



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Quality of Care Issues in the
Community Living Center
and Emergency Department
at the Dayton VA Medical
Center

Ohio



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous complainant's allegations regarding quality of care concerns at the Dayton VA Medical Center (facility), Ohio. OIG inspectors reviewed the care provided to a patient who was transferred from the facility's Community Living Center (CLC) to the Emergency Department and subsequently died in the Emergency Department.¹

The anonymous complainant reported specific allegations:

- An Emergency Department registered nurse (RN) failed to perform emergency procedures for a patient who experienced cardiac arrest and subsequently expired in the Emergency Department.
- This was "not the first time" for an incident with the Emergency Department RN and a patient's death.
- Due to an expired cardiopulmonary resuscitation (CPR) certification, the Emergency Department RN should not have been working.
- The Nursing Service allowed the Emergency Department RN 30 days to complete CPR re-certification requirements.
- The Emergency Department was inadequately staffed for the night shift.
- Night shift Emergency Department nurse staffing typically consisted of only two nurses.

The OIG initiated an inspection with a focus on deficiencies in provision of care and maintenance of required training by an Emergency Department RN, and inadequate night shift staffing in the Emergency Department. During the inspection, the OIG identified additional concerns related to delays and deficiencies in the identified patient's care, particularly the care provided by a facility's Emergency Department physician (subject physician) and deficits in the facility's peer review process.

The OIG found delays and deficits in quality of care for the patient in the Emergency Department. Deficits included failure in monitoring the patient, which may have delayed

¹ VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. In 2008, VHA replaced the title Nursing Home Care Unit with VA Community Living Center. A VA CLC provides a variety of specialty programming within a skilled nursing environment for individuals in need of both short and long stay services. The facility's CLC provides care to patients with a variety of medical conditions who need assistance with activities of daily living and skilled nursing care, and provides specialty services including geriatric care, memory care, and hospice. VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016. An Emergency Department is a unit in a VA medical facility equipped with acute care inpatient beds and whose "primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." The Emergency Department operates 24 hours a day, 7 days a week.

recognition of deterioration in the patient's condition. The OIG found that an Emergency Department RN failed to monitor for changes in the patient's condition, specifically identifying a lack of ongoing assessment, cardiac monitoring, and documentation of oxygen levels.

Additionally, deficiencies in care by the subject physician were identified. While the patient arrived in the Emergency Department at 2:35 a.m., the subject physician did not order labs until 4:16 a.m. or a computerized tomography (CT) scan until 6:15 a.m., delaying needed diagnostic tests. Despite documentation of vomiting and a distended abdomen, the subject physician failed to order medication to address the patient's vomiting. The OIG found no documentation to indicate that the subject physician considered placement of a nasogastric tube to evacuate the patient's stomach.

The OIG also found inaccurate handoff communication by the subject physician to the oncoming Emergency Department physician regarding the patient's admission status, and gaps in coordination for admission. The subject physician's electronic health record (EHR) note indicated a plan to sign over the patient to the oncoming Emergency Department physician for final disposition, and also documented that the patient was admitted to the medicine service in stable condition. The oncoming Emergency Department physician reported to the OIG team an understanding that the patient had been admitted to the medicine service and noted that the patient was "blue" on the Emergency Department Information System (EDIS) board.² The oncoming Emergency Department physician explained that the blue designation on the EDIS board denoted that a provider from the admitting service had seen the patient and was assuming care, and that the patient was awaiting transfer from the Emergency Department to the appropriate floor. However, the OIG confirmed via review of EHR documentation and interviews that the medicine service had not accepted the patient for admission.

EHR documentation from the medicine service consult stated that the patient was not admitted to medicine service and had a moderately distended abdomen. The documentation stated that the subject physician was informed of the patient's distended abdomen and agreed to obtain a CT scan for further evaluation. Results from the CT scan indicated that the patient had a surgical abdomen (bowel obstruction), indicating a need for admission by the surgical rather than medicine service. However, by the time results were available, a code blue had been called for the patient in the Emergency Department, and the code blue team was unable to resuscitate the patient.³

² Relevant patient information from the triage, including the assessed acuity level, is tracked and viewable by Emergency Department staff in EDIS, a VHA-wide application. The application allows the systematic collection, display, and reporting of patient status information.

³ Merriam-Webster, *Medical definition of code blue*. Code blue is a term used in a hospital or clinic for a patient in cardiopulmonary arrest, requiring a team of providers to rush to a specific location and begin immediate resuscitation. <https://www.merriam-webster.com/medical/code%20blue>. (The website was accessed on January 14, 2019.)

The OIG found deficiencies in medical decision-making and provision of care by the subject physician when reviewing documentation relative to specific topics:

- Lack of thorough history and physical examination
- Deficiencies in choice and timeliness of diagnostic tests
- Deficiencies in choice and timeliness of treatments
- Deficiencies with disposition of the patient

Following a more extensive examination of the subject physician's practice, the OIG determined that the deficits identified in the subject physician's evaluation and treatment practices were not limited to this case and had the potential for imminent impact on patient safety. OIG staff shared these concerns with facility leaders. The Facility Director responded promptly and placed the subject physician on a summary suspension from clinical care while facility leaders initiated a management review of the subject physician's practice.⁴ The Chief of Medicine conducted a review of the subject physician's cases, did not identify "serious breaches in care or documentation," and determined that the subject physician was "not a danger to the patients" evaluated and treated in the Emergency Department. The Chief of Medicine recommended removing the summary suspension, returning the subject physician to patient care duties, and initiating a focused professional practice evaluation to monitor the subject physician's quality of care.⁵

Prior to approving the Chief of Medicine's recommendation, the Facility Director consulted with Medical Affairs in VA Central Office. The Facility Director extended the subject physician's suspension from clinical care duties pending consultation with Veterans Integrated Service Network (VISN) 10 and further review. The Facility Director notified the VISN Acting Director of concerns regarding the subject physician's quality of care raised by the OIG inspection team. VISN and facility leaders determined that the subject physician would not be returned to clinical care until a more extensive management review was conducted and analysis completed. The VISN's Emergency Department Lead Physician coordinated an external management review.

⁴ VHA Directive 1100.19, *Credentialing and Privileging*, October 15, 2012. When imminent danger may result from failure to take action, a provider's clinical privileges may be summarily suspended pending a comprehensive review. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. A management review is conducted when a facility determines a need to undertake administrative action following a clinical review, such as peer review for quality management. Management reviews must be a distinct and separate process from quality management reviews. Unlike peer reviews, management reviews are not confidential and privileged under 38 U.S.C. § 5705. Findings from management reviews can affect privileges or personnel status.

⁵ VHA Handbook 1100.10. A facility may use a focused professional practice evaluation, a process to evaluate the privilege-specific competence of a physician, at the time of initial appointment to the medical staff, the granting of new, additional privileges, or when a question arises regarding a currently privileged physician's ability to provide safe, high-quality patient care.

The consensus findings from the VISN's external management review included "significant recurrent concerns" with the subject physician's "management and documentation" of patient care.

The facility's Clinical Executive Board met with physicians who conducted the VISN's external management review and discussed the subject physician's inability to manage medically complex patients and failure to adequately document care.⁶ The physicians reviewed potential actions and unanimously recommended revoking the subject physician's privileges. The Clinical Executive Board voted on the identified options, and with a majority vote, recommended revocation of privileges.⁷ The Facility Director approved the Clinical Executive Board's recommendation to revoke the subject physician's privileges.

The subject physician appealed the Clinical Executive Board's decision, and on June 4, 2019, a Disciplinary Appeals Board hearing was convened to review the subject physician's appeal. The Disciplinary Appeals Board reviewed submitted documentation and found it was insufficient to fully substantiate the findings upon which the revocation of privileges was predicated. The Disciplinary Appeals Board determined the charges were not sustained and recommended the removal of the subject physician from federal service be overturned.⁸ The Acting Principal Deputy Under Secretary for Health approved the Disciplinary Appeals Board's recommendation in September 2019. However, the subject physician did not return to the facility and resigned from VA in November 2019.

During its inspection, the OIG identified concerns related to the facility's quality management processes. Specifically, the facility's peer review process failed to identify trends in quality of care issues with the subject physician's medical practice. Deficits in the facility's peer review process limited the effectiveness of the peer reviews' function as part of the facility's quality management processes. In response to these concerns raised by the OIG's inspection team, the facility's Clinical Executive Board established a new threshold to improve the ability of the process to detect trends. The Facility Director reported this change was implemented immediately, while facility leaders were in the process of amending the local policy on peer reviews to reflect the change.⁹

⁶ The Clinical Executive Board is responsible for establishing peer review or professional activity triggers that lead to a focused review of a provider's clinical care.

⁷ Options considered by the Clinical Executive Board included revocation of privileges, placing the Emergency Department physician on a for-cause FPPE, or taking no further action. According to VHA Handbook 1100.19, clinical privileging is the process by which an independently licensed practitioner is legally permitted by the facility to provide specified medical or other patient care services. Re-privileging must be conducted at least every two years. Revocation of privileges refers to the permanent loss of clinical privileges.

⁸ A Disciplinary Appeals Board is a three-member board designated to hear an [full-time] employee's appeal of a major adverse action, which is based in whole or in part on a question of professional conduct or competence.

⁹ Medical Center Policy No. 11-49, *Professional Practice Evaluation*, April 14, 2016.

The OIG did not substantiate that an Emergency Department RN failed to perform emergency procedures on the patient. The OIG was unable to determine whether the resuscitation efforts for the patient were initiated timely due to the lack of monitoring, which potentially delayed the recognition of signs of the patient's deterioration, and discrepancies between EHR documentation of the patient's status by the Emergency Department RN, and observations reported by code team responders during interviews.

The OIG did not substantiate allegations that this was "not the first time" for an incident involving the Emergency Department RN and a patient's death. The OIG did not substantiate allegations that the Emergency Department RN should not have been working due to the expiration of CPR certification for Basic Life Support or that Nursing Services allowed the RN 30 days to complete re-certification.¹⁰

The OIG did not substantiate the allegation of inadequate staffing during the night shift in the facility's Emergency Department. The OIG determined that Emergency Department RN staffing was in accordance with Veterans Health Administration (VHA) directives.¹¹

During the OIG team's inspection, additional concerns were either brought to the attention of the OIG team by facility staff or identified by the team.¹²

The OIG found inconsistent implementation of standing orders in the Emergency Department. In May 2016, the facility's medical and nursing leaders approved 23 sets of Emergency Department standing orders. However, during interviews with Emergency Department staff, the OIG team was told that Emergency Department standing orders had limited implementation and not all Emergency Department physicians accepted the use of standing orders. In an emergent situation, standing orders allow staff to take action without waiting for physicians to enter orders specific to each patient. For the subject patient, had standing orders for cardiac monitoring and admission laboratory tests been implemented upon arrival to the Emergency Department, the cardiac monitoring and laboratory tests could have been immediately initiated. With earlier and

¹⁰ Encyclopedia of Intensive Care Medicine, 2012, *Basic Life Support*. Basic life support refers to noninvasive emergency procedures performed to assist in the immediate survival of individuals experiencing cardiac arrest, respiratory distress, or an obstructed airway. BLS requires knowledge of CPR. https://doi.org/10.1007/978-3-642-00418-6_365. (The website was accessed on October 25, 2018.) VHA Dayton Medical Center Memorandum, *Nursing Standard A-21 Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) Training*, October 9, 2012. Emergency Department staff must maintain both BLS and ACLS certification. The RN's BLS certification had lapsed while on an extended leave (the ACLS certification remained in effect). Facility policy allowed a two-week grace period upon return to recertify. BLS recertification was accomplished during the allowed grace period.

¹¹ VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 2017; VHA Directive 1101.05, *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

¹² The facility had taken action on reported environmental issues (mold and broken ceiling tiles) and remedied issues with expired supplies upon notification by OIG.

continuous cardiac monitoring and immediate laboratory testing, staff may have been able to detect changes in the patient's condition and intervene at an earlier time.

Unrelated to the patient case identified in the allegations, the OIG found evidence of CLC staff failures to follow the facility's bar code medication administration policy. When used as intended, bar code medication administration reduces medication administration errors by helping nursing staff to ensure that the right patient receives the right medication, at the right dose and right time, via the right route of administration. The OIG team immediately notified facility leaders of the breach in policy and the safety risk to residents in the CLC.¹³ Facility leaders implemented a prompt response that included observation of RNs administering medications and environment of care rounds, and a plan to continue monitoring for compliance.

A focused professional practice evaluation is a method used by facility leaders to monitor a provider's practice.¹⁴ The OIG determined that facility staff incorrectly destroyed a focused professional practice evaluation on the subject physician due to inaccurate classification of the document under the Records Control Schedule. The destruction of the focused professional practice evaluation precluded a comprehensive review of trends in quality of care concerns for the subject physician.

The OIG made 13 recommendations related to provider training and education, policy and procedures concerning coordination and transitions of care, use of standing orders, monitoring of critically ill patients, peer reviewer training, Peer Review Committee training and documentation, facility leader responses to identification of clinical care concerns, processing and maintenance of Emergency Department supplies, bar code medication administration compliance, and document management procedures.

¹³ Medical Center Policy No. 118E-04, *Bar Code Medication Administration (BCMA)*, May 5, 2017. An armband with a bar code is placed on the patient at admission. When administering medications, nursing staff scan the barcode on the patient's armband and then scan the barcode on the medication. A computerized system alert is activated if the barcode on the armband does not match the barcode on the medication. When an alert occurs, nursing staff have the opportunity to re-check the patient's medications and avert a medication error.

¹⁴ VHA Handbook 1100.10.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans. (See appendixes A and B for the Directors' comments.) The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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Contents

Executive Summary	i
Abbreviations	x
Introduction.....	1
Scope and Methodology	2
Patient Case Summary	4
Inspection Results	7
1. Deficiencies in Care by the Subject Physician.....	7
2. Deficiencies in the Peer Review Process	11
3. Deficiencies in Quality of Care for the Patient	17
4. Alleged Deficiencies in Care by an Emergency Department RN	25
5. Inadequate Emergency Department Night Shift Staffing.....	28
6. Other Findings.....	30
Conclusion	35
Recommendations 1–13.....	37
Appendix A: VISN Director Memorandum	39
Appendix B: Facility Director Memorandum.....	40
Glossary	47
OIG Contact and Staff Acknowledgments	55

Report Distribution56

Abbreviations

ACLS	advanced cardiovascular life support
BLS	basic life support
CBC	complete blood count
CLC	Community Living Center
CPR	cardiopulmonary resuscitation
CT	computerized tomography
EDIS	Emergency Department Information System
EHR	electronic health record
FPPE	focused professional practice evaluation
GI	gastroenterology
ICU	intensive care unit
LPN	licensed practical nurse
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
PRC	peer review committee
RN	registered nurse
SBAR	Situation, Background, Assessment and Recommendation
SpO2	pulse oximetry
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous complainant's allegations regarding quality of care concerns at the Dayton VA Medical Center (facility), Ohio. OIG inspectors reviewed the care provided to a patient who was transferred from the facility's Community Living Center (CLC) to the Emergency Department and subsequently died in the Emergency Department.¹⁵

Background

The facility, part of Veterans Integrated Service Network (VISN) 10, is associated with four community based outpatient clinics in Lima, Middletown, and Springfield, Ohio; and Richmond, Indiana. The facility has sharing agreements with Wright Patterson Air Force Base and 11 community hospitals. VA classifies the facility as a Level 1c—high complexity facility.¹⁶ From October 1, 2016, through September 30, 2017, the facility served 40,254 patients and had a total of 390 hospital operating beds, including 91 inpatient, 200 CLC, and 99 domiciliary beds. The facility has active affiliations with the Wright State University Boonshoft School of Medicine as well as affiliations with 50 other academic programs.

Prior OIG Reports

In the VA OIG report, *Alleged Inadequate Mental Health Treatment at the Dayton VA Medical Center, Ohio*, (Report No. 17-03382-294, September 20, 2018), the OIG did not substantiate that facility staff failed to treat a patient's mental health and addiction problems. The OIG was unable to determine whether the patient's cause of death was suicide due to insufficient evidence. Three recommendations were issued related to the Mental Health Residential Rehabilitation Treatment Program, including completion of clinical scales to quantify the severity of withdrawal symptoms for patients with opioid use disorder, timely provision of therapeutic activity schedules including weekend treatment activities, and evaluation of the program's privileging levels. As of April 2019, the recommendation regarding evaluation of the program's privileging levels was closed, while the other two recommendations remained open.

¹⁵Veterans Health Administration Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. In 2008, VHA replaced the title Nursing Home Care Unit with VA Community Living Center.

¹⁶ The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

Allegations and Related Concerns

In December 2017, the OIG received specific allegations from an anonymous complainant regarding quality of care issues for a patient who died at the facility in the Emergency Department:

- An Emergency Department nurse failed to perform emergency procedures for a patient who experienced cardiac arrest and subsequently died in the Emergency Department.
- This was “not the first time” for an incident with the Emergency Department registered nurse (RN) and a patient’s death.
- The Emergency Department RN should not have been working because his/her cardiopulmonary resuscitation (CPR) certification had expired.
- The Nursing Service allowed the Emergency Department RN 30 days to complete CPR recertification requirements.
- The Emergency Department was inadequately staffed for the night shift.
- Night shift Emergency Department RN staffing typically consisted of only two RNs.

The OIG requested clarifying information from the facility related to the allegations. As the facility’s response did not address all quality of care concerns, the OIG initiated an inspection with a focus on deficiencies in provision of care and maintenance of required training by an Emergency Department RN, and inadequate night shift staffing in the Emergency Department.

During the inspection, the OIG identified additional concerns related to delays and deficiencies in the patient’s care, particularly the care provided by a facility Emergency Department physician (subject physician) and deficits in the facility’s peer review process.

Scope and Methodology

The OIG initiated the inspection on July 30, 2018, and conducted a site visit from October 2 through October 4, 2018. The OIG team interviewed VISN and facility leaders, managers, and staff.¹⁷ The OIG team reviewed relevant facility policies and procedures, training records, staffing schedules, patients’ electronic health records (EHRs), Emergency Department

¹⁷ VISN and facility leaders and staff interviewed included: VISN 10 Acting Director, VISN 10 Chief Medical Officer, VISN 10 Quality Management Officer, VISN 10 Human Resource Officer, VISN 10 Emergency Department Lead, facility Director, the facility’s Chief of Staff, Associate Director for Patient Care Services, Risk Manager, Quality Manager, Patient Safety Manager, facility Chief of Medicine, Emergency Department Director, Emergency Department Chief, Gastroenterology Chief, Surgery Chief, Anesthesia Chief, CPR Committee Chair, Administrative Officer of the Day, Emergency Department attending physicians, residents from code team and consulting services, a Nurse on Duty, CLC and Emergency Department nurse managers and nurses, a respiratory therapist and a computerized tomography technician.

Information System (EDIS) data, facility quality management reviews, facility committee minutes and VISN reports, personnel documents, and medical literature.

In the absence of current VA or Veterans Health Administration (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 topic(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action likely took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action likely 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.

Patient Case Summary

The patient, who was in their 60s, lived in the facility CLC from late 2014 to late 2017.¹⁸ The patient was transferred from a community nursing home in 2014 to the CLC due to risk for falls, inability to provide self-care, an increasing need for assistance, and symptoms associated with a psychotic disorder.

The patient had a documented history of numerous medical and psychiatric conditions including poorly controlled non-insulin-dependent [diabetes](#), [hypertension](#), [congestive heart failure](#), chronic obstructive pulmonary disease ([COPD](#)) complicated by chronic [hypercapnic respiratory failure](#), ongoing tobacco use, chronic obstructive [sleep apnea](#), and non-adherence with bilevel positive airway pressure ([BiPAP](#)) treatments. Other diagnoses included gastroesophageal reflux disease ([GERD](#)), [hyperlipidemia](#), [hyponatremia](#), [prostatic adenocarcinoma](#) with a chronic indwelling [suprapubic catheter](#) and [paranoid schizophrenia](#). The patient ambulated with a motorized wheel chair secondary to weakness in both legs and a risk of falls.

The patient was hospitalized at the facility for a seven-day period in late 2017 (hospital days 1–7). The primary reason for admission to an acute inpatient unit was worsening [encephalopathy](#) and hyponatremia. During the first two days of hospitalization, the patient was in the intensive care unit ([ICU](#)). On hospital day 3, a resident physician noted complaints of leg pain and chest pressure; an EKG showed findings that were similar to those seen on admission. The chest pain was attributed to non-medical conditions. After discussion with another physician who agreed with a move to a non-ICU bed, the patient was transferred out of ICU.

On hospital day 4, a resident physician determined that the patient’s chest pain was likely due to a type of heart attack that is not associated with EKG changes. Over the next two days, the patient was evaluated by both medicine and pulmonary services. A pulmonary note showed “continue 2L [2 liters] NC [nasal cannula] appears stable.” A geriatrics consult showed improvement in hyponatremia and mental status. The patient was accepted back to the facility’s CLC.

The patient was discharged on hospital day 7, and readmitted to the facility’s CLC around noon. The admitting physician evaluated the patient upon readmission and wrote orders for continuing treatment in the CLC. Two CLC physicians who examined the patient at or about the time of the CLC readmission, stated that the patient’s abdomen was slightly distended but otherwise benign.

A [respiratory therapist](#) evaluated the patient about nine hours later and administered a [BiPAP](#) treatment with 5 liters per minute of oxygen. Just before midnight, the respiratory therapist in the CLC documented that the patient “seemed anxious,” was requesting pain medication, had removed the BiPAP mask, and was not tolerating the BiPAP machine. The machine was removed, and the patient’s oxygen therapy was changed to 6 liters per minute of oxygen via

¹⁸ The OIG uses the singular form of they (their) in this context for the purpose of patient privacy.

[nasal cannula](#). The EHR notes indicated that the patient was oxygenating at 90 percent saturation with the help of a [pursed lip breathing](#) technique.

Approximately one hour later, the respiratory therapist returned to the CLC to administer a scheduled [breathing treatment](#). The respiratory therapist was unable to administer the breathing treatment because the patient had vomited and required immediate nursing assistance. A CLC licensed practical nurse (LPN) documented in the EHR that the patient was disoriented, and that the patient stated, “I am in pain but I don’t know what’s really wrong.” The CLC LPN documented that the patient had [projectile vomiting](#) with the consistency of coffee grounds. The CLC LPN notified the CLC RN and continued observation. A CLC RN documented the patient’s vital signs, the vomiting, and that the patient was experiencing labored breathing, anxiety, and weakness. The CLC RN placed a call to the [hospitalist](#) on duty to report the patient’s condition. The hospitalist entered an order for the CLC staff to send the patient to the facility’s Emergency Department.

The patient was transported and arrived in the Emergency Department at 2:35 a.m. for evaluation. An Emergency Department RN [triaged](#) and recorded the patient’s vital signs, which showed a blood pressure reading of 126/53 millimeters of mercury, pulse rate of 67 beats per minute, [respiratory rate](#) of 24 breaths per minute, and a temperature of 99 degrees Fahrenheit. The patient, whose oxygen saturation was 79 percent, gave a [pain score](#) rating of 10 out of 10 on a scale of 1 to 10. The Emergency Department RN noted the patient was restless and short of breath with a [distended abdomen](#), stating “I need a shot to sleep.” EHR documentation indicated that the subject physician was at the patient’s bedside at 2:22 a.m.¹⁹ The subject physician’s note described the patient as “alert and oriented and not in distress.” The subject physician’s documentation of the patient’s abdominal exam stated that the patient’s abdomen was “soft, moderately distended with hypoactive bowel sounds.”

At 3:05 a.m., the subject physician ordered an injection of a benzodiazepine medication and a portable chest x-ray. At 3:25 a.m., a respiratory therapist administered a hand-held breathing treatment. At 4:16 a.m., the subject physician ordered blood work (complete blood count ([CBC](#)), chemistry panel, and lactic acid). At approximately 4:24 a.m., the subject physician entered orders for an intravenous (IV) saline solution, a dose of antibiotics, and a [urinalysis](#) with documentation indicating the physician was “concerned for aspiration pneumonia.” The Emergency Department RN established an IV line for fluids and antibiotics.

The facility’s laboratory received the patient’s blood work at 5:01 a.m. Blood work results were released by the laboratory to the subject physician at 5:31 a.m. The CBC revealed an elevated [white blood cell](#) count at 20,200 cells cubic millimeter (normal = 4,800-10,800). The

¹⁹ The times documented in the EHR would indicate that the Emergency Department physician was bedside at 2:22 a.m. prior to the Emergency Department nurse completing triage at 2:35 a.m., or alternatively could reflect an inaccurate statement of the times in the EHR.

hemoglobin (Hgb) and hematocrit (Hct) measured 12.5 grams per deciliter and 38.1 percent respectively (Hgb normal = 14-18; Hct normal = 42-52).

At 6:02 a.m., urinalysis results were reported as [leukocytes](#) being “large” and the urine [nitrite](#) as “negative.” The medicine service admitting resident was called to the Emergency Department to evaluate the patient for admission. The resident noted that the patient had a moderately distended abdomen, and discussed the patient’s physical finding with the subject physician, who agreed to obtain a CT scan of the abdomen. The patient’s potassium level was reported to the medicine service admitting resident at 6:05 a.m. as 7.1 milliequivalent per liter (mEq/L). The resident informed the subject physician about the elevated potassium and the subject physician ordered medications to treat the [hyperkalemia](#). At 6:15 a.m., the subject physician also ordered a [stat](#) CT scan of the abdomen and an [EKG](#). The patient received potassium lowering medications (insulin and glucose) and was taken to radiology for the CT scan. The EKG showed peaked T waves.²⁰

After the CT abdominal scan was performed, the patient was transported from the Radiology Department back to the Emergency Department. The medicine service admitting resident contacted a tele-radiologist on call for the CT results. However, the results were not yet available, and the tele-radiologist suggested a call back in 15 minutes. At 7:20 a.m., a [code blue](#) was called for the patient. The medicine service admitting resident wrote in a note that “during the code blue I received a phone call from the tele-radiologist who reported that the patient had a [surgical abdomen](#).” The EHR recorded that the patient died at 7:55 a.m. The case was reported to the coroner’s office; however, an autopsy was not performed.

²⁰ *EKG- Disorders of T Waves*. An EKG with peaked T waves is a sign of hyperkalemia. Early application of a monitoring device would have alerted the staff to the changes in the EKG rhythm. Peaked or tall T waves are commonly caused by hyperkalemia. <https://www.cancertherapyadvisor.com/home/decision-support-in-medicine/hospital-medicine/ekg-disorders-of-t-waves/>. (The website was accessed on March 17, 2019.)

Inspection Results

During the OIG's evaluation of the patient, team members identified concerns with the patient's medical care in the Emergency Department.²¹ The OIG determined that the deficiencies in care by an Emergency Department physician (subject physician) presented a significant impact for patient safety and quality of care. Therefore, this report describes the inspection findings related to the subject physician first. The facility's peer review process is discussed second, followed by the quality of care concerns related to the patient, concerns related to an Emergency Department RN, and Emergency Department staffing. The last section details other findings that were identified during the inspection.

1. Deficiencies in Care by the Subject Physician

Due to the delays and deficiencies in the Emergency Department treatment of the patient, the OIG determined that a more extensive evaluation of the subject physician's quality of care and medical decision-making was warranted.

The OIG found deficiencies in the subject physician's medical decision-making and provision of care. OIG inspectors interviewed staff, reviewed the patient's EHR, and evaluated peer reviews for quality management, the subject physician's ongoing and focused management reviews, patient complaints, and findings from a VISN management review that was initiated in response to notification of the OIG team's concerns.

The VHA directive that establishes policy and procedure for emergency departments indicates all physicians in an emergency department must possess training, experience, and competence to manage and treat all patients who seek emergency care.²² The facility's 2017 Bylaws and Rules of the Medical Staff listed the core competencies for clinical privileges:

- Appropriate patient care
- Clinical knowledge
- Practice-based learning
- Interpersonal skills

²¹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016. An emergency department is a unit in a VA medical facility equipped with acute care inpatient beds and whose "primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." The emergency department operates 24 hours a day, 7 days a week. At the time of the OIG's inspection, the facility's Emergency Department had 12 beds, with one designated for psychiatric patients. A separate area was used to expedite treatment of low acuity patients. From October 1, 2017, through September 30, 2018, the facility's Emergency Department provided medical care for 20,109 patients.

²² VHA Directive 1101.05.

- Professionalism
- System-based practices

The OIG reviewed the patient's EHR and identified examples of deficient practice by the subject physician relative to the specific topics listed below.

Lack of Thorough History and Physical Examination

The subject physician ordered a [benzodiazepine](#) within the first hour of the patient's arrival at the Emergency Department, despite admission and discharge notes from the patient's recent inpatient admission and treatment in CLC which indicated to "avoid opioids/benzodiazepines" secondary to chronic respiratory problems.

Deficiencies in Choice and Timeliness of Diagnostic Tests

The subject physician was significantly delayed in ordering diagnostic studies, including laboratory tests and a [CT scan](#), which delayed diagnosis and recognition of need for a surgical consult.

Deficiencies in Choice and Timeliness of Treatments

While the patient's presentation included shortness of breath and [low oxygen saturation](#), there was no documentation to indicate the patient was placed on oxygen prior to receiving a breathing treatment from respiratory therapy an hour after admission to the Emergency Department. The subject physician failed to order medication to address the patient's vomiting, and the OIG found no documentation to indicate that the subject physician considered placement of a nasogastric tube to evacuate the patient's stomach despite a [distended abdomen](#). Additionally, as noted in an example above, the delay in ordering diagnostics resulted in failure to refer the patient for a surgical consult.

Deficiencies with Disposition of the Patient

The subject physician incorrectly communicated the patient's status as being admitted to the inpatient medicine service when handing off care to an oncoming Emergency Department physician taking over at the end of shift. In actuality, CT scan results were pending to determine the cause for the distended abdomen and the medicine service had clearly documented the patient had not been admitted.

Patient Advocate Complaints

To consider patients' perspectives, the OIG reviewed complaints submitted to the facility's patient advocate office regarding patient care provided in the Emergency Department. The subject physician was identified in a disproportionate number of patient advocate complaints from October 1, 2016, through September 30, 2018, when considering the number of complaints relative to a total of 25 physicians providing care in the Emergency Department during that time frame.²³

Of the 50 complaints submitted between October 1, 2016, and September 30, 2017, 11 were related to care provided by the subject physician. Of the 49 complaints submitted between October 1, 2017, and September 30, 2018, 14 were related to care provided by the subject physician. The complaints referenced issues with access/timeliness, coordination of care, medication, preferences/decisions, risk management, and staff courtesy.

Peer Reviews

As part of the OIG's evaluation of quality of care, facility peer reviews for the subject physician were examined. Peer reviews are initiated for cause to identify areas for improvement in an individual provider's practice. Given the events that trigger peer reviews, described below, the presence of a high volume of peer reviews may raise concerns about a provider's practice; however, a high volume of peer reviews alone does not necessarily indicate problems. Providers working in certain medical settings with high-risk patient populations are likely to trigger more peer reviews than providers working in settings with lower-risk populations. Similarly, a provider with a high volume of peer reviews in which the reviews predominantly determined that the provider's care was consistent with the way most experienced, competent providers would have managed the case would not raise concerns. Alternatively, a provider with a high volume of peer reviews in which a significant number of peer reviews found the provider's practice failed to meet expected standards would raise concerns and suggest the need for a more extensive evaluation of the provider's practice.

The OIG found that the subject physician led the facility's Emergency Department providers in the number of peer reviews triggered yearly (thus the subject physician triggered peer reviews more frequently than physician peers working in the same medical setting). While a number of the peer reviews identified areas for improvement in practice, based on the facility policy,

²³ VHA Directive 1103.4, *VHA Patient Advocacy Program*, September 2, 2005. VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018. Each VA facility has a patient advocate designated to manage the complaint process, which includes documentation of the complaint, resolution of the complaint, and closing the complaint within seven days.

findings of the peer reviews did not trigger additional management reviews during that time frame.

VHA's protected peer review for quality management is an organized process for evaluating the quality of care provided to a patient by a provider and is intended to improve the quality of health care and/or the utilization of healthcare resources.²⁴ VHA requires that facility policy specify the circumstances under which peer reviews are considered. Facility policy established criteria for initiating a peer review, which included

- Readmission within 10 days of discharge from inpatient hospitalization,
- Admission within three days following an unscheduled ambulatory care visit,
- Mortalities during an inpatient admission,
- Major morbidities associated with clinical care,
- Completed suicides within 30 days of a provider encounter,
- Unexpected negative occurrences,
- Executive concerns,
- Tort claims, and
- Concerns of other facility groups.²⁵

Peer reviewers evaluate an episode of care, document findings from their review, provide a rationale, and assign a peer review level as follows:²⁶

- Level 1: “most experienced, competent practitioners would have managed the case in a similar manner.”
- Level 2: “most experienced, competent practitioners might have managed the case differently.”²⁷

²⁴ VHA Directive 2010-025, *Peer Review for Quality Management (QM)*, June 3, 2010. Peer reviews conducted for quality management are confidential and protected under Title 38 CFR § 5705. Protected peer review is intended to “promote confidential and non-punitive processes that consistently contribute to quality management efforts at the individual provider level.” Directive 2010-025 was in effect at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, which contains the same or similar language related to the definition of protected peer review.

²⁵ VHA Directive 2010-025; VHA Directive 1190; Dayton VA Medical Center Policy 00Q-08, *Peer Review*, March 18, 2014; Dayton VA Medical Center Policy 00Q-08, *Peer Review*, March 27, 2017. Dayton VA Medical Center Policy 00Q-08, 2014 and Dayton VA Medical Center Policy 00Q-08, 2017 contain the same or similar language related to the triggers for initiating peer review.

²⁶ VHA Directive 2010-025; VHA Directive 1190. A peer reviewer is a health care professional with comparable education, training, experience, licensure, or scope of practice to the provider under review and can make a fair and credible assessment of the care provided.

²⁷ VHA Directive 2010-025. The Level 2 definition was modified in VHA Directive 1190: “Level 2 is the level at which most experienced and competent clinicians might have managed the case differently, but it still remains within the standard of care.”

- Level 3: “most experienced, competent practitioners would have managed the case differently.”²⁸

Findings from peer reviews are presented to the facility’s Peer Review Committee (PRC) for deliberation and assignment of a final peer review level. The PRC determines any appropriate, non-punitive, non-disciplinary actions indicated to improve quality of health care delivery based on the findings of a review.²⁹

For the subject physician, the PRC retained the original peer review level in 65 percent of the cases, lowered the level in 29 percent of the cases, and raised the level in 6 percent of the cases reviewed. While the PRC meeting minutes documented discussion of the cases, the documentation was insufficient to ascertain the rationale for the PRC’s change in level for 7 out of the 11 cases in which the PRC assigned a different level than the original peer reviewer.

Considering the issues identified during the OIG’s review of the subject physician’s quality of care, the failure of the facility’s peer review process to trigger one or more management reviews during this time frame raised concerns.

2. Deficiencies in the Peer Review Process

The OIG found that the facility’s peer review process failed to identify trends in quality of care issues with the subject physician’s medical practice. Deficits in the facility’s peer review process limited the effectiveness of the peer review function as part of the facility’s quality management processes. The OIG team conducted interviews with facility leaders, reviewed documentation related to the peer review process, patient EHRs, and results of the VISN’s external management review of the subject physician’s patient cases. The OIG found that concerning trends with the subject physician were not recognized during the facility’s peer review process, which led to missed opportunities to implement performance improvement efforts to support safe, high-quality patient care.

According to facility policy, the PRC is responsible for reconsideration of all protected peer review cases within the facility.³⁰ The facility’s Chief of Staff, Chief of Medicine, and Chief of the Emergency Department serve on the facility’s PRC, thus had awareness of initial peer review findings, and participated in the PRC’s determination of the final peer review levels for the subject physician.

²⁸ VHA Directive 2010-025; VHA Directive 1190.

²⁹ Dayton VA Medical Center Policy 00Q-08, 2014; Dayton VA Medical Center Policy 00Q-08, 2017. A provider’s receipt of three level-3 peer reviews in a rolling, 12-month period triggers a review of the provider’s care by the appropriate service chief. The service chief provides a written response to the Professional Standards Board including both a recommendation for action and the rationale for the recommendation, which may include a focused review of the provider’s clinical care.

³⁰ Medical Center Policy No. 00Q-08, 2014; Medical Center Policy No. 00Q-08, 2017.

The facility’s PRC meeting minutes documented follow-up actions to be taken dependent on the assigned peer review level; however, documentation did not include further details. Thus, it is unclear if additional specific training or other means of remediating deficient practices were identified or offered to the subject physician.

The VISN’s external management review of the subject physician’s practice concluded that “significant recurrent concerns” were identified in the subject physician’s “management and documentation” of patient care. The VISN’s review was performed with a randomized sample of 60 patients treated in late 2018, and included four additional patients selected for cause, including the patient discussed in this report, and three other patients selected based on the subject physician’s peer reviews. Peer reviews at the facility were all triggered by specific occurrences of concern, as detailed in the facility policy (see table 1).³¹

Table 1. Triggers for Facility Peer Reviews of the Subject Physician

Triggers for Peer Review	# Peer Reviews Triggered
Negative occurrence/Unexpected patient outcome	10
Admission within three days following unscheduled ambulatory care visit	7
Concerns of other facility groups	5
Mortality during inpatient hospitalization	4
Executive concern	3
Readmission within 10 days of discharge following inpatient hospitalization	1
Tort claim	1

Source: Facility peer reviews (January 2015 through July 2018)

Statistically, it might be expected that more concerns would be identified in a sample of cases reviewed for cause, such as the triggered peer reviews, than a sample of randomly selected cases, such as the VISN management review. However, the facility’s peer review process failed to recognize the concerning trends in the subject physician’s practice, while these trends were identified by the VISN’s management review.

The Clinical Executive Board is responsible for establishing peer review or professional activity triggers that lead to a focused review of a provider’s clinical care.³² VHA policy states that a management review, such as a focused professional practice evaluation (FPPE), may be used

³¹ Medical Center Policy No. 00Q-08, 2014; Medical Center Policy No. 00Q-08, 2017.

³² The Clinical Executive Board is designated by the facility’s Bylaws and Rules of the Medical Staff as the Executive Committee of the Medical staff.

when a question arises regarding a provider's ability to provide safe, high-quality care.³³ Facility policy during the timeframe of the OIG review stated that the assignment of three peer review level 3s to the same provider in a rolling 12-month period would trigger a review of the provider's care by the service chief, which may include an FPPE.³⁴ Despite the quality of care concerns uncovered during the OIG review, no management reviews were triggered based on the subject physician's peer reviews from January 2015 through July 2018. This raised concerns about the sensitivity of the facility's established triggers for initiating management reviews to assess a provider's quality of care and ensure patient safety.

In response to concerns raised by the OIG's inspection, the facility's Clinical Executive Board met on November 13, 2018, and discussed changes to the facility's peer review triggers. The Clinical Executive Board established a point system in which peer review level 3s are assigned three points and peer review level 2s are assigned two points. The Clinical Executive Board determined that the threshold for peer reviews to trigger a management review would be changed to any combination of level 2s and 3s totaling 10 or more points in a rolling 12-month period. The Facility Director reported this change was implemented immediately, while the facility was in the process of amending the local policy on peer reviews to reflect this change.³⁵ Based on the revised policy, the subject physician's peer reviews would have triggered a management review on four occasions between January 2015 and July 2018.

The Clinical Executive Board also reviews a quarterly summary of the PRC's analysis and a summary report is sent to the VISN for review. VHA policy states that the summary report will minimally include the following:

- Number of peer reviews completed
- Number of deaths screened
- Assigned peer review levels by the peer reviewer and the PRC
- Number of peer review levels assigned to a higher or lower level by the PRC than the initial peer reviewer
- Delinquency rate for the timeliness of reviews³⁶

The content of the facility's summary reports to the VISN satisfied the requirements of VHA policy.³⁷ The aggregate data in the summary report does not facilitate identification of provider level trends at the VISN oversight level. The VISN Quality Management Officer told the OIG team that provider level concerns would typically be conveyed to the VISN from the facility via

³³ VHA Directive 2010-025.

³⁴ Medical Center Policy No. 00Q-08, 2014; Medical Center Policy No. 00Q-08, 2017.

³⁵ Medical Center Policy No. 11-49, *Professional Practice Evaluation*, April 14, 2016.

³⁶ VHA Directive 2010-025.

³⁷ VHA Directive 2010-025.

an issue brief, or outreach from the facility's Quality Management or Safety Officers.³⁸ In the case of the subject physician, the VISN was notified of concerns via direct communication from the Facility Director. Upon notification of the concerns, the VISN provided consultation and assisted the facility by initiating an external management review of the subject physician.

Ongoing and Focused Professional Practice Evaluations

The inspection team reviewed the subject physician's ongoing professional practice evaluations (OPPEs) and re-credentialing and privileging documents. Performance evaluations showed satisfactory performance, indicating consistent ratings of either "acceptable" or "outstanding."³⁹

Monitoring and surveillance of standards of performance and professional competency required to maintain privileges are the responsibility of facility leaders. Competency validation for providers at the facility is done through an OPPE process on a semiannual basis. Measures of competency in the facility OPPE for an Emergency Department physician included compliance with documentation, Basic Life Support (BLS) certification, timeliness of clinical notes, triggers for peer review, and patient complaints.

An FPPE of the subject physician was initiated in November 2013.⁴⁰ The PRC reported this information to the facility's Professional Standards Board in February 2014, and a plan was identified for an FPPE of the subject physician consisting of 15 chart reviews over the following two months. The Professional Standards Board meeting minutes from April 2014 showed the completion of medical reviews of the subject physician's provision of care for 15 cases between February and March 2014, and reported satisfactory findings for clinical care and documentation based on those reviews. The facility's PRC determined the issue closed. Peer review findings did

³⁸ Deputy Secretary for Health for Operations and Management, 10N *Guide to VHA Issue Briefs*, March 29, 2018. Issue Briefs are designed to provide clear, concise and factual information about unusual incidents, deaths, disasters, or anything else that might generate media interest or impact care.

³⁹ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. OPPE is a management review process for the ongoing monitoring of privileged practitioners to confirm the quality of care delivered. All privileged providers are subject to routine OPPEs, which are intended to help the facility "identify professional practice trends that impact the quality of care and patient safety." Credentialing is a "systematic process of screening and evaluating qualifications and other credentials, including, but not limited to licensure, required education, relevant training and experience, and current competence and health status." Clinical privileging is the process by which an independently licensed practitioner is legally permitted by the facility to provide specified medical or other patient care services. Re-privileging must be conducted at least every two years.

⁴⁰ VHA Handbook 1100.19. An FPPE is a management review process involving evaluation of the "privilege-specific competence" of a practitioner who does not have current documented evidence of competently performing requested clinical privileges. An FPPE is a non-protected management review activity and typically occurs at the time of initial appointment to the medical staff and prior to granting new or additional privileges. An FPPE may also be used "when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care."

not reach the facility's threshold for triggering an FPPE for the subject physician for the January 2015 through July 2018 time frame.

Facility and VISN Responses

The OIG determined that the deficits identified in the subject physician's evaluation and treatment practices had the potential for imminent impact on patient safety. OIG staff shared these concerns with facility leaders in October 2018. The Facility Director responded promptly by placing the subject physician on a summary suspension from clinical care while facility leaders initiated a management review of the subject physician's practice.⁴¹ The Chief of Medicine conducted a review of the subject physician's cases, did not identify "serious breaches in care or documentation," and determined that the subject physician was "not a danger to the patients" evaluated and treated in the Emergency Department. The Chief of Medicine recommended removing the summary suspension, returning the subject physician to patient care duties, and initiating an FPPE to monitor the subject physician's quality of care.⁴²

The Facility Director consulted with Medical Affairs in VA Central Office and extended the subject physician's suspension from clinical care duties pending consultation with the VISN regarding the subject physician's quality of care raised by the OIG inspection team. VISN and facility leaders determined that the subject physician would not be returned to clinical care until a more extensive management review was conducted and analysis completed. The VISN's Emergency Department Lead Physician coordinated an external management review.

The VISN's external management review encompassed 64 cases and was conducted by three physician peers from outside the facility. The VISN's review included 60 randomly selected cases from a list of patients treated by the subject physician from September 1 through October 19, 2018, with each physician reviewing 20 cases. An additional seven cases were selected for review including the patient discussed in this report. The review assessed specific aspects of care:

- Documentation
 - Inclusion of medical history
 - Physical exam
 - Relevant data

⁴¹ VHA Directive 1100.19, *Credentialing and Privileging*, October 15, 2012. When imminent danger may result from failure to take action, a provider's clinical privileges may be summarily suspended pending a comprehensive review. VHA Directive 2010-025; VHA Directive 1190. A management review is any review that is conducted when a facility determines a need to undertake administrative action following a clinical review, such as a peer review for quality management. Management reviews must be a distinct and separate process from quality management reviews. Management reviews are not confidential and privileged under 38 U.S.C. 5705. Findings from management reviews can affect privileges or personnel status.

⁴² VHA Handbook 1100.10.

- Diagnosis
 - Documentation of diagnosis
 - Diagnosis documented was supported by the evaluation
- Resources
 - Ordering of appropriate tests and procedures
 - Appropriate use of consults
- Therapeutics
 - Treatment plan consistent with history, physical exam, and reason for consult
 - Appropriate follow-up plan of care
- Prescription practices
 - Prescribing pattern
 - Overall quality of documentation

The consensus findings from the VISN’s external management review included “significant recurrent concerns” with the subject physician’s “management and documentation” of patient care. The findings of the VISN’s external management review validated the OIG concerns about the subject physician’s quality of care and the need for further action by the facility.

On February 12, 2019, the physicians who conducted the management review for the VISN submitted a recommendation to the facility’s Clinical Executive Board to revoke the subject physician’s privileges. The Clinical Executive Board and the Facility Director agreed with the recommendation. On February 26, the Chief of Staff authored a proposal for removal of the subject physician.

In March, the subject physician received a decision of removal and revocation of privileges from the Facility Director. Six days later, the subject physician appealed the decision.

A Disciplinary Appeals Board hearing was convened to review the subject physician’s appeal. In July 2019, the Disciplinary Appeals Board reviewed submitted documentation and found it was insufficient to fully substantiate the findings upon which the revocation of privileges was predicated. The Disciplinary Appeals Board determined the charges were not sustained and recommended the removal of the subject physician from federal service be overturned.⁴³ The Acting Principal Deputy Under Secretary for Health approved the Disciplinary Appeals Board’s recommendation in September 2019. In November 2019, the subject physician resigned from the VA.

⁴³ A Disciplinary Appeals Board is a three-member board designated to hear an [full-time] employee’s appeal of a major adverse action which is based in whole or in part on a question of professional conduct or competence.

3. Deficiencies in Quality of Care for the Patient

In this section, the OIG addresses allegations and other concerns related to the patient's medical and nursing care during the late 2017 Emergency Department evaluation, including communication and coordination of care issues. Coordination of care issues were also noted with gastroenterology (GI) staff related to a canceled procedure. Issues in this section are discussed in the order in which they occurred in the timeline of the patient's care:

- GI issues that occurred prior to the late 2017 Emergency Department evaluation
- Issues related to transfer from the CLC to the Emergency Department
- Deficits in care during the patient's treatment in the Emergency Department⁴⁴

A timeline of the Emergency Department evaluation is included to illustrate the chronology of events (see table 2).

The OIG found deficiencies in coordination of care in the CLC for the patient.⁴⁵ Specifically, a gap in communication between CLC staff and GI staff resulted in unnecessary administration of a laxative solution in preparation for a canceled GI procedure.⁴⁶

The OIG found delays and deficits in quality of care for the patient in the Emergency Department. Deficits included failure in monitoring the patient, which may have delayed

⁴⁴ A VA CLC provides a variety of specialty programming within a skilled nursing environment for individuals in need of both short- and long-stay services. The facility's CLC, which has four units, provides care to patients with a variety of medical conditions who need assistance with activities of daily living and skilled nursing care, and provides specialty services, including geriatric care, memory care, and hospice. The facility's CLC is not located in the same building as the inpatient side of the facility, the ambulatory care clinics, or the Emergency Department. The four units include a secure 18-bed memory care unit, serving veterans with cognitive issues that may impact their safety; a 20-bed long-term care unit serving veterans with medical and/or psychiatric issues; a 25-bed long-term care unit serving medically complex veterans who require a high degree of assistance with their care; and a 20-bed palliative care unit providing hospice services for veterans who are terminally ill.

⁴⁵ McDonald, et.al., 2007, *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies* (Vol. 7: Care Coordination), Agency for Healthcare Research and Quality. Coordination of care has been described as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services." Care coordination between a patient's primary care provider and specialty care providers is a critical component of safe, efficient, and patient-centered care. Failures in coordination of care can result in delays in diagnosis, iatrogenic complications, and even mortality. Effective communication between specialty care providers and the primary care provider is important to successful coordination of care. <https://www.ncbi.nlm.nih.gov/books/NBK44012/>. (The website was accessed on January 10, 2019). VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013. VHA policy for care planning in CLCs and long-term care programs stresses the importance of treatment planning and coordination of care by an interdisciplinary team of providers and staff involved in the patient's care.

⁴⁶ Mayo Clinic, *Gastroenterology and Hepatology*. Gastroenterology is a branch of medicine that specializes in preventing, diagnosing and treating conditions involving the pancreas, liver, gallbladder, esophagus, stomach, small intestine, and colon. <https://www.mayoclinic.org/departments-centers/gastroenterology-hepatology-digestive-care/sections/overview/ovc-20348241>. (The website was accessed on November 5, 2018).

recognition of deterioration in the patient's condition.⁴⁷ Deficiencies in provision of care by the subject physician were identified, as referenced in the section above. The OIG also found discrepancies in handoff communication between Emergency Department providers and coordination with admitting services.⁴⁸ Facility leaders conducted an institutional disclosure related to this patient's care to the patient's family in late 2018.⁴⁹

Failures in Coordination of Care for GI Procedure

The OIG found a failure in coordination between GI and CLC staff which resulted in unnecessary preparation of the patient for a canceled procedure.⁵⁰

In fall 2017, the patient was evaluated for difficulty swallowing solid food.⁵¹ The initial evaluation confirmed and indicated an increased risk for aspiration. The patient's primary care provider requested further evaluation by a GI specialist.

Approximately six weeks later, the patient was scheduled for additional testing related to difficulties in swallowing, as well as a screening colonoscopy.⁵² The GI specialist noted that

⁴⁷ Monitoring is the use of a device to observe a biological condition or function, such as a heart monitor, a blood pressure monitor, glucose monitor, or oxygen monitor.

⁴⁸ The Joint Commission, *Transitions of Care: The Need for a More Effective Approach to Continuing Patient Care*. https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care. (The website was accessed on September 20, 2018.) Two root causes contributing to ineffective transitions in care are related to communication and accountability. Communication breakdowns occur when there is a lack of a standardized hand-off procedure, inadequate amount of time for a successful hand-off, or differing expectations between senders and receivers of patients. Accountability breakdowns occur when there is no clinical entity who takes responsibility to ensure that the patient's health care is coordinated across various settings and among different providers.

⁴⁹ VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012, was in effect during 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. The handbook and directive contained similar definitions of an adverse event. Adverse events are "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." The 2018 directive further states an "[i]nstitutional 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."

⁵⁰ VHA Handbook 1142.01.

⁵¹ Mayo Clinic, *Dysphagia*. Difficulty swallowing, or dysphagia, may be evaluated via endoscopy or the insertion of a thin, flexible, lighted instrument (endoscope) into the throat so that a physician can see the esophagus. <https://www.mayoclinic.org/diseases-conditions/dysphagia/diagnosis-treatment/drc-20372033>. (The website was accessed on November 12, 2018.)

⁵² Mayo Clinic, *Colonoscopy*. A colonoscopy is a procedure in which a physician inserts a colonoscope into the rectum to check for abnormalities in the colon. at <https://www.mayoclinic.org/tests-procedures/colonoscopy/multimedia/colonoscopy-exam/img-20008879>. (The website was accessed on November 13, 2018.)

monitored anesthesia care would be required for the procedures; however, documentation did not indicate that CLC staff were notified of this requirement.⁵³

During interviews, CLC staff told the OIG team that this type of sedation was not commonly ordered for CLC patients.⁵⁴ Facility policy requires that an anesthesia provider perform this type of sedation.⁵⁵ The CLC staff did not receive notification that the procedure could not be completed as scheduled because anesthesia staff were unavailable. The CLC staff had already completed the bowel preparation when they discovered the tests had been canceled.⁵⁶ The CLC provider reported contacting GI staff immediately to ask that the procedures be performed as originally scheduled; however, the CLC provider was told that the procedure could not be done on that date because anesthesia staff were not available.

The patient received a medication to prepare the bowel for examination that increased absorption of water into the stool, allowing for cleansing of the bowel by causing diarrhea. A shift of water into the stool can increase fluid imbalances.⁵⁷

The patient had a history of hyponatremia and was not fully compliant with fluid restrictions, a mainstay of treatment for patients with chronic hyponatremia. The OIG staff were told that the patient drank excessive soda when outside the CLC unit, which limited the effectiveness of CLC staff's efforts to restrict fluid intake.⁵⁸ Factors that put the patient at additional risk for hyponatremia were age, decreased kidney function, and [syndrome of inappropriate anti-diuretic hormone \(SIADH\)](#).⁵⁹ The primary care provider recognized that a bowel prep with shifts in fluid might worsen hyponatremia, and monitored the patient's sodium levels. After the prep, the patient's sodium level decreased from 128 to 122, and continued to drop to a critically low level. After an evaluation in the Emergency Department, the patient was admitted to the facility's ICU

⁵³ Monitored anesthesia care is a type of anesthesia in which an anesthesia clinician continually supports and monitors the patient's vital functions. <https://www.uptodate.com/contents/monitored-anesthesia-care-in-adults#>. Footnote 55(The web site was accessed on January 24, 2019.)

⁵⁴ The CLC provider said that the usual method of notification was "tagging" a note so that another provider would receive a notification flag in the chart to look at the note.

⁵⁵ Medical Center Policy No. 112-05, *Anesthesia Care*, June 15, 2017.

⁵⁶ VerywellHealth, *How to do a Bowel Prep for Colonoscopy or Surgery*. Prior to performing a colonoscopy, bowel preparation is required and ordered by a provider. Bowel preparation is the process of removing all solids from the colon to allow the physician to see the tissue. <https://www.verywellhealth.com/bowel-prep-what-you-need-to-know-3157016>. (The website was accessed on November 20, 2018).

⁵⁷ VerywellHealth, *How to do a Bowel Prep for Colonoscopy or Surgery*.

⁵⁸ VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. CLC patients may leave the CLC if they have campus privileges or a pass for an authorized absence from the CLC for therapeutic reasons. Campus privileges are permissions to leave the CLC while remaining on the designated VA campus.

⁵⁹ Mayo Clinic, *Risk Factors in Hyponatremia*. <https://www.mayoclinic.org/diseases-conditions/hyponatremia/symptoms-causes/syc-20373711>. (The website was accessed on November 5, 2018.)

(for a seven day hospital stay as discussed in the patient case summary).⁶⁰The patient was discharged on hospital day 7 back to the CLC.

Though the OIG was unable to definitively determine the cause, the unnecessary bowel prep was one factor that may have caused the decrease in the patient's sodium levels, which precipitated the admission to the ICU. The OIG was unable to quantify frustration or disturbances in the patient's activities of daily living that may have resulted from the unnecessary bowel prep.

Deficiencies Related to CLC to Emergency Department Transfer

Less than 14 hours after discharge to the CLC, the patient developed signs and symptoms of GI distress that required a return trip to the Emergency Department. The OIG noted deficiencies in communication around the patient's transition of care from the CLC to the Emergency Department.

Soon after midnight of the day the patient returned to the CLC, the patient was noted to be disoriented, in pain, and had projectile vomiting. A CLC RN documented the appearance of the vomit as "coffee ground" and during an interview, reported the concern that this type of vomiting may have indicated that the patient was bleeding internally.⁶¹ A CLC RN recognized the change in the patient's condition as requiring an increased level of care and initiated a transfer to the Emergency Department.

At 1:17 a.m., the CLC RN documented an unsuccessful attempt to contact the on call physician. At 1:35 a.m., a second call was placed, and the CLC RN documented a verbal order from the on-call physician to send the patient to the Emergency Department. At that same time, CLC staff called for the patient to be transported to the Emergency Department. The patient arrived in the Emergency Department at 2:35 a.m.

Facility policy requires that the CLC RN contact the Nurse on Duty and Emergency Department Charge RN before a patient is transported.⁶² In addition, the Situation, Background, Assessment and Recommendation (SBAR) communication tool is to be used for documentation of the reason for the transfer, current medications, recent laboratory results, vital signs, and assessment for the

⁶⁰ Mayo Clinic, *Hyponatremia*. A normal blood sodium level is between 135 and 145 mEq/L. <https://www.mayoclinic.org/diseases-conditions/hyponatremia/symptoms-causes/syc-20373711>. (The website was accessed on November 5, 2018.)

⁶¹ Healthline, *Coffee Ground Vomitus*. Vomit that looks like coffee grounds occurs due to the presence of coagulated blood in the vomit. It is a serious condition and requires immediate attention. <https://www.healthline.com/health/coffee-ground-vomitus>. (The website was accessed on January 22, 2019.)

⁶² Medical Center Policy 111-25, *Patient Transfers to the Emergency Department*, July 13, 2017.

risks of elopement, wandering, or falls.⁶³ Documentation of the CLC RN's report to the Emergency Department RN did not contain the required elements of the SBAR communication tool and did not document communication of the CLC RN's concern of possible bleeding due to the "coffee ground" appearance of the patient's vomit.

The Emergency Department RN documented that the patient had emesis in the CLC but did not document report of concerns from the CLC RN regarding possible bleeding.⁶⁴ The subject physician reported awareness of documentation from the CLC indicating projectile vomiting, but told the OIG team that the patient did not projectile vomit while in the Emergency Department, and determination of treatment was based on assessment in the Emergency Department.

The OIG found a lack of documentation to show facility staff adherence to the hospital policy for transport of CLC residents to the Emergency Department. The CLC is located on the grounds of the facility, but not situated near the Emergency Department. The CLC must call an ambulance for emergency transport of residents to the Emergency Department. Facility policy states that after hours, non-ambulatory CLC patients are transferred to the Emergency Department with the assistance of the VA Police, and are accompanied by a CLC nursing staff member.⁶⁵ Although reports indicated the patient was transported to the Emergency Department via an ambulance or facility "ambulette," the facility could not locate a VA Police log entry for this transport.

The facility's transport policy was updated in August 2018, with inclusion of more specific guidance for communication, documentation, and transport.⁶⁶ The revised transport policy specifies requirements in detail including

- Contact between the residential or outpatient provider and an Emergency Department provider to discuss the reason for transport and other relevant medical factors,
- Documentation of the communication by the sending provider,
- Elements of SBAR communication required by nursing staff prior to transport,
- Documentation of SBAR communication by nursing staff prior to transport, and
- Methods for arranging transport dependent on emergent or non-emergent need and shift.

⁶³ Patient Safety Network, *Situation, background, assessment, and recommendation (SBAR) communication tool for handoff in health care; a narrative review*. SBAR, a mnemonic for situation, background, assessment, and recommendation, is a communication tool that structures information sharing to avoid communication failures during handoffs. <https://psnet.ahrq.gov/resources/resource/32213/Situation-background-assessment-recommendation-SBAR-communication-tool-for-handoff-in-health-care-a-narrative-review>. (The website was accessed February 5, 2019.)

⁶⁴ Merriam-Webster, *Definition of emesis*. Emesis is an act or episode of vomiting. <https://www.merriam-webster.com/dictionary/emesis>. (The website was accessed on January 7, 2019).

⁶⁵ Medical Center Policy No. 111-25, *Patient Transfers to the Emergency Department*, July 13, 2017.

⁶⁶ Medical Center Policy No. 136-25, *Patient Transports to and from Emergency Department*, July 13, 2017.

Failure to Monitor in the Emergency Department

The OIG found that an Emergency Department RN, who both triaged the patient and was assigned as the patient's primary nurse while in the Emergency Department, failed to monitor for changes in the patient's condition; specifically, identifying the lack of ongoing assessment, cardiac monitoring, and documentation of oxygen levels. The OIG's review of the patient's EHR found no documentation to indicate that the patient was placed on monitoring for cardiac rhythm or oxygenation levels. During an interview, the Emergency Department physician on duty at the time of the code blue told OIG inspectors that the patient had been found unresponsive and was not hooked up to a monitor. The OIG determined that the deficiencies in monitoring had the potential to delay recognition of the signs of the patient's deterioration, but were unable to definitively determine if these deficiencies delayed the timely administration of emergency procedures.

Delays in Diagnostic Testing and Treatment by the Subject Physician

The OIG found assessment delays and deficits in treatment of the patient by the subject physician as previously discussed. While the patient arrived in the Emergency Department at 2:35 a.m., the subject physician did not order labs until 4:16 a.m., or a CT scan until 6:15 a.m., thus diagnostic tests were delayed. Despite documentation of vomiting and a distended abdomen, the subject physician failed to order medication to address the patient's vomiting. In addition, the OIG found no documentation to indicate that the subject physician considered placement of a nasogastric tube to evacuate the patient's stomach.

Emergency Department Handoff Communication

The OIG found inaccurate handoff communication by the subject physician to the oncoming Emergency Department physician regarding the patient's admission status, and gaps in coordination of care for admission. Facility policy states that patients whose care is still in progress at the end of the treating physician's shift will be turned over to the arriving physician with "appropriate handoff communication and documentation of that handoff in CPRS [computerized patient record system]."⁶⁷

The subject physician's EHR note indicated a plan to sign over the patient to the oncoming Emergency Department physician for final disposition, and also documented that the patient was admitted to the medicine service in stable condition. The oncoming Emergency Department physician reported understanding that the patient had been admitted to the medicine service and

⁶⁷ Medical Center Policy No. 111-21, *Emergency Department Policies and Procedures*, April 7, 2016.

noted that the patient was “blue” on the EDIS board.⁶⁸ The oncoming Emergency Department physician explained that the blue designation on the EDIS board denoted that a provider from the admitting service had seen the patient and was assuming care, and that the patient was awaiting transfer from the Emergency Department to the appropriate floor. However, the OIG confirmed via review of EHR documentation and interviews that the medicine service had not accepted the patient for admission.

The oncoming Emergency Department physician acknowledged to the OIG that where the EDIS board shows a patient as blue, though they have not been accepted for admission, delays may occur when admission orders have not yet been entered. EHR documentation from the medicine service consult stated that the patient was not admitted to medicine service, and that the patient had a moderately distended abdomen. The documentation stated that the subject physician was informed of the patient’s distended abdomen and agreed to obtain a CT scan for further evaluation. Results from the CT scan indicated that the patient had a surgical abdomen (bowel obstruction), indicating a need for admission by the surgical service rather than medicine service. However, by the time results were available, a code blue had been called for the patient in the Emergency Department, and the code team was unable to resuscitate the patient. (See table 2 for a timeline of the patient’s late 2017 Emergency Department visit.)

Table 2: Summary of Events Related to the Patient’s Care Post-Hospital Discharge in Late 2017

Date	Time	Action
Day of Discharge	Mid-day	The patient is discharged to the CLC from the inpatient acute care unit. ⁶⁹
	Mid-evening	Respiratory therapist applies home BiPAP at 5 liters, pulse oximetry (SpO2) 94 percent.
	~Midnight	The patient is not tolerating BiPAP. Becomes anxious, requesting pain medications. Respiratory therapist applies oxygen via nasal cannula at 6 liters; SpO2 90 percent.
Day of Readmission	1:05 a.m.	Respiratory therapist is called to give a breathing treatment, but unable to give treatment; the patient, who had vomited, was getting cleaned up by an LPN.
	1:13 a.m.	LPN finds the patient “disoriented” and complaining of “pain.” The patient begins projectile vomiting. LPN notifies CLC RN.

⁶⁸ Relevant patient information from the triage, including the assessed acuity level, is tracked and viewable by Emergency Department staff in EDIS, a VHA-wide application. The application is used for the systematic collection, display, and reporting of patient status information.

⁶⁹ VHA Handbook 1006.02, *VHA Site Classification and Definitions*, December 30, 2013. Inpatient care is defined as care within the VA health care system that requires an overnight stay. An inpatient medical bed is associated with acute medical care.

1:17 a.m.	CLC RN assessed the patient and noted coffee ground projectile vomiting, labored breathing, very anxious, weak, and pale. SpO2 88 percent on 5 liters. CLC RN calls hospitalist (first call). CLC RN supervisor made aware.
1:35 a.m.	Hospitalist returns second call with order to send the patient to the Emergency Department. Ambulance called to pick up the patient.
2:32 a.m.	Hospitalist enters order to send the patient to the Emergency Department.
2:35 a.m.	The patient arrives in Emergency Department. Triageed by Emergency Department RN.
2:22 a.m.	Subject physician at bedside. Note indicates: “[a]lert and oriented not in distress. Abdomen soft, moderately distended, hypoactive bowel sounds.” ⁷⁰
3:00 a.m.	Emergency Department RN assesses the patient; note indicates “reported emesis.” Abdomen distended and tender. Pain rating at a 10, on a “0 to 10 scale.” Triage level 3 given by Emergency Department RN.
3:05 a.m.	Subject physician orders lorazepam.
3:06 a.m.	Portable chest x-ray done.
3:15 a.m.	Emergency Department RN administers lorazepam injection.
3:29 a.m.	Respiratory therapist gives hand-held nebulizer treatment to the patient; SpO2 97 percent.
4:07 a.m.	CXR results reported.
4:16 a.m.	Subject physician orders blood work that included CBC, chemistry panel, and lactic acid.
4:24 a.m.	Subject physician orders intravenous fluids and antibiotics.
4:25 a.m.	Subject physician orders urinalysis.
5:01 a.m.	Emergency Department RN obtains blood work, places an intravenous catheter, and administers antibiotic and fluids.
5:31 a.m.	Blood work results indicate elevated white blood cell count 20.2 (normal: 4.8-10.8).
6:02 a.m.	Urinalysis results are positive for blood, white cells, and bacteria. Medicine resident evaluates the patient and recommends CT of abdomen.

⁷⁰ Medline Plus, *Abdominal Sounds*. Hypoactive bowel sounds are a reduction in the loudness, tone, or regularity of sounds. <https://medlineplus.gov/ency/article/003137.htm>. (The website was accessed on February 6, 2019.) The timeline presented is based on times documented in the EHR and may be subject to inaccuracies. Times that actions are reported to have taken place, as recorded in the EHR by the author of the EHR note, may be subject to natural variations (such as the inaccuracies that occur when a time differs depending on the accuracy of the watch or clock which is referenced to determine the time), unintentional inaccuracies (such as occur if a writer did not specifically check the time before initiating an action and estimated the time incorrectly) or intentional inaccuracies (such as occur if a writer deliberately entered an incorrect time to influence the perceived timeline of events).

6:08 a.m.	Blood work results show critical potassium value: 7.1. A second Emergency Department RN receives the call and notifies medicine team of the critical laboratory value.
6:10 a.m.	Subject physician orders arterial blood gas.
6:15 a.m.	Subject physician orders a stat CT of abdomen.
6:16 a.m.	Subject physician orders stat EKG.
6:17 a.m.	Subject physician orders intravenous insulin and dextrose. Emergency Department RN administers intravenous insulin and dextrose. EKG done.
6:24 a.m.	CT performed.
6:31 a.m.	Arterial blood gas test results indicate low blood oxygen levels and other abnormal values.
6:45 a.m.	CT complete. The patient vomits upon return to Emergency Department (100 ccs thin black liquid).
7:05 a.m.	The patient is “resting quietly laying on side, watching TV.”
7:20 a.m.	Emergency Department RN finds the patient unresponsive. “Volumes” of black emesis in bed and on floor. CPR started. Code called.
7:29 a.m.	Code alert called “overhead” in hospital.
7:42 a.m.	Critical results for CT indicate a “surgical abdomen” and possible aspiration.
7:55 a.m.	The patient expires (less than 24 hours of discharge from an acute care setting).

Source: *OIG analysis of the patient’s EHR.*

4. Alleged Deficiencies in Care by an Emergency Department RN

Alleged Failure of an Emergency Department RN to Perform Emergency Procedures

The OIG did not substantiate that an Emergency Department RN failed to perform emergency procedures on the patient. However, the OIG was unable to determine whether the resuscitation efforts for the patient were initiated timely due to the lack of monitoring, which potentially delayed the recognition of signs of the patient’s deterioration, and discrepancies between EHR documentation of the patient’s status by the Emergency Department RN and observations reported by code team responders during interviews.

The OIG team reviewed the patient’s EHR and interviewed staff involved in the patient’s care in the Emergency Department.

On the day the patient died, the Emergency Department RN’s documentation indicated that the patient was “resting quietly” at 7:05 a.m. Fifteen minutes later, the patient was found

unresponsive, CPR was initiated, and a code was called.⁷¹ A Nurse on Duty documented in the patient's EHR CPR note that chest compressions were started at 7:29 a.m., but did not document who initiated compressions.⁷² The CPR/Debriefing Evaluation Report, completed by the Nurse on Duty after the code, indicated that resuscitation was started by the Emergency Department RN in question at 7:30 a.m. Staff present for the code indicated the code team responded to the Emergency Department within a minute of the code being called. Interviews with facility staff, who responded to the code, indicated CPR was in progress when they arrived; however, they were unable to recall who was performing compressions.

During interviews, some code team members shared impressions that the patient had been dead for some time before the code was called, citing observations that the patient's body temperature felt cool as support for this impression. Given the discrepancy between this observation and the documentation of the patient resting quietly 15 minutes prior to the code, the OIG was unable to establish an unequivocal time of death, thus could not determine if resuscitation efforts were delayed.

The facility report for evaluation of the code response indicated that the Emergency Department RN's competencies required a review and referred the concern to the Emergency Department RN manager.

The OIG review noted that the Emergency Department RN had been absent from the facility for an extended time but was cleared by the facility's Occupational Health Physician to return to work without restriction.⁷³ The OIG also noted that the Emergency Department RN is no longer employed at the facility.

Prior Patient Deaths

Due to the anonymity of the complainant, OIG inspectors were not able to clarify the allegation that "this was not the first time for an incident involving the Emergency Department RN and a patient's death." The OIG interpreted the allegation to mean that due to the Emergency

⁷¹ American Heart Association, 2018. *What is CPR?* CPR is a lifesaving technique, consisting of chest compressions and rescue breathing, used to reestablish someone's breathing and heart rate when they have stopped. https://cpr.heart.org/AHA/ECC/CPRECC/AboutCPRECC/WhatIsCPR/UCM_499896_What-is-CPR.jsp. (The website was accessed on July 30, 2018.)

⁷² Nurse on Duty is a reference to the nurse(s) who act(s) as supervisor(s) during hours when regular management staff is not available.

⁷³ Office of Personnel Management, *Fact sheet: Family and Medical Leave*. "Under the Family and Medical Leave Act of 1993 (FMLA), most federal employees are entitled to a total of up to 12 workweeks of unpaid leave during any 12-month period" for specifically identified purposes which include "a serious health condition of the employee that makes the employee unable to perform the essential functions of his or her positions." <https://www.opm.gov/policy-data-oversight/pay-leave/leave-administration/fact-sheets/family-and-medical-leave/>. (The website was accessed on December 11, 2018).

Department RN's deficient practice, other Emergency Department patients had died. Within this context, the OIG did not substantiate the allegation.

OIG inspectors reviewed EHRs for patients who died in the facility's Emergency Department between January 1, 2010, and November 19, 2018. The Emergency Department RN was involved in the care of three patients who died in the Emergency Department during this time frame, one of whom was the patient referenced above.

The OIG inspectors evaluated the care provided to the other two Emergency Department patients identified with a focus on Emergency Department nursing care. Both patients arrived in the Emergency Department with life-threatening conditions. Although the Emergency Department RN participated in resuscitation efforts for these two patients, the OIG's review of the patients' EHRs, documentation of the resuscitation efforts, and the facility's committee meeting minutes related to resuscitation events indicated no concerns.

VHA policy requires a mortality review of all deaths occurring within medical centers.⁷⁴ Facility policy indicates that major morbidities associated with clinical care are screened for peer review.⁷⁵ Nurse peer reviews were not conducted for the other two patients.

The OIG team interviewed supervisors and staff who worked with the Emergency Department RN and reviewed documents including evaluations of the Emergency Department RN. Interviews yielded no concerns related to the competencies or performance of the Emergency Department RN prior to the concerns identified with the patient. The Emergency Department RNs supervisory RN managers, Emergency Department educator, RN peers, and the facility's Risk Manager reported no knowledge of previous concerns about patient deaths related to the Emergency Department RN. Review of the Emergency Department RN's 2017 proficiency report showed that nursing practice and overall performance were rated as satisfactory by the Emergency Department RN manager.

Basic Life Support Certification

The OIG did not substantiate allegations that the Emergency Department RN at issue should not have been working due to an expired CPR certification for BLS, or that nurse managers allowed the RN 30 days to complete recertification.⁷⁶

⁷⁴ VHA Directive 2010-025. Mortality is the number of deaths during a given time or place.

⁷⁵ Medical Center Policy No. 00Q-08, *Peer Review*, March 27, 2017.

⁷⁶ Medical Center Policy No. 00Q-08; Encyclopedia of Intensive Care Medicine, 2012, *Basic Life Support*. BLS refers to procedures performed to assist in the immediate survival of individuals experiencing cardiac arrest, respiratory distress, or an obstructed airway. BLS requires knowledge of CPR. https://doi.org/10.1007/978-3-642-00418-6_365. (The website was accessed on October 25, 2018.)

The Emergency Department RN's BLS certification expired in fall 2017.⁷⁷ Because of a period of extended leave, the Emergency Department RN was unable to complete BLS recertification prior to the expiration date.

VHA requires that all clinically active staff, privileged licensed independent providers, and Emergency Department RNs maintain BLS and Advanced Cardiac Life Support (ACLS) certification.⁷⁸ Facility policy and the facility's Emergency Department RN functional statement require both BLS and ACLS certifications for RNs working in the Emergency Department.⁷⁹

The Emergency Department RN manager reported that RNs who work in the facility Emergency Department were allowed a two-week grace period to renew BLS certification if it expired while they were on leave. Facility policy states that RN staff with medical certification who are not on full duty status have two weeks from the time of return to complete recertification.⁸⁰

The Emergency Department RN educator reported communication with the Emergency Department RN about BLS recertification during the nurse's absence and instructed the Emergency Department RN to complete the CPR skills check-out in the facility's simulation lab.⁸¹

The Emergency Department RN completed BLS certification, eight days after returning to work. Training records provided by facility staff indicated that the Emergency Department RN met VHA and facility BLS requirements for clinically active staff.

5. Inadequate Emergency Department Night Shift Staffing

The OIG did not substantiate the allegation of inadequate staffing during the night shift in the facility's Emergency Department. To evaluate this concern, the OIG team interviewed staff, reviewed facility Emergency Department staffing policies and processes, Emergency Department RN staffing, including RN schedules and staffing methodology, and analyzed data on Emergency Department patient census and patient acuity ratings from October 1, 2014, through

⁷⁷ The Emergency Department RN's ACLS certification remained current.

⁷⁸ ACLS refers to emergency medical procedures to re-establish and maintain circulation, airway and breathing for individuals experiencing cardiac arrest or respiratory distress. ACLS expands upon BLS, with a continued emphasis on CPR, combined with medications, monitoring, and advanced airway management by a team of healthcare professionals. <https://cpr.heart.org>. (The website was accessed on September 4, 2018). VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018; VHA Directive 1177, *Cardiopulmonary Resuscitation*, April 6, 2017; VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016.

⁷⁹ VHA Dayton Medical Center Memorandum, *Nursing Standards A-21 Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) Training*, October 9, 2012.

⁸⁰ VHA Dayton Medical Center Memorandum, *Nursing Standard A-21*.

⁸¹ The simulation lab is the area where CPR mannequins and equipment are stored for CPR skills certification.

September 30, 2018. The OIG determined that the facility's Emergency Department RN staffing was in accordance with VHA directives.⁸²

Per staff interviews, three RNs were scheduled on night shift in the Emergency Department from 8:00 p.m. until 4:00 a.m., but between the hours of 4:00 a.m. to 8:00 a.m., RN staffing decreased to two. The Emergency Department RN schedule supported statements that two RNs were scheduled in the Emergency Department at night, and RNs work 12 hour shifts, often overlapping into the night shift until 4:00 a.m. Emergency Department staff reported that Emergency Department RN staffing was previously augmented as needed by use of float staff from the ICU or medical/surgical service, but reported they have been told those areas can no longer float RNs to the Emergency Department.⁸³ One Emergency Department RN interviewed described feeling "unsafe" during the night shift with only two RNs when Emergency Department census reached 8 to 10 patients, with additional patients checking in.

When asked about acuity of patients in the Emergency Department, the Emergency Department Medical Director indicated that the volume of patients had increased, but any increase in the volume of high-acuity patients was related to the overall increase in the number of patients seen over the last three years rather than an increase in the proportional acuity levels. During October 1, 2017, through September 30, 2018, the Emergency Department provided 2,179 more visits per year than October 1, 2014, through September 30, 2015. The percentage of patients admitted from the Emergency Department to the facility dropped from 20.2 percent during October 1, 2014, through September 30, 2015, to 16.4 percent during October 1, 2017, through September 30, 2018, while the percentage of patients transferred from the Emergency Department to an outside facility remained steady at one to two percent.

VHA policy requires that appropriately educated and qualified emergency care professionals are present in an emergency department during all hours of operation.⁸⁴ This includes, at minimum, two RNs with emergency department experience and/or current emergency department competencies.⁸⁵ The facility met minimum staffing levels for RNs in its Emergency Department for the night shift as required by VHA policy.

To further evaluate the allegation related to inadequate staffing and to determine whether Emergency Department RN staffing met the needs of the population of patients seen at the facility, OIG staff performed an assessment of Emergency Department RN staffing methodology. Per VHA policy, each medical facility must use the mandated staffing

⁸² VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 2017; VHA Directive 1101.05, *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

⁸³ Float staff are nursing staff that are pulled from one unit in the facility to cover shift staffing shortage on another unit.

⁸⁴ VHA Directive 1101.05.

⁸⁵ VHA Directive 1101.05.

methodology. An annual review of the staffing plan must be completed; a full staffing methodology process of the organization is completed biennially.⁸⁶ The OIG confirmed that the facility completed annual reviews of RN staffing.

The Emergency Department Medical Director told OIG staff that although nurse staffing had improved for the Emergency Department, there were challenges with the recent budget. For example, if an RN left the facility, they were not allowed to rehire. The current Emergency Department manager confirmed challenges with nurse staffing, but indicated there were currently 24 Emergency Department RNs, and approval to fill two vacant RN positions had been obtained.

6. Other Findings

Additional concerns that were either brought to the attention of the OIG by facility staff or identified by the OIG during the inspection are discussed below.

Emergency Department Standing Orders

The OIG found inconsistent implementation of standing orders in the Emergency Department. The VHA Office of Nursing Service defines a standing order as “a provider’s order that can be exercised by other health care workers when predetermined conditions have been met.”⁸⁷ The goal for standing orders is to facilitate early treatment for patients. Standing orders are used in emergency department settings because early implementation of standing orders has been reported to decrease delays in critical interventions, facilitate treatment, and decrease patient length of stay in the emergency department. The application of standing orders is completed by an RN, and is based on patient signs and symptoms identified during the triage process. Position statements of both the American College of Emergency Physicians and the Emergency Nurses Association support the use of standing orders as a method of enhancing safety while expediting patient care.⁸⁸

⁸⁶ VHA Directive 1351.

⁸⁷ Office of Nursing Services (ONS), *Guidance for the Development of Nursing Protocols without Medication Management for the Patient Aligned Care Team Setting*. The term “standing orders” and “protocols” are often used interchangeably.

https://vaww.va.gov/nursing/docs/7477114doc215434Guide_Develop_Nsg_ProtocolsNoMedication.pdf. (The website was accessed on September 4, 2018.) This is an internal website that is not accessible to the public.

⁸⁸ American College of Emergency Physicians, *Standardized Protocols for Optimizing Emergency Department Care*. <https://www.acep.org/patient-care/policy-statements/standardized-protocols-for-optimizing-emergency-department-care/>. (The website was accessed on October 16, 2018.) Emergency Nurses Association, *Position Statement on the Use of Protocols in the Emergency Setting, July 2015*. https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/useofprotocolsined.pdf?sfvrsn=43f282ab_6. (The website was accessed on October 16, 2018.)

The OIG staff noted that the facility's medical and nursing leaders had approved 23 sets of Emergency Department standing orders in May 2016. According to the facility's policy, the intent for implementing standing orders in the Emergency Department is to provide a pathway to facilitate early treatment, decrease delays in critical interventions, make diagnostic test results readily available, and decrease overall length of stay in the Emergency Department.⁸⁹ However, during interviews with Emergency Department staff, the OIG team was told that Emergency Department standing orders had limited implementation and not all providers accepted the use of standing orders. Emergency Department RN staff often waited for physicians' orders rather than initiating applicable standing order sets following triage.

The subject physician did not use standing orders due to a preference to order tests that the subject physician determined was warranted. The OIG team interviewed another Emergency Department physician and asked why applicable standing orders would not have been used for the patient; that physician was not able to say why the standing orders were not executed. If Emergency Department standing orders for abdominal pain had been implemented when the Emergency Department RN noted abdominal pain and distention, the patient would have been placed on a cardiac monitor and had labs ordered without delay. With earlier and continuous cardiac monitoring and immediate laboratory testing, staff may have been able to detect changes in the patient's condition and intervene at an earlier time.

Stocking and Maintenance of an Emergency Department Code Cart

The OIG found irregularities in the stocking and maintenance of a code cart located in the resuscitation room in the Emergency Department. Interviews with facility code team members who responded to the code for the patient indicated there were delays in care related to accessibility of a code cart and critical supplies during the resuscitation process. The use of a non-standard code cart located in the Emergency Department caused confusion for code team members and may have contributed to a delay in care for the patient. Interviews with facility and Emergency Department leaders confirmed there were known deviations from the standard maintenance and stocking processes for the non-standard code cart in the Emergency Department. The OIG team was told that concerns had been raised previously about ensuring quality control and safety measures for the non-standard code cart often used during codes in the Emergency Department.

Facility policy indicates designated staff ensure that emergency carts and equipment are maintained by completing a checklist and exchanging the cart following a code event.⁹⁰ Facility

⁸⁹ Dayton VA Medical Center, *Emergency Department Standing Orders*, May 2016. This is an internal document that is not accessible to the public.

⁹⁰ Medical Center Policy No. 111-21, *Emergency Department Policies and Procedures*, April 7, 2016.

policy further indicates the CPR committee addresses issues with availability of equipment needed for resuscitation.

The OIG performed a visual inspection of the non-standard code cart located in the resuscitation room of the Emergency Department and found the cart unlocked. The Joint Commission Standards for medication management require organizations safely store medications, preventing unauthorized individuals from access, and remove all expired medications, separating them from those available for administration.⁹¹ The OIG team was told that all RNs, nursing assistants, and intermediate care technicians in the Emergency Department had keys to access the content of the non-standard code cart. However, physicians and resident physicians did not.

According to the Emergency Department RN manager, it was the expectation that the non-standard code cart was locked with a key unless in use. Facility policy states a tamper-evident lock is applied to emergency carts. Locking the non-standard code cart in the Emergency Department was done using a key instead of the color-coded, tamper-evident lock described in the facility policy.⁹²

OIG staff were told that the non-standard code cart was used frequently and contained medications used during codes, as well as several additional medications and supplies not included in the standardly stocked code carts used at the facility. These additional medications and supplies were stocked in the cart at the request of an Emergency Department physician.

Following the OIG's inspection, the non-standard code cart was removed from the Emergency Department and replaced with a standard code cart and a small automated medication dispensing cabinet.

Emergency Department Resuscitation Room Supplies

The OIG found expired medications stocked in a storage cabinet in the resuscitation room during a visual inspection of the Emergency Department. This cabinet, located in the same resuscitation room as the non-standard code cart, contained emergency supplies such as medications, chest tubes, and central line kits. The Emergency Department Charge RN indicated uncertainty of the inventory list for stocking the cabinet and stated that the nursing assistants restocked it. The

⁹¹ The Joint Commission Standard MM.03.01.01, the organization safely stores medications; The Joint Commission Standard MM.03.01.03, organizations safely manage emergency medications; VHA Directive 1100.16 *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. VHA abides by The Joint Commission standards for medication management.

⁹² Medical Center Policy No. 11-10, *Medical Emergency/Cardiopulmonary Resuscitation (CPR) Procedures*, October 17, 2016; Medical Center Policy No. 111-10, *Medical Emergency Response*, June 7, 2018. A yellow, plastic, tamper-evident lock will be used to lock the medication drawer if the drawer has been accessed during a code, while a blue, plastic, tamper-evident lock is utilized if the drawer has not been accessed. Color coded locks provide a visual signal indicating whether a cart has been used and therefore needs processing or restocking.

cabinet contained medications and did not have a lock. Visual inspection of the cabinet contents by OIG staff determined that several items in this cabinet were beyond the expiration date. The Joint Commission Standards for medication management require organizations safely store medications, preventing unauthorized individuals from access, and remove all expired medications, separating them from those available for administration.⁹³ Facility leaders failed to ensure that the contents of the cabinet were monitored for expiration dates and secured. The OIG staff informed the Emergency Department Chief of this issue, who alerted the Emergency Department RN manager to have the expired medications removed and discarded. In a follow-up correspondence, the OIG team was advised that the cabinet and other supplies in the room were being checked daily by Emergency Department nursing staff to ensure there were no outdated supplies.

Emergency Department Environment of Care

The OIG found mold on a wall in the Emergency Department staff break room and areas of discoloration on ceiling tiles after being informed of these concerns by staff during the team's visual inspection of the Emergency Department. However, the OIG confirmed, while on site, that facility staff removed the alleged mold in the Emergency Department staff break room and remedied the discolored tiles.

VHA policy requires facilities' environmental services to ensure a state of physical and biological cleanliness.⁹⁴ VHA policy also requires facilities to participate in a comprehensive program for monitoring the environments using an interdisciplinary approach at least twice a year in patient care areas.⁹⁵

The OIG team interviewed Emergency Department staff who indicated that these issues had been brought up through the chain of command in the facility with no action taken. The OIG team reported these findings to facility leaders for prompt action in addressing these concerns. The facility's Environmental Management Service staff provided evidence of comprehensive monitoring of the Emergency Department every six months for the last two years. Results from previous environmental monitoring indicated concerns related to missing tiles, or mold, were addressed by the engineering department of the facility.

⁹³ The Joint Commission Standard MM.03.01.01, the organization safely stores medications; VHA Directive 1100.16 *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, VHA abides by The Joint Commission standards for medication management; The Joint Commission Standard MM.03.01.03, the organizations safely manage emergency medications; VHA Directive 1100.16 *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. VHA abides by The Joint Commission standards for medication management.

⁹⁴ VHA Directive 1850 *Environmental Programs Services*, March 31, 2017.

⁹⁵ VHA Directive 1306, *Comprehensive Environment of Care Program*, February 1, 2016.

Bar Code Medication Administration Procedures in the CLC

The OIG found evidence of CLC staff failures to follow bar code medication administration policy in the CLC. During interviews, one facility staff member informed the OIG team of concerns regarding medication safety risks related to staff non-compliance with bar code medication administration procedures in the CLC. OIG staff observed a collection of patient armbands, photocopies of multiple patient armbands on one page, and photocopies of medication labels that were reportedly used in the CLC to scan for medication dispensing to patients, and reviewed additional documents confirming the report.

The Joint Commission standards require hospitals to ensure medications are administered safely including verifying contraindications, times for administration, dose, and route.⁹⁶ Facility policy on medication administration indicates that bar code medication administration will be used for administration of medications to all inpatients regardless of where care is provided.⁹⁷

Bar code medication administration software was designed to “improve the accuracy of the medication administration process” by utilizing wireless, point-of care technology with an integrated bar code scanner to record the administration of patient medications. When RNs administer medications to a patient using bar code medication administration, the RN scans the barcode on the patient’s armband, and then scans the barcode on the medication. If the barcode on the patient wrist or extremity does not match the barcode on the medication, the bar code medication administration system will alert the RN of a discrepancy and the potential for a medication error. When used as intended, bar code medication administration reduces medication administration errors by helping RNs to ensure that the right patient receives the right medication, at the right dose and right time, via the right route of administration.

The OIG team immediately notified facility leaders of the breach in policy and the safety risk to residents in the CLC.⁹⁸ A prompt response was implemented that included observation of RNs administering medications and environment of care rounds. Facility leaders sent CLC staff a notice of bar code medication administration policy via an email with a read receipt and informed staff that non-compliance with bar code medication administration policy would result in disciplinary action. Facility leaders also indicated that a CLC RN manager and the Nurse on Duty would continue environment of care rounds on all tours of duty in the CLC to monitor compliance.

⁹⁶ The Joint Commission Standard MM.05.01.07, EP3, states the hospital administers medications safely. VHA Directive 1100.16 *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, VHA abides by The Joint Commission standards for medication management.

⁹⁷ Medical Center Policy No. 118E-04, *Bar Code Medication Administration (BCMA)*, May 5, 2017.

⁹⁸ Medical Center Policy No. 118E-04.

Document Management Error

The OIG determined that facility staff destroyed an FPPE evaluation on the subject physician. Facility leaders were unable to produce the FPPE evaluation, which was conducted on the subject physician in February through March 2014 and reported to the Professional Standards Board in April 2014. The facility's Risk Manager told the OIG team that the FPPE document had been destroyed after three years, consistent with guidelines for maintenance of quality management documents. However, FPPEs are considered an "evaluation of privilege-specific competence of a practitioner."⁹⁹ The VA Records Control Schedule, Section 1150, includes documents related to professional performance and "evaluation of clinical and/or technical skills" under the category of "Health Care Provider Credentialing and Privileging Records."¹⁰⁰ The Records Control Schedule requires these documents to be maintained by the facility for the duration of a provider's employment at the facility and for three years after separation.¹⁰¹

Conclusion

When evaluating the allegation related to the care of the patient, the OIG found deficiencies in medical decision-making and provision of care by the subject physician. The OIG identified the following concerns when reviewing documentation relative to specific topics:

- Lack of thorough history and physical examination
- Deficiencies in choice and timeliness of diagnostic tests
- Deficiencies in choice and timeliness of treatments
- Deficiencies with disposition of a patient

Following a more extensive examination of the subject physician's practice, the OIG determined that the deficits identified in the subject physician's evaluation and treatment practices were not limited to this case and had the potential for imminent impact on patient safety. The OIG team notified facility leaders about the identified deficits in October 2018. The Facility Director promptly placed the subject physician on a summary suspension from clinical care while facility leaders initiated a management review of the subject physician's practice. The Facility Chief of Medicine conducted a review of the subject physician's cases and recommended lifting the summary suspension, returning the subject physician to patient care duties, and initiating an FPPE to monitor and ensure the subject physician's quality of care. The Facility Director consulted with Medical Affairs in VA Central Office. The Facility Director extended the subject physician's suspension from patient care duties pending consultation with the VISN and further

⁹⁹ VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

¹⁰⁰ Department of Veterans Affairs, *Records Control Schedule 10-1*, May 2016.

¹⁰¹ Separations are actions that end employment with an agency. OPM, *The Guide to Processing Personnel Actions*, Chapter 31, Separations by other than Retirement, November 1, 2015.

review. The VISN's Emergency Department Lead Physician coordinated an external management review. Based on the facility's Clinical Executive Board's recommendation made after review of the VISN findings, the Facility Director initiated steps to revoke the physician's privileges. The subject physician appealed the revocation.

A Disciplinary Appeals Board hearing was convened to review the subject physician's appeal. The Disciplinary Appeals Board reviewed submitted documentation and found it was insufficient to fully substantiate the findings upon which the revocation of privileges was predicated. The Disciplinary Appeals Board determined the charges were not sustained and recommended the removal of the subject physician from federal service be overturned. The Acting Principal Deputy Under Secretary for Health approved the Disciplinary Appeals Board's recommendation in September 2019. The subject physician did not return to the facility and resigned from VA in November 2019.

The OIG found that the facility's peer review process failed to identify trends in quality of care issues with the subject physician's medical practice. In response to these concerns raised by the OIG's inspection, the facility's Clinical Executive Board made changes to the facility's policy on peer review triggers for initiating management reviews.

Deficiencies were found in the coordination of care in the CLC for the patient. After the patient arrived in the Emergency Department, deficits were identified in the monitoring of the patient and the timely ordering of (1) lab tests that would have guided further diagnostic testing, (2) medications to address the patient's vomiting, or (3) insertion of a nasogastric tube to evacuate the patient's stomach. The subject physician did not accurately convey the patient's admission status to the oncoming Emergency Department physician. The subject physician's EHR note indicated that the patient was admitted to the medicine service in stable condition. The medicine service EHR documentation reflected that the patient was not admitted to medicine service and the subject physician, who had been informed of the patient's distended abdomen, would obtain a CT scan for further evaluation and disposition. Results from the CT scan indicated that the patient had a surgical abdomen (bowel obstruction), indicating a need for admission by the surgical rather than medicine service. However, by the time the CT results were available, a code blue had been called for the patient in the Emergency Department. The code team was unable to resuscitate the patient.

The OIG did not substantiate allegations related to the Emergency Department RN. Emergency procedures including cardiopulmonary resuscitation were initiated for the patient. The Emergency Department RN was not implicated in the deaths of other Emergency Department patients, and the RN's BLS certificate was not considered expired.

The facility's Emergency Department RN staffing was in accordance with VHA policy.

The OIG identified a concern related to the inconsistent implementation of standing orders in the Emergency Department. Not all Emergency Department physicians accepted the use of standing

orders that would allow for immediate initiation of certain tests and procedures depending on triage findings.

After irregularities were found in the stocking and maintenance of a non-standard code cart and the storing of medications in the Emergency Department's resuscitation room, the non-standard code cart was removed and daily checks for outdated medications were initiated.

The OIG found evidence of CLC staff failures to follow bar code medication administration policy in the CLC, and immediately notified facility leaders of the breach in policy and the safety risk to residents in the CLC. A prompt response was implemented by facility leaders that included observation of RNs administering medications and environment of care rounds.

The OIG determined that facility staff incorrectly destroyed an FPPE evaluation on the subject physician due to inaccurate classification of the document under the Records Control Schedule.

Recommendations 1–13

1. The Dayton VA Medical Center Director identifies facility resources and other means for provider education and training to strengthen skills when deficiencies in care are identified during peer reviews.
2. The Dayton VA Medical Center Director ensures that Peer Review Committee meeting minutes document reasons for changes to peer review levels, and that changes are consistent with its review of relevant aspects of clinical care.
3. The Dayton VA Medical Center Director ensures review of procedures to make certain gastroenterology staff coordinate care with referring providers and provide staff training on care coordination procedures as needed.
4. The Dayton VA Medical Center Director makes certain that Community Living Center staff utilize the Situation, Background, Assessment, and Recommendation communication tool and document transfers to the Emergency Department in accordance with Dayton VA Medical Center policy.
5. The Dayton VA Medical Center Director considers consolidating Medical Center policies related to patient transfers and transports to and from the Emergency Department into one policy to provide clear guidance to staff to effect timely transfers.
6. The Dayton VA Medical Center Director ensures consistent implementation of standing orders in the Emergency Department.
7. The Dayton VA Medical Center Director verifies policies and procedures are in place for monitoring of critically ill patients to track deterioration and need for intervention in the Emergency Department and during transport, and monitor compliance.

8. The Dayton VA Medical Center Director ensures that handoff communication between Emergency Department providers is accurate and documented in the electronic health record during transitions in care in accordance with Dayton VA Medical Center policy, and compliance is monitored.
9. The Dayton VA Medical Center Director ensures review of results from the revision of the Dayton VA Medical Center policy on threshold for peer review findings to trigger management reviews in order to confirm the revised policy is appropriately sensitive to identify provider practice issues that constitute patient safety concerns, and revise the policy if needed.
10. The Dayton VA Medical Center Director confirms all code carts in the Emergency Department are processed and secured consistent with Dayton VA Medical Center policy.
11. The Dayton VA Medical Center Director ensures Emergency Department supplies are secured and maintained consistent with Dayton VA Medical Center policy.
12. The Dayton VA Medical Center Director ensures continued monitoring and compliance with bar code medication administration policy in the Community Living Center.
13. The Dayton VA Medical Center Director reviews document management procedures for professional practice evaluations and takes actions as needed to comply with the VA Records Control Schedule.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 11, 2019

From: Director, VA Healthcare System (VISN 10)

Subj: Healthcare Inspection—Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio

To: Director, Office of Healthcare Inspections (54HL06)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have reviewed the draft report Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio.
2. I concur with the responses and action plans submitted by the Dayton VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Signed by: Ronald E. Stertzbach
VISN 10 Deputy Network Director

for

RimaAnn O. Nelson
VISN 10 Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 11, 2019

From: Director, Dayton VA Medical Center (552)

Subj: Healthcare Inspection—Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio

To: Director, VA Healthcare System (VISN 10)

1. The following facility director's comments are submitted in reference to the recommendations identified in the OIG Draft Report.

(Original signed by:)

James Thomas Hardy
Chief of Staff

for

Andrew D. Pacyna
Acting Medical Center Director

Facility Director Response

Recommendation 1

The Dayton VA Medical Center Director identifies facility resources and other means for provider education and training to strengthen skills when deficiencies in care are identified during peer reviews.

Concur.

Target date for completion: 7/1/2020

Director Comments

a. The Education and Research Service helps coordinate educational/training needs in support of a Clinical Service Chiefs' request to address peer review findings. The Education and Research Service provides support through the Simulation Center, medical library services, electronic education services, and one-on-one support where indicated.

b. Education and training deficiencies identified during peer review will be referred to Education and Research Service by the appropriate Clinical Service Chief. Compliance of referral process will be monitored until 90% compliance achieved for 6 consecutive months and will be reported to Clinical Executive Board (CEB).

Recommendation 2

The Dayton VA Medical Center Director ensures that Peer Review Committee meeting minutes document reasons for changes to peer review levels, and that changes are consistent with its review of relevant aspects of clinical care.

Concur.

Target date for completion: 6/1/2020

Director Comments

a. A review of the Peer Review Committee (PRC) minutes found that the documentation for changes to peer review levels is inconsistent. The Chief of Quality Management will ensure that the PRC minutes document reasons for changes to peer review levels by completing a monthly audit of PRC minutes and will monitor until 90% compliance achieved for 6 consecutive months, results reported to CEB.

b. The review of the PRC minutes did find documentation of the aspects of care related to the level assignment. Each level 2 and level 3 case had the reason for the level assignment

documented which correlates with one of the 9 aspects of care. Additionally, the aspects of care for all PRC level 2 and level 3 cases is tracked in the mandated spreadsheet.

Recommendation 3

The Dayton VA Medical Center Director ensures review of procedures to make certain gastroenterology staff coordinate care with referring providers and provide staff training on care coordination procedures as needed.

Concur.

Target date for completion: 7/1/2020

Director Comments

a. Training was provided to staff regarding coordination of procedures. A new Standard Operating Procedure was instituted, gastroenterology nurses will place any changes as addendum to the original consult and document which nurse practitioner or Community Living Center (CLC) nurse was informed. Medicine Service will monitor consult documentation until 90% compliance achieved for 6 consecutive months, results reported to CEB.

Recommendation 4

The Dayton VA Medical Center Director makes certain that Community Living Center staff utilize the Situation, Background, Assessment, and Recommendation communication tool and document transfers to the Emergency Department in accordance with Dayton VA Medical Center policy.

Concur.

Target date for completion: 7/1/2020

Director Comments

a. CLC nursing staff will be re-educated on Medical Center Policy (MCP) 00Q-11 (Hand Off Communication) and Nursing Standard C6 (Hand Off Report Contents), both which direct utilization of Situation, Background, Assessment, and Recommendation (SBAR) communication tool. Nurse Managers will educate 90 percent of CLC nursing staff and training will be recorded per sign-in sheet.

b. CLC Nurse Managers will review 100 percent of EHRs of Veterans transferred from the CLC to the Emergency Department (ED) to ensure compliance with utilization of SBAR communication and documentation, will monitor until 90 percent compliance is maintained for 6 consecutive months, results reported to Nurse Executive Board (NEB).

Recommendation 5

The Dayton VA Medical Center Director considers consolidating Medical Center policies related to patient transfers and transports to and from the Emergency Department into one policy to provide clear guidance to staff to effect timely transfers.

Concur.

Target date for completion: 9/20/2018

Director Comments

a. Policy was moved to Patient Business Service and consolidated to one policy (Patient Transfers to ED/Urgent Care – MCP 136-25). An interdisciplinary team of subject matter experts were brought together to develop the new policy, effective date 9/28/2018.

OIG Comment

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

Recommendation 6

The Dayton VA Medical Center Director ensures consistent implementation of standing orders in the Emergency Department.

Concur.

Target date for completion: 8/1/2020

Director Comments

a. Standing orders are in place and were reviewed and approved by NEB and Chief of Medicine in August 2019 and are consistently available to nursing staff. Standing orders are optional and used based on Provider workload. NEB and Chief of Medicine will re-evaluate a trigger for use to achieve consistent implementation and monitor compliance until 90 percent compliance is maintained for 6 consecutive months results reported to CEB.

Recommendation 7

The Dayton VA Medical Center Director verifies policies and procedures are in place for monitoring of critically ill patients to track deterioration and need for intervention in the Emergency Department and during transport and monitor compliance.

Concur.

Target date for completion: 7/1/2020

Director Comments

a. Standard Operating Procedures (SOP) are in place for patients who are on cardiac and respiratory monitors. The RN transports and monitors the patient for all exams and procedures outside of the ED. The ED Charge Nurse will monitor compliance with SOP until 90 percent compliance is maintained for 6 consecutive months, results reported to NEB.

Recommendation 8

The Dayton VA Medical Center Director ensures that handoff communication between Emergency Department providers is accurate and documented in the electronic health record during transitions in care in accordance with Dayton VA Medical Center policy and compliance is monitored.

Concur.

Target date for completion: 7/1/2020

Director Comments

a. Warm handoffs are required when one provider hands off a patient to another provider and is documented in CPRS. Medicine Service will monitor compliance with accurate documentation by reviewing a minimum of 30 (or 10 percent) EHR charts monthly until 90 percent compliance is maintained for 6 consecutive months, results reported to CEB.

Recommendation 9

The Dayton VA Medical Center Director ensures review of results from the revision of the Dayton VA Medical Center policy on threshold for peer review findings to trigger management reviews in order to confirm the revised policy is appropriately sensitive to identify provider practice issues that constitute patient safety concerns and revise the policy if needed.

Concur.

Target date for completion: 11/12/2019

Director Comments

a. Sensitivity of new trigger reviewed by the CEB and confirmed to be appropriate. A review identified an increase in providers triggering for management review; 1 provider triggered in fiscal year 2018 compared to 8 providers triggering in fiscal year 2019.

OIG Comment

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

Recommendation 10

The Dayton VA Medical Center Director confirms all code carts in the Emergency Department are processed and secured consistent with Dayton VA Medical Center policy.

Concur.

Target date for completion: 1/1/2020

Director Comments

a. The code carts are now standardized and processed by Supply Chain Management. A medication Omnicell has been installed in the resuscitation room and is maintained by pharmacy. The code carts are checked daily by ED Charge Nurse and the Omnicell is maintained by Pharmacy, will continue monitoring until 90 percent compliance is maintained for 6 consecutive months, results reported to NEB.

Recommendation 11

The Dayton VA Medical Center Director ensures Emergency Department supplies are secured and maintained consistent with Dayton VA Medical Center policy.

Concur.

Target date for completion: 6/1/2020

Director Comments

a. Supplies are maintained and secured per policy. The ED rooms are restocked with needed supplies twice daily and Supply Chain Management monitors the par levels and restocks the supply Omnicell as needed. Nursing Assistants (NA) stock rooms twice daily per NA checklist. ED Charge Nurse monitors NA checklist, will continue monitoring until 90 percent compliance is maintained for 6 consecutive months, results reported to NEB.

Recommendation 12

The Dayton VA Medical Center Director ensures continued monitoring and compliance with bar code medication administration policy in the Community Living Center.

Concur.

Target date for completion: 7/1/2020

Director Comments

a. Compliance with BCMA policy and wristband scanning will be monitored by direct observation of 10 percent of medication passes weekly and reported monthly to NEB until 90% compliance achieved for 6 consecutive months.

Recommendation 13

The Dayton VA Medical Center Director reviews document management procedures for professional practice evaluations and takes action, as needed, to comply with the VA Records Control Schedule.

Concur.

Target date for completion: a. 10/24/2019
b. 6/30/2020
c. 12/30/2020

Director Comments

a. Service chiefs for all services that have staff with professional practice evaluation requirements were educated on the records control requirements.

b. Services are responsible for maintaining OPPE and FPPE records while the staff member is still employed. The service chief will ensure the records are forwarded to the Medical Staff Office upon separation/retirement. The Medical Staff Office maintains the records the required 3 years and then archives them with the VA Records Center. The Service Chiefs or their representatives will stipulate to the compliance with this requirement at the first semi-annual review of their OPPE/FPPE program at the Professional Standards Board (PSB).

c. The Chief of the Medical Staff Office will stipulate to compliance with the process annually at the December PSB.

Glossary

acute or surgical abdomen. Rapid onset of severe pain, nausea, vomiting, and other abdominal symptoms that may indicate a potentially life-threatening disorder.¹⁰² The most severe of these disorders may require urgent surgical intervention. “Immediate assessment should focus on distinguishing patients with true acute abdomen that requires urgent surgical intervention from patients who can initially be managed conservatively.” Additionally, a “patient with acute surgical pathology may deteriorate rapidly; therefore, patients with severe unremitting symptoms in the first few hours warrant vigorous investigation and close monitoring.”¹⁰³

antibiotic. A “substance that inhibits the growth and replication of a bacterium or kills it outright.” Antibiotics are used to treat bacterial infections.¹⁰⁴

aspiration pneumonia. “Pneumonia is a breathing condition in which there is a swelling or an infection of the lungs or large airways. Aspiration pneumonia occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading into the lungs, instead of being swallowed into the esophagus and stomach.”¹⁰⁵

benzodiazepines. A class of drugs that act as tranquilizers and may be used in the treatment of anxiety.¹⁰⁶

BiPAP. Also called a bilevel positive airway pressure machine that is a device that helps with breathing.¹⁰⁷

¹⁰² Doherty GM. Doherty G.M. Doherty, Gerard M. Chapter 21. The Acute Abdomen. In: Doherty GM. Doherty G.M. Ed. Gerard M. Doherty. eds. *Current Diagnosis & Treatment: Surgery*, 13e New York, NY: McGraw-Hill; 2010. <http://accesssurgery.mhmedical.com/content.aspx?bookid=343§ionid=39702809>. (The website was accessed on December 13, 2018.)

¹⁰³ BMJ, *Best Practice*. <https://bestpractice.bmj.com/topics/en-gb/503>. (The website was accessed on November 26, 2018.)

¹⁰⁴ Microbiology Society, *What are antibiotics and how do they work?* <https://microbiologysociety.org/education-outreach/antibiotics-uncarthed/antibiotics-and-antibiotic-resistance/what-are-antibiotics-and-how-do-they-work.html>. (The website was accessed on March 21, 2019.)

¹⁰⁵ MedlinePlus, *Aspiration pneumonia*. <https://medlineplus.gov/ency/article/000121.htm>. (The website was accessed on February 27, 2019.)

¹⁰⁶ MedicineNet, *Medical Definition of Benzodiazepines*. <https://www.medicinenet.com/script/main/art.asp?articlekey=9950>. (The website was accessed on February 27, 2019.)

¹⁰⁷ Johns Hopkins Medicine, *BiPap*. https://www.hopkinsmedicine.org/healthlibrary/test_procedures/neurological/bipap_135.314. (The website was accessed on August 14, 2018.)

breathing treatment. A treatment for respiratory diseases, also known as nebulizer treatments, that allows delivery of medications in a mist form.¹⁰⁸

complete blood count (CBC). A test used to evaluate overall health and identify a wide range of disorders including a wide range of medical problems.¹⁰⁹

chronic obstructive pulmonary disease (COPD). A lung disease that makes it hard to breathe.¹¹⁰

code blue or code. A term often used in a medical facility for a patient in cardiopulmonary arrest, requiring a team of providers to rush to a specific location and begin immediate resuscitation.¹¹¹

computerized tomography scan. A cross sectional or three-dimensional image of an internal body part by assembling multiple x-ray images and is used for diagnostic purposes commonly referred to as CT scan.¹¹²

congestive heart failure. A condition that occurs when the heart muscle is unable to pump blood as well as it should to maintain adequate circulation of blood in the bodily tissues.¹¹³ Common causes of heart failure include coronary artery disease, hypertension and diabetes.¹¹⁴

diabetes. A disease that occurs when the body cannot effectively process sugar (glucose) due to not recognizing or producing little or no insulin, a hormone that regulates blood glucose. Diabetes affects over 30 million Americans.¹¹⁵ Patients with type 1 diabetes require insulin injections to regulate their blood glucose.¹¹⁶ Patients with type 2 diabetes, the most common type, initially produce some insulin and may make lifestyle changes, such as diet and exercise, or use oral medications to regulate blood

¹⁰⁸ Healthgrades, *Breathing Treatments*. <https://www.healthgrades.com/right-care/lungs-breathing-and-respiration/breathing-treatments>. (The website was accessed on January 16, 2019.)

¹⁰⁹ Mayo Clinic, *Complete blood count (CBC)*., <https://www.mayoclinic.org/tests-procedures/complete-blood-count/about/pac-20384919>. (The website was assessed on August 9, 2018.)

¹¹⁰ Medline Plus, *Chronic obstructive pulmonary disease*. <https://medlineplus.gov/ency/article/000091.htm>, (The website was accessed on November 29, 2018.)

¹¹¹ Merriam-Webster, *Medical Definition of code blue*. <https://www.merriam-webster.com/medical/code%20blue>. (The website was accessed on January 14, 2019.)

¹¹² Merriam-Webster, *Medical Definition of CT scan*. <https://www.merriam-webster.com/dictionary/CT%20scan#medicalDictionary>. (The website was accessed on February 27, 2019.)

¹¹³ Merriam-Webster, *Definition of congestive heart failure*. <https://www.merriam-webster.com/dictionary/congestive%20heart%20failure>. (The website was accessed on January 17, 2019.)

¹¹⁴ MedlinePlus, *Heart Failure*. <https://medlineplus.gov/heartfailure.html>. (The website was accessed on November 29, 2018.)

¹¹⁵ National Institute of Diabetes and Digestive and Kidney Disease (NIDDK), National Institutes of Health (NIH), <https://www.niddk.nih.gov/health-information/diabetes>. (The website was accessed on January 17, 2019.)

¹¹⁶ <https://www.niddk.nih.gov/health-information/diabetes>.

glucose.¹¹⁷ However, some patients with type 2 diabetes develop insulin resistance over time and may eventually require insulin.¹¹⁸

distended abdomen. A condition of the stomach area that is larger than normal and may result from different causes. A swollen abdomen is often uncomfortable or even painful.¹¹⁹

electrocardiogram or EKG. A non-invasive diagnostic test which records the electrical signals in the heart and is used to detect problems or monitor the heart's status.¹²⁰

encephalopathy. A disease of the brain.¹²¹

gastroesophageal reflux disease or GERD. A condition that occurs when a muscle at the end of stomach does not close properly allowing stomach contents to leak back, or reflux, into the esophagus and irritate it.¹²²

hospitalist. A physician whose primary professional focus is the general medical care of hospitalized patients.¹²³

hypercapnic respiratory failure. A condition that results when there are normal or low levels of oxygen and too much carbon dioxide in the blood. This occurs when the body is unable to remove enough carbon dioxide from the blood or when the respiratory system cannot take in enough oxygen. Hypercapnic respiratory failure can result in difficulty breathing, altered mental state, discoloration of the skin, fingertips, or lips, and anxiety.¹²⁴ One method of diagnosing hypercapnic respiratory failure is using pulse oximetry (SpO₂), which is a non-invasive test used to indicate how well oxygen is reaching various parts of the body. Normal pulse oximetry range is between 95-100 whereas a reading below 90 indicates abnormal blood oxygen.¹²⁵ Imaging tests such as chest radiography (X-ray) or CT scan may also aid in diagnosing hypercapnic

¹¹⁷ <https://www.niddk.nih.gov/health-information/diabetes>.

¹¹⁸ <https://www.niddk.nih.gov/health-information/diabetes>.

¹¹⁹ Healthline, *What Causes Abdominal Swelling?* <https://www.healthline.com/symptom/abdominal-swelling>. (This website was accessed on January 23, 2019.)

¹²⁰ Mayo Clinic, *Electrocardiogram (ECG or EKG)*. <https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983>. (The website was accessed on February 28, 2019.)

¹²¹ Merriam-Webster, *Definition of encephalopathy*. <https://www.merriam-webster.com/dictionary/encephalopathy>. (The website was accessed on January 14, 2019.)

¹²² MedlinePlus, *GERD*. <https://medlineplus.gov/gerd.html>. (The website was accessed on November 29, 2018.)

¹²³ University of California, San Diego Department of Medicine, *What is a Hospitalist?* <http://hospitalmedicine.ucsd.edu/people/about.shtm>. (The website was accessed on March 4, 2019.)

¹²⁴ Healthline, *Acute Respiratory Failure, March 30, 2017*. <https://www.healthline.com/health/acute-respiratory-failure>. (The website was accessed on August 1, 2018); Healthline, *Chronic Respiratory Failure, March 30, 2017*. <https://www.healthline.com/health/chronic-respiratory-failure>. (The website was accessed on August 1, 2018.)

¹²⁵ Mayo Clinic, *Hypoxemia*. <https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930> (The website was accessed on February 27, 2019.)

respiratory failure.¹²⁶ Chronic hypercapnic respiratory failure is sometimes treated with BiPAP.¹²⁷

hyperkalemia. A condition of having abnormally high potassium in the blood that is serious and potentially life-threatening. Normal potassium levels are between 3.6 and 5.2 millimoles per liter while levels higher than 6.0 require immediate treatment.¹²⁸

hyperlipidemia. Elevated levels of fats (cholesterols and triglycerides) in the blood.¹²⁹

hypertension. Also known as high blood pressure, affecting 85 million Americans.¹³⁰ Medical guidelines define hypertension as a blood pressure that consistently ranges higher than 130 (systolic) over 80 (diastolic) millimeters of mercury documented over time.¹³¹ There are two types of hypertension, primary and secondary. Primary hypertension can result from multiple factors, and is influenced by environmental factors, such as stress and lack of exercise.¹³² Secondary hypertension has specific causes and develops as a complication of another problem. Several conditions may cause secondary hypertension; some of which include diabetes, kidney disease, and sleep apnea.¹³³

hyponatremia. A condition of abnormally low concentration of sodium in the blood. A normal sodium blood level is between 135 and 145 milliequivalents per liter (mEq/L). Hyponatremia occurs when the sodium level falls below 135 mEq/L.¹³⁴ Sodium helps regulate the amount of water that is in and around the cells in the body.¹³⁵ Low sodium levels may be caused by several factors, including age, certain medications, medical conditions that increase the risk of hyponatremia such as kidney disease, syndrome of inappropriate anti-diuretic hormone and heart

¹²⁶ Healthline, *Chronic Respiratory Failure*.

¹²⁷ Healthline, *Chronic Respiratory Failure*.

¹²⁸ Mayo Clinic, *High potassium (hyperkalemia)*.

<https://www.mayoclinic.org/symptoms/hyperkalemia/basics/definition/sym-20050776>. (The website was accessed on August 8, 2018 and December 20, 2018.)

¹²⁹ Merriam-Webster, *Definition of Hyperlipidemia*. <https://www.merriam-webster.com/dictionary/hyperlipidemia>. (The website was accessed on January 14, 2019.)

¹³⁰ *Everything you need to know about hypertension*. <https://www.medicalnewstoday.com/articles/150109.php>. (The website was accessed on January 17, 2019.)

¹³¹ *Understanding Blood Pressure Readings*, <https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings>, (The website was accessed on January 17, 2019.);

Everything you need to know about hypertension.

¹³² *Everything you need to know about hypertension*.

¹³³ *Everything you need to know about hypertension*.

¹³⁴ Mayo Clinic, *Hyponatremia*. <https://www.mayoclinic.org/disease-conditions/hyponatremia/symptoms-causes/syc-20373711>. (The website was accessed on November 15, 2018.)

¹³⁵ *Hyponatremia*.

failure, as well as drinking too much water.¹³⁶ When the sodium in the body becomes too diluted, the body's water levels rise, and cells begin to swell. This swelling can cause many health problems, from mild to life-threatening. Hyponatremia may be chronic, with sodium levels dropping gradually over a period of 48 hours or longer, or acute, with a rapid drop in sodium levels, resulting in severe symptoms such as brain swelling, coma, and death.

infection. A disease in a part of the body that is caused by bacteria or a virus.¹³⁷

intensive care unit (ICU). A section of a hospital where special medical equipment and services are provided for patients who are seriously ill or injured.¹³⁸

intubation. Insertion of a tube into the mouth near the lungs to assist with breathing.¹³⁹

leukocyte. A colorless blood cell of the immune system, such as a white blood cell, which may be a sign of infection.¹⁴⁰

kidney disease. A generic term for diseases of the kidneys that affect approximately 26 million Americans. Kidneys are organs that filter the blood and remove waste and excess fluid from the body. The kidneys also regulate potential of hydrogen (pH)¹⁴¹, salt, and potassium levels in the body. Kidney disease occurs when the kidneys become damaged and cannot perform their function. Damage may be caused by diabetes, high blood pressure, and various other chronic conditions.¹⁴²

nasal cannula. A small tube inserted into the nostrils used to deliver oxygen.¹⁴³

¹³⁶ Medscape, *Syndrome of Inappropriate Antidiuretic Hormone Secretion*. SIADH is defined by the hyponatremia and hypo-osmolality resulting from inappropriate, continued secretion or action of the antidiuretic hormone arginine vasopressin (AVP) despite normal or increased plasma volume, which results in impaired water excretion. <https://emedicine.medscape.com/article/246650-overview>. (The website was accessed on December 10, 2018.)

¹³⁷ Cambridge Dictionary, *Infection*. <https://dictionary.cambridge.org/us/dictionary/english/infection>. (The website was accessed on January 14, 2019.)

¹³⁸ Merriam-Webster, *Definition of intensive care unit*. <https://www.merriam-webster.com/dictionary/intensive%20care%20unit>. (The website was accessed on January 12, 2019.)

¹³⁹ Merriam-Webster, *Definition of intubation*. <https://www.merriam-webster.com/dictionary/intubation>. (The website was accessed on January 14, 2019.)

¹⁴⁰ Merriam-Webster, *Definition of leukocyte*. <https://www.merriam-webster.com/dictionary/leukocyte#medicalDictionary> (The website was accessed on March 4, 2019.)

¹⁴¹ pH is an abbreviation for "potential of hydrogen" and is a measure of the acidity or alkalinity of a solution. <https://www.reference.com/science/scientific-term-ph-mean-f401c5118ce3fd78>. (The website was accessed on February 11, 2019.)

¹⁴² Healthline, *What is kidney disease?* <https://www.healthline.com/health/kidney-disease>. (The website was accessed on January 17, 2019.)

¹⁴³ Merriam-Webster, *Definition of Cannula*. <https://www.merriam-webster.com/dictionary/cannula#medicalDictionary>. (The website was accessed on February 28, 2019.)

nasogastric tube. A flexible tube that is passed through the nose into the stomach. It can be used to decompress or remove contents of the stomach, or to place nutrients directly into the stomach.¹⁴⁴

nitrites. “Normal urine contains chemicals called nitrates. If bacteria enter the urinary tract, nitrates can turn into different, similarly named chemicals called nitrites. Nitrites in urine may be a sign of a urinary tract infection.”¹⁴⁵

opioid use disorder. A problematic pattern of opioid drug use leading to significant impairments or distress that may involve misuse of prescribed opioid medications, use of diverted opioid medications, or use of illicitly obtained opioids.¹⁴⁶

oxygen saturation. The amount of oxygen in the blood, or more specifically the extent to which hemoglobin, found in red blood cells, is saturated with oxygen. “Normal oxygen saturation is usually between 96 percent and 98 percent.”¹⁴⁷

pain rating scale. A scale used to measure pain intensity that is determined by the patient’s report. The pain score refers to the patient’s rating of pain most commonly on a scale of 0 to 10. Pain scales are reliable only to compare the intensity of a patient’s pain at different times to allow clinicians and patients to judge whether pain intensity is increasing or decreasing with time and treatment.¹⁴⁸

paranoid schizophrenia. “...a serious mental illness characterized by incoherent or illogical thoughts, bizarre behavior and speech, and delusions or hallucinations, such as hearing voices.”¹⁴⁹ The paranoid subtype of schizophrenia features “auditory hallucinations or prominent delusions about persecution or conspiracy.”¹⁵⁰

¹⁴⁴ MedicineNet, *Nasogastric tube*. <https://www.medicinenet.com/script/main/art.asp?articlekey=9349>. (The website was accessed on February 27, 2019.)

¹⁴⁵ MedlinePlus, *Nitrites in Urine*. <https://medlineplus.gov/lab-tests/nitrites-in-urine/>. (The website was accessed on March 18, 2019.)

¹⁴⁶ American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, *Opioid use disorder: Epidemiology, pharmacology, clinical manifestations, course, screening, assessment, and diagnosis*. <https://www.uptodate.com/contents/opioid-use-disorder-epidemiology-pharmacology-clinical-manifestations-course-screening-assessment-and-diagnosis>. (The website was accessed on January 14, 2019.)

¹⁴⁷ Wellhealth, *Understanding Oxygen Saturation*. <https://www.verywellhealth.com/oxygen-saturation-914796>. (The website was accessed on March 20, 2019.)

¹⁴⁸ Up-to-date, *Evaluation of Chronic Pain in Adults*, October 4, 2018. <https://www.uptodate.com/contents/evaluation-of-chronic-pain-in-adults>. (The website was accessed on November 7, 2019.)

¹⁴⁹ American Psychological Association, *Schizophrenia*. <https://www.apa.org/topics/schiz/>. (The website was accessed on February 26, 2019.)

¹⁵⁰ PsychCentral, *Paranoid Schizophrenia*. <https://psychcentral.com/lib/paranoid-schizophrenia/>. (The website was accessed on February 26, 2019.)

projectile vomiting. Sudden and vigorous vomiting that forcefully projects vomitus to a distance. It can occur with little or no warning.¹⁵¹

prostatic adenocarcinoma. A type of cancer that develops in gland cells of the prostate. It is the most common type of cancer found in the prostate gland.¹⁵²

psychiatry. A branch of medicine that deals with mental, emotional, or behavioral disorders.¹⁵³

pursed lip breathing. A technique for controlling shortness of breath by slowing the pace of breathing to make each breath more effective.¹⁵⁴

radiology. “A branch of medicine concerned with the use of radiant energy (as X-rays or ultrasound) in the diagnosis and treatment of disease.”¹⁵⁵

renal failure. A condition that occurs when the kidneys become unable to filter waste products from the blood, causing dangerous levels of waste to accumulate in the body.¹⁵⁶

respiratory rate. The number of breaths per minute.¹⁵⁷

respiratory therapy. Treatment concerned with the maintenance or improvement of respiratory function.¹⁵⁸

sleep apnea. A disorder that causes breathing to stop or become very shallow.¹⁵⁹

stat. A Latin term meaning without delay, or immediate.¹⁶⁰

¹⁵¹ Merriam-Webster, *Definition of Projectile Vomiting*. <https://www.merriam-webster.com/dictionary/projectile%20vomiting>. (The website was accessed on January 22, 2019.) Healthline, *Everything You Should Know about Projectile Vomiting*, <https://www.healthline.com/health/projectile-vomiting>. (The website was accessed on January 23, 2019.)

¹⁵² American Cancer Society, *Understanding Your Pathology Report: Prostate Cancer*. <https://www.cancer.org/treatment/understanding-your-diagnosis>. (The website was accessed on January 14, 2019.)

¹⁵³ *Psychiatry*. <https://www.merriam-webster.com/dictionary/psychiatry>. (The website was accessed on January 12, 2019.)

¹⁵⁴ Cleveland Clinic, *Pursed Lip Breathing*. <https://my.clevelandclinic.org/health/articles/9443-pursed-lip-breathing>. (The website was accessed on February 28, 2019.)

¹⁵⁵ Merriam-Webster, *Definition of Radiology*. <https://www.merriam-webster.com/dictionary/radiology#medicalDictionary>. (The website was accessed on February 27, 2019.)

¹⁵⁶ Mayo Clinic, *Acute Kidney Failure*. <https://www.mayoclinic.org/diseases-conditions/kidney-failure/symptoms-causes/syc-20369048>. (The website was accessed on February 27, 2019.)

¹⁵⁷ Cleveland Clinic, *Vital Signs*. <https://my.clevelandclinic.org/health/articles/10881-vital-signs>. (The website was accessed on February 24, 2019.)

¹⁵⁸ Merriam-Webster, *Definition of Respiratory Therapy*. <https://www.merriam-webster.com/medical/respiratory%20therapy>. (The website was accessed on January 12, 2019.)

¹⁵⁹ Medline, *Sleep Apnea*. <https://medlineplus.gov/sleepapnea.html>. (The website was accessed on November 29, 2018.)

¹⁶⁰ Merriam-Webster, *Definition of Stat*. <https://www.merriam-webster.com/dictionary/stat#medicalDictionary>. (The website was accessed on March 4, 2019.)

suprapubic catheter. A tube inserted directly into the bladder through the abdominal wall that is used to drain urine from the bladder.¹⁶¹

tachycardia. A heart rhythm disorder in which the heart beats faster than normal while at rest. “Tachycardia occurs when an abnormality in the heart produces electrical signals that quicken the heart rate.”¹⁶²

triage. A term that refers to the sorting of patients (as in an emergency department) according to the urgency of their need for care.¹⁶³

troponins. Proteins found in the skeletal and heart muscles that are involved in regulating muscular contraction. Tests for cardiac troponins help detect heart injury or determine if an individual has suffered a heart attack.¹⁶⁴

urinalysis. A test of urine.¹⁶⁵

white blood cell. A type of blood cell that fights infections. An elevated white blood cell count in the blood may reflect infection, inflammation, bone marrow disease, or a reaction to a medication.¹⁶⁶

x-ray. A photograph created by use of electromagnetic radiation that can pass through objects and make it possible to see inside. X-rays may be used to make images of bones and organs inside the body for medical purposes.¹⁶⁷

¹⁶¹ Medlineplus, *Suprapubic catheter care*. <https://medlineplus.gov/ency/patientinstructions/000145.htm>. (The website was accessed on January 12, 2019.)

¹⁶² Mayo Clinic, *Tachycardia*. <https://www.mayoclinic.org/diseases-conditions/tachycardia/symptoms-causes/syc-20355127>. (The website was accessed on February 28, 2019.)

¹⁶³ Merriam-Webster, *Definition of Triage*. <https://www.merriam-webster.com/dictionary/triage>. (The website was accessed on December 17, 2018.)

¹⁶⁴ Lab Tests Online, *Troponin: What is being tested?* <https://labtestsonline.org/tests/troponin>. (The website was accessed on March 13, 2019.)

¹⁶⁵ Mayo Clinic, *Urinalysis*. <https://www.mayoclinic.org/tests-procedures/urinalysis/about/pac-20384907>. (The website was accessed on August 13, 2018.)

¹⁶⁶ Mayo Clinic, *Complete blood count (CBC)*. <https://www.mayoclinic.org/tests-procedures/complete-blood-count/about/pac-20384919>. (The website was assessed on August 9, 2018.)

¹⁶⁷ Merriam-Webster, *Definition of X-Ray*. <https://www.merriam-webster.com/dictionary/x-ray#medicalDictionary>. (The website was accessed on March 14, 2019.)

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