could have been used as a weapon in the general psychiatric unit requiring admission to the geropsychiatric unit until otherwise stabilized.

6:45 p.m. because the patient did not wish to be admitted and attempted to leave. Around 10 p.m., the psychiatry resident wrote admission orders. The next morning, the admitting psychiatric nurse wrote an admission note in anticipation of transferring Patient E to the psychiatry unit. However, Patient E remained in the ED approximately 47 hours after admission orders were written, before being transferred to the APU. Patient E stayed in the APU for eight days before being discharged home.

Concerns: Boarding, Level of Mental Health Care in ED

Patient F

The patient, who was in his/her 50s, had a history of morbid obesity, diabetes, and hypertension. Patient F was admitted to the system CLC in late summer 2016 for treatment of a foot infection. In late winter 2017, Patient F developed a cough accompanied by shortness of breath. A chest x-ray was ordered and showed an abnormality, which could have been related to poor aeration in the lung, mass, pneumonia, or an image artifact. The EHR does not contain documentation as to what actions—diagnostic or therapeutic—were taken for this finding.

Two days after the chest x-ray was completed, Patient F complained of not feeling well, was found to have a fever and fast pulse, and was transported from the CLC to the ED for evaluation. The ED nurse had a hard time waking the patient. The ED physician on duty concluded that Patient F had an infection from an unknown source. A chest x-ray was completed and did not show signs of pneumonia. The ED physician ordered labs, blood cultures, a computed tomography scan of the head, two antibiotics (vancomycin and Zosyn®–a combination of piperacillin and tazobactam), intravenous fluids, breathing treatments, and acetaminophen (Tylenol®).

Approximately five hours after arriving in the ED, Patient F developed low blood pressure. The ED physician ordered intravenous fluids and requested an ICU bed. The patient remained hypotensive. About two hours later, the patient was found in a pulseless state. The staff's resuscitation attempts were unsuccessful.

Concerns: Death in ED, Boarding, Level of Critical Care in ED

Patient G

The patient, who was in his/her mid-80s, had a history of oxygen-dependent lung disease, bilateral groin hernias, and cognitive impairment. In summer 2016, Patient G was brought to the system ED by the patient's spouse as Patient G had abdominal pain and the spouse was unable to provide care for the patient at home. Although the abdominal pain largely resolved in the ED, the ED physician admitted Patient G to the system for further treatment of the abdominal pain and

nursing home placement. The ED physician ordered "ad lib" activity for Patient G upon admission to a medical bed.[92]

The nurse on the admitting unit determined that Patient G was at high risk for falling and implemented fall prevention measures. During the first night after admission, Patient G woke up, questioned the reason for admission to the hospital, and called the spouse. Patient G wanted to go home but calmed down after speaking with the nurse and the spouse. The physician was notified of Patient G's concerns. Patient G was reminded to call for assistance when needing to get out of bed.

Approximately three hours later, the night shift nurse found Patient G on the floor complaining of right hip pain. The nurse documented that there were no difficulties moving and notified the on-call physician. The EHR did not contain documentation as to whether the on-call physician evaluated Patient G or gave orders to the nurse.

A few hours later, the day shift nurse informed the physician who had admitted Patient G that there was discoloration over the hip with continued complaints of right hip pain. The physician ordered x-rays that revealed a right hip fracture. The radiologist who read the films documented that the abnormality required attention but did not document calling the ordering physician.

In mid-afternoon, a nurse took Patient G to the bathroom. The nurse noted increased effort with urination and documented that after returning to the bed, Patient G appeared "ashen," was complaining of severe hip pain, and had worsening shortness of breath that required more oxygen than usual. The admitting physician ordered intravenous fluids and diagnostic tests. Approximately 3.5 hours after the hip x-ray was completed, the physician noted being informed by radiology staff that Patient G had a hip fracture. The physician called the orthopedic surgeon who stated that Patient G would be examined that day.

Patient G continued to decompensate, required more oxygen, and was transferred from the CLC to the ICU. The respiratory symptoms (the shortness of breath and increased need for oxygen) were thought to be possibly due to a fat embolism from the hip fracture.[93] The patient was not a surgery candidate and the family had requested a "Do Not Resuscitate" status. Five days later, the patient was discharged to a nursing home. According to a family member, Patient G died at the nursing home almost a month later.

Concerns: Death in a Non-VA Nursing Home after Discharge, Adverse Event Fall with Injury

[92] An "ad lib" activity order allows the patient to ambulate freely without restrictions.

[93] A fat embolus is a small fragment of fat that can break off from a fractured bone and travel to the lungs, causing an occlusion of the blood vessels in the lung, brain, or other organs. Treatment is mostly supportive.

Patient H

The patient, who was in his/her late 70s, had a history of dementia. Patient H was admitted to the system CLC in spring 2017 for respite care.[94] At admission, Patient H weighed 85 pounds and was confused at baseline. Patient H required help with all activities of daily living but was able to walk with supervision.

Patient H had requested a "Do Not Resuscitate" status in the event of a medical emergency.[95] A nurse at the CLC determined that the patient was at high risk for falls and implemented fall prevention measures such as a low bed, call bell within easy reach from the bed, and frequent observation.

One day after admission, staff found Patient H minimally responsive on the bedroom floor with a severe head cut. After transfer to the ED, Patient H was diagnosed with intracranial hemorrhaging (bleeding in the brain). The ED physician contacted the patient's spouse and indicated that Patient H had a poor prognosis. The spouse requested that Patient H be transferred to another hospital for neurosurgery evaluation and treatment. Patient H was transferred to a non-VA hospital where a neurosurgeon determined that the patient was not a surgical candidate. Patient H was admitted for hospice care and died approximately one week later.

Concerns: Death in a Non-VA hospice, Adverse Event Fall with Injury.

Patients I–M

The OIG reviewed five additional patient cases (I, J, K, L, and M). The OIG found that patients I, J, and K died in the ED, but did not identify concerns with the quality of care provided for the five patients.

[94] Respite care is a temporary living situation for a patient (usually disabled or elderly) so that the caregiver may have time to rest.

[95] For admitted patients, the physician discusses the type of resuscitation treatment the patient wishes to have in case he or she becomes unresponsive. For patients who elect Do Not Resuscitate (DNR)/Do Not Attempt Resuscitation (DNAR) status, cardiopulmonary resuscitation (CPR), defibrillation (administration of electrical shock during a cardiac cycle to restart the heart), and/or medications are not initiated.

Appendix B: Summary of Concerns

Table B.1. Summary of Concerns

Concerns	Number of patients*
Deaths in ED	5
Non-ED deaths	3
Boarded in ED	5
Level of required acute care not provided	3
Level of required mental health care not provided	2
Falls with injury	2
Coordination of care concerns	1

Source: OIG analysis from EDIS and patient case summaries
**When summed, the total number of patients exceeds 13, as the OIG team found some patients with more than one concern.*

Appendix C: VISN 22 Director Comments

Department of Veterans Affairs Memorandum

Date: March 6, 2019

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

Subj: Healthcare Inspection—Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California

To: Director, Office of Healthcare Inspections (54HL02)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, Healthcare Inspection—Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California
2. If you have any additional questions, please contact me at (562) 826-5963. Thank you.

//Original signed by//

Michael W. Fisher
VISN 22 Director

Appendix D: VA Loma Linda Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 6, 2019

From: Director, VA Loma Linda Healthcare System (605/00)

Subj: Healthcare Inspection—Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California

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

1. Thank you for the opportunity to review and comment on the draft report, Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System.
2. I have reviewed and concur with the status of the actions and recommendations as submitted.
3. If you have any additional questions, please contact me at (909) 825-7084 ext. 6005.

//Original signed by//

Stewart R. Quinton
Interim Medical Center Director

Comments to OIG's Report

Recommendation 1

The VA Loma Linda Healthcare System Director defines goals, implements measures, and monitors outcomes to improve the flow of patients throughout the hospital, including the Emergency Department, inpatient medical and surgical units, mental health units, and the Community Living Center.

Concur.

Target date for completion: September 30, 2019

Director Comments

We are engaged in an ongoing comprehensive flow management initiative and Emergency Department (ED) systems redesign. The improvements include implementation of paperless data capture, increased staffing, and focused provider training, both in fast track and non-fast track triage, and management. To address delays in admission, we are implementing an escalation protocol, point of care testing, and pathways to standardize evaluation of patients with common admission diagnoses, imbedding support staff (LVN navigator, pharmacy, social work, UM) in the ED, and reevaluating rapid access initiative. Flow metrics from the ED, such as Average ED Visit Time and Average Admit to Decision Time, are reported to the Medical Center Director daily.

Recommendation 2

The VA Loma Linda Healthcare System Director conducts a review to evaluate the accuracy of data entered in Emergency Department Integration Software and takes action to ensure that the data collection tool may be used for operational improvement.

Concur.

Target date for completion: April 3, 2019

Director Comments

This has been completed and verified with transition to paperless data capture and EDIS training of incumbent and newly onboarded provider staff.

Executive leadership team was involved in looking at EDIS data and providing oversight to ensure appropriate actions were taken to correct and monitor deficiencies. Daily reports are presented to the Medical Center Director that looks at several ED measures with regards to provider data such as Percent of Provider Entry of Assignment, Percent of Provider Entry of Disposition, and Percent of Correct Disposition. The daily reporting of the EDIS data has led to

improvements in ED operations because the Medical Center Leadership have data to act on before an adverse situation happens.

The data reliability indicators in EDIS have improved. These values determine the reliability of the data that is entered in EDIS. Accurate EDIS data assist us to determine our Vulnerability Score of the ED. This is the risk of an adverse event occurring at a site because of inadequate or failed processes or systems.

Recommendation 3

The VA Loma Linda Healthcare System Director ensures that patients admitted to a unit where there is no bed available receive the same level of care that is provided in the unit to which they are assigned.

Concur.

Target date for completion: April 30, 2019

Director Comments

We have modified the policy for the ED inpatient holding protocol. Inpatient admitting orders will be released on the following, for patients held in the ED for greater than:

- 2 hours for ICU admissions
- 4 hours for TELE/SDU admissions
- 8 hours for MED SURG/2NE admissions
- RNs will document medications in BCMA
- The Nurse on Duty (NOD) will float an RN from the admitting unit to the Emergency Department to provide care for ED inpatients who are holding, if nurse staffing permits
- Providers will follow an algorithm for admission of patients to Acute Psychiatric Unit (APU)

All ED nursing staff will be educated on the following ICU training modules; Acute Coronary Syndromes, Thrombolytic Therapy, Heparin Infusion Protocol, Ventilator Associated Pneumonia, ICU Insulin Protocol, Pacemakers, Performance of a 12 Lead EKG, Policy of Care of the Adult/Geriatric patient Receiving Mechanical Ventilation, Sepsis, Critical Care Infusion Medications Table, and Hemodynamic monitoring, within 30 days. This will be evidenced by affirmations signed by the staff that education was received. In addition, the ED Nurse Educator will include ICU training modules during the Annual ED skills days.

ED Nurse Manager maintains and tracks competencies of ED Nursing staff. ED staff have completed training of Intelliview Critical Care Anesthesia (ICCA) electronic flowsheet, which is used for electronic healthcare documentation in the ICU.

Recommendation 4

The VA Loma Linda Healthcare System Director ensures that bed closures are reported to the Veterans Integrated Service Network as required by VA Loma Linda Healthcare System policy.

Concur.

Target date for completion: March 31, 2019

Director Comments

Bed closure reporting under VA Loma Linda Healthcare System Policy 11-51: Bed Management Solution Policy is currently under review and will be approved to ensure compliance with VHA, VISN, and Facility policy.

Recommendation 5

The VA Loma Linda Healthcare System Director evaluates the care of patients with sepsis in the Emergency Department, identifies opportunities for improvement, and takes actions to improve care.

Concur.

Target date for completion: June 30, 2019

Director Comments

A more robust triage process has been implemented and identifies patients at risk. A sepsis bundle has been incorporated into our electronic health record order set to provide earlier goal-directed therapy. The sepsis bundle will be used by all nurses and physicians in the ED as their Sepsis Screening Tool in our electronic health record. On-going training is provided to new Nurse and Physicians regarding this Sepsis Bundle by the ED Nurse Educator and ED Medical Director.

Recommendation 6

The VA Loma Linda Healthcare System Director evaluates the response time of psychiatrists consulted for the care of mental health patients in the Emergency Department and takes action if required.

Concur.

Target date for completion: June 30, 2019

Director Comments

Facility leadership conducted an analysis of time to decision and admit for psychiatry. Time to decision is similar to averages for other services. There are slight delays from decision to admit. Psychiatry leadership has worked closely with the Residency program to improve response time to the ED as well as with Nursing to avoid any delays in admission. Psychiatry and Nursing are implementing comprehensive time studies for each step in the current admission process. The time studies will evaluate average times, steps to complete actions, and barriers that may arise. It is anticipated that the time studies will be completed by F19 Q3. The studies and analysis will be conducted collaboratively with Mental Health, the Residency program, and the ED and will take appropriate operational actions.

Recommendation 7

The VA Loma Linda Healthcare System Director conducts an evaluation of Patient C's 2016 coordination of care, discharge planning, and transfer of care, including but not limited to, conferring with the Robley Rex VA Medical Center Director, and takes action as necessary.

Concur.

Target date for completion: Closed

Director Comments

On February 25, 2019 the Chief of Staff from Loma Linda VAMC and the Robley Rex VAMC reviewed the case of Patient "C". Both parties agreed that this situation may have been handled as an inpatient transfer. Both VAMC's have policies and coordinators that would have effectively made the transfer and acceptance possible. This was an uncommon occurrence that has given insight to both VAMC's. The situation has increased our awareness to act in a more efficient, cooperative, and timely manner for the best medical outcome for our veterans.

OIG Comment

The OIG considers this recommendation open to allow time for the VA Loma Linda Healthcare System Director to provide supporting documentation.

Recommendation 8

The VA Loma Linda Healthcare System evaluates, develops, and implements processes for veterans who have anticipated, or unexpected medical needs coordinated by their preferred system and an alternate system.

Concur.

Target date for completion: June 30, 2019

Director Comments

An interdisciplinary approach, including physicians, inpatient RN care managers, social workers, pharmacist, and staff nurses, is used to ensure safe discharge processes are operationalized efficiently. There are several physician-led daily discharge rounds in various inpatients wards as well as the daily interdisciplinary huddles. The purpose of the interdisciplinary discharge processes is to identify patients deemed appropriate for discharge, coordinate safe and timely discharges from acute care to home destination, meet anticipated post-hospitalization discharge needs (e.g., transportation, home health, SNF placement, ancillary services), and address barriers to accomplishing a safe and timely discharge. If a Veteran is a transfer, we will utilize our interfacility transfer policy, which would require a referring physician and coordination by the Clinical Transfer Coordinator or designee. We have a communication mechanism that is utilized in our electronic health record than can flag high risk patients.

The Mental Health Chief has provided guidance to all Social Workers that all patient transfer inquires will be routed to the Clinical Transfer Coordinator. We have also conducted a recent training on Interfacility Transfers with the new Administrative Officers of Day (AOD) group. Our Clinical Transfer Center is also required to audit at least 10 transfer s per month, which the results are provide to our Quality Management Service each quarter.

Recommendation 9

The VA Loma Linda Healthcare System Director evaluates and ensures that root cause analyses are completed in accordance with the VHA directives.

Concur.

Target date for completion: October 1, 2019

Director Comments

The VA Loma Linda Healthcare System Director evaluates and ensures that Root Cause Analysis (RCAs) are completed in accordance with VHA directives. Historically, the VHA directive for conducting RCAs has been the guide for specific handling of sentinel events. Patient G had an independent RCA conducted in June 2017, shortly after the event occurred. However, Patient H's case was handled differently since the patient was transferred outside of the Loma Linda Healthcare System to another healthcare entity for treatment. Therefore, the patient did not have an immediate RCA, but instead, was included in the falls aggregate this year.

Loma Linda VA Healthcare System's aggregate RCA no longer include those that fall into the category of sentinel event. Every sentinel event has their own independent RCA and will not be included in the aggregate RCA. Currently, we are logging all falls in the Joint Patient Safety Reporting System that result in an injury whether permanent or temporary; and conducting an

RCA on each event immediately upon notification. The RCA policy is being followed for all falls that result in deaths, permanent injury damage, temporary damage, and near misses that a Veteran may sustain during an injury/near injury fall.

Risk Management makes recommendation to the Chief of Staff regarding Clinical and Institutional disclosures. The process now includes notification of the Facility Director when a recommendation for disclosure has been made to the Chief of Staff.

Patient Safety Manager reports to the Medical Center Director daily, any adverse or sentinel events that occur over the past 24-hour period. For high risk issues, a Safety Huddle is conducted to determine if an Issue Brief and/or additional actions are required. If an RCA is warranted, the Medical Center Director issues an immediate Charge Letter to begin the process.

Recommendation 10

The VA Loma Linda Healthcare System Director reviews the care of the two fall patients with injuries discussed in this report, adheres to Veterans Health Administration policies and takes action as appropriate.

Concur.

Target date for completion: Closed

Director Comments

Review of the patients were completed through RCAs by Patient Safety. All completed RCAs are reported to our Executive Leadership Board.

OIG Comment

The OIG considers this recommendation open to allow time for the VA Loma Linda Healthcare System Director to provide supporting documentation.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Ann Ver Linden, MBA, RN, Team Leader Katharine Brown, JD Erin Butler, LCSW Katherine Gemmell, MPH, LCSW, Jennifer Kubiak, MPH, RN Mary Taylor, BSN, RN
Other Contributors	Alicia Castillo-Flores, MBA, MPH Kathy Gudgell, JD, RN Natalie Sadow, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Desert Pacific Healthcare Network (10N22)
Director, VA Loma Linda Healthcare System (605/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Dianne Feinstein, Kamala D. Harris
U.S. House of Representatives: Pete Aguilar, Ken Calvert, Gilbert Cisneros, Paul Cook, Raul Ruiz, Mark Takano, Norma Torres

The OIG has federal oversight authority to review the programs and operations of VA medical facilities. OIG inspectors review available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leadership on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

OIG reports are available at www.va.gov/oig