



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Deficiencies in the
Management of Staff
Exposure to a Patient with
COVID-19 at the VA
Portland Health Care System
in Oregon



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a request from the U.S. Office of Special Counsel to determine the validity of allegations related to staff's failure to use proper safety measures in the management of a patient with a confirmed case of COVID-19 and leaders' failure to take action following staff exposure to a patient diagnosed with COVID-19 in early March 2020 at the VA Portland Health Care System (facility) in Oregon.¹

The allegations focused on staff's possible exposure during this patient's care and facility leaders' actions:

- Emergency Department staff sent a patient who was suspected positive for COVID-19 to the Imaging Department without notifying Imaging Department staff of the patient's suspected infectious status. As a result, no additional precautions were taken by Imaging Department staff.
- After the patient was confirmed positive with COVID-19, Imaging Department supervisors failed to properly and promptly notify Imaging Department staff who had contact with the patient.
- Facility leaders did not take action following the incident, which may constitute a substantial and specific danger to public health.² Imaging Department staff who had contact with the patient were not tested for COVID-19 and continued duties at the facility (with the exception of one Imaging Department staff member who self-quarantined).

Assessing the validity of these allegations requires an appreciation of the evolution of scientific understanding of COVID-19. The timing of these specific allegations adds complexity to a review of the appropriateness of the response to patients with symptoms or increased risk factors for COVID-19. When the patient presented to the facility in March 2020

¹ World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it*. [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). (The website was accessed on April 2, 2020.) COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The allegations refer to events that occurred at the Portland VA Medical Center, one of the two campuses of the VA Portland Health Care System.

² U.S. Office of Special Counsel, *Disclosure of Wrongdoing Overview*. The U.S. Office of Special Counsel handles disclosure of wrongdoing, "within the executive branch of the federal government from current federal employees, former federal employees, and applicants for federal employment." The U.S. Office of Special Counsel reviews six types of disclosures, with one type being disclosure of, "a substantial and specific danger to public health or safety." <https://osc.gov/Services/Pages/DU.aspx>. (The website was accessed on May 11, 2020.)

- The World Health Organization had not yet declared COVID-19 a pandemic.
- The Centers for Disease Control and Prevention reported that COVID-19 was a new disease and was still learning how it spread.
- The Centers for Disease Control and Prevention recommended healthcare personnel's use of personal protective equipment such as facemasks, eye protection, gloves, and gowns when caring for patients with suspected or confirmed COVID-19.³
- Testing for COVID-19 at the facility was available only through the Oregon Health Authority and was limited to symptomatic inpatients.⁴
- The facility had high-consequence infection and pandemic response policies, but no prior experience with patients with COVID-19.⁵

Providing quality care to patients and educating the staff to safely provide such care in the midst of evolving guidelines related to presumed mode of transmission, use of personal protective equipment, and protocols for screening and testing patients for infection presented notable challenges for the facility in March 2020.

As with any respiratory virus, healthcare personnel are at increased risk for contracting COVID-19 through close, prolonged exposure while providing care for patients with the disease. Healthcare personnel who become infected with COVID-19 present risks for spreading the disease to other patients and healthcare personnel if precautions are not followed. Failure to implement appropriate infection prevention precautions in the healthcare setting may constitute a danger to public health.

Synopsis of Events

In early March 2020, the patient at issue presented to the facility's Emergency Department via ambulance with complaints of falling twice during the day and confusion after being found on the floor by friends. Emergency medical technicians discovered the patient's insulin pump was

³ Occupational Safety and Health Administration, *Personal Protective Equipment*. Personal protective equipment, commonly referred to as "PPE" is equipment worn to minimize exposure to hazards that cause serious workplace injuries or illnesses. <https://www.osha.gov/SLTC/personalprotectiveequipment/>. (The website was accessed on April 1, 2020.)

⁴ The Oregon Health Authority serves as the lead agency for the public health response to COVID-19 in Oregon. Oregon Health Authority, "COVID-19 Updates." <https://govstatus.egov.com/OR-OHA-COVID-19>. (The website was accessed on May 6, 2020.)

⁵ COVID-19 is a high-consequence infection—a moderate to highly contagious infection for which no known vaccine exists and a concern to public safety because of its morbidity and mortality rate, or both.

off and the battery depleted.⁶ Initial screening in the Emergency Department did not identify a concern for COVID-19.

The patient did not present with a fever, but shortly thereafter registered a fever of 101.7 degrees Fahrenheit. Upon evaluation, the Emergency Department staff noted the patient to have a rapid heart rate, fast breathing, occasional coughing, and laboratory testing evidence of sepsis. An Emergency Department physician ordered an influenza (flu) laboratory test along with a computed tomography of the head to evaluate for bleeding and chest radiograph to evaluate for pneumonia. The imaging orders did not include information regarding the pending flu test or direction for the Imaging Department staff to take infection control precautions appropriate for a patient with a pending flu test.⁷ Following procedures, an Emergency Department nurse placed a mask on the patient while the result of the flu test was pending.

Three Imaging Department staff participated in obtaining the imaging examinations of the patient. Approximately two hours after completion of the imaging examinations, the patient was admitted to the inpatient Medicine Service for further care with a diagnosis of sepsis and community acquired pneumonia. Shortly over an hour after admission, the medicine physician continued the evaluation of the patient and ordered a laboratory test for COVID-19 and initiated “purple” isolation precautions.⁸

The patient was transferred to the Intensive Care Unit approximately eight hours after being admitted to the inpatient Medicine Service due to increased difficulty breathing. Approximately 17 hours after the physician ordered the laboratory test for COVID-19, the Oregon Health Authority, which completed the testing, called the facility’s epidemiologist to report that the patient’s COVID-19 test result was positive. This was the facility’s first patient diagnosed with COVID-19. The patient continued to receive care in the Intensive Care Unit over several days, but experienced worsening clinical condition and died six days after presenting to the Emergency Department.

Healthcare Inspection Results

The OIG did not substantiate that Emergency Department staff failed to notify Imaging Department staff that a patient was suspected to have COVID-19 before sending the patient to the Imaging Department. At the time of the patient’s transport to the Imaging Department,

⁶ An insulin pump is a small, computerized device for people with diabetes that delivers insulin, either in a steady measured and continuous dose or as a surge at the patient’s direction, usually around mealtime.

⁷ Infection control precautions are measures taken to prevent the spread of infections. The type of precautions that should be used depends on how an infection spreads.

⁸ The “purple” isolation precautions order includes the use of purple-colored indicators in charts and on patient arm bands to signal suspected or confirmed COVID-19 cases and alert staff of the need to take appropriate precautions to reduce risk for transmission of the disease. “Purple” infection prevention precautions include use of a mask, eye protection, gown, and gloves. Precautions also include patient isolation in a private room.

Emergency Department staff had not identified suspicion of a COVID-19 diagnosis for the patient.

However, Emergency Department staff failed to alert Imaging Department staff of the patient's potential for infectious flu before transporting the patient to the Imaging Department. Facility policy specifies that the sending department is responsible for instituting any transmission-based precautions and notifying transportation staff and receiving department staff of any infection control precautions beyond standard precautions.⁹ One Emergency Department staff member reported there was not a "coherent system" for communicating infection control precautions to the Imaging Department and another Emergency Department staff member stated "every nurse has a different way" for notification of a potentially infectious patient being sent to the Imaging Department.

The OIG found that, despite past efforts to address transmission-based precaution communication deficiencies for patients transported from the Emergency Department to the Imaging Department, infection control precautions were not consistently communicated prior to patient transport. At the time of the patient's transfer from the Emergency Department to the Imaging Department, the facility's policy directed implementation of transmission-based precautions. However, Emergency Department and Imaging Department leaders indicated the facility policy did not include specific guidelines for notification about a patient's infectious status and associated transmission-based precautions, which should take place prior to transport.

While the facility developed a policy for the transport of patients with COVID-19 in early April 2020, Imaging Department staff told the OIG in mid-April 2020 that Emergency Department staff were "still not consistently letting us know" prior to transporting patients who require transmission-based precautions. Imaging Department and Emergency Department leaders indicated discussing these communication failures and efforts to improve compliance with the policy through continuing education of staff. Adhering to established facility transport protocols for patients requiring infection control precautions may reduce the likelihood of staff exposure to infectious diseases.

The OIG did not substantiate that Imaging Department supervisors failed to properly and promptly notify Imaging Department staff who had contact with a patient diagnosed with COVID-19. While Imaging Department staff learned of the patient's COVID-19 positive status through informal routes of communication prior to supervisors, Imaging Department supervisors acted promptly to confirm and assess staff exposure to the patient after they became aware of the situation. Imaging Department supervisors followed guidance received from Infection Prevention

⁹ Standard precautions are infection control measures used to protect healthcare providers from infection and prevent the spread of infection based on risk assessment and common-sense practices. Transmission based precautions are used in addition to standard precautions for patients with confirmed or suspected infection with a highly transmittable pathogen.

and Control staff to gather information from the exposed employees to determine the level of risk, identify applicable guidelines following exposure, and communicate this information with staff that same day. The OIG concluded that Imaging Department supervisors promptly acted to confirm and assess the staff exposure.

The OIG did not substantiate that leaders failed to take appropriate action following staff exposure to a patient with COVID-19. Facility and department leaders took timely action to identify staff who had contact with the patient, assess staff risk level, and determine whether further monitoring or self-quarantine was required. While staff were not tested for COVID-19, the lack of testing was in alignment with available resources and guidance, as there were national and regional shortages in the availability of COVID-19 tests at the time. One quarantined employee reported developing symptoms consistent with COVID-19 but declined an offer of testing when testing resources later became available.

The OIG did not identify specific or substantial dangers to public health caused by the facility's management of staff exposure to the patient with COVID-19. However, the OIG identified missteps in the facility's processes when responding to staff exposure to the facility's first patient diagnosed with COVID-19:

- Communication about identification of staff with exposure to the patient was premature.
- The facility's definition of prolonged exposure as exceeding 10 minutes led to an overemphasis on the duration of contact time during exposure risk assessments.
- Incomplete information and emphasis on exposure time led to inaccurate categorization of the exposure risk levels for some staff.
- The facility's exposure risk assessment process lacked a procedure for validation of supervisors' assessment and risk categorization by Employee Health Service.
- The facility lacked a reliable and accurate process for tracking and monitoring staff with COVID-19 exposure.

While missteps were noted, the OIG found that the facility made a significant and timely effort to identify staff with potential exposure and respond in accordance with the most current guidance from the Centers for Disease Control and Prevention and Oregon Health Authority. Facility leaders and Infection Prevention and Control staff developed and revised COVID-19 related policies, including procedures for the management of staff exposure, as new guidance became available and lessons were learned through experience treating subsequent patients with COVID-19 at the facility. The new COVID-19 policies addressed specific procedures for management of staff exposure that were not detailed in existing high-consequence infection or

pandemic response policies.¹⁰ The OIG acknowledges the dedication and tireless work of facility staff to care for patients while also working to maintain the safety of staff during the COVID-19 pandemic.

The OIG made five recommendations to the Facility Director related to processes for communicating patients' infectious disease status and infection control precautions prior to transfer; processes for identification, exposure risk assessment, monitoring, and provision of guidance for staff with exposure to high-consequence infections; and inclusion of a detailed staff exposure management process in relevant facility policies.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes C and D). The OIG will follow up on the planned actions until they are completed.



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¹⁰ The Joint Commission, *Concerning High Consequence Infections in a VA Hospital*, February 7, 2020; VA Portland Health Care System, *High Consequence Infection Preparedness and Response Plan*, February 12, 2020. A high-consequence infection is one that is moderately to highly contagious for which no known vaccine exists and is a concern to public safety because of its morbidity and or mortality rate.

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Abbreviations

CDC	Centers for Disease Control and Prevention
COVID-19	coronavirus disease
OHA	Oregon Health Authority
OIG	Office of Inspector General
PPE	personal protective equipment
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a request from the U.S. Office of Special Counsel to determine the validity of allegations related to staff's failure to use proper safety measures in the management of a patient with a confirmed case of COVID-19 and facility leaders' failure to take action following staff exposure to a patient with COVID-19 at the VA Portland Health Care System (facility) in Oregon.¹ The OIG acknowledges the dedication and tireless work of facility staff to care for patients while also working to maintain the safety of staff during the COVID-19 pandemic.²

Background

The allegations refer to events that occurred at the Portland VA Medical Center, the main tertiary care medical center of the facility, and part of Veterans Integrated Service Network (VISN) 20. The facility includes two campuses—one in Portland, Oregon, and one in Vancouver, Washington, and 10 outpatient clinics in Central and Northwest Oregon.³ From October 1, 2018, through September 30, 2019, the facility served 98,409 patients and had a total of 278 hospital operating beds, including 167 inpatient beds, 76 community living center beds, and 35 domiciliary beds. A full spectrum of care including inpatient, outpatient, long-term, and emergency treatment is provided.⁴ The facility has an affiliation with the Oregon Health and Science University and is physically connected to the university campus.

COVID-19

COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a newly discovered coronavirus. The Centers for Disease Control and Prevention (CDC) indicate that illnesses from COVID-19 have “ranged from mild symptoms to

¹ World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it*. [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). (The website was accessed on April 2, 2020.)

² Merriam Webster, *Definition of pandemic*. A pandemic is an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population. <https://www.merriam-webster.com/dictionary/pandemic>. (The website was accessed on April 1, 2020.)

³ The clinics include Bend Community-Based Outpatient Clinic (CBOC), Community Resource and Referral Center clinic (CRRC) in downtown Portland, Fairview Clinic, Hillsboro CBOC, North Coast CBOC (Camp Rilea), Newport CBOC, Lincoln City CBOC, Salem CBOC, the Dalles CBOC (Loren R. Kaufman VA Clinic) and the West Linn CBOC. Department of Veterans Affairs, *VA Portland Health Care System*. <https://www.portland.va.gov/about/index.asp>. (The website was accessed on May 12, 2020.)

⁴ Department of Veterans Affairs, *VA Portland Health Care System*. <https://www.portland.va.gov/about/index.asp>. (The website was accessed on May 12, 2020.)

severe illness and death.”⁵ Common symptoms of COVID-19 include fever, cough, and shortness of breath. Other symptoms may include tiredness, aches, nasal congestion, runny nose, sore throat, or diarrhea. On March 11, 2020, due to its “alarming levels of spread and severity,” the World Health Organization declared COVID-19 a pandemic.⁶

Transmission of COVID-19

COVID-19 is mainly spread person-to-person through close contact with someone infected with SARS-CoV-2. The most common way the virus is transmitted is through small respiratory droplets from the nose or mouth, which occur when someone coughs or exhales. Those droplets may be inhaled by others in close proximity, thus spreading the virus. The droplets may also land on surfaces, where the virus survives for varying lengths of time. If a person touches an infected surface, then touches their eyes, nose, or mouth, they may become infected.

Current evidence suggests that the risk of transmission is highest from close, prolonged contact with someone who is symptomatic. It is also possible for the virus to be spread by someone who has been infected but who is without symptoms or is only experiencing mild symptoms. According to the CDC, the incubation period, or amount of time between exposure to the virus and development of symptoms, ranges from 2 to 14 days. The period of time individuals can remain infectious with COVID-19 is not yet known.⁷

COVID-19 Precautions for Healthcare Personnel

CDC guidance highlights that healthcare personnel caring for patients with suspected or confirmed COVID-19 are at increased risk of exposure to the virus. The CDC provides infection prevention and control recommendations for healthcare personnel caring for patients with suspected or confirmed COVID-19.⁸ The CDC recommends healthcare personnel utilize [standard precautions](#) and [transmission-based precautions](#), including use of personal protective equipment (PPE) such as facemasks, eye protection, gloves, and gowns, when caring for patients

⁵ Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19)*. <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>. (The website was accessed on April 1, 2020.)

⁶ World Health Organization, *WHO Director-General’s opening remarks at the media briefing on COVID-19*, March 11, 2020. <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. (The website was accessed on April 1, 2020.)

⁷ Centers for Disease Control and Prevention, *Healthcare Professionals: Frequently Asked Questions and Answers*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html>. (The website was accessed on April 1, 2020.)

⁸ Centers for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease (COVID-19) in Healthcare Settings*. <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>. (The website was accessed on March 25, 2020.)

with suspected or confirmed COVID-19.⁹ The Veterans Health Administration (VHA) developed a COVID-19 Response Plan that was consistent with CDC guidance on the matter and published it on March 23, 2020. VHA's COVID-19 Response Plan specifies a primary goal to "protect Veterans and staff from acquiring COVID-19 infection."¹⁰

Managing Healthcare Personnel Exposure to COVID-19

Healthcare personnel are at increased risk for contracting the disease through close, prolonged exposure while providing care for patients with COVID-19. Healthcare personnel who become infected present risks for spreading the disease to other patients and healthcare personnel if precautions are not followed. The CDC provides guidance to assist healthcare leaders in assessing the risk associated with staff exposure to patients with COVID-19 and identify appropriate strategies for reducing the risk of further transmission of the disease. The CDC recommends precautions dependent on the exposure risk category, specified as high-risk, medium-risk, low-risk or no identifiable risk. Precautions may include a period of self-monitoring for development of symptoms, regular contact with a facility's Employee Health Service or Infection Prevention and Control program during the monitoring period to ensure appropriate follow-up if symptoms occur, and restriction from work, with 14 days of [self-quarantine](#) following exposure. The CDC acknowledges that guidance is based on data available at the time the guidance is issued, and may change as new information becomes available.¹¹

Allegations

The OIG received a request in March 2020, from the U.S. Office of Special Counsel, to review allegations that facility staff failed to use proper safety measures in the handling of a patient diagnosed with COVID-19. The U.S. Office of Special Counsel referred the case to the OIG for review, as the conduct reported may have constituted a danger to public health.

The OIG conducted an inspection to determine the validity of the allegations:

1. Emergency Department staff sent a patient who was suspected positive for COVID-19 to the Imaging Department without notifying Imaging Department staff of the patient's

⁹ Occupational Safety and Health Administration, *Personal Protective Equipment*. Personal protective equipment, commonly referred to as "PPE" is equipment worn to minimize exposure to hazards that cause serious workplace injuries or illnesses. <https://www.osha.gov/SLTC/personalprotectiveequipment/>. (The website was accessed on April 1, 2020.)

¹⁰ Department of Veterans Affairs, *COVID-19 Response Plan*, March 23, 2020. https://www.va.gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf. (The website was accessed on April 1, 2020.)

¹¹ Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>. (The website was accessed on March 25, 2020.)

suspected infectious status.¹² As a result, no additional precautions were taken by Imaging Department staff.

2. After the patient was confirmed positive with COVID-19, Imaging Department supervisors failed to properly and promptly notify Imaging Department staff who had contact with the patient.
3. Leaders did not take action following the incident, which may constitute a substantial and specific danger to public health.¹³ Imaging Department staff who had contact with the patient were not tested for COVID-19 and continued performing duties at the facility (with the exception of one Imaging Department staff member who self-quarantined).¹⁴

During the course of the inspection, the OIG identified concerns related to facility procedures for communication of patients' infectious disease status and associated [infection control precautions](#) prior to transporting patients with infectious diseases and missteps in the facility's processes when responding to staff exposure to the facility's first patient diagnosed with COVID-19.

¹² The facility groups radiology services, such as computed tomography and radiograph tests, under a department named Imaging Services. For the purposes of this report, the OIG uses the term Imaging Department to identify where the patient's computed tomography and radiograph tests were conducted. Staff who conducted the tests are referred to as Imaging Department staff.

¹³ The U.S. Office of Special Counsel handles disclosure of wrongdoing, "within the executive branch of the federal government from current federal employees, former federal employees, and applicants for federal employment." The Office of Special Counsel reviews six types of disclosures, with one type being disclosure of, "a substantial and specific danger to public health or safety." U.S. Office of Special Counsel, *Disclosure of Wrongdoing Overview*. <https://osc.gov/Services/Pages/DU.aspx>. (The website was accessed on May 11, 2020.)

¹⁴ Within the context of this report, the OIG interpreted the term, leaders, to include executive leadership, supervisors, and subject matter experts in Infection Prevention and Control and Employee Health services.

Scope and Methodology

The OIG initiated the inspection in March 2020. The OIG conducted interviews with facility staff involved in the patient's care in the Emergency Department and the Imaging Department, Imaging Department supervisors, the Chief of Staff, and program leaders in Infection Prevention and Control, Employee Health, and Quality, Safety and Value programs between the dates of April 8, 2020, and April 22, 2020. The OIG did not visit the facility for this inspection given ongoing concerns with travel and the potential spread of COVID-19.

The OIG reviewed relevant facility policies and procedures in place at the time of the patient's care in March 2020, as well as relevant policies and procedures put in place or revised following the patient's care. In addition, the OIG reviewed COVID-19 related guidance from the CDC and the Oregon Health Authority (OHA).¹⁵ The OIG also reviewed the electronic health record of the patient and occupational health entries in the electronic health records of staff with COVID-19 exposure.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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.

¹⁵ The Oregon Health Authority serves as the lead agency for the public health response to COVID-19 in Oregon. Oregon Health Authority, "COVID-19 Updates." <https://govstatus.egov.com/OR-OHA-COVID-19>. (The website was accessed on May 6, 2020.)

Summary of Events

The summary of events is compiled from the patient's electronic health record and staff interviews. The patient, who was in their early 70s at the time of admission, had a medical history of uncontrolled diabetes, and coronary heart disease with a recent heart attack in early 2020.¹⁶

Timeline of Events in the Emergency Department

10:12 p.m. In March 2020, the patient presented to the facility's Emergency Department via ambulance with complaints of falling twice during the day and confusion. The patient was found at home on the floor by friends. [Emergency medical technicians](#) discovered the patient's insulin pump was off and the battery depleted.

The initial Emergency Department nurse documented a screening question in which the patient denied having traveled outside of the country in the past 30 days or having close contact with anyone who had traveled. The patient reported a minimal cough but denied shortness of breath and gastrointestinal symptoms. Prior to awakening that morning, the patient reported feeling in a usual state of health.

10:25 p.m. During interviews with the OIG, Emergency Department staff stated the patient did not present with a fever, but later felt warm to the touch and on recheck of temperature, the patient registered a fever of 101.7 degrees Fahrenheit at 10:25 p.m. Upon evaluation, the Emergency Department staff noted the patient to have a rapid heart rate, fast breathing, occasional coughing, and laboratory testing evidence of [sepsis](#).

10:48 p.m. An Emergency Department physician ordered an [influenza](#) (flu) laboratory test along with a [computed tomography](#) of the head to evaluate for bleeding and chest [radiograph](#) to evaluate for pneumonia. The imaging orders did not include information regarding the pending flu test or direction for the Imaging Department staff to take infection control precautions appropriate for a patient with a pending flu test.

10:55 p.m. An Emergency Department nurse placed a mask on the patient while the result of the flu test was pending.

11:01 p.m. Facility transport staff transferred the patient to the Imaging Department. Three Imaging Department staff participated in obtaining the imaging examinations of the patient.

11:24 p.m. Following completion of the ordered imaging examinations, facility transport staff transferred the patient back to the Emergency Department.

¹⁶ The OIG uses the singular form of they (their) in this instance for patient privacy.

Further Hospital Course

1:27 a.m. Early the following morning, the inpatient Medicine Service admitted the patient for further care with a diagnosis of sepsis and [community acquired pneumonia](#).

2:42 a.m. After admission, the medicine physician ordered a laboratory test for COVID-19 and initiated “purple” isolation precautions.¹⁷ (See figure 1 for timeline of events.)

10:20 a.m. The treating physicians transferred the patient to the Intensive Care Unit due to the patient’s increased difficulty breathing.

Approximately 7:30 p.m. OHA, which completed the patient’s COVID-19 laboratory testing, called the facility’s [epidemiologist](#) to report that the patient’s COVID-19 test result was positive.

The patient continued to receive care in the Intensive Care Unit over several days but experienced worsening clinical condition. The patient’s family, with guidance from treating physicians, decided to prioritize treatment focused on the patient’s comfort. The patient died a short time later, six days after presenting to the Emergency Department.

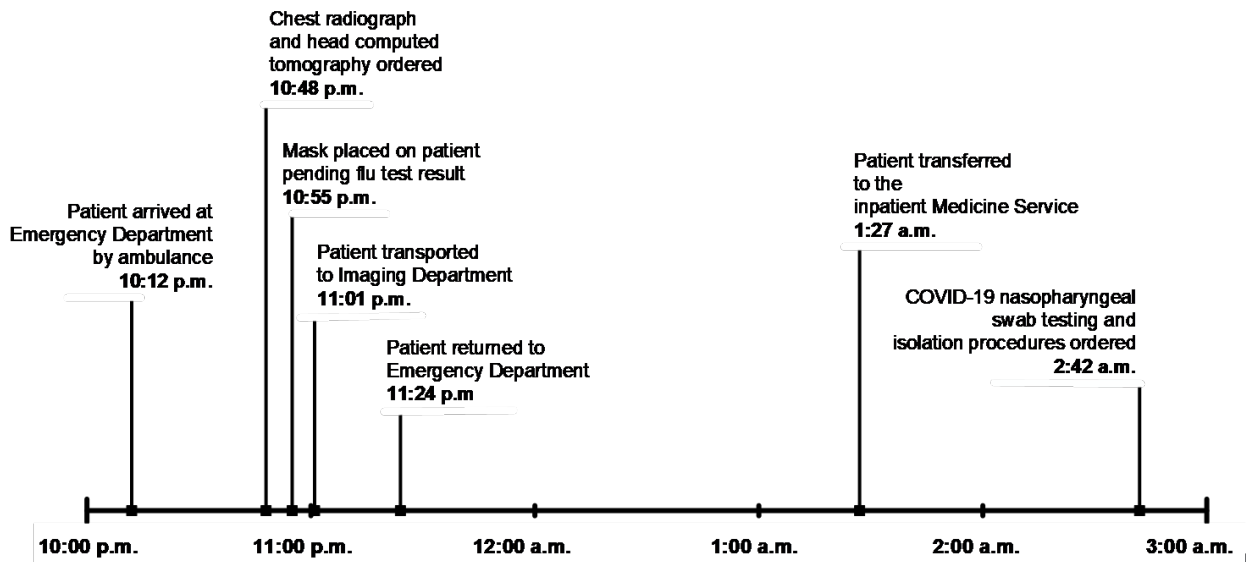


Figure 1. Patient care and movement in the Emergency Department
Source: OIG analysis of electronic health record

¹⁷ The “purple” isolation precautions order includes the use of purple-colored indicators in charts and on patient arm bands to signal suspected or confirmed COVID-19 cases and alert staff of the need to take appropriate precautions to reduce risk for transmission of the disease. “Purple” infection prevention precautions include use of a mask, eye protection, gown, and gloves. Precautions also include patient isolation in a private room. Patients with respiratory infections are placed on contact and droplet precautions.

Inspection Results

1. Notification of Imaging Department Staff of Patient's Suspected COVID-19 Status

The OIG did not substantiate that Emergency Department staff failed to notify Imaging Department staff that a patient was suspected to have COVID-19 before sending the patient to the Imaging Department. The OIG determined that, at the time of the patient's transport to the Imaging Department, Emergency Department staff had not identified suspicion of a COVID-19 diagnosis for the patient. However, Emergency Department staff identified a suspicion for an infectious disease (influenza) that was not conveyed to Imaging Department staff. The OIG found inconsistencies in the Emergency Department's process for notifying the Imaging Department of a patient's infectious disease status prior to transfer. The OIG also identified factors that contributed to a mistaken impression that the patient's COVID-19 status had been known, but not communicated.

The patient was not suspected to have COVID-19 when initially assessed in the Emergency Department and sent to have imaging studies the evening prior to hospital admission (Day 1, at 11:01 p.m.). Suspicion of COVID-19 was identified later, with orders for a COVID-19 test and associated infection precautions occurring after the patient's admission (Day 2, at 2:42 a.m.). The facility received notice of the patient's positive COVID-19 test from OHA on the evening after the patient was seen in the Emergency Department and sent for imaging studies (Day 2, at 7:37 p.m.).

Failure in Emergency Department Processes for Communicating Infection Control Precautions

The OIG determined that Emergency Department staff failed to alert Imaging Department staff of the patient's potential for infectious flu before transporting the patient to the Imaging Department.

The Emergency Department physician ordered a flu test at the same time imaging studies were ordered. A mask was placed on the patient pending the flu test result. Approximately 10 minutes after the flu test and imaging studies were ordered, the patient was transported to the Imaging Department with a mask in place.

Facility policy requires the use of [contact and droplet precautions](#) for patients with suspected flu.¹⁸ The facility's contact and droplet precautions instructed staff to wear gloves, gown, and a surgical mask when providing care to a patient with suspected flu to prevent the spread of

¹⁸ VA Portland Health Care System, Infection Control Manual - Infection Specific Precautions Table, revised July 2019.

infectious disease. The facility policy also specifies that, when a patient is being transported, the sending department is responsible for instituting any transmission-based precautions and notifying transportation staff and receiving department staff of any infection control precautions beyond standard precautions.¹⁹ The OIG found that Emergency Department staff did not inform the Imaging Department staff of the patient's pending flu test or the need for infection control precautions which would have provided staff the information needed for them to comply with the facility's transmission-based precautions.

Misunderstanding that COVID-19 was Known or Suspected Prior to Transport

During the facility's initial information gathering on staff exposure, Imaging Department leaders erroneously informed exposed Imaging Department staff that the Emergency Department suspected the patient had COVID-19 prior to transport to the Imaging Department. The OIG opines there were two factors that likely contributed to this error.

First, during the process of identifying staff exposure, facility and department leaders incorrectly understood that an interaction that included discussion of the patient's COVID-19 infectious state between an Emergency Department leader and an Imaging Department staff member took place on the day the imaging studies were done and was a [warm handoff communication](#). However, the interaction occurred the following day, after the patient's COVID-19 test results returned positive. Imaging Department staff correctly asserted that a warm hand-off did not take place prior to the patient's transport for imaging studies; but facility leaders' acknowledgment of the interaction as communication of the patient's infectious status furthered Imaging Department staff's misunderstanding that the Emergency Department staff had transported a patient with suspected COVID-19 without proper notification.

Second, the patient's COVID-19 test results were incorrectly associated in the electronic health record with the [nasopharyngeal swab](#) for the flu test collected in the Emergency Department instead of the swab collected after admission to the medical unit, which led at least one facility leader to conclude that the patient had been identified by the Emergency Department as a patient suspected positive for COVID-19. As a result, Imaging Department staff initially concluded that the patient had been transported to the Imaging Department without communication regarding infection control precautions for COVID-19, precluding their ability to take transmission-based precautions and decrease their risk for transmission of the disease. While Imaging Department staff incorrectly made this conclusion, Emergency Department staff did fail to communicate the patient's potential infectious flu.

¹⁹ VA Portland Health Care System, *Infection Control Manual - Standard Precautions*, revised September 2019.

Lack of Specific Notification Guidance in Facility Policy

An Imaging Department leader told the OIG that the Imaging Department had previously requested the Emergency Department staff document in the orders if the patient required infection control precautions. However, the leader did not know if that process had been incorporated into official guidance. Another Imaging Department leader reported that past efforts to address transmission-based precautions communication deficiencies from the Emergency Department staff included meeting with Emergency Department leaders and calling the Emergency Department when a patient arrived wearing PPE, but infection control precautions were not consistently communicated prior to arrival. One Emergency Department staff reported there was not a “coherent system” for communicating infection control precautions to the Imaging Department and another Emergency Department staff member stated “every nurse has a different way” for notification of a potentially infectious patient being sent to the Imaging Department.

At the time of the patient’s transfer from the Emergency Department to the Imaging Department, the facility’s policy directed implementation of transmission-based precautions.²⁰ However, Emergency Department and Imaging Department leaders indicated the facility policy did not include specific guidelines for notification about a patient’s infectious status and associated transmission-based precautions, which should take place prior to transport. Infection Prevention and Control leaders described active involvement in developing and revising COVID-19 related policies as new guidance became available and lessons were learned through subsequent experience with treating patients with COVID-19 at the facility.

Facility Development of COVID-19 Specific Policies

The facility developed a policy for the transport of patients with COVID-19 on April 1, 2020. The policy directs “a person to person report” to the receiving department and the placement of a purple armband to denote the patient’s positive COVID-19 status and signal the need for associated infection control precautions prior to patient transport.²¹ However, Imaging Department staff told the OIG in mid-April 2020 that Emergency Department staff were “still not consistently letting us know” prior to transporting patients who require transmission-based precautions. Imaging Department staff indicated that a list of infectious patients transferred without notification of infectious status was compiled and provided to the Imaging Department leaders. Imaging Department and Emergency Department leaders indicated discussing these communication failures and efforts to improve compliance with the policy through continuing

²⁰ VA Portland Health Care System, *Influx of Infectious Patients: Pandemic Preparedness and Response*, revised August 2019.

²¹ VA Portland Health Care System, *Transportation of Confirmed or Rule Out COVID-19 Patients*, April 1, 2020.

education of staff. Adhering to established facility transport protocols for patients requiring infection control precautions may reduce the likelihood of staff exposure to infectious diseases.

2. Notification to Imaging Department Staff of COVID-19 Exposure

The OIG did not substantiate that the Imaging Department supervisors failed to properly and promptly notify Imaging Department staff who had contact with a patient diagnosed with COVID-19. While the OIG confirmed that Imaging Department staff learned of the patient's COVID-19 positive status through informal routes of communication prior to supervisors, the OIG concluded that Imaging Department supervisors took action promptly to confirm and assess staff exposure to the patient after they became aware of the situation. (See [appendix A](#) for a timeline of events.)

Facility policy, in place at the time, provided guidance for managing an influx of patients with infectious diseases, but guidance was not specific to COVID-19.²² The facility's Infection Prevention and Control staff began drafting a process for management of staff exposure to COVID-19 four days after receiving notification of the positive test results for the facility's first patient diagnosed with COVID-19. The policy went into effect seven days later.²³

On the night the patient was seen in the Imaging Department, the patient was not known or suspected to have COVID-19. The OHA notified the facility's epidemiologist that the patient's COVID-19 test result was positive the following evening (Day 2, at 7:37 p.m.). Upon notification of the patient's positive test results, the epidemiologist immediately notified the Director, Infection Prevention and Control, who notified the facility's Executive Leadership Team contact. The Director, Infection Prevention and Control, was on site at the facility when notification of the positive test result was received and began coordination with staff in the Intensive Care Unit where the patient was receiving treatment. The Director, Infection Prevention and Control, also initiated contact with Emergency Department leaders where the patient was treated prior to admission.

Approximately three hours after notification of the patient's positive COVID-19 test result, an Imaging Department staff member completed a portable radiograph on a patient in the Intensive Care Unit and learned from nursing staff that the patient tested positive for COVID-19. The Imaging Department staff member communicated the patient's positive COVID-19 status to one of the Imaging Department staff who had performed the patient's imaging examination the prior evening. In turn, that staff member contacted the other two staff who were involved in the patient's imaging studies, and sent text messages to Imaging Department supervisors with notice of staff's exposure to the patient. Both Imaging Department supervisors stated that because this

²² VA Portland Health Care System, *Influx of Infectious Patients: Pandemic Preparedness and Response*, revised August 2019.

²³ VA Portland Health Care System, *COVID-19 Exposed Employees Process*, March 20, 2020.

communication occurred during the night shift, the message was not received that evening. Imaging Department supervisors learned of staff exposure the following morning, after one of the exposed staff called into an Imaging Department meeting and informed a supervisor about being exposed to the patient. Imaging Department leaders took action to notify facility leaders and obtain guidance from Infection Prevention and Control staff.

Imaging Department supervisors followed guidance received from Infection Prevention and Control staff to gather information from the exposed employees to determine the level of risk, and identify applicable guidelines following exposure, and communicated this information with staff that day. The OIG concluded that Imaging Department supervisors promptly acted to confirm and assess the staff exposure.

3. Leaders' Response Following Staff Exposure

The OIG did not substantiate that facility or Imaging Department leaders failed to take appropriate action following staff exposure to a patient with COVID-19. The OIG found that leaders took timely action to identify staff who had contact with the patient, assess staff risk level, and determine whether further monitoring or self-quarantine was required. While the OIG confirmed that exposed staff were not tested for COVID-19, the OIG determined the lack of testing was in alignment with available resources and guidance, as there were national and regional shortages in the availability of COVID-19 tests at that time. OHA was the only COVID-19 testing resource available to the facility at the time and limited testing to symptomatic inpatients. Employee testing was not available through OHA, but was subsequently offered to symptomatic staff when testing resources became available. (See [appendix A](#) for a timeline of events.) The OIG did not identify specific or substantial dangers to public health caused by the facility's management of staff exposure to the patient with COVID-19.

4. Missteps in Facility Processes Following Staff Exposure

The OIG concluded that facility leaders implemented a timely and informed plan for responding to staff exposure to COVID-19. Policies related to COVID-19 were issued and revised as updated information became available. The facility's new COVID-19 policies addressed specific procedures for management of staff exposure, which were not detailed in existing [high-consequence infection](#) or pandemic response policies.²⁴ However, the OIG also identified missteps in the facility's processes when responding to staff exposure to the facility's first patient diagnosed with COVID-19:

- Premature communication that all exposed staff were identified and notified,
- Inaccurate categorization of staff exposure risk levels,

²⁴ COVID-19 is a high-consequence infection.

- Facility definition of prolonged exposure,
- Lack of Employee Health Service collaboration during the exposure risk assessments, and
- Deficits in Employee Health Service tracking of some exposed employees.

Premature Communication about Staff Exposure Identification

The OIG found that the Facility Director's email to all staff discussing the patient's epidemiologic trace was sent prematurely.

The Facility Director notified all staff via email that the facility had admitted its first patient with confirmed COVID-19 (Day 3, at 7:58 a.m.). The email also advised staff that an [epidemiologic trace](#) had been completed and any impacted employees had been notified, indicating that "every precaution is being taken to protect those individuals." The timing of the Director's email overlapped with the Imaging Department meeting during which an Imaging Department staff member communicated concerns to management about staff exposure to the patient. When the email was sent, the exposed Imaging Department staff had not yet been identified in the facility's epidemiologic trace, nor officially notified of the exposure or provided guidance about the next steps to be taken. The concerns of Imaging Department staff prompted action by the Imaging Department supervisors to engage with facility leaders to confirm and address staff exposure.

Inaccurate Categorization of Staff Exposure Risk Levels

The OIG determined that incomplete information and emphasis on exposure time led to inaccurate categorization of the exposure risk levels for some staff.

Inaccurate Initial Categorization of Exposure Risk Due to Incomplete Information

The OIG determined that incomplete information about PPE use and contact time with the patient with COVID-19 initially led to inaccurate categorization of exposure risk for two Imaging Department staff. The OIG found that Imaging Department supervisors initially relied on indirect reports of staff contact with the patient, which contained inaccurate information. This resulted in an erroneous initial risk categorization for two of the three exposed Imaging Department staff. After receiving written communication from the two Imaging Department staff later that day, the inaccurate risk categorization for one of the staff was revised and Infection Prevention and Control issued corrected guidance to self-quarantine.

Imaging Department supervisors gathered information about staff use of PPE and duration of exposure to the patient via phone calls, texts, and emails since the exposed Imaging Department staff were not at the facility during the day shift. However, since Imaging Department supervisors were initially unable to reach all exposed staff, the information gathering process

continued over the course of the day. The initial information provided was based on one staff member's recollection of the type of PPE worn by all three Imaging Department staff, confirmation that the patient was masked, and report that the patient contact time had been brief. This resulted in the supervisors' mistaken belief that all Imaging Department staff had been masked during contact with the patient. Based on the initial reports of the exposure and guidance issued by the OHA, Infection Prevention and Control staff assisted supervisors in assigning risk categories for exposed staff. The inaccurate information led to Imaging Department supervisors incorrectly assigning a low-risk categorization for all three exposed Imaging Department staff, which resulted in initial guidance for the staff to continue working as scheduled.

Once Imaging Department supervisors received complete and direct communication from all staff later the same day, statements from two staff contradicted the supervisors' original understanding. Two Imaging Department staff reported not wearing masks. One estimated spending 5 to 10 minutes in contact with the patient while the other reported a contact time of 15 minutes or longer. As a result of the new information, the risk-categorization level for the Imaging Department staff member who reported the longer contact time without a mask was revised upward. An Imaging Department supervisor communicated the new elevated risk categorization to the staff member that afternoon, with instructions to self-quarantine for 14 days, check temperature twice daily, monitor for symptoms, and contact a healthcare provider if symptoms developed.

At the conclusion of the information gathering process, two of the exposed Imaging Department staff were categorized as low-risk and instructed to continue working as scheduled, wear a mask, and self-monitor; while the third was categorized as high-risk and instructed to self-quarantine for 14 days. The OIG concluded that the initial reliance on inaccurate information when assessing the staff's risk levels led to confusion, incorrect supervisory guidance, and exacerbated staff concerns.

Inaccurate Categorization of Exposure Risk Due to Focus on Duration of Exposure Time

The OIG determined that the facility's emphasis on exposure time during the risk-categorization process led to inaccurate categorization of one of the Imaging Department staff as low-risk and guidance to continue working as scheduled, instead of being instructed to self-quarantine.

The facility used OHA guidance available at the time to assess the staff exposure risk level as low-, medium-, or high-risk based on multiple factors, including prolonged exposure time.²⁵

OHA guidance indicated that staff who engaged in care activities while not wearing a mask that involved direct physical contact with the patient or the patient's secretions would be categorized at a higher risk level, regardless of whether or not the patient was masked. OHA also identified corresponding precautions including self-quarantine and active monitoring for symptoms for a period of 14 days after exposure. (See [appendix B](#) for OHA guidance.)

OHA guidance acknowledged duration of exposure as one factor that may impact exposure risk level, but did not offer specific guidance regarding what duration of contact time would result in a heightened risk. CDC guidance stated that "[d]ata are insufficient to precisely define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it is reasonable to consider an exposure greater than a few minutes as a prolonged exposure."²⁶ The Director, Infection Prevention and Control, told the OIG that CDC and OHA guidance did not define what constituted prolonged exposure. Therefore, the facility decided to define prolonged exposure as longer than 10 minutes.

While the patient was masked prior to transport to the Imaging Department, the staff member deemed to be low-risk was not wearing a mask at the time the imaging study was conducted. The staff member reported having direct physical contact with the patient, including close proximity to the patient's face while positioning the patient's head for imaging studies.

The facility's Infection Prevention and Control staff worked with supervisors, utilizing OHA guidance, to categorize staff exposure risk levels and identify recommended actions. Despite the description of the staff member's close contact with the patient without use of recommended

²⁵ OHA guidance outlined risk exposure categories based on common healthcare activities with focus on presence or absence of source control measures (for example, a patient wearing a face mask), use of PPE by healthcare personnel (for example, staff use of masks, eye protection, gowns and gloves), and degree of contact with the patient (for example, prolonged versus brief), and was consistent with CDC guidance. Oregon Health Authority, *Provisional Guidance: Clinical Care and Healthcare Infection Prevention and Control for COVID-19*, March 9, 2020. Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)*, March 7, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>. (The website was accessed on March 25, 2020.)

²⁶ Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)*, March 7, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>. (The website was accessed on March 25, 2020.)

PPE, an assessment of low-risk was assigned.²⁷ The staff member was instructed to report to work as scheduled, wear a mask, self-monitor temperature twice daily, and report any symptoms.

The facility's definition of prolonged contact as 10 minutes or longer and emphasis on the time criteria during the exposure risk assessment resulted in the staff member being inaccurately categorized as low-risk and provision of guidance that the exposure did not meet the criteria to self-quarantine. The staff member reported no symptoms within the 14-day self-monitoring period. There were no indications that the staff member contracted COVID-19; however, an individual can be infected but asymptomatic. Therefore, the OIG was unable to determine whether or not the inaccurate risk categorization and failure to issue guidance for self-quarantine resulted in further exposures.

The Director, Infection Prevention and Control, told the OIG that after using the OHA tool to assess staff exposure levels to COVID-19, the facility decided to change to the CDC's tool for categorizing exposure risk, as the CDC's tool was thought to present the guidance more clearly. However, the OIG was unable to determine if use of the CDC tool would have resulted in accurately categorizing risk for this staff member as the facility policy emphasized time to categorize exposure risk.

Facility Definition of Prolonged Exposure

The OIG found that the facility's definition of prolonged exposure as exceeding 10 minutes led to an overemphasis on the duration of contact time during exposure risk assessments. The OIG determined that the emphasis placed on exposure time exceeding 10 minutes led to uncertainty regarding self-quarantine guidance for a facility's Emergency Department physician identified with high-risk exposure to the patient.

March 7, 2020, CDC guidance directed healthcare workers who had prolonged contact with a patient suspected of having COVID-19 without wearing proper PPE to self-quarantine for 14 days.²⁸ As noted above, neither the CDC nor OHA guidance provided a definition for prolonged exposure. CDC guidance identified that the assessment of exposure risk level would be elevated to the next higher category if a provider had extensive body contact with the patient. CDC guidance also included a statement indicating that facilities could consider allowing asymptomatic staff with medium- or high-risk exposure to continue work if "options to improve

²⁷ CDC guidance defined close contact for healthcare exposures to include being within approximately six feet (two meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the patient; or sitting within six feet of the patient in a healthcare waiting area or room); or having unprotected direct contact with infectious secretions or excretions of the patient (for example, being coughed on, or touching used tissues with a bare hand).

²⁸ Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)*, March 7, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>. (The website was accessed on March 25, 2020.)

staffing have been exhausted” but staff should monitor symptoms daily, wear a mask, and discontinue patient care activities if they develop any symptoms.²⁹

The Chief, Emergency Department, informed a facility’s Emergency Department physician of the patient’s positive COVID-19 test results on the evening the results were received by the facility. The Emergency Department physician reported not wearing a mask or gloves while assessing and treating the unmasked patient in the Emergency Department. In response, the Chief, Emergency Department, initially instructed the physician to self-quarantine for 14 days. Two days later, the Chief, Emergency Department, contacted the physician and requested further details about the timeline; specifically, the duration of the physician’s contact with the patient and PPE used, in order to confirm a final risk level categorization. The Emergency Department physician noted that the subsequent communication with the Chief, Emergency Department, focused on the timeline of care and the Chief indicated if the physician’s recollection of the exposure time without appropriate PPE was shorter than the facility’s criteria, the physician could return to work. The OIG found CDC guidance to elevate the risk level was applicable for the Emergency Department physician based on the description of physical contact with the patient without PPE, such as helping move the patient from the ambulance stretcher to the bed in the Emergency Department.

The Emergency Department physician provided a description of the contact with the patient and estimated timeframes, as well as expressing concerns about the risk of exposure to co-workers or patients to COVID-19 by returning to work prior to completion of the self-quarantine period. The next day, the Chief, Emergency Department provided the additional details of the Emergency Department physician’s patient contact and timeline to Infection Prevention and Control staff for further guidance. The following day, the Director, Infection Prevention and Control, responded that the Emergency Department physician’s description exceeded 10 minutes of close contact without a mask and should continue to self-quarantine for 14 days.

Despite some ambiguity introduced into the risk-categorization process by emphasis on the facility-generated exposure duration criteria, the physician continued to self-quarantine, thus the outcome presented no heightened risk of exposure for other staff or patients.

²⁹ Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)*, March 7, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>. (The website was accessed on March 25, 2020.)

Lack of Employee Health Service Collaboration During Exposure Risk Assessments

The OIG identified a potential vulnerability in the facility's information gathering and exposure risk-categorization process, noting that lack of validation of supervisors' assessment and risk categorization by Employee Health Service may increase risks for variability or unintended bias.

Prior to the facility drafting COVID-19 specific policies, the facility's Infection Control Manual provided guidance related to employee exposures to infectious disease. The guidance specified that the Employee Health Service would provide an initial risk assessment for employees with exposure or potential exposure to an infectious disease and collaborate with Infection Prevention and Control staff or infectious disease staff as needed to determine guidance on returning to work following any exposure that poses an infectious disease threat.³⁰ The day following the patient's diagnosis of COVID-19, a staff member in the Chief of Staff's office emailed facility supervisors with instructions for employee notification, monitoring, and Employee Health Service follow-up procedures for staff placed on a 14-day self-quarantine by Infection Prevention and Control. Three days later, the facility began drafting a process for management of staff COVID-19 exposures and the process went into effect the following week.³¹

At the time of the OIG's review in April 2020, the facility's guidance on managing staff exposure to COVID-19 assigned the responsibility for gathering staff exposure information and designating the risk level to supervisors. The process instructed supervisors to assess the level of exposure via interview with the staff member utilizing a set of questions detailed in the policy and contact Infection Prevention and Control staff with questions. Supervisors were responsible for categorizing the staff's risk level and consulting with Infection Prevention and Control staff if the risk categorization was unclear. After assessment, the supervisor informed the staff member of risk level and then notified Employee Health Service with information including the staff's name, contact information, date of exposure, and risk category. Employee Health Service staff were then responsible for initiating and maintaining contact with the exposed employee to provide information about monitoring and guidance about recommendations based on the assessed risk level and CDC guidance, and contacting the exposed staff member prior to returning to work.

Following interviews with staff and supervisors, the OIG team considered that, while supervisors may be most familiar with staff's daily activities and in the best position to promptly engage their staff, perceptions on both sides of the supervisor-staff relationship may influence the process, to include

³⁰ VA Portland Healthcare System, *Infection Control Manual – Employee Health*, revised June 2018.

³¹ VA Portland Healthcare System, Standard Operating Procedure (SOP): *Identifying, Assessing Risk, and Monitoring Staff and Trainees with Potential Exposure to Persons Confirmed to Have COVID-19*, revised March 20, 2020.

- Conflicts in the supervisor-staff relationship could impair communications,
- Concerns that details of the exposure events could be evaluated negatively by the supervisor that may affect accurate reporting, and
- Negative perceptions by the supervisor about staff self-quarantine could influence the assessment.

The OIG also considered that supervisors from different services may be more or less familiar with identifying important factors in assessing exposure risk, which could affect the accuracy of the supervisors' risk assessments.

The OIG found that in this first facility case of a patient with COVID-19, while Employee Health Service staff were not involved in the risk assessment, Infection Prevention and Control staff collaborated with supervisors in assessing the risk for exposed employees, thus addressing the identified concerns. However, the facility's process in effect in April 2020 for responding to staff exposure did not include a verification process to ensure that supervisors were accurately assessing and categorizing risk levels. The facility's process relied upon supervisors seeking guidance if needed. Validation of the supervisor's risk assessment by Employee Health Service staff may strengthen the accuracy of the risk assessment process.

Deficits in Employee Health Service Tracking of Exposed Employees

The OIG found that the facility lacked a reliable and accurate process for identifying, tracking and monitoring staff with COVID-19 exposure.

Process of Identification and Tracking Exposed Employees

The morning following notification to the Executive Leadership of the patient's diagnosis of COVID-19, facility leaders, to include Infection Prevention and Control and Employee Health Service, met to discuss the situation and identify all staff who had COVID-19 exposure. Supervisors in departments where the patient with COVID-19 received care consulted with Infection Prevention and Control to complete staff exposure assessments and provided the information to the Executive Leadership Team. Supervisors then contacted Employee Health Service and provided names of staff and their exposure risk level. Employee Health Service initiated and maintained a registry of staff members with COVID-19 exposure, monitored staff with exposure according to their risk level, and documented contacts with staff in the employee's health record.

The facility's policy on pandemic preparedness and response identified that a key element to a successful response to a pandemic is effective personnel management, but did not include specific guidance regarding how Employee Health Service should be notified regarding staff exposure, or how Employee Health Service should conduct monitoring of staff with exposure.

OHA guidance for monitoring included maintaining a log of staff and visitors entering the room of any patient with known or suspected COVID-19. At that time, the CDC guidance for risk assessment and management of healthcare personnel included [contact tracing](#) and risk assessment of all potentially exposed personnel. However, the CDC also acknowledged that it might not be “practical or achievable in all situations” and warned that “contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities.”³²

The Director, Infection Prevention and Control, reported that historically the facility’s process for identifying staff exposure entailed staff going through the electronic health record of the patient line by line to identify staff involved in the patient’s care and notifying supervisors of staff with potential exposure. The facility’s Executive Leadership Team coordinated outreach to department leaders in the facility to identify and assess staff with possible exposures. That effort began on the same evening of the positive test results from the OHA and continued the next morning. The OIG found that the facility made a significant and timely effort to identify staff with potential exposure. However, the lack of a standardized process for notifying Employee Health Service of all exposed staff may have led to a difference in the number of staff who were identified by facility leaders as being exposed and the number of staff who were tracked by Employee Health Service.

Executive leaders, Infection Prevention and Control staff, and department leaders worked together and identified 13 staff members with COVID-19 exposure. In contrast, Employee Health Service staff members completed employee health record entries for eight staff members in the Employee Health Service exposure tracking roster. The OIG found that Employee Health Service did not monitor five staff with COVID-19 exposure: a nurse in the Emergency Department, two of the three staff working in the Imaging Department, and two residents from the Oregon Health and Science University.³³ The failure by Employee Health Service to track five of the exposed staff precluded follow-up monitoring of those staff after exposure. Employee Health consistently cleared all quarantined facility staff prior to their return to work.

³² Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)*, March 8, 2020.
<https://web.archive.org/web/20200308174643/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>. (The website was accessed on May 20, 2020.)

³³ Monitoring of residents with exposure was coordinated through the Oregon Health and Science University Employee Health Service. The facility subsequently developed procedures which specified that the Oregon Health and Science University Employee Health Service would assume responsibility for implementing tracking, monitoring, and work restrictions for residents with exposure to COVID-19. *Standard Operating Procedure: Identifying, Assessing Risk, and Monitoring Staff and Trainees with Potential Exposure to Persons Confirmed to Have COVID-19*. March 31, 2020.

Limitations in the Use of a Patient's Electronic Health Record for Contact Tracing

Initially, the facility's process for identifying staff exposure entailed staff reviewing the patient's electronic health record line by line to identify staff involved in the patient's care and notifying supervisors of staff with potential exposure.

To better understand the challenge with staff exposure identification and assessment, the OIG developed a computer algorithm to analyze data from the patient's electronic health record that would identify potentially exposed staff based on electronic health record entries and positions that typically involved direct patient contact. During the time span from 14 days prior to the patient's onset of symptoms through facility staff initiating "purple" infection control orders, the OIG identified 31 staff with potential COVID-19 exposure.³⁴ In contrast to the manual line by line review, the computer algorithm results comprised staff who documented in different components of the electronic health record and included the Imaging Department staff who were not captured in the initial manual review by the facility. The facility began implementation of a computer algorithm to scan the electronic health record and identify patients' healthcare contact points.

The OIG identified a limitation in the utility of the electronic health record for contact tracing. The electronic health record does not capture staff who do not document in the electronic health record such as housekeeping and transport staff. Neither the facility's electronic health record review nor the OIG's computer algorithm addressed this limitation. The analysis highlights the facility's challenge to identify staff with exposure, especially those staff not readily identified through the electronic health record.

Employee Health Service Tracking

To further examine the accuracy of the Employee Health Service exposure tracking roster, the OIG reviewed the Employee Health exposure tracking roster for subsequent staff COVID-19 exposures through April 14, 2020. The OIG found that the facility did not accurately track all staff with COVID-19 exposure. The facility's process, which relied on the supervisor evaluation of exposure and notification to Employee Health Service, may be responsible for the discrepancy between the facility leaders' count of staff with COVID-19 exposure and Employee Health Service's count.

At the time of this staff exposure, there were 16 patients in the state of Oregon that were considered positive for COVID-19; the patient discussed in this report was the first case for this county. While early CDC guidance encouraged a conservative approach in monitoring healthcare

³⁴ While the OIG's computer algorithm identified 31 staff with potential exposure, the OIG was unable to evaluate whether or not all of those staff had actual exposure to the patient. Supervisor follow-up of identified staff with an exposure risk assessment would be needed to evaluate actual exposure.

providers, a continuing lack of consistent identification and monitoring of staff with exposure to COVID-19 may impair the ability of the facility's Employee Health Service to provide guidance and support to all exposed staff.³⁵

Conclusion

The OIG did not substantiate the allegation that Emergency Department staff failed to notify Imaging Department staff that a patient was suspected to have COVID-19 before sending the patient to the Imaging Department. At the time of the patient's transport to the Imaging Department, Emergency Department staff had not identified suspicion of a COVID-19 diagnosis for the patient. However, Emergency Department staff failed to alert Imaging Department staff of the patient's potential for infectious flu before transporting the patient to the Imaging Department, and the facility's infection control policy did not sufficiently address the range of measures to minimize staff exposure to COVID-19.

The OIG did not substantiate that Imaging Department supervisors failed to properly and promptly notify Imaging Department staff who had contact with a patient diagnosed with COVID-19. While Imaging Department staff learned of the patient's COVID-19 positive status through informal routes of communication prior to supervisors, Imaging Department supervisors promptly acted to confirm and assess staff exposure to the patient after they became aware of the situation.

The OIG did not substantiate that leaders failed to take appropriate action following staff exposure to a patient with COVID-19. Facility and department leaders took timely action to identify staff who had contact with the patient, assess staff risk level, and determine whether further monitoring or self-quarantine was required. While staff were not tested for COVID-19, the lack of testing was in alignment with available resources and guidance, as there were national and regional shortages in the availability of COVID-19 tests at that time. Employee testing was subsequently offered to symptomatic staff when testing resources became available.

The OIG concluded that facility leaders implemented a timely and informed plan for responding to staff exposure to COVID-19 and revised policies as updated information became available. The events under review involved the facility's first patient diagnosed with COVID-19, and the OIG identified some missteps in the facility's processes when responding to the staff exposure. Communication about identification of staff with exposure to the patient was premature. The facility's definition of prolonged exposure as exceeding 10 minutes led to an overemphasis on

³⁵ Centers for Disease Control and Prevention, *Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)*, March 8, 2020. <https://web.archive.org/web/20200308174643/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>. (The website was accessed on May 20, 2020.)

the duration of contact time during exposure risk assessments. Incomplete information and emphasis on exposure time led to inaccurate categorization of the exposure risk levels for some staff. The facility's exposure risk assessment process lacked a procedure for validation of supervisors' assessment and risk categorization by Employee Health Service. The facility lacked a reliable and accurate process for tracking and monitoring staff with COVID-19 exposure.

While missteps were noted, the OIG found that the facility made a significant and timely effort to identify staff with potential exposure and respond in accordance with the most current guidance from the CDC and OHA. Facility leaders and Infection Prevention and Control staff developed and revised COVID-19 related policies, including procedures for management of staff exposure, as new guidance became available and lessons were learned through experience treating subsequent patients with COVID-19 at the facility. The OIG acknowledges the dedication and tireless work of facility staff to care for patients while also working to maintain the safety of staff during the COVID-19 pandemic.

Recommendations 1–5

1. The Portland VA Health Care System Director ensures that a consistent notification process is implemented and monitored to ensure the sending department notifies the receiving department of a patient's potential infectious disease status prior to transfer and verifies appropriate infection control precautions are implemented prior to transfer.
2. The Portland VA Health Care System Director ensures that the standard process for contact tracing for staff exposure to high-consequence infections such as COVID-19 includes a process for identification of potentially exposed staff who cannot be identified through electronic health record documentation.
3. The Portland VA Health Care System Director ensures that standard processes for assessment of staff exposure to high-consequence infections such as COVID-19, including a process for validation of supervisors' initial risk categorizations, are implemented and monitored to support reliable and accurate exposure risk categorization.
4. The Portland VA Health Care System Director ensures that standard processes are implemented and monitored for tracking staff exposure, providing guidance on self-monitoring, self-quarantine, and returning to work, and documenting Employee Health Service contacts with exposed employees.
5. The Portland VA Health Care System Director ensures facility policies are reviewed and updated to include a detailed staff exposure management process to leverage lessons learned from the current pandemic response and to enhance preparedness for future events.

Appendix A: Timeline of Events³⁶

Day and Time	Event
Day 1 at 10:26 p.m.	Emergency Department triage screening question negative for international travel.
Day 1 at 10:48 p.m.	Nasopharyngeal swab for flu ordered Chest radiograph ordered.
Day 1 at 10:49 p.m.	Head computed tomography ordered.
Day 1 at 10:55 p.m.	Blue mask placed on patient pending flu result.
Day 1 at 11:01 p.m.	Patient transported from Emergency Department to Imaging Department.
Day 1 at 11:24 p.m.	Patient transported from Imaging Department to Emergency Department.
Day 2 at 1:27 a.m.	Patient admitted to inpatient medical unit.
Day 2 at 2:42 a.m.	Nasopharyngeal swab for COVID-19 ordered Initiated “purple” isolation precautions.
Day 2 at 10:20 a.m.	Patient transferred to Intensive Care Unit.
Day 2 at 7:37 p.m.	OHA laboratory contacted hospital epidemiologist with notification of positive COVID-19 test results.
Day 2 at approximately 10:30 p.m.	Imaging staff member reported hearing through informal channels that the patient had COVID-19. Staff member contacted the other two staff and informed them of the exposure to a patient with COVID-19. Staff member sent texts to Imaging Department supervisors. Because of the late time, supervisors reported not seeing the text until the following morning.
Day 3 at 7:00 a.m. to 8:00 a.m.	Imaging Department morning meeting was held during which an exposed staff member called in and notified supervisor of staff exposure to a patient with COVID-19. Chief, Imaging Department, reported learning of the Imaging Department staff exposure following this meeting.
Day 3 at 7:58 a.m.	Facility Director emailed all facility staff with notice that the facility had its first patient test positive for COVID-19. The email prematurely advised staff that an epidemiologic trace had been completed and impacted employees had been notified.
Day 3 at approximately 8:00 a.m.	Chief, Imaging Department reported initiating communications with facility leaders about Imaging Department staff exposure.

³⁶ This timeline of events was constructed by the OIG through interviews and review of documents to include emails, texts, and EHR entries. The OIG did not independently verify details of all events provided through interview.

Alleged Deficiencies in the Management of Staff Exposure to a Patient
with COVID-19 at the VA Portland Health Care System in Oregon

Day and Time	Event
Day 3 at 9:00 a.m.	<p>During the facility morning report meeting with facility leaders the Chief of Staff reported that the Chief, Emergency Department reviewed issue of a patient with COVID-19. The Chief of Staff reported that during the meeting it was stated that while the patient was in the Emergency Department, the patient went to Imaging Department prior to admission to inpatient. Facility Leaders ordered continuation of the tracer to identify all staff with exposure to the COVID-19 positive patient, dating back to 14 days prior to the patient's presentation in the Emergency Department.</p> <p>Due to failure of initial screening questions and triage in Emergency Department to identify suspicion of COVID-19 diagnosis for the patient, a decision was made to initiate new precautions in the Emergency Department. Enhanced precautions included having all Emergency Department staff wear masks and eye protection, as well as gloves and gowns for physical contacts with all patients. Enhanced precautions also included universal masking for all patients with respiratory symptoms or altered mental status.</p>
Day 3 at 9:15 a.m.	<p>Facility sent an issue brief about the patient with COVID-19 to the VISN.</p> <p>The issue brief identified staff exposure in the Emergency Department and two outpatient clinics visited in the prior 14 days but did not identify the exposure of Imaging Department staff.</p>
Day 3 at 10:30 a.m.	<p>The Chief of Staff reported that a meeting was conducted with the Chief of Staff's office, Infection Prevention and Control staff, and the chiefs of departments with potentially exposed staff.</p> <p>The Chief of Staff reported that the Chief, Imaging Department identified three Imaging Department staff with exposure to the patient, but the PPE worn by the Imaging Department staff was unclear at that time.</p>
Day 3 at 11:00 a.m.	<p>Imaging Department supervisor reported beginning exchange of text messages with exposed Imaging Department staff to gather information about the exposure, PPE worn, and amount of contact time with the patient. The text exchanges continued into the afternoon.</p>
Day 3 at 4:02 p.m.	<p>Chief, Imaging Department emailed the leadership group involved in the staff exposure tracing and advised of three Imaging Department staff who had contact with the patient. Chief, Imaging Department indicated that one of the exposed Imaging Department staff met criteria for moderate to high-risk and relayed that the staff member was instructed to self-quarantine for the next 14 days.</p> <p>Facility leaders concluded that all staff with exposure to the patient had been identified. Using CDC and OHA guidelines, Infection Prevention and Control provided supervisors with instructions on guidance to be given to exposed staff.</p>
Day 3 at 4:18 p.m.	<p>Chief of Staff's office emailed supervisors the Employee Health Service process for monitoring an employee placed on a 14-day self-quarantine by Infection Prevention and Control due to COVID-19 exposure.</p>

Alleged Deficiencies in the Management of Staff Exposure to a Patient
with COVID-19 at the VA Portland Health Care System in Oregon

Day and Time	Event
Day 3 at 4:57 p.m.	Imaging Department supervisor reported texting Imaging Department employee identified with heightened risk with guidance from Infection Prevention and Control that staff member would need to self-quarantine for 14 days, check temperature twice a day, monitor for symptoms, and contact staff member's medical provider if symptoms developed.
Day 3 at 5:05 p.m.	Imaging Department supervisor sent email notification to Employee Health Service, advising that the Imaging Department had one employee placed on a 14-day self-quarantine by Infection Prevention and Control based on most current OHA COVID-19 guidelines.
Day 4	Employee Health Service contacted Imaging Department staff member, who was instructed to self-quarantine following exposure.
Day 5	Self-quarantined Imaging Department staff member reported developing symptoms and contacting a medical provider.
Day 6	Self-quarantined Imaging Department staff member reported trying to get tested for COVID-19 through the facility and also in the community through a medical provider and emergency room. Staff member was informed by the facility and community sources of inability to be tested because of very limited test availability and staff member not meeting criteria for testing at that time.
Day 10	Employee COVID-19 testing became available at the facility. Employee Health Service received approval to begin scheduling employee testing for symptomatic employees who had known exposure to COVID-19 positive patients.
Day 13	Self-quarantined Imaging Department staff member was contacted by Employee Health Service with offer to arrange COVID-19 testing, but declined at that time, as symptoms were improving.
Day 16	Projected return to work date for quarantined Imaging Department staff member. Imaging Department staff reported less than 72 hours since resolution of symptoms, so remained self-quarantined per medical provider's instructions.
Day 20	Self-quarantined Imaging Department staff member returned to work.

Source: OIG analysis of electronic health record, documented communications, and interviews

Appendix B: Oregon Health Authority Guidance³⁷

Table A.1. Work Exclusion and Monitoring Plan Considerations for Healthcare Provider (HCP) Activities by PPE and Source Control Utilization

- = without the specified PPE + = with the specified PPE -/+ = with or without the specified PPE

Sample Activity	Personal Protective Equipment Used by HCP					Source Control	Work Restriction	Follow-up and Monitoring Plan
	Respirator ^d	Regular Mask	Goggles or Face Shield	Gown	Gloves	Patient Masked		
HCP[health care provider] walks by patient, but has no direct contact with patient or their secretions	-	-	-	-	-	-/+	None	Standard respiratory illness precautions ^a
Brief check-in interactions or brief entrance into patient room without contact with patient secretions	-	-	-	-	-	-/+	None	HCP self-monitoring for 14 days after last exposure ^b
Patient care with <u>no</u> aerosol-generating procedures ^e	+	-	+	+	+	-/+	None	HCP self-monitoring for 14 days after last exposure ^b
	-	+	+	+	+	-/+	None	HCP self-monitoring for 14 days after last exposure ^b
	-	+	+	-	-	-/+	None	HCP self-monitoring for 14 days after last exposure ^b
	+	-	-	-	-	+	None	HCP self-monitoring for 14 days after last exposure ^b
	-	+	-	-	-	+	None	HCP self-monitoring for 14 days after last exposure ^b

³⁷ Oregon Health Authority, *Provisional Guidance: Clinical Care and Healthcare Infection Prevention and Control for COVID-19*, March 9, 2020. <https://www.oregondental.org/docs/librariesprovider42/default-document-library/oha-covid-19-provsional-guidance-on-healthcare-infection-prevention-and-control.pdf?sfvrsn=0>. (This website was accessed on June 29, 2020.)

Alleged Deficiencies in the Management of Staff Exposure to a Patient
with COVID-19 at the VA Portland Health Care System in Oregon

Sample Activity	Personal Protective Equipment Used by HCP					Source Control	Work Restriction	Follow-up and Monitoring Plan
	Respirator ^d	Regular Mask	Goggles or Face Shield	Gown	Gloves	Patient Masked		
Patient care with aerosol- generating procedures	+	-	+	+	+	N/A	None	HCP self-monitoring for 14 days after last exposure ^b
Patient care with <u>no</u> aerosol- generating procedures	-	-	-	-	-	-/+	Work exclusion ^f	Active monitoring for 14 days after last exposure ^c
	-	-	+	+	+	-/+	Work exclusion ^f	Active monitoring for 14 days after last exposure ^c
	+	-	-	+	+	-	Work exclusion ^f	Active monitoring for 14 days after last exposure ^c
	-	+	-	+	+	-	Work exclusion ^f	Active monitoring for 14 days after last exposure ^c
Patient care with aerosol- generating procedures	Any variation that does not include the full recommended PPE (respirator, eye protection, gown, and gloves)					N/A	Work exclusion ^f	Active monitoring for 14 days after last exposure ^c

Source: Oregon Health Authority, Provisional Guidance: Clinical Care and Healthcare Infection Prevention and Control for COVID-19, March 9, 2020

a. Standard respiratory illness precautions: All HCP should stay home if ill.

b. HCP self-monitoring: HCP perform self-monitoring for fever or respiratory symptoms for 14 days from last exposure under the supervision of a healthcare facility's occupational health or infection control program.

c. Active monitoring: Daily communication to assess for the presence of fever or respiratory symptoms (cough, sore throat, or shortness of breath) conducted by healthcare facility's occupational health or infection control program.

d. Respirator: Refers to respiratory protection at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator, including NIOSH-approved powered air-purifying respirators (PAPRs).

e. Provision of patient care that requires extensive direct contact with the patient and their immediate environment (e.g. logrolling, toileting) should include use of gown, gloves, and appropriate hand hygiene. Failure to use gown and gloves in addition to specified PPE would elevate exposure risk and may warrant work exclusion and active monitoring.

f. Work exclusion period should be 14 days from last exposure. Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient continue to work after consultation with their occupational health program. The decision to allow continued work should be made on an individual.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 27, 2020

From: Acting Director, VISN 20: Northwest Network (10N20)

Subj: Healthcare Inspection—Alleged Deficiencies in the Management of Staff Exposure to a Patient
with COVID-19 at the VA Portland Health Care System in Oregon

To: Director, Office of Healthcare Inspections (54HL10)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to provide a response to the findings from the Draft Report: Healthcare Inspection—Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon.
2. I concur with the recommendations and responses to the findings.

(Original signed by:)

David Wood, MHA, FACHE
Acting Director, Northwest Network (10N20)

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 20, 2020

From: Director, VA Portland Health Care System (648/00)

Subj: Healthcare Inspection—Alleged Deficiencies in the Management of Staff Exposure to a Patient
with COVID-19 at the VA Portland Health Care System in Oregon

To: Director, VISN 20: Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the recommendations from the Draft Report: Healthcare Inspection—Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon.

2. Portland VA Healthcare System concurs with the recommendations and will ensure that actions to correct these findings are completed as described in the responses.

(Original signed by:)

Darwin G. Goodspeed, FACHE

Director, Portland VA Healthcare System

Facility Director Response

Recommendation 1

The Portland VA Health Care System Director ensures that a consistent notification process is implemented and monitored to ensure the sending department notifies the receiving department of a patient's potential infectious disease status prior to transfer and verifies appropriate infection control precautions are implemented prior to transfer.

Concur.

Target date for completion: September 30, 2020

Director Comments

A facility-wide Standard Operating Procedure (SOP) will be developed, educated, and implemented to provide staff guidance on verbal and written hand-off communication for internal patient transfers and transports.

Recommendation 2

The Portland VA Health Care System Director ensures that the standard process for contact tracing for staff exposure to high-consequence infections such as COVID-19 includes a process for identification of potentially exposed staff who cannot be identified through electronic health record documentation.

Concur.

Target date for completion: September 30, 2020

Director Comments

Portland has developed an electronic process to identify and trace patient encounters by date, location and time. Portland created a process to trace staff exposures who are not identified with electronic health record. In the event of identification of a COVID-19 positive Veteran, the list generated by the electronic search of the electronic health record identifies employees in clinical and administrative areas the Veteran was for 48 hours before symptom onset through the current date. This list is sent by Executive Leadership or delegate to area supervisors who contact employees in the record and others whose names may not be reflected in the record. Supervisors then interview the employees per the policy questions (based on CDC guidance), which includes exposure risks and the Personal Protective Equipment (PPE) worn. This includes COVID-19 positive patients in isolation. Employee names are entered into an excel spreadsheet with options to select based on the employee's answers to the interview questions. The spreadsheet calculates whether the

exposure risk was high or low. Supervisors send the completed spreadsheet to Employee Health. Employee Health contacts employees and provides them instructions based on the risk assessment. This process is being further developed to ensure employees that are not in the electronic record are being traced. These areas include such departments as housekeeping and transportation.

Recommendation 3

The Portland VA Health Care System Director ensures that standard processes for assessment of staff exposure to high-consequence infections such as COVID-19, including a process for validation of supervisors' initial risk categorizations, are implemented and monitored to support reliable and accurate exposure risk categorization.

Concur.

Target date for completion: Completed June 9, 2020

Director Comments

Portland developed a spreadsheet that automatically assigns level of risk when populated with characteristics of each person's exposure. This highly reliable and objective process is used by the supervisor when conducting an exposure tracer. When complete, the risk assessment is sent to Employee Health.

OIG Comment

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

Recommendation 4

The Portland VA Health Care System Director ensures that standard processes are implemented and monitored for tracking staff exposure, providing guidance on self-monitoring, self-quarantine and returning to work, and documenting Employee Health Service contacts with exposed employees.

Concur.

Target date for completion: Completed March 18, 2020

Director Comments

The policy has been developed, and a training gap in how supervisors are informed of their required actions for identifying and reporting possible exposed staff was identified and rectified. The policy has been revised several times resulting from lessons learned and evolving guidelines. Supervisors receive "just in time" training through an email notification of possible staff

exposure which includes a link to the current policy describing all aspects of employee exposure management. The policy includes guidance on self-monitoring, self-quarantine, and returning to work. In Employee Health, standard employee health practices for documentation in the employee health record and on the employee COVID-19 tracking tool are followed.

OIG Comment

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

Recommendation 5

The Portland VA Health Care System Director ensures facility policies are reviewed and updated to include a detailed staff exposure management process to leverage lessons learned from the current pandemic response and to enhance preparedness for future events.

Concur.

Target date for completion: November 25, 2020

Director Comments

Policies will be reviewed and revised to incorporate lessons learned from this pandemic into relevant Infection Prevention and Control and Employee Health policies, such as those relating to influenza and other communicable diseases. The facility is developing a COVID-19 SOP repository for the ability to rapidly identify and edit based on evolving standards of care using CDC Guidelines and best practices.

Glossary

community acquired pneumonia. An illness causing inflammation of the lungs. The lung infection can be caused by different germs and arises outside of hospitals and other healthcare settings.³⁸

computed tomography. A three-dimensional image of a body structure which is constructed from a series of cross-sectional images produced by a form of radiation, such as X-ray photography.³⁹

contact and droplet precautions. Measures taken in advance to prevent transmission of an infectious illness which may be spread through close contact with an infected person or through respiratory droplets generated by an infected person.⁴⁰

contact tracing. The identification, monitoring, and support of individuals who have been exposed to, and possibly infected with a disease, such as COVID-19, through their contact with someone who was diagnosed or suspected to have the illness.⁴¹

emergency medical technician. A specially trained medical technician certified to provide basic emergency services (such as cardiopulmonary resuscitation) before and during transportation to a hospital.⁴²

epidemiologic trace. Tracking the pattern of movement or behavior of a person with an infectious disease in order to identify others who may have become infected, with the aim of preventing further infections.⁴³

epidemiologist. A specialist in the medical science that deals with the incidence, distribution, and control of disease in a population.⁴⁴

³⁸ Mayo Clinic, *Pneumonia*. <https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204>. (The website was access on May 14, 2020.)

³⁹ Meriam-Webster Dictionary, *Definition of computed tomography*. <https://www.merriam-webster.com/dictionary/computed%20tomography>. (The website was accessed on May 7, 2020.)

⁴⁰ The Centers for Disease Control and Prevention, *Transmission-Based Precautions*. <https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>. (The website was accessed on May 5, 2020.)

⁴¹ The Centers for Disease Control and Prevention, *Health Departments: Interim Guidance on Developing a COVID-19 Case Investigation & Contact Tracing Plan*, May 16, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/downloads/case-investigation-contact-tracing.pdf>. (The website was accessed on May 20, 2020.)

⁴² Meriam-Webster Dictionary, *Definition of EMT*. <https://www.merriam-webster.com/dictionary/EMT>. (The website was accessed on May 7, 2020.)

⁴³ Encyclopedia.com, “Epidemiology, tracking diseases with technology.” <https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/epidemiology-tracking-diseases-technology>. (The website was accessed on May 19, 2020.)

⁴⁴ Meriam-Webster Dictionary, *Definition of epidemiology*. <https://www.merriam-webster.com/dictionary/epidemiologist>. (The website was accessed on May 7, 2020.)

flu test. A diagnostic test for detection of influenza virus in respiratory specimens of patients.⁴⁵

high-consequence infections. Moderate to highly contagious infections for which no known vaccine exists and which are a concern to public safety because of their morbidity and or mortality rate.⁴⁶

infection control precautions. Measures taken to prevent the spread of infections in healthcare settings. The type of precautions which should be used depend on how an infection spreads.⁴⁷

influenza. An acute, highly contagious, viral infection that affects the respiratory system.⁴⁸

insulin pump. A small, computerized device for people with diabetes that delivers insulin, either in a steady measured and continuous dose or as a surge at the patient's direction, usually around mealtime.⁴⁹

nasopharyngeal swab. A test used to diagnose upper respiratory tract infections, in which secretions from the back of the nose and upper throat are collected using a swab.⁵⁰

radiograph. A picture produced on a sensitive surface by a form of radiation other than visible light, such as an X-ray or gamma ray photograph.⁵¹

self-quarantine. Refraining from any contact with other individuals for a period of time (such as two weeks) during the outbreak of a contagious disease usually by remaining in one's home and limiting contact with others.⁵²

sepsis. A potentially life-threatening condition caused by the body's response to an infection.⁵³

⁴⁵ The Centers for Disease Control and Prevention, *Overview of Influenza Testing Methods*. <https://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm>. (The website was accessed on May 7, 2020.)

⁴⁶ The Joint Commission, *Concerning High Consequence Infections in a VA Hospital*, February 7, 2020; VA Portland Health Care System, *High Consequence Infection Preparedness and Response Plan*, February 12, 2020.

⁴⁷ The Centers for Disease Control and Prevention, *Infection Control*. https://www.cdc.gov/infectioncontrol/basics/infection_control.html. (The website was accessed on May 7, 2020.)

⁴⁸ Meriam-Webster Dictionary, *Definition of influenza*. <https://www.merriam-webster.com/dictionary/influenza>. (The website was accessed on May 19, 2020.) Mayo Clinic, *Influenza*. <https://www.mayoclinic.org/diseases-conditions/flu/symptoms-causes/syc-20351719>. (The website was accessed on May 19, 2020.)

⁴⁹ American Diabetes Association, *Insulin Pumps: Relief and Choice*. <https://www.diabetes.org/diabetes/medication-management/insulin-other-injectables/insulin-pumps-relief-and-choice>. (The website was accessed on May 7, 2020.)

⁵⁰ Health Navigator, *Nasal swab test*. <https://www.healthnavigator.org.nz/health-a-z/n/nasal-swab-test/>. (The website was accessed on May 19, 2020.)

⁵¹ Meriam-Webster Dictionary, *definition of radiograph*. <https://www.merriam-webster.com/dictionary/radiograph>. (The website was accessed on May 7, 2020.)

⁵² Meriam-Webster Dictionary, *Definition of self-quarantine*. <https://www.merriam-webster.com/dictionary/self-quarantine>. (The website was accessed on May 18, 2020.)

⁵³ Mayo Clinic, *Sepsis*. <https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214>. (The website was accessed on May 7, 2020.)

standard precautions. Infection control measures which are used for all patient care to protect healthcare providers from infection and prevent the spread of infection from patient to patient, based on risk assessment and common-sense practices.⁵⁴

transmission-based precautions. The second tier of basic infection control, used in addition to standard precautions for patients with confirmed or suspected infection with a highly transmittable or epidemiologically important pathogen for which additional precautions are needed to prevent infection transmission.⁵⁵

warm hand-off communication. A direct discussion for transmitting information about a patient from one provider to another when transferring responsibility for a patient's care.⁵⁶

⁵⁴ The Centers for Disease Control and Prevention, *Standard Precautions*.
<https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html>. (The website was accessed on May 19, 2020.)

⁵⁵ The Centers for Disease Control and Prevention, *Transmission-Based Precautions*.
<https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>. (The website was accessed on May 5, 2020.)

⁵⁶ Department of Health and Human Services, Patient Safety Network, *Handoffs and Signouts*.
<https://psnet.ahrq.gov/primer/handoffs-and-signouts>. (The website was accessed on May 19, 2020.)

OIG Contact and Staff Acknowledgments

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