



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Mismanagement of a  
Resuscitation and Other  
Concerns at the Gulf Coast  
Veterans Health Care  
System

Biloxi, Mississippi



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a request from the OIG Office of Investigations to evaluate the care of a patient who died (event) in an acute inpatient behavioral health unit at the Gulf Coast Veterans Health Care System (facility), Biloxi, Mississippi. The specific concern was the unit staff's failure to initiate full resuscitation efforts at the time the patient was found unresponsive.<sup>1</sup> In late 2017, the facility's VA police informed the OIG Office of Investigations of the event. Reportedly, the patient was found unresponsive on the behavioral health unit while on close observation orders and was pronounced dead less than 24 hours after admission.<sup>2</sup> Due to concerns surrounding the medical circumstances and events in response to the patient's death and the timing of the death, the Office of Investigations referred the concerns to the OIG Office of Healthcare Inspections.

The OIG determined that behavioral health unit staff did not initiate appropriate resuscitation efforts after finding the patient unresponsive. However, based on the available facts and circumstances, the OIG was unable to determine whether initiating full resuscitation efforts would have been successful if employed at the time the patient was found unresponsive. The OIG determined that staff, after finding an unresponsive patient, did not quickly assess the patient, act with a sense of urgency, alert the care team, immediately initiate basic life support (BLS), locate the nearest automated external defibrillator, nor activate the community 9-911 emergency response system, all of which were required by policy.<sup>3</sup>

The OIG determined that the behavioral health unit registered nurses (RNs) did not fulfill the duties and responsibilities expected of their positions. Multiple RNs reported to have assessed the patient for several minutes; however, they did not initiate an immediate resuscitation response, or continue resuscitation efforts until the patient was stable or emergency responders arrived.

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<sup>1</sup> For this report, the OIG uses the term resuscitation to include CPR, Basic Life Support, Code Blue, and emergency medical condition; Facility Memorandum No. 11-46-17, *Medical Emergencies/Code Blue*, July 21, 2017.

<sup>2</sup> Close observation requires monitoring every 15 minutes.

<sup>3</sup> OIG from this point forward refers to the OIG Office of Healthcare Inspections; For the purposes of this report the cart found on unit 25-B will be referred to as an emergency cart, there were no emergency medications on this cart; automated external defibrillators (AEDs) were developed to save the lives of people experiencing sudden cardiac arrest. Defibrillators are devices that restore a normal heartbeat by sending an electric pulse or shock to the heart. They are used to prevent or correct an arrhythmia, a heartbeat that is uneven or that is too slow or too fast. Defibrillators can also restore the heart's beating if the heart suddenly stops. U.S. Department of Health and Human Services website, National Heart, Lung, and Blood Institute, <https://www.nhlbi.nih.gov/health-topics/defibrillators>. (The website was accessed on July 30, 2018.); Facility Memorandum No. 11-46-17.

RNs who meet certain functional levels at the facility are expected to be proficient in taking care of patients with complex nursing care needs. Behavioral health RNs are expected to apply critical thinking skills that demonstrate the nurse

- Recognized the patient had a problem,
- Managed the problem safely and effectively within the scope of practice,
- Had a relative sense of urgency, and
- Took the right action for the right reason.

By not recognizing the patient's acute medical emergency and not acting with a sense of urgency, the rounding nurse, the charge nurse, the assigned nurse, and the unit 25-A nurse were not practicing within their expected roles and duties to initiate and sustain resuscitation.

The medical officer of the day (MOD) documented in the electronic health record (EHR) being called by a nurse from the behavioral health unit who stated the need to "pronounce a patient...that [behavioral health] nurses cannot pronounce patients." The MOD documented that a nurse had examined the patient and deemed the patient to be dead. The MOD further documented telling the nurse that "if you have determined that the patient was dead then at this time, CRP [*sic*] would not likely be helpful." Veterans Health Administration Directive 2011-016 states that only medical doctors can pronounce patient death while the patient is under the care of the VA.<sup>4</sup>

The OIG determined that facility staff did not consistently track documentation of the behavioral health unit RNs for BLS competency and training (certification). According to facility policy "[s]taff who do not maintain current training will not be allowed to work in positions that require BCLS [Basic Cardiac Life Support]/ACLS [Advanced Cardiac Life Support] until training is current unless a waiver has been obtained."<sup>5</sup> When asked, facility leaders could not provide documentation of BLS certification or a waiver indicating BLS was not required for two of the four RNs at issue.

Behavioral health unit nursing staff did not ensure accurate and complete EHR documentation for the subject patient. When the patient was admitted to the unit, the physician ordered observation every 15 minutes. Assigned staff were expected to conduct rounds to check on the patient and document the checks on the Restraints/Seclusion/Suicide Observation Flow Sheet (observation flow sheet). OIG staff compared observations viewed on the behavioral health unit's consolidated monitoring system video recordings with nursing documentation of patient observation checks on the observation flow sheet, and determined nursing staff documented a

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<sup>4</sup> VHA Directive 2011-016, *Pronouncement of Death and Request for Autopsy by a Registered Nurse, Advanced Practice Nurse or Physician Assistant in VA Community Living Center*, March 16, 2011.

<sup>5</sup> Facility Memorandum No. 11-46-17.

15-minute patient check that was not performed.<sup>6</sup> Due to the missing entries on the observation flow sheet and lack of video footage evidence that would corroborate the observation flow sheet entries, the OIG was unable to determine when the patient became unresponsive, or whether earlier interventions might have changed the outcome.

The OIG did not find evidence that emergency department providers documented a discussion with the admitting behavioral health provider in the patient's EHR. The emergency department provider, who initially assessed and treated the patient, informed the OIG that the behavioral health assessment team is usually contacted for behavioral health patients, but this service was not available during the early morning hours and the emergency department provider did not speak to a psychiatrist. The admitting psychiatrist informed the OIG of being contacted about the patient; however, the contact was not documented. The admitting psychiatrist did enter the admission orders to the behavioral health unit in the EHR. While a lack of documented communication may not have contributed to the patient's outcome in this instance, the OIG was concerned that the hand-off communication could not be readily confirmed.

During the site visit in January 2018, the OIG found the behavioral health unit's emergency cart was unlocked and identified an expired tubing package on the cart. The expired tubing package would not generally impact emergency care; however, the presence of an expired supply reflects an inattention to detail when verifying emergency equipment.

The OIG reviewed facility leaders' responses to the event and determined that the facility removed the involved staff from patient care; completed peer reviews, a fact-finding review, and a root cause analysis; and submitted an issue brief to the Veterans Integrated Service Network. The OIG identified deficiencies in the facility's response to the events surrounding the patient's death and actions for the findings, to include the reporting requirements to the State Licensing Board and consideration of an institutional disclosure.

Facility leaders initiated a fact-finding review in 2017, and assigned the Chief Nurse of Behavioral Health as the reviewer. The facility's fact-finding review included a recommendation to discuss reporting of nurses to the state licensing boards. Reporting to state licensing boards is required when a licensed health care professional "substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients."<sup>7</sup>

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<sup>6</sup> The consolidated monitoring system is a camera monitoring system that uses video without audio to monitor patient safety on the acute inpatient behavioral health unit. The monitoring system footage obtained and used in this report was from a camera located in the hallway above the door leading into the patient's room. Individuals entering the area directly outside the patient's door were captured by video. However, because of the camera's position, an individual passing below the camera was out of the camera's view so it is unknown whether an individual entered the patient's room or remained at the patient's doorway out of the camera's range. Cameras do not provide monitoring within patient rooms; Facility Standard Operating Procedure #9, *Consolidated Monitoring System Acute Inpatient Behavioral Health Unit*, February 9, 2015.

<sup>7</sup> VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. This handbook was scheduled for recertification on December 31, 2010, and has not been recertified. A state licensing board, with respect to a healthcare provider, is the state agency that is primarily responsible for the licensing of the physician or licensed health care professional to furnish health care services.

However, facility leaders did not have documentation that the state licensing boards were contacted as some of the nurses involved in this event resigned or retired. While some nurses have resigned or retired, the recommendation to report to the state licensing boards remains.

The OIG team determined that the facility did not ensure consideration of institutional disclosure in this event involving an unanticipated outcome. Facility staff indicated that conclusions from the root cause analysis did not trigger an institutional disclosure. The intent of institutional disclosure is to inform patients and their families about substantive issues related to their care and options for redress, when appropriate. In this event, Veterans Health Administration leaders should disclose the event to the patient's family as it could not be determined if the patient could have been resuscitated with timely cardiopulmonary resuscitation (CPR).

Despite the claim that CPR was initiated for the subject patient, the OIG did not find documentation of therapeutic measures on the facility required forms. The designated facility critical care committee did not review the event as the unit RNs did not complete the required event documentation. Facility staff informed the OIG the critical care committee did not review the event because staff did not call a code blue and therefore, did not transmit documentation of a resuscitative event to the committee for review.

The OIG made nine recommendations for emergency/code blue procedures, pronouncement of death, BLS competency and training (certification), patient health record documentation, documentation of behavioral health information on transfers of patients, emergency carts compliance, actions from fact-finding review, institutional disclosure, and critical care committee review of BLS events.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the OIG's recommendations and submitted acceptable action plans. (See appendixes A and B, pages 20–28 for the comments.) The OIG considers all recommendations open and will follow up on the planned actions until they are completed.



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## Abbreviations

AED	automated external defibrillator
AHA	American Heart Association
BLS	basic life support
CPR	cardiopulmonary resuscitation
DNR	do not resuscitate
EHR	electronic health record
MOD	medical officer of the day
OIG	Office of Inspector General
RCA	root cause analysis
RN	registered nurse
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a request from the OIG Office of Investigations to evaluate the care of a patient who died (event) in an acute inpatient behavioral health unit at the Gulf Coast Veterans Health Care System (facility), Biloxi, Mississippi. The specific concern was the unit staff's failure to initiate full resuscitation efforts at the time the patient was found unresponsive.

## Background

The facility, part of Veterans Integrated Service Network (VISN) 16, is a tertiary care hospital consisting of a main hospital complex in Biloxi, Mississippi and four community based outpatient clinics.<sup>8</sup> The facility, along with its associated community based outpatient clinics, served over 70,000 veterans from October 1, 2016, through September 30, 2017, and operated 243 beds, including 70 inpatient beds, 72 domiciliary beds, and 101 community living center beds.

## Inpatient Behavioral Health

The facility has two locked inpatient behavioral health units, units 25-A and 25-B, that are located on the same floor and separated by a locked door. The behavioral health units are located within an outlying building, separate from the main hospital. Unit 25-B has 22 total operating beds and is equipped with a consolidated monitoring system that records video but not audio.<sup>9</sup>

## *Behavioral Health Unit Nurse Staffing and Reporting Structure*

Staffing on units 25-A and 25-B include registered nurses (RNs), licensed practical nurses, and nursing assistants. A nurse manager, who reports to the Chief Nurse for Behavioral Health,

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<sup>8</sup> One community based outpatient clinic is located in Mobile, Alabama; the other three are located in Pensacola, Eglin Air Force Base (Valparaiso); and Panama City, Florida.

<sup>9</sup> Facility SOP #9, *Consolidated Monitoring System Acute Inpatient Behavioral Health Unit*, February 9, 2015. The consolidated monitoring system is a camera monitoring system that uses video without audio to monitor patient safety on the two units. The monitoring system footage obtained and used in this report was from a camera located in the hallway above the door leading into the room of the subject patient. Individuals entering the area directly outside the patient's door were captured by video. Because of the camera's position, an individual passing below the camera was out of the camera's view. Cameras do not provide monitoring within patient rooms.

oversees both units 25-A and 25-B. Because a nurse manager is not always present, each unit is also staffed with an assigned charge nurse.<sup>10</sup>

### *RN Duties and Responsibilities*

Major duties and responsibilities of RNs in the facility's behavioral health units include demonstrating critical thinking skills (such as recognizing if a patient has a problem), managing the problem safely and effectively, and having a sense of urgency.

RN orientation and competency requirements include instructions related to calling a medical emergency by dialing 9-911, knowledge of the location of the emergency cart and automated external defibrillator (AED), and familiarity with the contents of the emergency cart and role during a code blue.<sup>11</sup> Basic life support (BLS) certification is required for behavioral health RNs in direct patient care positions and all other clinically-active staff employed within VA.<sup>12</sup>

### *Degrees of Supervision for Behavioral Health Unit Patients*

According to facility policy, during the admission process, the admitting physician completes an initial risk assessment and determines the appropriate degree of supervision needed for each patient. When a patient is under routine supervision, an assigned member of the nursing staff monitors the patient at least every 30 minutes. Close observation requires monitoring every 15 minutes, and 1:1 observation requires an assigned member of the nursing staff to be within an arm's length of the patient at all times.<sup>13</sup> Monitoring is completed through observation safety

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<sup>10</sup> Charge nurses are expected to lead staff while managing the work systems and processes on their units to ensure that the needs of patients are met. International Scholarly Research Notices, *Charge Nurse Perspectives on Frontline Leadership in Acute Care Environments*, Volume 2011, Article ID 164052, <https://www.hindawi.com/journals/isrn/2011/164052>. (This website was accessed on July 27, 2018.)

<sup>11</sup> For the purposes of this report, the cart found on unit 25-B is referred to as an emergency cart, although no emergency medications were located on this cart. An AED is a device used when an individual experiences sudden cardiac arrest to restore a normal heartbeat; it transmits an electric pulse or shock to the heart. AEDs are also used to prevent or correct heartbeats that are uneven, too slow, or too fast. U.S. Department of Health & Human Services website, National Heart, Lung, and Blood Institute, <https://www.nhlbi.nih.gov/health-topics/defibrillators>. (This website was accessed on July 30, 2018.) The facility policy defines a *code blue* as an acute onset of complete cardiac or respiratory failure (arrest). Facility Memorandum No. 11-46-17, *Medical Emergencies/Code Blue*, July 21, 2017.

<sup>12</sup> BLS certification is awarded to individuals who demonstrate the ability to perform certain activities that may save lives after cardiac arrest. BLS fundamentals include immediate recognition of sudden cardiac arrest, activation of the emergency response system, early cardiopulmonary resuscitation, and rapid defibrillation with an AED. Kleinman ME, Brennan EE, Goldberger ZD, Swor RA, Terry M, Bobrow BJ, Gazmuri RJ, Travers AH, Rea T. "Part 5: adult basic life support and cardiopulmonary resuscitation quality: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care," *Circulation*. 2015;132(suppl 2): S414–S435; VHA Directive 1177, *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*, April 6, 2017.

<sup>13</sup> Facility Memorandum No. 116-13-16, *Degrees of Supervision for Patients on the Behavioral Health Acute Inpatient Unit*, June 8, 2016.

rounds, in which nursing personnel are assigned to visualize and document the patient's behavior. Documentation is completed on a paper form titled Restraints/Seclusion/Suicide Observation Flow Sheet (observation flow sheet). The paper form is scanned into the patient's electronic health record (EHR).<sup>14</sup>

## **Medical Emergency Guidance**

### *Facility Medical Emergency Policy*

The facility's policy requires that the initial response to a patient in cardiac arrest is to call for assistance, initiate a code blue response, and begin cardiopulmonary resuscitation (CPR) unless there is a do not resuscitate (DNR) order in the patient's EHR.<sup>15</sup> Each patient care area should have prepared personnel, equipment, and supplies in readiness for life-threatening medical emergencies.<sup>16</sup> Facility policy for CPR protocol of life-threatening medical emergencies references the American Heart Association (AHA) Guidelines and advises doing multiple steps and patient assessments simultaneously, including emergency response activation.<sup>17</sup>

Specific instructions are included in the facility's policy for the behavioral health units as they are separated from the main building. Unit 25-B staff are directed to dial 9-911 for community fire/ambulance assistance and to provide BLS until emergency responders arrive.<sup>18</sup> Medical emergency equipment on the behavioral health units included an AED and an emergency cart that contained oxygen, a backboard, oxygen tubing, a suction machine, and a bag valve mask.<sup>19</sup> The cart contained no emergency medications. Facility policy indicated that the unit 25-B AED was located on the nurse's station in a cabinet that alarms when it is accessed.

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<sup>14</sup> Facility Memorandum No. 116-13-16.

<sup>15</sup> Facility Memorandum No. 11-46-17; VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017. Cardiopulmonary resuscitation (CPR) is the part of BLS and Advanced Cardiac Life Support that attempts to restore spontaneous circulation following cardiopulmonary arrest (the loss of airway, breathing, or circulation necessary to maintain life); a Do Not Attempt Resuscitation Order (DNAR/DNR) is an order that establishes that CPR shall not be attempted for a patient in cardiopulmonary arrest.

<sup>16</sup> For this report, the OIG uses the term resuscitation to include CPR, basic life support, code blue, and emergency medical condition.

<sup>17</sup> Kleinman et al, 2015.

<sup>18</sup> Facility Memorandum No. 11-46-17.

<sup>19</sup> A bag valve mask ventilation provides oxygen to the lungs when a patient is unable to protect the airway. Bucher JT, Cooper JS. Bag Mask Ventilation (Bag Valve Mask, BVM) [Updated 2017 Jun24]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2018 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK441924/> (The website was accessed on October 12, 2018.)

## *Behavioral Health Unit Medical Emergency Standard Operating Procedure*

The behavioral health unit standard operating procedure (SOP) defines an emergency medical condition as “acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily function, or serious dysfunction of bodily parts.”<sup>20</sup> The SOP further states, “[w]hen such signs or symptoms are observed, the care team must act immediately to optimize positive outcomes.”<sup>21</sup>

The behavioral health unit SOP outlines that when an urgent situation warrants, nursing staff should initiate appropriate actions within their scope, such as BLS, based on their assessment of the patient.<sup>22</sup> If the situation warrants an emergency response, the SOP directs staff members to call

- 9-911,
- VA police,
- Patient Care Services Coordinator, and <sup>23</sup>
- The [behavioral health] provider.

## **Concerns**

In late 2017, the facility’s VA police informed the OIG Office of Investigations of a patient death. Due to concerns surrounding the medical circumstances and events in response to the patient’s death, the Office of Investigation referred the concerns to the OIG Office of Healthcare Inspections for review.

On January 25, 2018, Office of Healthcare Inspections staff paused their inspection and referred additional concerns that fell under their jurisdiction to the Office of Investigations.

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<sup>20</sup> Facility SOP #11, *Procedures for Medical Emergencies on the Acute Inpatient Behavioral Health Unit*, December 11, 2014.

<sup>21</sup> Facility SOP #11.

<sup>22</sup> Facility SOP #11.

<sup>23</sup> In the absence of the Associate Director for Patient/Nursing Services during non-administrative tours, the Patient Care Services Coordinator is designated authority, responsibility, and accountability for managing and directing employees, staffing units, and allocating resources as necessary due to tour-to-tour unplanned leave or a change in patient acuity. The Patient Care Services Coordinator collaborates with the Administrative Officer of the Day as needed for decisions related to on-going patient care and actions taken in emergency situations and disasters. Gulf Coast Healthcare System, Functional Statement: Patient Care Services Coordinator (PCSC), Registered Nurse: Nurse 1/Level 1, August 10, 2015.

On May 30, after Office of Investigation clearance, Office of Healthcare Inspections staff re-initiated the clinical inspection of the circumstances surrounding the patient's death.

The OIG team identified other concerns related to documentation and tracking of BLS training and competency, review and documentation of resuscitation equipment on the unit, and review of the event by the facility committee designated to review patients who undergo cardiopulmonary arrest.<sup>24</sup>

## Scope and Methodology

The OIG initiated an inspection on January 4, 2018, and conducted a site visit from January 9 through January 11. The OIG team toured the emergency department and the behavioral health unit where the patient received care (unit 25-B). The OIG team also reviewed consolidated monitoring system video recordings prior to and during the event.

The OIG team reviewed the patient's EHR, AHA standards, Veterans Health Administration (VHA) and facility policies, administrative investigation documents, facility committee meeting minutes, nursing records, and other relevant documents.

Prior to the site visit, the OIG team interviewed the unit 25-B nurse practitioner. On-site, the OIG team interviewed unit nurses, providers, Chief of Primary Care, Chief Nurse for Behavioral Health, the Behavioral Health Unit Nurse Manager, Patient Care Service Coordinator, a pathologist, Chief of Education, Patient Safety Manager, Quality Manager, and a police officer.

A limitation in the inspection was the unavailability of the behavioral health unit staff member who first noticed a potential issue with the patient's respirations.<sup>25</sup>

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

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<sup>24</sup> OIG from this point forward refers to the OIG Office of Healthcare Inspections.

<sup>25</sup> This individual no longer works at the facility.

## Event Summary

The OIG team synthesized the following information from the patient's EHR, written statements from staff on the day of the event, unit 25-B's consolidated monitoring system video footage, the patient's observation flow sheet, and interviews with staff.<sup>26</sup>

The patient, in their late fifties, had medical conditions and a history of intravenous substance abuse.<sup>27</sup> The patient received care at the facility for approximately a two-year period (2004–2006) but was not seen by a VHA provider between early 2006 and late 2017.

On a day in late 2017 (Day 1), in the early morning, one week after being seen by a newly assigned VHA primary care physician, the patient presented to the emergency department with complaints of self-inflicted stab wounds to both thighs during an episode of alcohol and cocaine intoxication in which the patient “freaked out.”<sup>28</sup> In the emergency department, the patient underwent a medical evaluation and “medical clearance” for admission to the inpatient behavioral health unit for the diagnosis of depression, suicidal gesture, substance abuse, and lacerations.<sup>29</sup> The medical clearance in the emergency department included a physical examination with documented normal heart exam and electrocardiogram, and laboratory studies that were positive for cocaine along with a minimally elevated alcohol level.<sup>30</sup> A complete drug screen showed no other illicit substances. The emergency department physician sutured the lacerations, documented medical clearance in the EHR, and entered a transfer order to the behavioral health unit. A behavioral health unit bed was not immediately available. The patient's care was transferred to a second emergency department physician approximately four hours later. at the time of a physician shift change. While the patient was still in the emergency department, in the late morning, the on-call psychiatrist wrote initial admission orders for the patient to the unit.

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<sup>26</sup> Facility Memorandum No. 116-13-16.

<sup>27</sup> The OIG uses the singular form of they (their/them) to protect the patient's privacy. *Substance abuse* is a medical term used to describe a pattern of using a substance (drug) that causes significant problems or distress. Intravenous describes using the substance by vein. Johns Hopkins Medicine Health Library, [https://www.hopkinsmedicine.org/healthlibrary/conditions/adult/mental\\_health\\_disorders/substance\\_abuse\\_chemical\\_dependency\\_85.p00761](https://www.hopkinsmedicine.org/healthlibrary/conditions/adult/mental_health_disorders/substance_abuse_chemical_dependency_85.p00761). (The website was accessed on May 22, 2018.)

<sup>28</sup> Cocaine intoxication causes patients to experience a euphoric “high,” which may lead to impaired decision making.

<sup>29</sup> Within this context, *medical clearance* is the process used by the emergency department physician to evaluate a patient presenting to the emergency department with psychiatric symptoms in order to rule out medical conditions that may be causing or worsening the psychiatric symptoms before admission to a behavioral health unit. Feyi N. Emembolu, Leslie S. Zun, “Medical Clearance in the Emergency Department: Is Testing Indicated?” *Primary Psychiatry* 17, no. 6 (2010):29-34. *Depression* is a feeling of sadness that is intense enough to interfere with functioning with or without a decreased interest in activities. Merck Manuals, <http://www.merckmanuals.com/home/mental-health-disorders/mood-disorders/depression>. (The website was accessed on February 15, 2018.) A *laceration* is a cut that penetrates the skin.

<sup>30</sup> An electrocardiogram is a tracing that shows the electrical activity produced by the heart.

That afternoon, the patient was admitted to unit 25-B and evaluated by nursing staff. The degree of supervision for the patient was ordered as close observation every 15-minutes. Documentation of the observation safety rounds was initiated on the paper observation flow sheet.<sup>31</sup>

Unit 25-B's medical nurse practitioner examined the patient and documented a medical history and physical. The patient denied chest pain, leg swelling, or palpitations.<sup>32</sup> The nurse practitioner recorded a normal heart exam and ordered the blood pressure medication that the patient had been taking prior to admission, an antibiotic, wound care, and Motrin as needed for pain.

The EHR indicated a subsequent nurse evaluation in the evening. The nurse's note stated in part

Met with patient 1:1 on the unit. [The patient] appeared calm and is cooperative...Patient endorses anxiety 3/10, saying it's due to [patient's] predicament. [Patient] denies depression, suicidal, homicidal ideations, auditory, and visual hallucinations. [Patient] describes mood as "I'm alright" and stated that goal is "to be sober and productive."

The patient received medications and underwent a mouth check in the late evening to ensure that the medications had been swallowed.

For the observation safety rounds performed between 12:00 a.m. and 1:00 a.m., nursing staff documented the patient to be in the room sleeping. No observation safety rounds were documented at 1:15 a.m.

Per the report during the 1:15 a.m. observation safety rounds, the rounding nurse was unable to determine whether the patient was breathing (could not see the chest rising and falling).<sup>33</sup> The rounding nurse left the room to inform the preceptor who was the shift charge nurse about the difficulty discerning if the patient was breathing. The charge nurse was in the nurses' station. The monitoring system video showed the rounding nurse walking to the nurses' station. According to interviews, when the rounding nurse reported to the charge nurse being unsure if the patient was breathing, but did not convey the information with a sense of urgency. The rounding nurse and the charge nurse returned to the patient's room. Before entering the room, the charge nurse called an RN from unit 25-A (unit 25-A nurse) on a cell phone for assistance. Upon entering the patient's room, the charge nurse discovered the patient was pulseless and not breathing.

The rounding nurse walked back to the nurses' station to retrieve a stethoscope for further assessment and returned to the patient's room. Per the monitoring system video, the rounding nurse left the patient's room a second time. Per interviews, the OIG learned that the rounding nurse

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<sup>31</sup> Entries were recorded on a two-page document. Page one of the observation flow sheet was dated a month before day 1 and contained entries beginning at 1330 until 2400. Entries were recorded on a second sheet dated day 2 (*the month's difference in the dates is not a typographical error*) beginning in the early morning for an hour. The two-page document was later scanned into the patient's EHR.

<sup>32</sup> Palpitations are the sensations or feelings of a racing or pounding heart.

<sup>33</sup> The rounding nurse documented in an incident report that the patient was non-responsive during the 1:15 a.m. observation safety rounds. The OIG's review of the monitoring system video showed the rounding nurse outside the patient's room at 1:30 a.m. and not 1:15 a.m.

returned to the nurses' station and alerted the patient's assigned nurse (assigned nurse), of a concern with the patient. The assigned nurse went with the rounding nurse to the patient's room. Upon arrival at the room, the rounding nurse told the assigned nurse "we think [the patient] is dead." Upon entering the patient's room, the assigned nurse saw the charge nurse standing at the head of the bed. The assigned nurse thought CPR had been performed. The assigned nurse informed the OIG of assessing the patient, noting no respirations or carotid pulse, and that the patient was expired.

The unit 25-A nurse arrived to provide assistance. When the unit 25-A nurse entered unit 25-B, the staff in the nurses' station were unaware of the charge nurse's location or that an emergency was taking place on the unit. The unit 25-A nurse entered the patient's room and observed the patient lying supine in the bed; the rounding nurse, the charge nurse, and the assigned nurse were standing at the patient's bedside. When interviewed, the unit 25-A nurse told the OIG that the patient did not have a pulse or respirations and did not respond to verbal or tactile stimuli.

The charge nurse informed the OIG about performing chest compressions and mouth-to-mouth resuscitation during a time frame while alone in the room with the patient. The unit 25-A nurse left the patient's room soon after arrival to call the medical officer of the day (MOD).<sup>34</sup> The unit 25-A nurse relayed to the MOD that the patient did not have a pulse, was not breathing, and was beyond CPR. When interviewed, the unit 25-A nurse told the OIG team the MOD said, "no CPR." The rounding nurse, who had also left the patient's room, returned to relay the "no CPR" message from the MOD. According to the EHR, the MOD documented that "the patient was pronounced dead at 01:44 [a.m.]" An autopsy listed the cause of death as sudden cardiac death due to cardiac arrhythmia (abnormal heart rhythm) and myocardial ischemia caused by cocaine use and high blood pressure.<sup>35</sup>

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<sup>34</sup> VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010. MOD is the designated inpatient physician or practitioner who is physically present during periods when the regular medical staff is not on duty.

<sup>35</sup> Myocardial ischemia is the loss of blood flow to the muscles of the heart, which can cause a heart attack.

## Inspection Results

### 1. Failure to Initiate Appropriate Resuscitation Efforts

The OIG determined the behavioral health unit staff did not initiate appropriate resuscitation efforts after finding the patient unresponsive. However, based on the available facts and circumstances, the OIG was unable to determine whether initiating full resuscitation efforts would have been successful if employed at the time the patient was first found unresponsive. Staff did not

- Quickly assess the patient,
- Act with a sense of urgency to a potential or actual emergency medical condition,
- Alert the care team of the emergency medical condition,
- Immediately initiate BLS and locate the nearest AED,
- Activate the community 9-911 emergency response system, and
- Contact the (behavioral health) provider.<sup>36</sup>

Facility policy, which refers to AHA guidelines, requires that each patient care area have prepared personnel, equipment, and supplies in readiness for life-threatening emergencies, and states that “the first person to witness the need for emergency resuscitation will initiate lifesaving steps.”<sup>37</sup>

According to the AHA guidelines, trained rescuers are encouraged to simultaneously perform some steps, such as checking for breathing and a pulse to reduce the time to first chest compressions.<sup>38</sup> After finding the patient with an emergency medical condition, the behavioral health unit staff should have quickly assessed the patient and taken the steps outlined above (specific staff duties and responsibilities are addressed in the next section).

The behavioral health unit medical emergency SOP required staff to contact VA police, the Patient Care Service Coordinator, and the behavioral health provider. A VA police officer was on unit 25-B during the event and the Patient Care Service Coordinator was called. However, the RNs did not document contact with the patient’s behavioral health provider in the EHR. The patient’s behavioral health provider was not aware of the patient’s death until the next day. If contacted by nurses, the behavioral health provider would have come to the unit at that time.

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<sup>36</sup> Facility SOP #11.

<sup>37</sup> Facility Memorandum No. 11-46-17.

<sup>38</sup> Kleinman ME, et. al., “Part 5.” Additional AHA guidance reflects that healthcare providers should call for help upon finding the unresponsive victim, but it would be practical to continue to assess for breathing and pulse simultaneously, then fully activate the emergency response system.

## 2. RN Duties and Responsibilities

The OIG determined that the behavioral health unit RNs did not fulfill the duties and responsibilities expected of their positions.<sup>39</sup> Specifically, staff did not initiate timely resuscitation or continue resuscitation efforts until the patient was stable or emergency responders arrived.

By not recognizing the patient's acute medical emergency and not acting with a sense of urgency, the rounding nurse, the charge nurse, the assigned nurse, and the unit 25-A nurse were not practicing within the expected roles and duties to initiate and sustain resuscitation. The behavioral health RN functional statement requires a nurse to use critical thinking skills to recognize a patient has a problem, manage the problem safely and effectively, and have a relative sense of urgency. Behavioral health unit policy requires that all patients on the unit be assessed, as clinically indicated, for warning signs of acute medical emergencies and when such signs or symptoms are observed, the care team must act immediately to optimize positive outcomes.<sup>40</sup>

Upon finding the patient unresponsive, the rounding nurse did not show a sense of urgency or initiate BLS. The rounding nurse notified the charge nurse who was down the hall in a nurses' station. The rounding nurse did not notify the rest of the healthcare team or call 9-911.

Upon entering the patient's room, the charge nurse did not initiate timely CPR. The charge nurse informed the OIG of performing chest compressions and mouth-to-mouth resuscitation while alone in the room with the patient and documented performing CPR in the EHR. From consolidated monitoring system video recordings, the charge nurse was the only person in the patient's room about 12 minutes after the patient was first discovered for approximately two minutes. During interviews, other staff informed the OIG they did not witness the charge nurse performing CPR.

The assigned nurse was aware of the policy that required dialing 9-911, calling the VA police, and initiating CPR for an unresponsive patient. The assigned nurse reported not recalling being provided emergency response training when starting to work at the facility.<sup>41</sup>

The unit 25-A nurse acted outside assigned duties and responsibilities by not initiating resuscitation and not calling 9-911 as required by unit policy. The unit 25-A nurse assessed the patient and left the room. The unit 25-A nurse called the MOD, and documented in the EHR the patient had no pulse, no respirations, and did not respond to verbal or tactile stimuli. When the unit 25-A nurse informed the MOD of the findings, the MOD ordered "no CPR." The unit 25-A nurse documented asking the MOD for clarification about performing CPR and the MOD replied "[n]o." The "no CPR" order was relayed to the unit 25-B staff.

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<sup>39</sup> An RN is a professional member of the health care team, and as such functions independently, exercising initiative and judgment. RNs assess patients, plan patient care, collaborate with other members of the healthcare team, provide physical and psychological support, and respond to healthcare needs as the situation arises. Facility Functional Statement Registered Nurse: Nurse 1/Level 3, Direct care/Staff Nurse Behavioral Health Service Line, June 17, 2017.

<sup>40</sup> Facility SOP #11.

<sup>41</sup> Facility SOP #11.

The MOD documented in the EHR being called by a nurse from the behavioral health unit in the early morning and being informed of the need to “pronounce a patient.” The MOD indicated that a nurse had examined a patient and deemed the patient to be dead, and the nurse stated unit nurses cannot pronounce patients deceased. The MOD documented telling the nurse if the nurse had “determined the patient was dead, then at the time CRP [*sic*] would not likely be helpful.” VHA Directive 2011-016 states that only medical doctors can pronounce patient death while the patient is under the care of the VA.<sup>42</sup>

By not initiating a timely emergency response, providing continuous resuscitation, or contacting the behavioral health provider, the behavioral health unit staff did not follow the facility policy or fulfill the duties and responsibilities expected of their positions. The unit 25-A nurse spoke with the MOD and informed the MOD of the need to pronounce the patient’s death.

### **Other Finding—Behavioral Health Unit Staff BLS Certification**

The OIG determined that facility staff did not consistently track documentation of the behavioral health unit RNs for BLS competency and training (certification). According to facility policy, “[s]taff who do not maintain current training will not be allowed to work in positions that require BCLS [Basic Cardiac Life Support]/ACLS [Advanced Cardiac Life Support] until training is current unless a waiver has been obtained.”<sup>43</sup> Documentation of current BLS training is to be maintained by the education and training service.<sup>44</sup> When asked, facility leaders could not provide documentation of BLS certification or a waiver indicating BLS was not required for two of the four RNs at issue.

Table 1 depicts deficiencies in the actions taken by the four RNs in reference to facility policies that were in effect at the time of the events discussed in this report and the status of their BLS certifications at the time of the patient’s death.<sup>45</sup>

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<sup>42</sup> VHA Directive 2011-016, Pronouncement of Death and Request for Autopsy by a Registered Nurse, Advanced Practice Nurse or Physician Assistant in VA Community Living Center, March 16, 2011. The MOD documented this note on October 16, 2017, four days after the patient’s death.

<sup>43</sup> Facility Memorandum No. 11-46-17.

<sup>44</sup> Facility Memorandum No. 11-46-17.

<sup>45</sup> Facility Memorandum No. 11-46-17; Facility SOP #11.

**Table 1. Behavioral Health Unit RN Failures to Execute Required Actions and the Status of Their BLS Certifications on Day 2**

Staff Member	Recognized an Emergency Medical Condition and Called 9-911	Initiated BLS (CPR)	Located and Brought AED to Patient's Room	Continued BLS (CPR) Until 9-911 Help Arrived	Acted Within Expected Duties and Responsibilities of Position	Evidence of BLS Certification at Time of Patient's Death
Rounding Nurse	No	No	No	No	No	Yes
Charge Nurse	No	Yes	No	No	No	Not Provided
Assigned Nurse	No	No	No	No	No	Yes
Unit 25-A Nurse	No	No	No	No	No	Not Provided

*Source: VA OIG analysis of the patient's EHR, BLS certification documentation, review of consolidated monitoring video recordings and staff interviews*

### 3. Documentation Deficiencies

#### Nursing Staff Documentation

The OIG determined that the behavioral health unit nursing staff did not ensure accurate and complete EHR documentation for the subject patient.

OIG staff compared observations viewed on the behavioral health unit's consolidated monitoring system video recordings with nursing documentation of patient observation checks on the observation flow sheet. VHA requires the scope of documentation in the patient's EHR to reflect accurate and clinically-relevant statements and be comprehensive enough to provide continuity of care and be concise and complete.<sup>46</sup>

On Day 2, at 12:45 a.m., the charge nurse documented completing the patient's 15-minute check. However, the consolidated monitoring system video footage showed no one in the hall near the patient's room around this time. At 1:15 a.m., no staff were visualized going toward the patient's room and the observation flow sheet contained no documentation. The rounding nurse was observed in the hallway by the patient's room at 1:30 a.m. There is no documentation on the observation flow sheet for the 1:30 a.m. 15-minute patient check. Table 2 depicts patient checks

<sup>46</sup> VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

starting just after midnight until 1:30 a.m. in correlation with Day 2, consolidated monitoring system video footage.<sup>47</sup>

**Table 2. Day 2, Observation Flow Sheet Documentation and Review of Consolidated Monitoring System Video Footage**

<b>Time of Observation on Flow Sheet a.m. (military time)</b>	<b>Behavior Code Documented on Flow Sheet</b>	<b>Review of Consolidated Monitoring System Video Footage<sup>48</sup></b>	<b>Documented by Nurse</b>
12:01 (0001)	Sleeping, Lying, Patient Room	Rounding Nurse seen in Hallway by Patient Room	Rounding Nurse
12:15 (0015)	Sleeping, Lying, Patient Room	Rounding Nurse seen in Hallway by Patient Room	Rounding Nurse
12:30 (0030)	Lying, Patient Room, Sleeping	Charge Nurse seen in Hallway by Patient Room	Charge Nurse
12:45 (0045)	Lying, Patient Room, Sleeping	No Staff seen in Hallway by Patient Room	Charge Nurse
1:00 (0100)	Lying, Patient Room, Sleeping	Rounding Nurse seen in Hallway by Patient Room	Rounding Nurse
1:15 (0115)	None	No Staff seen in Hallway by Patient Room	None
1:30 (0130)	None	Rounding Nurse seen in Hallway by Patient Room	None

*Source: VA OIG analysis of documentation on the patient's observation flow sheet and consolidated monitoring system video footage*

<sup>47</sup> As the observation flow sheet documentation used a military time format, the OIG has inserted military times corresponding to a.m. times in the first column using parentheses.

<sup>48</sup> The consolidated monitoring system is a camera monitoring system that uses video without audio to monitor patient safety on the two units. The monitoring system footage obtained and used in this report was from a camera located in the hallway above the door leading into the room of the subject patient. Individuals entering the area directly outside the patient's door were captured by video. Because of the camera's position, an individual passing below the camera was out of the camera's view. Cameras do not provide monitoring within patient rooms.

When the patient was admitted to the unit, the physician ordered observation every 15 minutes. Assigned staff were expected to conduct rounds to check on the patient and document the checks on the observation flow sheet.

Due to the missing entries on the observation flow sheet and lack of video footage evidence that would corroborate the flow sheet entries, the OIG was unable to determine when the patient became unresponsive, or whether earlier interventions might have changed the outcome.

## **Provider Documentation**

The OIG did not find evidence that emergency department providers documented a discussion with the admitting behavioral health provider in the patient's EHR.<sup>49</sup> The emergency department provider who initially assessed and treated the patient informed the OIG that the behavioral health assessment team is usually contacted for behavioral health patients; however, the emergency department provider did not speak to a psychiatrist. The second emergency department provider informed the OIG of being informed there were no available behavioral health beds and the patient may need to be transferred to another facility. The second provider also informed the OIG of assuming that the emergency department provider who had initially assessed and treated the patient had spoken to a behavioral health provider.

The admitting psychiatrist informed the OIG of being contacted about the patient; however, did not document that contact. The admitting psychiatrist did enter the admission orders to the behavioral health unit in the EHR.

VHA policy outlines routine communication from physician to physician during a shift hand-off or a transition in care usually includes standard patient data elements such as allergies, medications, problems, history and physical, admitting diagnosis, laboratory results, and consults.<sup>50</sup> VHA policy requires provider to provider communication for behavioral health patients to be documented in the patient's medical record.<sup>51</sup> Facility policy on hand-off communication states that physician to physician hand-off should occur when patients are transferred between levels of care or service, such as from the emergency department to an inpatient bed. The hand-off may be a verbal discussion where the receiving physician accepts the patient before the transfer.<sup>52</sup>

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<sup>49</sup> The patient presented to the emergency department in the early morning hours. Physicians changed shifts prior to the patient's transfer from the emergency department; therefore, the patient was under the care of two emergency department providers during the stay.

<sup>50</sup> VHA Handbook 1907.01

<sup>51</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

<sup>52</sup> Facility Memorandum 00F-03-12, *Hand Off Communication*, June 24, 2012. This memorandum was in place at the time of the event. The memorandum was rescinded and replaced by Facility Memorandum 00F-03-17, *Hand-Off Communication*, November 28, 2017. The facility policy was not specific to behavioral health patients and did not have documentation requirements.

While a lack of documented communication may not have contributed to the patient's outcome in this instance, the OIG is concerned that the hand-off communication between the behavioral health service and emergency department providers could not be readily confirmed.

### **Resuscitation Equipment Documentation and Review**

During the site visit in January 2018, the OIG found the behavioral health unit's emergency cart was unlocked and identified an expired tubing package on the cart. Staff had completed and signed verifying checks of the emergency cart that indicated there were no expired supplies. Facility policy requires the emergency carts to be checked each shift during operational hours and the checklist included locked drawers.<sup>53</sup>

The expired tubing package would not generally impact emergency care; however, the presence of an expired supply reflects an inattention to detail when verifying emergency equipment. The individual units are responsible for the BLS emergency carts and their contents unlike advanced cardiac life support (crash) carts which are reviewed by the critical care committee.

## **4. Facility Response to the Event**

The OIG reviewed facility leaders' response to the event and determined that the facility removed the involved staff from patient care, completed peer reviews, a fact-finding review, a root cause analysis (RCA), and submitted an issue brief to the VISN.<sup>54</sup> The OIG identified deficiencies in the facility's response to the events surrounding the patient's death and actions for the findings, to include the reporting requirements to the state licensing boards and consideration of an institutional disclosure of this event involving an unanticipated outcome.

### **Fact-Finding Review**

Facility leaders removed the staff involved in the event from patient care on the behavioral health unit. On Day 8, facility leaders started a fact-finding review and assigned the Chief Nurse of Behavioral Health as the reviewer. The Chief of Quality Management stated that upon

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<sup>53</sup> Facility Memorandum No. 11-46-17. The unit has an AED and an emergency cart with oxygen, oxygen tubing, a backboard, a suction machine, and a bag-mask device for rescue breathing.

<sup>54</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. RCA "is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

completion of the fact-finding review, the human resources department can take personnel action or recommend an administrative investigation board review to the Facility Director.<sup>55</sup>

The fact-finding review was conducted over a period of a month. The Chief Nurse of Behavioral Health submitted a memorandum and the findings included

- Communication issues between staff,
- Improper pronouncement of death by RN and/or MD,
- Administrative and clinical processes were not followed including lack of 15-minute observations for a period of time,
- The protocol of calling 9-911 was not followed, and
- Clinical staff reported that CPR was initiated.

The recommendations in the memorandum included

- Staff to be re-educated on the emergency management process for the unit,
- A peer review,
- Disciplinary action for RNs for not initiating the medical emergency process of 9-911 and not maintaining BLS code during Veteran cardiac arrest,
- Review with Quality Management, as it relates to state reporting requirements for the Board of Nursing, and
- Taking actions to be considered for the behavioral health unit staff.

As of September 11, 2018, the facility could not provide documentation that all actions were completed for the staff.

## Reporting to State Licensing Boards

Reporting to state licensing boards is required when a licensed health care professional “substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.”<sup>56</sup> The facility’s fact-finding review included a

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<sup>55</sup> VA Directive 0700, *Administrative Investigations*, March 25, 2002. Administrative investigation boards are VA’s primary tool for a systematic, thorough, and objective analysis of evidence, documented in a manner that clearly conveys not only the facts found, but also the evidence from which those facts are ascertained, and the investigator’s conclusions about matters that may be disputed. VA’s administrative investigation board procedures will be designed to ensure timely, objective, complete, and thoroughly documented investigations, and shall be sufficiently flexible to address the wide array of situations meriting such investigations within VA in an efficient manner.

<sup>56</sup> VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. This handbook was scheduled for recertification on December 31, 2010, and has not been recertified. A state licensing board, with respect to a healthcare provider, is the state agency that is primarily responsible for the licensing of the physician or licensed health care professional to furnish health care services.

recommendation to discuss reporting of nurses to the State Licensing Board; however, the facility leaders did not have documentation that the state licensing boards were contacted as some of the nurses involved in this event resigned or retired. While some nurses have resigned or retired, the recommendation to report to the state licensing boards remains.

## **Institutional Disclosure**

The OIG team determined that the facility did not ensure consideration of institutional disclosure in this event involving an unanticipated outcome. Facility staff indicated that conclusions from the RCA did not trigger an institutional disclosure. The OIG determined that the facility failed to consider provisions from VHA Handbook 1004.08 on adverse events that would have warranted an institutional disclosure for this patient.

VHA policy indicates that “potential and actual causes of harm to patients” are “safety-related issues” that require “rapid communication throughout the organization” to prevent similar events in the future.<sup>57</sup> In this event, VHA leaders should disclose the event to the patient’s family as it could not be determined if the patient could have been resuscitated with timely CPR.

VHA policy requires that patients, and when appropriate, their families, be informed of unanticipated outcomes related to an adverse event that occurred during care.<sup>58</sup> The intent of institutional disclosure “is to inform patients and their families about substantive issues related to their care” and options for redress, when appropriate.<sup>59</sup>

## **5. Other Finding—Review of the Patient’s Resuscitation**

Per facility policy, service chiefs, chief nurses, and section chiefs are responsible for assuring applicable staff, including nursing personnel, are oriented to the facility’s medical emergencies/code blue policy and are compliant.<sup>60</sup> The facility policy requires that

[a] record of the therapeutic measures taken during an arrest will be made on the Cardiopulmonary Arrest Record...During the code, a Registered Nurse (RN) will

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<sup>57</sup> VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012, corrected Copy October 12, 2012 was in place at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018 that contains same or similar language related to notification of the family.

<sup>58</sup> VHA Handbook 1004.08; VHA Directive 1004.08. Adverse events include those that result in, or are reasonably expected to result in, death or serious injury; prolonged hospitalization; or life-sustaining intervention or intervention to prevent impairment or damage.

<sup>59</sup> VHA Handbook 1004.08.

<sup>60</sup> Facility Memorandum No. 11-46-17.

document the verbal orders of the physician. The form will require signatures of the nurse and physician directing the procedure.<sup>61</sup>

Despite the claim that CPR was initiated for the subject patient, the OIG did not find documentation of therapeutic measures taken. Besides attachment B, the facility expects providers who initiate CPR to complete a cardiopulmonary arrest critique (facility policy attachment C) to evaluate the quality of the resuscitative actions taken including equipment concerns and personnel issues.<sup>62</sup>

The designated facility committee, the critical care committee, did not review the event as the unit RNs did not complete the required event documentation. Facility staff informed the OIG the critical care committee did not review the event because staff did not call a code blue and therefore, did not transmit documentation of a resuscitative event to the committee for review.

Without consistent documentation being provided to the critical care committee, the committee could not review the quality of the BLS resuscitative event and take steps to make improvements to include the contents of the emergency cart and cardiopulmonary arrest record paper form.

## Conclusion

Four behavioral health unit RNs did not fulfill their duties and responsibilities after finding the subject patient unresponsive in the room. The four RNs did not act with a sense of urgency to perform timely CPR, locate and bring the transport AED to the patient's room, or activate the community 9-911 emergency response system as required by facility policy. The facility could not provide the OIG team with BLS certification for two of the four nurses at issue. Based on the available facts and circumstances, however, the OIG was unable to determine whether initiating full resuscitation efforts would have been successful if employed at the time the patient was found unresponsive.

The unit 25-A nurse called the MOD to "pronounce a patient." The MOD documented a nurse had examined the patient and deemed the patient to be dead. VHA policy states only medical doctors can pronounce patient death while the patient is under the care of the VA.

The behavioral health unit nursing staff did not document accurate and complete 15-minute patient observation checks. A behavioral health assessment treatment provider was not available when the patient presented to the emergency department. Emergency department providers did

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<sup>61</sup> Facility Memorandum No. 11-46-17. The cardiopulmonary arrest record is used to capture relevant information related to the timing of events, actions taken such as AED use, medications administered, and disposition of the patient.

<sup>62</sup> Facility Memorandum No. 11-46-17, Attachment C. The facility's critical care committee reviews attachments B and C and makes recommendations regarding action plans as necessary to the executive committee of the medical staff.

not document hand-off communication with each other or with the behavioral health admission provider.

The OIG reviewed facility leaders' response to the event and found facility leaders removed the involved staff from patient care and completed an issue brief, a fact-finding review, and an RCA. Facility leaders did not pursue reporting staff to state licensing boards and did not conduct an institutional disclosure.

During the site visit in January 2018, the OIG found an expired tubing package on the behavioral health unit's emergency cart although staff had signed the cart's checklist verifying that there were no expired supplies. The designated facility committee did not review the resuscitation as the unit RNs did not complete the required cardiopulmonary arrest record.

## **Recommendations 1–9**

1. The Gulf Coast VA Health Care System Director ensures behavior health staff at the Gulf Coast VA Health Care System follow the Emergency/Code Blue procedures for patients needing resuscitative care and compliance is monitored.
2. The Gulf Coast VA Health Care System Director ensures behavior health nurses adhere to Veterans Health Administration Directive 2011-016 for pronouncement of deaths.
3. The Gulf Coast VA Health Care System Director makes certain behavioral health unit nurses maintain basic life support competency and training (certification) and monitors compliance.
4. The Gulf Coast VA Health Care System Director evaluates the Inpatient Behavioral Health Unit 25-B nurses' patient health record documentation (including but not limited to the observations every 15-minutes) for accurate and complete statements and takes action as necessary based on the findings.
5. The Gulf Coast VA Health Care System Director ensures Gulf Coast VA Health Care System policy and providers comply with Veterans Health Administration policy on the documentation requirements of provider to provider communication of transfer of behavioral health patients.
6. The Gulf Coast VA Health Care System Director reviews the policy and procedure for use of the emergency carts to include checks, expired equipment, and locked drawers and ensures compliance and oversight.
7. The Veterans Integrated Service Network Director evaluates the recommendations from the fact-finding review and takes action as necessary.
8. The Gulf Coast VA Health Care System Director complies with Veterans Health Administration policies regarding institutional disclosure.
9. The Gulf Coast VA Health Care System Director ensures that required documentation is completed on all basic life support events and reviewed by the critical care committee.

## Appendix A: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: June 25, 2019

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Mismanagement of a Resuscitation and Other Concerns at the Gulf Coast Veterans HCS, Biloxi, Mississippi

To: Director of Healthcare Inspections, (54HL09)  
Director, GAO/OIG Accountability Liaison (GOAL) Office (VHA 10EG GOAL Action)

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the action plan developed to address the nine (9) recommendations included in the Mismanagement of a Resuscitation and Other Concerns draft report.

*(Original signed by:)*

John P. Arenó, MD  
VISN 16 Chief Medical Officer

For and on behalf of  
Skye McDougall, PhD  
Director, South Central VA Health Care Network (10N16)

## **Comments to OIG's Report**

### **Recommendation 7**

The Veterans Integrated Service Network Director evaluates the recommendations from the fact-finding review and takes action as necessary.

Concur.

Target date for completion: August 31, 2019

### **Director Comments**

The Veterans Integrated Service Network Director was provided with a copy of the fact-finding report and will be reviewing the six (6) recommendations for appropriateness and to ensure appropriate actions are taken as necessary.

## Appendix B: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: June 7, 2019

From: Director, Gulf Coast Veterans Health Care System (520/00)

Subj: Healthcare Inspection—Mismanagement of a Resuscitation and Other Concerns at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi

To: Director, South Central VA Health Care Network (10N16)

1. Gulf Coast Veterans Health Care System has reviewed and concurs with this Health Inspection report.
2. We recognize opportunities for improvements in our practice and corrective actions are being implemented to address the recommendations.

*(Original signed by:)*

Bryan C. Matthews, MBA  
Director, Gulf Coast Veterans Health Care System

## Comments to OIG's Report

### Recommendation 1

The Gulf Coast VA Health Care System Director ensures behavior health staff at the Gulf Coast VA Health Care System follow the Emergency/Code Blue procedures for patients needing resuscitative care and compliance is monitored.

Concur.

Target date for completion: May 2, 2019

### OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

### Director Comments

In accordance with station memorandum 11-46-17, Medical Emergencies/Code Blue, staff in Building 25 on acute psychiatry currently operates with the understanding that they are to go to the nearest phone and dial 9-911 for community ambulance assistance and provide basic support until aid arrives. Training of acute psychiatry staff on calling 9-911 and initiating medical codes was provided to all staff starting October 19, 2017 with the last staff member trained October 26, 2017. To ensure understanding and compliance, mock drills for Emergency/Code Blue procedures in the acute inpatient psychiatry setting was initiated. Three mock codes were completed: January 4, 2018; August 7, 2018; and, November 21, 2018. Outcomes were reviewed for accuracy of adherence with outlined procedures for patients needing resuscitative care. The outcome of all events met the established response procedures/guidelines. In addition, two Skill Fairs were held for Behavioral Health staff which included a training module on responding to emergency/code events. The Fair dates were May 3 and 4, 2018; and April 3 and May 2, 2019. Lastly, training on responding to emergency/code events is included in the unit level orientation for Registered Nurses, Licensed Practice Nurses and Nursing Assistants. Monitoring of code events (mock or real) will continue with reporting of outcomes Critical Care Committee.

### Recommendation 2

The Gulf Coast VA Health Care System Director ensures behavior health nurses adhere to Veterans Health Administration Directive 2011-016 for pronouncement of deaths.

Concur.

Target date for completion: July 6, 2019

### **Director Comments**

Nursing staff assigned to acute inpatient psychiatry have received training on responding to emergency/code blue responses. Staff are aware that a call to 9-911 is required per policy and that basic life support procedures are to be maintained until the medical response team arrives. As an adjunct to the emergency/code blue response training, nursing staff assigned to acute inpatient psychiatry are being educated on Veterans Health Administration Directive 2011-016 for pronouncement of a death should a Veteran death occur on the unit. It is expected that all staff training will be completed by July 6, 2019.

### **OIG Comment**

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

### **Recommendation 3**

The Gulf Coast VA Health Care System Director makes certain behavioral health unit nurses maintain basic life support competency and training (certification) and monitors compliance.

Concur.

Target date for completion: June 24, 2019

### **Director Comments**

Tracking of behavioral health nurses that require basic life support competency and certification is in place. As of June 24, 2019, 55 of 55 (100%) employees have current certification in basic life support. Two employees were excluded. One (1) employee was noted to be on extended military leave for greater than one (1) year while another has been on extended sick leave since November 2018. Compliance monitoring will continue with reporting to the Critical Care Committee as required.

### **OIG Comment**

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

### **Recommendation 4**

The Gulf Coast VA Health Care System Director evaluates the Inpatient Behavioral Health Unit 25-B nurses' patient health record documentation (including but not limited to the observations every 15-minutes) for accurate and complete statements and takes action as necessary based on the findings.

Concur.

Target date for completion: August 31, 2019

### **Director Comments**

During the week of April 2, 2018, forty-five (45) Nursing staff members received education on station memorandum 116-13-16 Degrees of Supervision for Patient on the Behavioral Health Acute Inpatient Unit. This station memorandum includes documentation requirements for daily assessments of patients, documentation of patient behaviors on the Behavioral Observation Check Sheet, and the expectation to assess and summarize the patient's behavior in the electronic medical record as part of routine care, at designated specific intervals and/or while on close observation. In addition, training on documentation requirements are included in the annual behavioral health Nurses' Skills Fair, as well as part of the annual competency checklist for nursing and unit level orientation.

An audit of Q15, Q30 and EOC rounds on acute psychiatry were initiated by Nursing Service in April 2018. Staff were observed via the surveillance monitoring system to determine if practices were compliant with required EOC rounding and engagement and/or observation with Veterans during Q15 and Q30-minute checks. There were a total of 11 observation periods from April 3, 2018 to March 26, 2019. Compliance was noted with required rounding and staff interaction with Veterans on the unit.

To ensure compliance, the agency is utilizing service-level pertinence record reviews to ensure all required documentation elements are captured in the electronic medical record by nursing staff. If any documentation deficiencies are identified, appropriate action will be taken by the Manager and/or Chief Nurse.

### **Recommendation 5**

The Gulf Coast VA Health Care System Director ensures Gulf Coast VA Health Care System policy and providers comply with Veterans Health Administration policy on the documentation requirements of provider to provider communication of transfer of behavioral health patients.

Concur.

Target date for completion: August 31, 2019

### **Director Comments**

A review of the local facility policy on hand-off communication was initiated. Current station policy outlines the required tool for documentation in the electronic medical record but opportunities for improvement were noted in speaking directly to the practice of hand-offs as it relates to behavioral health patients and the expected written documentation requirement of providers. Training on the revised policy will commence for providers who are routinely

involved in the transfer of behavioral health patients to ensure understanding and facilitate adherence to these guidelines. In addition, audits of behavioral health transfers will be utilized to ensure compliance with the policy guidelines.

## **Recommendation 6**

The Gulf Coast VA Health Care System Director reviews the policy and procedure for use of the emergency carts to include checks, expired equipment, and locked drawers and ensures compliance and oversight.

Concur.

Target date for completion: July 31, 2019

### **Director Comments**

A review of local facility policy on medical emergencies and code blues has been completed. Language in the current policy speaks to practices as it relates to checks of crash carts, AEDs and first responder bags. Emergency carts are utilized on the acute psychiatry unit for basic life support/medical emergencies but the check/maintenance of such equipment is not outlined in current station policy. A revision of local policy has been initiated to address this oversight. Despite this, there is a local practice in place for staff to check and maintain emergency carts in their designated areas. This includes cart checks, expired equipment checks, and confirmation of locked drawers. A review of the checklists used by staff on acute inpatient psychiatry for the months of March–May 2019 shows compliance that the carts have been checked daily per shift (100%) as outlined on the emergency equipment cart checklist. Equipment cart checks will continue as the policy revision is finalized. Compliance has been confirmed and monitoring will continue with reporting to the Critical Care Committee. A revised copy of the Medical Emergency/Code Blue policy will be submitted as final confirmation of compliance to fully address this recommendation.

### **OIG Comment**

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

## **Recommendation 8**

The Gulf Coast VA Health Care System Director complies with Veterans Health Administration policies regarding institutional disclosure.

Concur.

Target date for completion: July 1, 2019

## **Director Comments**

A preliminary call has been held with the Veteran's next-of-kin. A meeting is scheduled with the family for July 1, 2019, to complete the institutional disclosure in accordance with Veterans Health Administration Handbook 1004.08.

## **OIG Comment**

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

## **Recommendation 9**

The Gulf Coast VA Health Care System Director ensures that required documentation is completed on all basic life support events and reviewed by the Critical Care Committee.

Concur.

Target date for completion: August 31, 2019

## **Director Comments**

Required documentation and code event analyses are being reported to the Critical Care Committee as recommended. Critical Care Committee minutes from the months of February 2019 – May 2019, includes reporting outcomes of all mock codes, code blues and RRT events over this time period. Reporting of all event outcomes to the Critical Care Committee will continue as recommended.

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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