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VETERANS HEALTH ADMINISTRATION

Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California

HEALTHCARE INSPECTION | REPORT #19-08411-12 | NOVEMBER 19, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review an allegation that a patient was found dead in the VA Loma Linda Healthcare System (facility) Emergency Department waiting room. During the inspection, the OIG identified additional concerns related to documentation and care coordination at the facility's Ambulatory Care Center (ACC), compliance with the facility's revised first look nurse policy, and facility leaders' response to the event.[1]

The OIG did not substantiate that the patient expired in the Emergency Department waiting room. In 2019, two of the patient's family members brought the patient to the ACC for a same day visit with the patient's primary care provider due to deterioration in condition. On the way to the primary care clinic, the patient first presented to the mental health clinic where staff replaced the patient's Foley catheter bag. Although the patient did not present to the primary care clinic, a primary care nurse care manager, based on information from the patient's family member, directed the family member to take the patient to the Emergency Department. The patient was checked in to the Emergency Department and the first look nurse assigned an Emergency Severity Index (ESI) level 3.[2] Approximately two hours later, the triage nurse obtained the first set of vital signs, noting that the patient had a rapid heart rate and was unarousable.[3] The patient was immediately transported via wheelchair to an Emergency Department room, where a physician examined the patient and noted no heart sounds and no pulse. The family declined life-sustaining interventions and the patient died shortly thereafter.

The OIG found that mental health clinic nursing staff at the ACC did not comply with Veterans Health Administration (VHA) and facility policies requiring documentation of encounters and interventions in the patient electronic health record by not including an assessment of the

[1] Facility Policy, *Emergency Department (ED) Nurse First (ED-NF*), revised February 7, 2016; Facility Policy, *Emergency Department Guidelines First Look RN Process in the Emergency Department,* October 17, 2019. The first look nurse is a registered nurse who is the first contact for patients checking into the Emergency Department. The first look nurse performs a quick visual assessment for each patient and assigns an Emergency Severity Index level. At the time of the event discussed in this report, the role was called "nurse first" and in the updated policy, the role is called "first look nurse." For the purpose of this report, the OIG chose to consistently use "first look nurse" when describing this role. The facility's ACC is located 2.6 miles from the medical center and offers outpatient services. The ACC does not have an emergency department or pharmacy services but does have limited laboratory and imaging services.

[2] Agency for Healthcare Research and Quality, *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4*, 2012 Edition. ESI is an emergency department algorithm that categorizes patients into five groups for triage, from 1(most urgent) to 5 (least urgent).

[3] MedlinePlus, *Vital signs*. Vital signs are a measure of essential body functions including blood pressure, breath, pulse, and body temperature. https://medlineplus.gov/ency/article/002341.htm. (The website was accessed on May 15, 2020).

patient's condition while providing maintenance care for the Foley bag.[4] Although the OIG was unable to determine if the lack of assessment and documentation affected the patient's care or wait time, complete and accurate documentation is an essential component to coordinating care and providing comprehensive care to patients.

The OIG found that primary care nursing staff did not provide a hand-off communication to the Emergency Department when the primary care nursing staff recommended to the patient's family that the patient be evaluated in the Emergency Department.[5] The OIG recognizes the complexity of this situation because the patient did not directly present to the primary care clinic and the facility policy is ambiguous as to the requirement in this type of situation.[6] The OIG was unable to determine if the lack of hand-off communication affected the patient's outcome in the Emergency Department.

VHA does not have a specific policy related to the role and responsibilities of the first look nurse.[7] At the time of the event, the facility had a first look nurse policy, but the policy did not require the first look nurse to obtain or document the patient's vital signs or document the patient's ESI level. In response to the event, the facility conducted a fact-finding review and revised the first look nurse policy to include the requirement of the first look nurse to obtain and document the patient's vital signs within the first 10 minutes upon arrival.

To evaluate whether staff were complying with the facility's revised first look policy, the OIG reviewed all patients who presented during a 30-day period in 2020.[8] The OIG found that the first look nurse obtained vital signs on 97 percent of patients, but only documented the vital signs within 10 minutes of arrival in 65 percent of the patients.

The patient waited approximately two hours from arrival at the Emergency Department to being seen by the triage nurse. The OIG determined that Emergency Department staff followed

[4] VHA Handbook 1907.01, *Health Information Management and Health Records,* March 19, 2015. Facility Policy 136-04, *Completion of Medical Records,* July 12, 2016. The policy was rescinded and replaced by Facility Policy 136-04, *Completion of Medical Records*, April 20, 2020. The two policies contain similar language related to documentation of care. Facility Policy 118-21, *Urinary Catheter Maintenance and Removal Procedure,* October 26, 2018. The policy was incorporated into Facility Policy 118-27, *Urinary Catheter Maintenance and Removal Procedure*, May 1, 2019, and contains similar language related to assessment and documentation of Foley catheter maintenance.

[5] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

[6] Facility Policy 00-07, *Patient Safety Plan*, June 16, 2017. The facility defines "hand-off communication" as "interactive communication that allows opportunity for questioning between the give[r] and receiver of patient information, including information regarding the patient's care for the purpose of ensuring the continuity and safety of the patient's care."

[7] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. Facility Policy, *Emergency Department (ED) Nurse First (ED-NF),* revised February 7, 2016.

[8] Facility Policy, *Emergency Department Guidelines First Look RN Process in the Emergency Department*, October 17, 2019. This policy was updated after the death of the patient to require the first look nurse to obtain patients' vital signs within 10 minutes of arriving to the Emergency Department.

guidelines and protocols regarding who to see first, based on the assigned ESI level and the urgency of the identified need.[9]

Following the patient's death, the facility conducted a fact-finding review of the event and completed 9 of the 11 identified systems issues, including updates to the first look nurse policy and removal of privacy dividers in the waiting room. The facility planned to complete the remaining two identified systems issues, training nursing staff to cover in the Emergency Department and redefining the Emergency Department cleaning processes, in fall 2020.

The OIG made three recommendations to the Facility Director related to providing documentation training for mental health clinic staff, reviewing the hand-off communication policy, and ensuring compliance with the revised first look nurse policy.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B for the Directors' comments). The OIG will follow up on the planned actions until they are completed.

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[9] Within the 24-hour period of the patient's presentation and death, just over 100 patients sought care at the facility's Emergency Department.

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Abbreviations

ACC	Ambulatory Care Center
EDIS	Emergency Department Integration Software
EHR	electronic health record
ESI	Emergency Severity Index
OIG	Office of Inspector General
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess if delays in Emergency Department processes contributed to a patient death at the VA Loma Linda Healthcare System (facility) in California.

Background

The facility is part of the Desert Pacific Healthcare Network, Veterans Integrated Service Network (VISN) 22 and includes six community-based outpatient clinics located in nearby counties. The facility provides acute care and outpatient services in medicine, primary care, and mental health. From October 1, 2018, through September 30, 2019, the facility served 74,209 patients and had a total of 269 operating beds, including 159 inpatient beds and 110 Community Living Center beds.

Ambulatory Care Center

The facility's Ambulatory Care Center (ACC) is located 2.6 miles from the medical center and offers outpatient services in primary care, geriatrics, mental health, physical medicine and rehabilitation, dental, and women's health. The ACC does not have an emergency department or pharmacy services but does have limited laboratory and imaging services.

Emergency Department

The facility's Emergency Department operates 15 beds, 24 hours per day, 7 days a week, and treats illnesses, injuries, and psychiatric disorders. The Emergency Department's primary responsibility is to stabilize patients in life-threatening situations.

Emergency Severity Index

The Emergency Severity Index (ESI) is an emergency department assessment tool that categorizes patients into five groups for triage, from 1(most urgent) to 5 (least urgent).[1] The triage nurse performs a brief assessment and assigns an ESI level, which provides an estimate of how long a patient can safely wait for treatment and intervention. ESI level 3 patients require

[1]Agency for Healthcare Research and Quality, *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4, 2012 Edition*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf. (The website was accessed on April 20, 2020.)

that the nurse obtain vital signs and determine if the vital signs are appropriate.[2] If the vital signs are not appropriate, the nurse must determine if it is safe for the patient to remain in the waiting room, and should be upgraded to ESI level 2 or 1.[3]

Emergency Department Integration Software

Emergency Department Integration Software (EDIS) is a computer program that is used in conjunction with the electronic health record (EHR) to track and manage patient flow and care in emergency departments.[4] Emergency department staff document detailed information from check-in through disposition for each patient, including changes in level of care. The computer program also captures various time frames for each patient's care.

Prior OIG Report

In a prior OIG inspection, *Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System*, Report No. 17-02186-114, published on May 6, 2019, the OIG identified quality of care issues for patients boarded in the Emergency Department and poor patient flow to other units.[5] The recommendations for the Emergency Department included provisions for the same level of care when boarding patients, patient flow, accuracy of EDIS data including wait times, care of sepsis patients, and psychiatry response time.

Allegations and Related Concerns

The OIG received an allegation in 2019 that a patient was found dead in the facility's Emergency Department waiting room. The OIG requested that the facility review the allegation and provide a response. The OIG found the facility's responses to be inadequate. In early 2020, the OIG initiated a healthcare inspection. During the inspection process, the OIG identified additional concerns related to documentation and care coordination at the ACC, compliance with the facility's revised first look nurse policy, and facility leaders' response to the event.

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[2] MedlinePlus, *Vital signs*. Vital signs are a measure of essential body functions including blood pressure, breath, pulse, and body temperature. https://medlineplus.gov/ency/article/002341.htm. (The website was accessed on May 15, 2020.)

[3] Facility Policy, *Emergency Department (ED) Nurse First (ED-NF),* revised February 7, 2016; Facility Policy, *Emergency Department Guidelines First Look RN Process in the Emergency Department*, October 17, 2019. The first look nurse is a registered nurse who is the first contact for patients checking into the Emergency Department. The first look nurse performs a quick visual assessment for each patient and assigns an ESI level. At the time of the event the role was called "nurse first" and in the updated policy, the role is called "first look nurse." For the purpose of this report, the OIG chose to consistently use "first look nurse" when describing this role.

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

[5] VA OIG, *Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California,* Report #17-02186-114, May 6, 2019.)

Scope and Methodology

The OIG initiated the inspection early 2020, and conducted a virtual site visit two months later.

The OIG interviewed the Facility Director; Chiefs of Staff, Quality Management, Emergency Medicine, and Cardiology; the Associate Director for Patient Care Services; Emergency Department nursing staff; ACC primary care clinic and mental health clinic nursing staff; Patient Safety Managers at the time of the event; the Peer Review Coordinator; and the Risk Manager.

The OIG reviewed relevant Veterans Health Administration (VHA) and facility policies, EDIS data, Patient Advocate Reports, patient safety reports, quality reviews and responses, relevant staff trainings, and the identified patient's EHR.

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.

Patient Event Summary

The summary of events was compiled from the patient's EHR, a fact-finding report completed by the facility following the patient's death, EDIS data, and staff interviews.

The patient was in their 90s with a history of high blood pressure, mild cognitive impairment, atrial fibrillation, heart failure, and urinary retention requiring Foley catheter placement.[6]

In 2019, the patient was brought to the ACC by two family members for deterioration in condition. On the way to the primary care clinic, nursing staff in the mental health clinic noticed the patient's Foley bag was leaking and assisted with changing it. One of the patient's family members went ahead to the primary care clinic on the second floor to request a same day visit with the patient's provider. The family member spoke with a licensed vocational nurse at the primary care clinic who consulted with the patient's nurse care manager. The nurse care manager recommended that the family member take the patient to the Emergency Department for an evaluation.

The patient checked in to the Emergency Department and underwent an evaluation by the first look nurse within the first two minutes.[7] The first look nurse assigned the patient an ESI level 3 and directed the patient and family members to the waiting room. Roughly two hours later, the triage nurse noted that the patient was unarousable, with rapid pulse and shallow breathing, and brought the patient via wheelchair to an Emergency Department room. The patient's family members declined any further life-sustaining interventions. An Emergency Department physician declared the time of death shortly thereafter.

[6] The OIG uses the singular form or they (their) in this context for the purpose of patient privacy. Mayo Clinic, *Mild cognitive impairment*. "Mild cognitive impairment (MCI) is the stage between the expected cognitive decline of normal aging and the more serious decline of dementia. It can involve problems with memory, language, thinking and judgment that are greater than normal age-related changes." https://www.mayoclinic.org/diseases-conditions/mild-cognitive-impairment/symptoms-causes/syc-20354578. (The website was accessed on April 20, 2020.) Merriam-Webster, *Atrial fibrillation.* Atrial Fibrillation is a rapid, uncoordinated contractions of the heart chambers that results in unsynchronized heartbeat and pulse. https://www.merriam-webster.com/medical/atrial%20fibrillation. (The website was accessed on April 20, 2020.) Merriam-Webster, *Heart failure.* Heart failure is when the heart is unable to pump blood at an adequate rate or volume. www.merriam-webster.com/dictionary/heart%20failure. (The website was accessed on June 1, 2020.) Merck Manual, *Urinary retention*. "Urinary retention is incomplete emptying of the bladder or cessation of urination." https://www.merckmanuals.com/professional/genitourinary-disorders/voiding-disorders/urinary-retention?query=urinary. (The website was accessed on April 20, 2020.) Merriam-Webster, *Foley catheter*. A Foley catheter is "a thin, flexible catheter [or tube] used especially to drain urine from the bladder by way of the urethra." https://www.merriam-webster.com/dictionary/Foley%20catheter. (The website was accessed on April 20, 2020.)

[7] Facility Policy, *Emergency Department (ED) Nurse First (ED-NF),* revised February 7, 2016.

Inspection Results

1. Alleged Patient Death in the Emergency Department Waiting Room

The OIG did not substantiate that the patient expired in the facility's Emergency Department waiting room. When the triage nurse obtained the patient's vital signs in the waiting room, the patient was breathing and had a rapid heart rate. The triage nurse escorted the patient via wheelchair to an Emergency Department room for further evaluation and care.

After checking the patient in to the facility's Emergency Department, the first look nurse conducted a quick visual assessment of the patient, assigned an ESI level 3, and directed the patient and family members to the waiting room. Approximately two hours later, the triage nurse obtained the first set of vital signs on the patient. The triage nurse documented that the patient was unarousable and had a rapid heart rate. The triage nurse brought the patient via wheelchair to an Emergency Department room where a physician examined the patient. The physician documented that, "I was unable to hear heart sounds and no activity on bedside ultrasound and no pulse."[8] The family declined life-sustaining interventions and the patient had a "do not resuscitate" order. The physician declared the time of death shortly thereafter.

Although the OIG did not substantiate that the patient expired in the Emergency Department waiting room, additional concerns related to the documentation and care coordination at the ACC, first look nurse policy, and facility leaders' response were identified.

2. Concern: Documentation and Care Coordination at the Ambulatory Care Center

Documentation

The OIG determined that the mental health nursing staff did not comply with VHA and facility documentation requirements.

VHA requires that documentation in the EHR is "accurate, relevant, timely, and complete."[9] Facility policy requires clinical staff to document all encounters and interventions with patients in the EHR.[10] The facility also has a policy that outlines specific procedures for the proper

[8] Mayo Clinic, *Ultrasound*. An ultrasound uses high frequency sound waves from an external device to show images of internal body structures for information used in treating a variety of illnesses and diseases. https://www.mayoclinic.org/tests-procedures/ultrasound/about/pac-20395177. (The website was accessed on May 27, 2020.)

[9] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[10] Facility Policy 136-04, *Completion of Medical Records*, July 12, 2016. The policy was rescinded and replaced by Facility Policy 136-04, *Completion of Medical Records*, April 20, 2020. The two policies contain similar language related to documentation of care.

maintenance and replacement of indwelling Foley catheters, including an assessment of the patient's condition and documentation of actions taken.[11]

According to the fact-finding review completed by the facility, the patient was brought to the ACC by two family members for deterioration in condition. The patient's Foley bag was leaking and mental health clinic nursing staff offered assistance to the patient and family member and changed the patient's Foley bag. The OIG did not find documentation of the assessment of the patient's condition, vital signs, or the Foley bag change in the EHR. A licensed vocational nurse told the OIG that nursing staff spoke with the patient and patient's family member and offered assistance with the patient's Foley bag, but did not obtain the patient's information or document the interaction in the patient's EHR. The patient's family member appeared upset and tearful and was focused on getting to either the patient's primary care clinic or the Emergency Department. The licensed vocational nurse stated that the patient should have been more thoroughly assessed and the interaction documented in the EHR.

The OIG concluded that mental health nursing staff did not comply with VHA and facility policy by not documenting encounters and interventions, including an assessment of the patient's condition while providing maintenance care for the Foley bag. Although the OIG was unable to determine if the lack of assessment and documentation affected the patient's care or wait time, complete and accurate documentation is an essential component to coordinating care and providing comprehensive care to patients.

Care Coordination

The OIG determined that hand-off communication did not occur during the patient's episode of care and that facility policy is ambiguous as to hand-off communication requirements in this type of complex situation.

VHA requires each primary care clinic staff member to be responsible for managing communications and facilitating the transition of patients between the primary care clinic and other health care settings, such as an emergency department.[12] Facility policy states that hand-offs can occur at numerous points in care and allows for communication between providers

[11] Facility Policy 118-21, *Urinary Catheter Maintenance and Removal Procedure*, October 26, 2018. The policy was incorporated into Facility Policy 118-27, *Urinary Catheter Maintenance and Removal Procedure*, May 1, 2019, and contains similar language related to assessment and documentation of Foley catheter maintenance.

[12] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

on the patient's situation, background, assessment, and recommendations.[13] Documentation of the hand-off must be entered in the EHR.

While the patient received care for a leaking Foley bag, one of the family members went to the primary care clinic, requested a same day visit, and informed the licensed vocational nurse about the patient's deteriorating condition. The licensed vocational nurse informed the nurse care manager of the family member's concern. The nurse care manager instructed the licensed vocational nurse to tell the patient's family member to take the patient to the Emergency Department.

Although the patient was within the ACC, the nurse care manager and the licensed vocational nurse did not have direct contact with or assess the patient because the patient never presented to the primary care clinic. The nurse care manager told the OIG that she was unaware that the patient was having a Foley bag changed in the mental health clinic. The nurse care manager recommended that the patient go to the Emergency Department and the patient's family members agreed; however, the OIG found no documentation that the nurse care manager provided hand-off communication to the Emergency Department.

The OIG recognizes the complexity of this situation and the facility policy is ambiguous as to requirements. Although the OIG was unable to determine if the lack of hand-off communication affected the patient's outcome in the Emergency Department, the facility would benefit from a review of its hand-off communication policy to assess whether it should be more specific as to requirements for situations that fall outside of the more traditional transitions.

3. Concern: First Look and Triage Process

Compliance with Policies

The OIG identified that VHA does not have a specific policy related to the practices of a first look nurse. In addition, VHA's policy related to emergency medicine outlines the responsibilities of the triage nurse role but does not mention specific responsibilities of the first look nurse. VHA and the facility require that emergency departments utilize ESI levels when triaging patients. This process includes the triage nurse looking at the patient's vital signs and deciding if they are acceptable or outside acceptable parameters based on the patient's age.[14] At the time of the event, the facility's first look nurse policy did not require the first look nurse to obtain the

[13] Facility Policy 00-07, *Patient Safety Plan*, June 16, 2017. The facility defines hand-off communication as "interactive communication that allows opportunity for questioning between the give[r] and receiver of patient information, including information regarding the patient's care for the purpose of ensuring the continuity and safety of the patient's care."

[14] VHA Directive 1101.05(2); Nursing Service Memorandum 118-D-22, *Triage in Emergency Department*, October 24, 2016.

patient's vital signs or document the patient's assigned ESI level.[15] However, first look nurses were instructed to utilize the ESI framework when prioritizing patient needs.[16]

Upon the patient's arrival to the Emergency Department, the first look nurse assigned and documented an ESI level 3 and directed the patient and family members to the waiting room. Nearly two hours later, the triage nurse called for the patient. At that time, the triage nurse noted that the patient was unarousable, with rapid heart rate and shallow breathing. The triage nurse obtained the patient's vital signs, changed the ESI level to a 2, and brought the patient via wheelchair into an Emergency Department room. The patient died shortly thereafter.

The OIG found no documented evidence that the first look nurse obtained or considered the patient's vital signs when assigning an ESI level 3. Emergency Department nurses and leaders stated that the first look nurse did not obtain patient's vital signs during the time frame of this patient's death. As noted above, at the time of the event, there was no requirement or expectation for the first look nurse to obtain or document vital signs related to their assessment.

In response to the patient's death, the facility conducted a fact-finding review and updated the first look nurse policy.[17] The updated policy requires that the first look nurse obtain (or direct staff to obtain) and document the patient's initial vital signs within 10 minutes of the patient's arrival to the Emergency Department.

In order to determine if the facility was complying with the policy change, the OIG reviewed the patients who accessed care in the facility's Emergency Department from January 1, 2020, through January 31, 2020. The OIG found that of the 2,953 patients who sought care in the Emergency Department during that time, 2,876 (97 percent) had vital signs documented. However, only 1,910 patients (65 percent) had vital signs documented within 10 minutes of arrival.

The OIG concluded that although the facility first look nurse policy has been updated, nurses assigned to the first look position have not been consistently compliant with documenting patients' vital signs within 10 minutes of the patients' arrival to the Emergency Department.

Timeliness of Care

The OIG found that the patient waited approximately two hours between seeing the first look nurse and the triage nurse. The OIG determined that the facility's Emergency Department staff

[15] Facility Policy, *Emergency Department (ED) Nurse First (ED-NF)*, revised February 7, 2016.

[16] Facility Policy, *Emergency Department (ED) Nurse First (ED-NF)*, revised February 7, 2016.

[17] Facility Policy, *Emergency Department Guidelines First Look RN Process in the Emergency Department*, October 17, 2019.

followed guidelines and protocols regarding who to see first, based on the assigned ESI level and the urgency of the identified need.[18]

The first look nurse policy that was in effect at the time of the patient's death stated that an ESI level 3 patient is stable and should be seen as soon as possible by the triage nurse.[19]

Within the three hours prior to the patient's arrival in the Emergency Department, nine patients, including the identified patient, were checked in to the Emergency Department.[20] The first look nurse assessed eight patients at an ESI level 3 and one patient at an ESI level 4. Five of the nine patients waited as long if not longer than the identified patient to be seen by the triage nurse.

Within the three hours after the patient's arrival, 14 patients were checked in to the Emergency Department. The OIG found that three patients who arrived after the identified patient were seen prior to the identified patient. Two of the three patients had an ESI level of 2 and one patient had an ESI level of 3. All three patients had a more urgent need, as identified by the first look nurse, to be seen by the triage nurse.[21]

The OIG concluded that the facility's Emergency Department staff followed guidelines and protocols on when to see patients.

4. Facility Leadership Response to the Event

The OIG determined that facility leaders appropriately reviewed the death of the identified patient.

VHA and facility policies define adverse events as untoward incidents, therapeutic misadventures, adverse occurrences, or inadvertent injuries directly associated with care or services provided within a VHA facility.[22] Adverse events may result from acts of commission, omission, or failure to institute appropriate therapeutic interventions.[23] According to one of the Patient Safety Managers interviewed by the OIG, the facility did not categorize this event as an adverse event; however, the facility conducted a fact-finding review to assess and improve systems issues related to the event. The Patient Safety Manager told the OIG that the facility

[18] Within the 24-hour period of the patient's presentation and death, just over 100 patients sought care at the facility's Emergency Department.

[19] Facility Policy, *Emergency Department (ED) Nurse First (ED-NF)*, revised February 7, 2016.

[20] The patient checked in to the Emergency Department at 2:35 p.m.

[21] One patient presented with suicidal ideation. One patient presented with squeezing chest pain/pressure. One patient presented with syncope. Merriam-Webster, Syncope. Syncope is the "loss of consciousness resulting from insufficient blood flow to the brain." https://www.merriam-webster.com/dictionary/syncope. (The website was accessed May 7, 2020.)

[22] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Facility Policy 00-07.

[23] VHA Handbook 1050.01.

completed a fact-finding review because the patient's episode of care included both the ACC and the Emergency Department.

During the fact-finding review, 11 systems issues related to the patient's episode of care were identified. The Chief of Quality Management told the OIG that the facility was utilizing a Patient Safety Action Plan to track completion of the action items developed to address the identified systems issues.[24]

The OIG confirmed that the facility had completed 9 of the 11 safety action items. The facility planned to complete the remaining two identified systems issues in fall 2020.[25] As discussed above, the facility updated the first look nurse policy by requiring the first look nurse to obtain (or direct staff to obtain) and document the patient's vital signs within 10 minutes of arrival to the Emergency Department. Emergency Department nursing staff received training on the changes in the first look nurse process. The facility also indicated in their action plans the removal of the privacy dividers that blocked staff's view of patients in the waiting room. During interviews, staff and facility leaders confirmed that the privacy dividers had been removed.

Conclusion

The OIG did not substantiate that the patient expired in the facility's Emergency Department waiting room. When the triage nurse obtained the patient's vital signs, the patient was breathing and had a rapid heart rate. The patient was escorted via wheelchair to a bed for further evaluation and care. After the family declined life-sustaining interventions, the Emergency Department physician declared the time of death.

The OIG found that mental health clinic nursing staff did not comply with VHA and facility policies requiring documentation of encounters and interventions, including an assessment of the patient's condition while providing maintenance care for the Foley bag in the patient's EHR.

In addition, hand-off communication did not occur when transitioning the patient between providers and healthcare settings. The OIG recognizes the complexity of this situation because the patient did not directly present to the primary care clinic. Although the OIG was unable to determine if the lack of hand-off communication affected the patient's outcome, the facility would benefit from a review of its hand-off communication policy to assess whether it should be more specific as to requirements for situations that fall outside of the traditional transitions.

[24] The Chief of Quality Management and a Patient Safety Manager developed the Patient Safety Action Plan to track the action items identified in the fact-finding review to completion.

[25] The two remaining identified systems issues include (1) training for nursing staff covering in the Emergency Department, and (2) redefining the process for cleaning Emergency Department rooms and notifying when ready for the next patient.

The OIG identified that VHA does not have a specific policy related to the role and responsibilities of a first look nurse. At the time of the event, the facility had a first look nurse policy, but the policy did not require the first look nurse to obtain or document the patient's vital signs or document the patient's ESI level. In response to the event, the facility conducted a fact-finding review and revised the first look nurse policy to include the requirement that the first look nurse obtain and document a patient's vital signs within the first 10 minutes of arrival to the Emergency Department. The OIG reviewed patients who presented to the Emergency Department for a specific time frame after the policy was updated and found that the facility did not fully comply with the revised requirement to obtain and document vital signs within 10 minutes of a patient's arrival. While the first look nurse had obtained vital signs on 97 percent of patients presenting to the Emergency Department in January 2020, vital signs were documented within 10 minutes of arrival in only 65 percent of the patients.

The OIG found that the patient waited approximately two hours from arriving at the Emergency Department to being seen by the triage nurse. Emergency Department staff followed guidelines and protocols regarding who to see first, based on the assigned ESI level and the urgency of the identified need.

In response to the event, the facility conducted a fact-finding review and implemented changes to 9 of the 11 identified systems issues, including updating the first look nurse policy and removing privacy dividers in the waiting room. The facility plans to complete the remaining two identified systems issues in fall 2020.

Recommendations 1–3

1. The VA Loma Linda Healthcare System Director ensures that mental health clinic nursing staff are trained on documentation requirements when providing patient care and monitors compliance with training.

2. The VA Loma Linda Healthcare System Director reviews the facility's hand-off communication policy to ensure that nursing staff are aware of all circumstances in which hand-off communication must occur and takes action as necessary.

3. The VA Loma Linda Healthcare System Director ensures that all nurses filling the first look nurse role obtain and document each patient's vital signs within 10 minutes of the patient's arrival to the Emergency Department and monitors compliance.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 7, 2020

From: Network Director, Desert Pacific Health Care Network (10N22)

Subj: Healthcare Inspection—Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California

To: Director, Joanne Wasko, Office of Healthcare Inspections (54HL08)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have reviewed and concur with Loma Linda's actions and recommendations on the Healthcare Inspection – Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California.

2. If you have any additional questions, please contact me at (562)826-5963. Thank you.

(*Original signed by*:)

Michael W. Fisher
VISN 22 Network Director (10N22)
VA Desert Pacific Healthcare Network

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 29, 2020

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

Subj: Healthcare Inspection—Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California

To: Director, Desert Pacific Health Care Network (10N22)

1. Thank you for the opportunity to review and comment on the draft report for deficiencies in Ambulatory Care Center and Emergency Department processes at the VA Loma Linda Healthcare System.
2. I have reviewed and concur with your findings and recommendations.
3. The actions that will be taken and timeframe for monitoring compliance are listed as Facility Director Response.

(*Original signed by*:)

Karandeep S. Sraon
Medical Center Director

Facility Director Response

Recommendation 1

The VA Loma Linda Healthcare System Director ensures that mental health clinic nursing staff are trained on documentation requirements when providing patient care and monitors compliance with training.

Concur.

Target date for completion: May 31, 2021

Director Comments

The VA Loma Linda Ambulatory Care Center (ACC) Nurse Educator will train all ACC licensed nursing staff on the importance of accurate, relevant, timely and complete documentation. Education will consist of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) education course "Charting: General Principles" that will be completed by November 30, 2020.[26] Monthly monitoring for compliance will be conducted between December 1, 2020 – May 31, 2021. The Nurse Educator is to conduct compliance chart reviews. Monthly oversight will be conducted by the Quality Council.

Recommendation 2

The VA Loma Linda Healthcare System Director reviews the facility's hand-off communication policy to ensure that nursing staff are aware of all circumstances in which hand-off communication must occur and takes action as necessary.

Concur.

Target date for completion: May 31, 2021

Director Comments

The VA Loma Linda Ambulatory Care Center (ACC) Nurse Educator will train all ACC licensed nursing staff on the principles of hand-off communication. These principles include Situation, Background, Assessment and Recommendation (SBAR). Education will be completed by November 30, 2020. Monthly monitoring for compliance will be conducted by the respective

[26] CINAHL provides access to the top nursing and allied health literature available including nursing journals and publications from the National League for Nursing and the American Nurses Association. It includes health care books, nursing dissertations, selected conference proceedings, standards of practice, audiovisuals and book chapters. It includes full-text journals, legal cases, clinical innovations, critical paths, research instruments and clinical trials.

Nurse Manager between December 1, 2020 – May 31, 2021. Monthly oversight will be conducted by the Quality Council.

Recommendation 3

The VA Loma Linda Healthcare System Director ensures that all nurses filling the first look nurse role obtain and document each patient's vital signs within 10 minutes of the patient's arrival to the Emergency Department and monitors compliance.

Concur.

Target date for completion: May 31,2021

Director Comments

The VA Loma Linda Emergency Department (ED) Nurse Manager will train the ED Registered Nurses on the First Look Nurse Functional Statement. This Functional Statement now includes the requirement for the First Look Nurse, who is a licensed Registered Nurse, to take and document vitals within 10 minutes of a patient's arrival to the ED. Education will be completed by November 30, 2020. Monthly monitoring for compliance will be conducted by the respective Nurse Manager between December 1, 2020 – May 31, 2021. Monthly oversight will be conducted by the Quality Council.

OIG Contact and Staff Acknowledgments

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