DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure at the Malcom Randall VA Medical Center in Gainesville, Florida

HEALTHCARE INSPECTION | REPORT #20-04443-167 | MAY 31, 2022

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to review the care of an unresponsive patient (later verified to be an eligible veteran) by Emergency Department staff and the subsequent response of leaders at the Malcom Randall VA Medical Center (facility) in Gainesville, Florida, after the death of the patient at the University of Florida Health Shands Hospital (Shands).[1]

During the course of another OIG hotline inspection at the facility, the OIG learned of an Emergency Department-related patient incident.[2] Specifically, in summer 2020, community emergency medical services (EMS) transported an unresponsive patient with a Glasgow Coma Scale score of 8 to the facility's Emergency Department.[3] During transport, EMS personnel conveyed the patient's initials and a contact number for a family member, and informed facility staff that they did not have any other patient identifying information. Facility staff, including four nurses, met the EMS responders at the Emergency Department ambulance bay and again requested the patient's identification information. Later, at the request of one of the nurses, an Administrative Officer of the Day joined the nurses to request identifying information to verify the patient was an eligible veteran.[4] The EMS responders reiterated they were unable to provide additional identifying information. After waiting for a period of time in the ambulance bay, without facility staff attending to the patient, EMS responders asked if they should take the patient to Shands and facility staff responded "yes." EMS then reloaded the patient into the ambulance and transported the patient to Shands where the patient died later that day.

An Administrative Investigation Board (AIB) reviewed the patient incident and determined the event to be a Veterans Health Administration (VHA) Emergency Medical Treatment and Labor Act (EMTALA)-related policy violation, substantiated an inappropriate delay of care, and

[1] Shands is a community hospital located directly across the street from the facility.

[2] VA OIG, *Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida*, Report No. 20-03535-146, June 3, 2021.

[3] GCS, "Frequently Asked Questions," *The Glasgow Structured Approach to Assessment of the Glasgow Coma Scale,* accessed March 31, 2022, https://www.glasgowcomascale.org/faq/. Rhea Mehta and Krishna Chinthapalli, "Glasgow coma scale explained," *BMJ* 2019;365, (May 2, 2019): 1-7. The Glasgow Coma Scale (GCS) is a tool used by medical professionals to assess the level of consciousness of a patient. The scale is used to convey a picture of the patient's condition in clear and objective terms. A GCS score of 8 or less indicates a severe impairment of consciousness and almost always requires emergency intubation.

[4] At the time of this incident, facility protocols included Emergency Department nursing staff meeting EMS in the ambulance bay, screening the patient for COVID-19, and transporting the patient into the Emergency Department to limit exposure to COVID-19. Prior to the COVID-19 pandemic, patients transported to the Emergency Department by ambulance were brought directly into the Emergency Department by EMS responders and a charge nurse would direct them to a room for triage.

partially substantiated an inappropriate denial of care of the patient seeking treatment in the facility's Emergency Department.[5] The OIG team learned that similar patient incidents had occurred in 2019, resulting in Emergency Department staff being required to complete EMTALA-related training.

Due to the serious nature of the reported patient incident, the AIB's partial versus full substantiation regarding the inappropriate denial of patient care, and the history of EMTALA-related incidents, the OIG opened a hotline to determine whether Emergency Department nursing staff failed to provide medical care to the patient and whether the facility's executive leadership team (facility leaders) adequately responded to the patient incident. During the course of the inspection, the OIG team identified additional concerns related to the Emergency Department nurses' failure to recognize and accurately assess the patient's emergency medical condition, and nursing competencies.

The OIG determined that facility Emergency Department nurses failed to provide emergency care to a patient who arrived at the facility by ambulance. Despite having been informed of the limited patient identifying information EMS personnel had received prior to arrival, Emergency Department nurses and an Administrative Officer of the Day wasted critical time by continuing to concentrate efforts on patient identification versus patient care. The Emergency Department nurses' failure to prioritize medical intervention resulted in EMS personnel reloading the patient into the ambulance for transport to Shands where the patient died approximately 10 hours after admission.

The OIG determined that facility Emergency Department nurses failed to recognize and accurately assess the patient's emergency medical condition. Although informed of, and preparing to receive, a critical patient with a Glasgow Coma Score of 8 arriving by ambulance, Emergency Department nurses dismissed the reported criticality of the patient's condition based on their own inaccurate visual assessment of the patient and the primary focus on verifying the patient's eligibility status.[6] The OIG found EMS and Shands evaluations of the patient's critical medical condition were consistent with one another and confirmed by the patient medical evaluations, the need for immediate life-saving interventions upon arrival to Shands Emergency

[5] VA Handbook 0700, *Administrative Investigations*, July 31, 2002. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Handbook 0700, *Administrative Investigation Boards and Factfindings,* August 17, 2021. Both handbooks contain the same or similar language regarding Administrative Investigation Boards. VA defines an Administrative Investigation Board, in part, as an administrative investigation conducted for the purpose of "collecting and analyzing evidence, ascertaining facts, and documenting complete and accurate information regarding matters of interest to VA." Center for Medicare and Medicaid Services, *Emergency Medical Treatment & Labor Act (EMTALA)*, accessed October 21, 2020, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA. EMTALA is a federal law enacted by Congress in 1986 to ensure that individuals with an emergency medical condition who present to a Medicare-participating hospital are treated and stabilized.

[6] Rhea Mehta and Krishna Chinthapalli, "Glasgow coma scale explained," *BMJ* 2019;365, (May 2, 2019): 1-7.

Department, and the cause of death noted on the patient's death certificate. The OIG concluded that facility Emergency Department nurses disregarded the EMS personnel's patient status report, failed to recognize the patient's emergency medical condition, and inaccurately assessed the patient's condition as less critical. As a result of this finding, the OIG questioned the Emergency Department nurses' competence to treat patients seeking emergency care and reviewed select nurses' competencies and competency folders. The OIG identified deficiencies in the completion, validation, and oversight of Emergency Department nursing competencies and competency folders and had concerns regarding the replication of Ongoing Nursing Competency Assessments.

Although nursing and administrative staff were issued proposed removals, the Facility Director rescinded the removals and issued written warnings.[7] The OIG determined that the Facility Director's decision to rescind the recommended discipline of the involved facility staff, while not a violation of policy, potentially compromised patient safety in the Emergency Department. The OIG found that the Facility Director's decision to reverse the proposed removals was based on reports from the interviewed staff that were disputed by others involved. In addition, the information on which the Facility Director relied was not material to the failure of staff to provide medical care to the patient. Instead, the Facility Director relied on disputed facts such as the criticality of the patient's medical status and confusion in the ambulance bay.

Although facility leaders implemented actions to address concerns identified in the AIB, the OIG determined that since implementation, the actions have not been effective in preventing the occurrence of additional patient incidents. Despite the simulation education and interventions, the OIG learned through interviews, emails, and document reviews that there continues to be a delay in the provision of emergency care to patients in the Emergency Department due to inefficient registration processes and practices.

The OIG made one recommendation to the Veterans Integrated Service Network Director to determine whether administrative action or reporting to the state licensing board(s) is warranted for facility staff involved in the incident.

Along with the status of the action plans referenced in this report, four recommendations were addressed to the Facility Director and focus on prioritizing patient care when patients present with an emergency medical condition; nurse competencies; an internal review of the Emergency Department Nurse Educator's replication of 2019 Ongoing Competency Assessments; and attestations of competency completion to determine whether administrative action is warranted.

[7] According to Veterans Integrated Service Network 8 staff, the Facility Director referenced in this report retired from VHA employment on July 3, 2021; a new Facility Director began on August 8, 2021.

Comments

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

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Contents

Abbreviations

AIB	Administrative Investigation Board
AOD	administrative officer of the day
COVID-19	coronavirus disease 2019
EHR	electronic health record
EMS	emergency medical services
EMT	emergency medical technician
EMTALA	Emergency Medical Treatment and Labor Act
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection to review the care of an unresponsive patient by Emergency Department staff and the subsequent response of leaders at the Malcom Randall VA Medical Center (facility) in Gainesville, Florida, after the death of the patient at a nearby community hospital.[1]

Background

The facility is part of the North Florida/South Georgia Veterans Health System within Veterans Integrated Service Network (VISN) 8. The Veterans Health Administration (VHA) classifies the system as a Level 1a—high complexity system.[2] From October 1, 2019, through September 30, 2020, the system served 139,839 patients. The facility offers acute medical, surgical, and specialty services and is affiliated with, and located directly across the street from, the University of Florida Health Shands Hospital (Shands).[3]

Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted by Congress in 1986 to ensure that individuals with an emergency medical condition who present to a Medicare-participating hospital are treated and stabilized.[4] An emergency medical condition is a condition with severe acute symptoms that, without immediate medical attention, could reasonably be expected to place the health of an individual in serious jeopardy.[5] Under EMTALA, hospitals with emergency services are obligated to provide medical screening examinations and stabilizing treatment to patients with emergency medical conditions.[6] While VA is "not technically subject to EMTALA and the regulations implementing the Act issued by the Centers for Medicare and Medicaid Services," pursuant to VHA policy, "VA complies with

[1] According to VISN 8 staff, the Facility Director referenced in the prior OIG report and this report retired from VHA employment on July 3, 2021, and a new Facility Director began on August 8, 2021.

[2] The VHA Facility Complexity Model categorizes medical facilities by complexity level. Complexity levels include 1a, 1b, 1c, 2, or 3, with 1a being the most complex. Facilities with a Level 1a complexity rating are described as having "high volume, high risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing.

[3] University of Florida Health Shands Hospital, accessed March 18, 2021, https://ufhealth.org/uf-health-shands-hospital.

[4] Center for Medicare and Medicaid Services, *Emergency Medical Treatment & Labor Act (EMTALA)*, accessed October 21, 2020, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA.

[5] Electronic Code of Federal Regulations, *42 CFR §489.24,* accessed November 4, 2020, https://www.ecfr.gov/cgi-bin/ECFR?page=browse.

[6] Center for Medicare and Medicaid Services, Emergency Medical Treatment & Labor Act (EMTALA).

the intent of EMTALA requirements regarding the transfer of acute patients among health care facilities."[7]

Emergency Medicine

VHA policy emphasizes, that "universal access to appropriate emergency services is the cornerstone of basic health care in the United States."[8] According to VHA policy, the practice of emergency medicine includes, "An evaluation and emergency care provided to individual patients presenting to the ED [Emergency Department] or UCC [Urgent Care Center] that is consistent with all applicable standards and regulations, including compliance with the intent of the Emergency Medicine Treatment and Active Labor Act (EMTALA), 42 United States Code (U.S.C.) § 1395dd."[9]

Glasgow Coma Scale

The Glasgow Coma Scale (GCS) is a tool used by medical professionals to assess the level of consciousness of a patient. The scale is used to convey a picture of the patient's condition in clear and objective terms.[10] The total GCS score is calculated from assessing three aspects: eye-opening, motor, and verbal response. The lowest score is 3 and the highest is 15. A GCS score of 8 or less indicates a severe impairment of consciousness and almost always requires emergency intubation.[11] The GCS may be used by paramedics and emergency medical technicians to facilitate communication with the receiving emergency department in order to streamline trauma protocols."[12]

Prior OIG Report

The OIG published a related report on June 3, 2021, with one recommendation addressing initial screening and assessment of patients who arrive at the Emergency Department. The OIG recommended that the Facility Director evaluate processes and implement a requirement, as

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

[8] VHA Directive 1101.05(2).

[9] VHA Directive 1101.05(2).

[10] GCS, "Frequently Asked Questions," *The Glasgow Structured Approach to Assessment of the Glasgow Coma Scale,* accessed March 31, 2022, https://www.glasgowcomascale.org/faq/. Rhea Mehta and Krishna Chinthapalli, "Glasgow coma scale explained," *BMJ* 2019; 365, (May 2, 2019): 1-7.

[11] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[12] Rhea Mehta and Krishna Chinthapalli, "Glasgow coma scale explained," *BMJ* 2019; 365, (May 2, 2019): 1-7.

necessary, that Emergency Severity Index level 2 patients do not remain in the Emergency Department waiting room.[13]

The VISN and Facility Directors agreed with the finding and recommendation, and provided an acceptable plan for improvement.[14] As of October 22, 2021, the recommendation was closed.

Concerns

During the course of the above-referenced inspection, the OIG team learned of an additional Emergency Department-related patient incident.[15] Specifically, in summer 2020, community emergency medical services (EMS) transported an unresponsive patient with a GCS score of 8 to the facility's Emergency Department. Facility staff met the EMS responders at the Emergency Department ambulance bay and requested the patient's identification information to verify the patient was an eligible veteran.[16] The EMS responders were unable to provide the patient's identifying information and, after waiting for a period of time in the ambulance bay without staff attending to the patient, asked if they should take the patient to Shands and facility staff responded "yes." EMS then reloaded the patient into the ambulance and transported the patient to Shands. The patient died later that day.

An Administrative Investigation Board (AIB) reviewed the patient incident and determined the event to be a VHA EMTALA-related policy violation, substantiated an inappropriate delay of care, and partially substantiated an inappropriate denial of care of the patient seeking treatment at

[13] VA OIG, *Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida,* Report No. 20-03535-146, June 3, 2021. Emergency Nurses Association, *Emergency Severity Index (ESI). A Triage Tool for Emergency Department Care*, Version 4, 2020 Edition. The Emergency Severity Index is a five-tiered, structured triage assessment tool used by registered nurses when triaging patients in Emergency Departments. An ESI level 2 indicates a high-risk patient whose medical condition could easily deteriorate or whose symptoms suggest the patient requires time-sensitive treatment.

[14] VA OIG, *Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida*.

[15] VA OIG, *Delay in Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida*.

[16] "COVID-19," World Health Organization, accessed April 6, 2021, https://www.who.int/health-topics/coronavirus#tab=tab_1. COVID-19 is "an infectious disease caused by a newly discovered coronavirus." At the time of this incident, facility protocols included Emergency Department nursing staff meeting EMS in the ambulance bay, screening the patient for COVID-19, and transporting the patient into the Emergency Department to limit exposure to COVID-19. Prior to the COVID-19 pandemic, patients transported to the Emergency Department by ambulance were brought directly into the Emergency Department by EMS responders and a charge nurse would direct them to a room for triage.

the facility's Emergency Department.[17] The OIG team learned that similar patient incidents had occurred in 2019, resulting in Emergency Department staff being required to complete EMTALA-related training.

Due to the serious nature of the reported patient incident, the AIB's partial versus full substantiation regarding the inappropriate denial of patient care, and the history of EMTALA-related incidents, the OIG team had concerns regarding practices within the facility's Emergency Department. On September 30, 2020, the OIG opened a hotline to determine whether Emergency Department staff failed to provide medical care to the patient and whether the facility's executive leadership team (facility leaders) adequately responded to the patient incident. During the course of the inspection, the OIG team identified additional concerns related to the Emergency Department nurses' failure to recognize and accurately assess the patient's emergency medical condition and nursing competencies.

Table 1 is a timeline of known EMTALA-related patient incidents and a brief description of facility and service line leaders' incident-related actions.

Table 1. EMTALA-Related Incidents and Associated Actions

Date	Incident	Action
Summer 2018	EMTALA-related patient incident	A facility fact-finding investigation found Administrative Officer of the Day staff refused to register non-veteran patients and were unaware of EMTALA-related requirements. Administrative Officer of the Day staff trained on VHA Emergency Medicine policy and EMTALA requirements.
Winter 2018	EMTALA-related patient incident	
Fall 2019	EMTALA-related patient incident	Emergency Department leaders outlined EMTALA requirements to physicians and nursing staff. Nursing staff completed EMTALA training.
Fall 2019	EMTALA-related patient incident	Nurse Manager discussed incident with involved staff.

[17] VA Handbook 0700, *Administrative Investigations*, July 31, 2002. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Handbook 0700, *Administrative Investigation Boards and Factfindings,* August 17, 2021. Both handbooks contain the same or similar language regarding Administrative Investigation Boards. VA defines an Administrative Investigation Board, in part, as an administrative investigation conducted for the purpose of "collecting and analyzing evidence, ascertaining facts, and documenting complete and accurate information regarding matters of interest to VA."

Date	Incident	Action
Summer 2020	EMTALA-related patient incident (subject patient)	The day following the patient incident the Facility Director initiated an AIB. The AIB cited the incident as an EMTALA violation, substantiated an inappropriate delay of care of a patient seeking treatment, and partially substantiated an inappropriate denial of care. Approximately one month after the patient incident, facility leaders conducted an institutional disclosure to the patient's family. Approximately two months after the patient incident, service leaders issued proposed discharge letters to nursing and administrative staff. Three weeks after the proposed discharge letters were issued, the Facility Director rescinded all proposed discharges.
Spring 2018—late Fall 2020	OIG requested that the Patient Safety Coordinator search their database for related patient safety reports	Patient Safety Coordinator identified nine additional patient safety reports related to delays or denial of care due to EMTALA-related or patient registration issues.
Late 2020	EMTALA-related patient incident	Emergency Department nurse manager discussed concern with the Assistant Chief of Patient Processing.

Source: OIG analysis of timeline using EHRs, OIG interviews, and review of facility documents.

Scope and Methodology

The OIG initiated the inspection on September 30, 2020, and conducted virtual interviews from November 30, 2020, through March 16, 2021.

The OIG team interviewed facility leaders, former and current service chiefs, assistant chiefs, the Director of Simulation, the Patient Safety Manager, and former and current facility staff with

knowledge of the patient incident.[18] The OIG team interviewed non-VHA staff including a former contract security guard, the EMS lead paramedic (paramedic), the EMS emergency medical technician (EMT), and the EMS District Chief (District Chief).

The OIG team reviewed relevant external standards and guidelines, VHA and facility policies, facility administrative investigations and responses, Emergency Department action plans, human resource and personnel documents, Emergency Department nurse training and competencies, Administrative Officer of the Day (AOD) staff trainings, email communications, Emergency Department video footage from the day of the incident, organizational charts, and the patient's electronic health record (EHR).[19] The OIG team also reviewed four prior Emergency Department-related incidents identified in the AIB.

The OIG team reviewed non-VHA records, including: EMS dispatch recordings, patient care records, emergency care protocols, responder statements, EMS and facility discussion summaries, Shands medical records, and the patient's death certificate.

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. 1101, 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.

[18] Facility executive leaders interviewed included the Director, Chief of Staff, and Associate Director of Patient Care Services. Current and former facility staff included the Chief and Assistant Chief of Emergency Services, Chief of Quality Management, retired Acting Chief Nurse of Operations, Chief Nurse Critical Care, Chief of Medical Administration Service, Chief of Nurse Education, Section Chief of Labor and Employee Relations, former Assistant Chief of Patient Processing and Benefits, and an Administrative Officer of the Day. Facility Emergency Department staff interviews included a physician, former and acting nurse managers, nurse supervisors, nurses, and former healthcare technicians.

[19] VHA Directive 1096, *Administrative Officer of the Day*, March 27, 2020. An AOD serves as the administrative person on duty, acting on behalf of the VA medical facility director during non-business hours. Administrative functions include determining eligibility and enrolling patients in VA health care and, at times, ensuring VHA medical facilities provide humanitarian services in cases of emergency. The AOD serves as the administrative authority on all issues involving the enrollment and eligibility determination process.

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

Patient Case Summary

The patient was 60 years old with a history of hypertension, type 2 diabetes, hyperlipidemia, diastolic heart failure, atrial fibrillation (not treated with anticoagulation), coronary artery disease (received a three vessel coronary artery bypass graft in 2008), chronic obstructive pulmonary disease, obesity, benign prostatic hypertrophy, and lymphedema.

In spring 2020, the patient was admitted to the facility for acute onset chronic heart failure. One month later, the patient was discharged following treatment for heart failure, acquired Factor VIII deficiency/Hemophilia A, right lower leg cellulitis, chronic venous stasis disease, and other medical problems.

In summer 2020, EMS was dispatched to the patient's home after a neighbor found the patient unresponsive. Upon arrival, the neighbor informed EMS responders that the patient had been recently discharged from the VA hospital. The patient was in significant distress, had "large amounts of swelling and large open wounds on both legs and feet," made loud groaning sounds, and withdrew from touch, "but did not open [their] eyes or speak."[20] The EMS responders' preliminary evaluation noted the patient was unresponsive with the following vital signs: blood pressure of 162/120, pulse of 135 beats per minute, respiratory rate of 49 breaths per minute, oxygen saturation of 86 percent on room air, and a GCS score of 8.[21] After the patient was in the ambulance, the paramedic placed electrodes on the patient for an electrocardiogram, began an intravenous line, and provided oxygen via nasal cannula.

EMS responders issued a sepsis alert to the facility's Emergency Department.[22] While en route to the facility, EMS dispatch notified the responders that the facility was requesting additional patient identifying information. EMS responders said the patient was unconscious and relayed the limited information available. Upon arrival to the facility, Emergency Department staff

[20] The OIG uses the singular form of they (their) in this instance for privacy purposes.
[21] Cleveland Clinic, *Vital Signs*, accessed January 25, 2021, https://my.clevelandclinic.org/health/articles/10881-vital-signs. The normal ranges for vital signs may vary because of age, weight, and other factors. A healthy blood pressure for an adult at rest is 120/80. A normal pulse rate for an adult at rest ranges from to 60 to 80 beats per minute. The normal respiration rate for an adult at rest is 12 to 20 breaths per minute. The average body temperature is 98.6, however, can range between 97.8 to 99.1. Pulse Oximeter Accuracy and Limitations: FDA Safety Communication, accessed May 12, 2021, https://www.fda.gov/medical-devices/safety-communications/pulse-oximeter-accuracy-and-limitations-fda-safety-communication. "Normal oxygen saturation values are usually between 95 percent and 100 percent for healthy individuals."
[22] Geoffrey E. Hayden, et al, "Triage sepsis alert and sepsis protocol lower times to fluids and antibiotics in the Emergency Department," *The American Journal of Emergency Medicine*, *34*(1), (August 28, 2015) 1–9. https://doi.org/10.1016/j.ajem.2015.08.039. A sepsis alert involves the rapid identification of sepsis during triage, and the mobilization of a sepsis work-up and treatment protocol.

"advised that they can not [*sic*] prove the patient can be accepted at the VA without more identifying information." EMS responders placed the patient back into the ambulance and transported the patient to Shands Emergency Department.[23]

The paramedic provided the patient report to the Shands Emergency Department triage nurse and the patient was registered and admitted. The patient's triage vital signs were taken and the patient was described as being in acute distress, ill appearing, with a rapid heart rate, wheezing, and both legs foul smelling with wounds and chronic venous stasis.[24] The patient was immediately intubated and shortly after intubation had two episodes of cardiac arrest. The patient was treated with medications, fluids, and antibiotics. The physical examination, head/chest computerized tomography scans, and blood work indicated the patient required admission to the hospital. The patient was evaluated by medicine and neurology services and treated for the following diagnoses:

- Severe sepsis with septic shock,
- Acute respiratory failure,
- Anoxic brain damage,
- Cardiac arrest,
- Pneumonia,
- Acute pyelonephritis,
- Chronic kidney disease, and
- Abnormal blood work values (hyperkalemia and leukopenia).

The patient died approximately 10 hours after admission to Shands. The death certificate showed that the cause of death was septic shock, acute onset chronic heart failure, acute pyelonephritis, and multifocal pneumonia.

[23] It should be noted that because the patient was not admitted to the facility on the day of the incident, there are no related facility medical records. The information in this section was obtained from the non-VA EMS patient care record. Additional findings and details about this event were learned during the course of the OIG inspection and are described later in this report.

[24] The triage vital signs were blood pressure 107/88, pulse 136, respiratory rate 33, temperature 99.7F, oxygen saturation 90 percent.

Inspection Results

1. Failure to Provide Emergency Care to a Patient

The OIG determined that facility Emergency Department nurses failed to provide emergency care to the patient. The OIG found that the nurses prioritized obtaining the patient's veteran and eligibility status, creating a barrier to moving the patient from the ambulance bay into the Emergency Department where a physician was prepared to receive and intubate the patient. The OIG also found that a facility AOD contributed to the delay in care by joining the nurses' efforts to acquire patient identifiers without prioritizing care for the patient, resulting in EMS responders reloading the patient into the ambulance and transporting the patient to Shands.

VHA policy states that VHA emergency departments are responsible for providing "emergency care to Veterans, staff, and other non-veterans who experience a medical emergency while in or near a VA facility."[25] Additionally, emergency departments "must never turn away an ambulatory patient or a patient who has arrived by ambulance; a medical screening exam must always be performed in accordance with the provisions of EMTALA."[26]

Further, VHA policy specifies that "the determination of eligibility for benefits for patients with emergent conditions can be made after the initial examination and essential treatment. Based on the patient's medical condition, the examining physician determines whether an administrative interview is permitted…"[27] Facility policy provides detailed instructions regarding the registration of an incapacitated, unidentified, or unresponsive patient into the facility record system until the identity of the patient can be verified.[28]

After conducting interviews with facility Emergency Department nursing staff and EMS personnel, the OIG noted significant discrepancies in the description of the patient incident to include differing accounts of professionalism among EMS and VA staff, and VA staff member' repeated attempts to verify the patient's identification and veteran status. Ultimately, based on the review of facility documents, the patient's EHR, the patient's medical records from EMS and Shands, interviews, and the EMS audio recordings, the OIG found that the Emergency Department nurses failed to provide emergency care access to the patient.

Facility Staff Account of the Patient Incident

The OIG interviewed the following Emergency Department staff: a nurse (Nurse 1) who received one of the EMS radio calls and reported witnessing the patient incident from the

[25] VHA Directive 1101.05(2).

[26] VHA Directive 1101.05(2).

[27] VHA Directive 1601A.02(1), *Eligibility Determination*, July 6, 2020, amended October 15, 2020.

[28] Facility Memorandum 136-15, *Patient Identification*, August 20, 2019.

Emergency Department entrance doors, the Charge Nurse who received the EMS telephone call, and three additional nurses (Nurse 2, Nurse 3, and Nurse 4) who took a stretcher outside to receive the patient from EMS responders in the ambulance bay.

According to the Charge Nurse and two of the four nurses, after receiving the patient's medical information from EMS responders and dispatch, they initiated the necessary preparations to receive a critical patient. The preparations included assigning Nurse 2 to the patient, preparing a room, and notifying a physician and respiratory therapist that they may need to intubate the patient.

After assisting with preparations to receive the patient, Nurse 1 proceeded to the AOD work station and informed the AOD that EMS was in transport with a patient who had no identifying information and needed to be registered. Nurse 1 reported to the OIG that this was not the first time they had had "trouble" with EMS, and that upon sharing that a patient was arriving without identifiers, the AOD asked if it was the same County EMS with whom they had had prior difficulties. Nurse 1 reported confirming the AOD's question and relayed that the AOD then went outside to obtain the patient's identifiers.

The AOD informed the OIG team that on the day of the incident, Nurse 1 requested the AOD's assistance in obtaining the patient's identifiers and that, according to Nurse 1, EMS had been "belligerent" over the phone when asked for the patient's identifying information. The AOD also stated that Nurse 1 and Nurse 2 had previously informed the AOD of past problems with this County EMS, specifically claiming that County EMS personnel have been "loud and uncooperative when asked for patient information several time[s] before." This information prompted the AOD to go outside to request the patient identifiers. The AOD reported asking the EMS responder for the name of their supervisor with the intention of filing a complaint with EMS headquarters regarding the responders' actions.

The OIG team reviewed a statement written by the AOD after being contacted by Emergency Department nurses and the District Chief, who visited the facility the evening of the incident to speak with facility staff. The statement is the AOD's account of the patient incident and the interaction between EMS responders and facility staff. In the statement, the AOD reported that Nurse 1 came to the AOD "with a complaint" regarding EMS responders "not giving them patient information so they can determine if [the patient being transported to the facility] is a veteran or not." The AOD followed Nurse 1 outside and requested the patient information, informed EMS personnel that based on the patient information provided they could not determine if the patient was a veteran, and asked if EMS had the patient's wallet. Following this question, "That's when the EMT personnel got loud and start yelling, I [the EMT] can take [the patient] to another hospital. I [the AOD] said is [the patient] stable? The EMT shouted I [the EMT] can take [the patient] to Shands and I [the AOD] said it [is] right across the street." In the statement, the AOD estimated this exchange to be between three and four minutes and added that "the EMT did not say the patient was in critical condition as [the patient] was tossing around on

the stretcher." The AOD reiterated in the statement, "Again, I was asked to try and retrieve information from the uncooperative EMT personnel by the nurses, and the EMT was visibly upset and made the decision to take the patient over to Shands without myself telling him so or the nurses."

The OIG team interviewed a contract security guard who was stationed outside of the Emergency Department on the day of the incident and witnessed the interaction between EMS and facility staff, and the interaction between the District Chief and facility staff later that evening. The contract security guard reported there were approximately 15 facility staff who were either outside with the ambulance or inside the Emergency Department glass doors at the time of the incident, most of whom were observers, with four to five staff interacting with EMS personnel. The contract security guard recalled facility staff arguing with the EMS personnel stating that if they could not obtain the patient's information, and determine veteran status, then they could not take the patient. The contract security guard also stated the facility staff inside the Emergency Department doors were discussing that the facility was not supposed to refuse the patient, regardless of veteran status. The contract security guard reported that later that evening when the District Chief came to discuss the incident with facility staff, some Emergency Department nurses described the EMS responders' behavior as aggressive and rude, which was contrary to what the contract security guard had observed. The contract security guard reported the concerns to his supervisor and wrote an incident report.

When interviewed, Nurses 2, 3, and 4 denied having any responsibility for the EMS responders' decision to reload the patient into the ambulance and take the patient to Shands. Nurse 2 was assigned to the patient and instructed to go outside with a stretcher and bring the patient back to a room that was prepared for the patient. Nurse 2 reported going out to the ambulance bay with a team of nurses. Nurse 2 stated that the EMS responders did not have any patient identifiers other than the patient's initials, and that the responders became angry when Nurse 2 requested identification. All three nurses stated that the EMS responders became upset, and abruptly removed the patient's oxygen tubing and pushed the patient back into the ambulance.

EMS Personnel Account of the Patient Incident

According to one of the paramedics, EMS responders waited in the facility ambulance bay per facility COVID-19 protocol and were met by a series of Emergency Department staff, who repeatedly requested the patient's identifying information. The paramedic reiterated the patient information previously conveyed by radio and dispatch, and the facility staff responded that the information provided did not prove the patient's eligibility for admission. The paramedic acknowledged becoming "flustered and annoyed" because facility staff were only focused on patient identifiers as opposed to making efforts to provide patient care. The paramedic stated that despite the patient's medical presentation, the Emergency Department nurses, "didn't fully seem to grasp the critical nature of this patient." After waiting 5 to 10 minutes in the ambulance bay, and encountering the unwillingness of the staff to take the patient, the paramedic asked the

facility staff if they would prefer that the patient be taken across the street to Shands. The paramedic reported that a facility staff member dressed in business attire versus hospital scrubs responded, "yes, please, and next time one of my nurses asks you to do something, I expect you to do it." The paramedic stated there was confusion because there had been no prior indication that the facility would not accept this patient. After transporting the patient to Shands, the paramedic reported the incident to the District Chief.

EMS and Facility Communications During Patient Transport

EMS audio recordings, obtained by the OIG, provided an unfiltered and real time account of the patient information exchanged between EMS personnel (responders and dispatch) and facility Emergency Department nursing staff while the patient was in transport to the facility. The key information from the recordings are summarized below.

During transport, EMS responders and dispatch alerted facility Emergency Department staff on two separate occasions, via telephone and radio, that a patient was being transported to the facility. After requesting an EMS dispatch call to the facility to issue a sepsis alert, the paramedic contacted the Emergency Department nursing staff by radio. The paramedic informed Nurse 1 that a sepsis alert had been issued due to the patient's significant leg wounds, and relayed that the patient was unresponsive and had a GCS score of 8 based on the patient not opening eyes, making incomprehensible sounds, and withdrawing to touch. The paramedic provided the patient's vital signs, adding that the patient was tachycardic, had labored breathing, and was on a nasal cannula. Nurse 1 answered the radio and asked for the patient's "identifiers." The paramedic provided the known information, which included the patient's initials and a family contact number. Nurse 1 responded, "and we're sure he's a veteran?" The paramedic stated a neighbor informed them that the patient had been discharged from the facility a few weeks prior.

At the same time, dispatch called the facility's Emergency Department, spoke with a nursing staff member, issued a sepsis alert, and informed them of an expected EMS arrival time of 10 minutes. The Charge Nurse then asked dispatch for additional information and the last four numbers of the patient's social security number. While awaiting dispatch to provide the information, the Charge Nurse can be heard verbally relaying a request for staff to prepare a room for a patient with a "sepsis alert."

Dispatch relayed the facility's request for the last four of the patient's social security number to the paramedic who provided the patient's initials but explained that the patient was unresponsive, and they were unable to obtain the social security number; dispatch relayed the information to the Charge Nurse and added that the neighbor said the patient had been recently discharged from the facility. The Charge Nurse replied, "That doesn't help us at all. Um, was there no family there, um, that we could get that information?" Dispatch responded that they were transporting the patient and that was all the information they had. The Charge Nurse asked, "Well is [the patient] a veteran? Do we know that? Because we can't prove that now." The dispatch

representative responded by stating that the EMS responders assumed the patient was a veteran because the patient was a frequent VHA patient. The Charge Nurse stated, "I'm just trying to find out. How do you know that then, if [the patient] is unresponsive? Or is [the patient], because we can't look [the patient] up with just two initials." Dispatch responded that EMS could not obtain the information because the patient was unconscious. Prior to ending the call, the Charge Nurse was heard giving directions to staff and informing them that EMS doesn't have patient-specific information.

The OIG team learned that select Emergency Department nurses alleged prior difficulties with the County EMS and described EMS personnel's (dispatch and responders) radio communications as belligerent. The OIG team listened to the EMS audio recordings, which included the communication to and from facility Emergency Department staff, and found that EMS responders and dispatch communications to the facility were professional, both in content and tone. The OIG concluded that sharing these opinions with other nursing and AOD staff, and enlisting the AOD's assistance in obtaining more patient information versus registering the unresponsive patient per facility policy, encouraged the staffs' focus on obtaining identifying information. These factors contributed to an escalation of tension and a lack of coordinated effort to attend to the medical needs of the patient despite nursing staffs' awareness of the lack of patient-specific information and having been informed of the patient's critical medical status.

Given the patient's critical medical condition, the OIG found that Emergency Department nurses and the AOD wasted critical time by continuing to concentrate efforts on identifying the patient while failing to prioritize immediate medical intervention.

2. Failure to Recognize and Accurately Assess a Patient's Emergency Medical Condition

During the course of the review, the OIG identified concerns regarding the visual assessment of the patient's medical condition conducted by the Emergency Department nurses who met the EMS responders and the patient in the ambulance bay. Despite being informed of and making preparations to receive the critical patient arriving by ambulance, the OIG found that the Emergency Department nurses conducted their own assessment and failed to recognize the criticality of the patient's condition. The OIG determined that the nurses' inaccurate visual assessment impeded the patient's access to an emergency medical evaluation and care.

VHA requires that emergency medicine include "evaluation, management, and treatment provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[29] As discussed above, Emergency Departments "must never turn away an ambulatory patient or a patient who has arrived by ambulance; a medical screening exam must

[29] VHA Directive 1101.05(2).

always be performed in accordance with the provisions of EMTALA."[30] "The determination of eligibility for benefits for patients with emergent conditions can be made after the initial examination and essential treatment. Based on the patient's medical condition, the examining physician determines whether an administrative interview is permitted…"[31]

Nurses 2, 3, and 4 acknowledged, during OIG interviews, their awareness that a patient with a GCS score of 8 was en route to the facility. Nurse 2 was assigned as the patient's primary nurse. Upon EMS' arrival to the facility, Nurses 2, 3, and 4 went out to the ambulance bay to receive the patient. During interviews, the OIG team asked each of the three nurses about the patient's presenting status and how they would respond to a patient assessed to have a GCS score of 8. The three nurses acknowledged the severity of a GCS score of 8 and reported the expectation that a patient with this score would be intubated prior to arrival at the Emergency Department. The nurses also shared that they did not perceive the patient's condition to be as serious as reported, with a primary factor being that the patient was not intubated. When asked about the patient's condition, each nurse reported similar explanations of their assessment; the patient was only placed on a nasal cannula, and the patient was not using accessory muscles to breathe.[32] Nurses 2 and 4 added the patient was not in respiratory distress; however, Nurse 4 reported that the patient was moaning constantly and appeared to be in pain. Nurse 2 emphasized that she has many years of nursing experience and can recognize when someone is in distress. None of the nurses considered that their assessment of the patient, that was based solely on visual observation, may have been inaccurate.

The OIG team interviewed the Emergency Department Health Care Technician who was conducting COVID-19 screenings in the ambulance bay on the day of the incident. Based on a brief meeting with the EMS responders and a visual assessment of the patient, the Health Care Technician reported the patient looked very ill, was unresponsive, in respiratory distress, and should have been immediately taken into the Emergency Department.

The OIG team reviewed the patient's medical records from Shands Emergency Department. Shands staff evaluated the patient and determined acuity consistent with the patient evaluation and report EMS responders provided to the facility's Emergency Department nursing staff while en route to the facility. Shands medical records indicated that EMS responders transported the patient to their hospital from the facility parking lot. Within minutes of the patient's arrival, Shands Emergency Department staff initiated life-saving interventions, including intubation for respiratory distress and cardiopulmonary resuscitation. The patient died approximately 10 hours

[30] VHA Directive 1101.05(2).

[31] VHA Directive 1601A.02(1), *Eligibility Determination*, July 6, 2020.

[32] Mary E. Lough, Kathleen M. Stacy, Linda D. Urden, *Critical Care Nursing Diagnosis and Management* (Elsevier Inc., 2022), 421-440. "Accessory muscles of ventilation usually are considered muscles that enhance chest expansion during exercise but that are not active during normal, quiet breathing."

after admission, with the cause of death reported as sepsis, acute onset chronic heart failure, acute pyelonephritis, and multifocal pneumonia.

Based on the evaluations by EMS responders and Shands staff, the need for immediate life-saving interventions upon arrival to the Shands Emergency Department, a review of the medical records, and the cause of death noted on the patient's death certificate, the OIG found the patient's medical condition to be critical and requiring emergent medical intervention. The OIG determined that the facility nurses dismissed the patient report given by EMS, inaccurately assessed the patient's condition as less critical based solely on visual observation, and failed to recognize the patient's emergency medical condition.

Emergency Department Nursing Staff Competency

As a result of the above finding, the OIG had concerns related to the Emergency Department nurses' competence to assess and treat patients seeking emergency care. Therefore, the OIG team reviewed the competencies and competency folders of the Emergency Department nurses involved in the patient incident.

According to The Joint Commission, a competency is a "combination of observable and measurable knowledge, skills, abilities, and personal attributes that constitute an employee's performance. The ultimate goal is that the employee can demonstrate the required attributes to deliver safe, quality care."[33] Each nurse working in the emergency department is to "demonstrate evidence of the knowledge and skills necessary to deliver nursing care in accordance with the Standards of Emergency Nursing Practice."[34] Facility policy requires nursing staff competency to be verified three times annually and prior to performing care. Competencies are to be maintained and documented in employee competency folders.[35]

The OIG identified deficiencies in the completion, validation, and oversight of Emergency Department nurse competencies. Specifically, a review of selected Emergency Department nurse competency folders revealed that some Ongoing Competency Assessments were incomplete and individual competencies were not validated. Further, the OIG found a lack of oversight measures for Emergency Department nurse competencies.

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[33] The Joint Commission, *Competency Assessment vs Orientation*, accessed April 12, 2021, https://www.jointcommission.org/standards/standard-faqs/nursing-care-center/human-resources-hr/000002152.

[34] VHA Directive 1101.05(2). Sarah Berry, *Sheehy's Emergency Nursing: Principles and Practices*, (Elsevier Inc. 2020), 1, 2-8, accessed April 1, 2021, https://www.clinicalkey.com/nursing/#!/content/book/3-s2.0-B9780323485463000011?scrollTo=%23top. The standards of emergency nursing include practice standards and professional standards, guided by the Emergency Nursing Association, an association that provides national nursing guidance. The Emergency Nursing Association standards include, but are not limited to assessment, diagnosis, outcome identification, quality of practice, and ethics. Each standard has accompanying competencies with the expectation that emergency nurses will demonstrate proficiency.

[35] Facility Memorandum 05-07, *Competency Assessment and Documentation*, July 25, 2019.

The OIG team obtained and reviewed fiscal year 2019 nursing competency folders for the Emergency Department nurses involved in the patient incident.[36] The OIG found that two nurses had not completed a 2019 Ongoing Competency Assessment. Of further concern, the OIG confirmed that 4 of 14 individual competencies for one of the nurses were incomplete and lacked the required verification. During an interview and correspondence with the OIG team, the Chief of Nurse Education confirmed that the 2019 Ongoing Competency Assessments should have been completed and maintained in the employee competency folder.

The Chief of Nurse Education and the Emergency Department Nurse Educator confirmed that the competency folders for two nurses did not contain the 2019 Ongoing Competency Assessments as required. When questioned about the assessments, the Emergency Department Nurse Educator wrote in an attestation statement to the OIG that although they could not locate the assessments, she was "certain that I [she] signed off the ongoing competency by the end of the fiscal year as all requirements were met." The Emergency Department Nurse Educator submitted newly created 2019 Ongoing Competency Assessments for both nurses, which were backdated and indicated that the original documents were not in the nurses' competency folders and were "replicated for documentation purposes." However, the OIG noted some discrepancies between the replicated 2019 Ongoing Competency Assessments and the individual competencies contained in the competency folder.

Further, when asked about nurse competency oversight measures, the Chief of Nurse Education stated that an Annual Nursing Competency Certification form must be completed annually. When the OIG requested copies of the completed 2018 and 2019 Annual Nursing Competency Certification forms, the Chief of Nurse Education stated she had not completed the assessments as required.

Following multiple inquiries regarding Emergency Department nurse competencies, the Chief of Quality Management responded to the OIG team via email noting that during the COVID-19 pandemic that "routine nursing competency completion and monitoring fell off the radar." The email acknowledged the "opportunity for improvement," and contained information regarding the Chief of Nurse Education's initial plans for improvement.

The OIG concluded that select Emergency Department nursing competencies and competency folders, and the oversight of such, were deficient. Further, the OIG did not consider the "replicated" 2019 Ongoing Competency Assessments to be acceptable forms of verification that the competency assessments were completed and had concerns regarding the accuracy and

[36] Fiscal year 2019 began on October 1, 2018, and ended on September 30, 2019. The OIG learned from a nurse manager that following the patient incident, the nurses were detailed out of the Emergency Department from June to September 2020 while the facility conducted the AIB. Following a VHA internal review by the Office of the Medical Inspector, the nurses were again placed on a detail outside of patient care on November 20, 2020, and remained on detail throughout the OIG review. As the details began prior to the completion of the fiscal year 2020 competency cycle, the OIG reviewed fiscal year 2019 competency folders.

appropriateness of the Nurse Educator's attestation statement and the replication of the documents.

3. Facility Leaders' Failure to Effectively Address EMTALA-related Incidents

The OIG determined that facility leaders failed to implement effective and coordinated interventions and ensure staffs' compliance with EMTALA regulations, including after the patient incident, in order to prevent further delays or denial of care for veteran and non-veteran patients presenting for emergency medical treatment at the facility.[37]

Facility Leaders' Failure to Effectively Address the Patient Incident

The OIG found that the implementation of AIB action items developed in response to the patient incident lacked urgency, oversight, and evaluation. The OIG also found that the Facility Director rescinded the recommended removal of Emergency Department staff, which potentially compromised patient safety in the Emergency Department.

Lack of Urgency, Oversight, and Evaluation in the Implementation of Emergency Department Action Items

The OIG found that although the Facility Director promptly initiated an AIB to investigate the patient incident, and facilitated a corresponding action plan in July 2020, the implementation of the associated action items lacked urgency, oversight, and evaluation.

In summer 2020, the day after the patient incident, the Facility Director initiated an AIB to "conduct a thorough investigation into the facts and circumstances regarding allegations of inappropriate denial/delay of care of a patient seeking treatment in the Gainesville emergency department." The AIB's final report, completed approximately two weeks later:

- Cited the incident as an EMTALA violation;
- Substantiated the inappropriate delay of care of a patient seeking treatment in the Gainesville Emergency Department; and
- Partially substantiated the inappropriate denial of care for the patient stating the patient's wait in the facility's ambulance bay without receiving care "was denial through the act of omission."

In response to the AIB, facility leaders developed an action plan with nine action items, key findings, and concerns. The OIG team reviewed the facility's action plan and found that, as of November 27, 2020, five months after the AIB final report, action items had no target dates for

[37] This was despite a history of EMTALA-related patient incidents and prior interventions. The OIG team reviewed these prior events to better understand what had transpired in the past.

completion, many remained unresolved, and the documented status of the action items (most of which noted "ongoing") was not current. The status on seven of nine action items had not been updated since July 2020. Specifically, the OIG noted that only one of the nine action items and a component of another item was marked complete.

According to the Chief of Quality Management, the quality management team was responsible for tracking action items through completion; however, when asked about action item progress, the quality management team often did not have the information and, at times, provided incorrect information. Overall, the OIG found that the quality management team had not been monitoring the action items and only took action upon the OIG's inquiry into the status. The OIG concluded that the unresolved action items and inattention to the action plan reflected an overall lack of urgency and oversight to ensuring its completion.

The following are examples of the incomplete, delayed, or ineffective action items.

Facility Relationship with Shands and County EMS

Within the action plan, facility leaders identified that the patient incident had damaged the facility's reputation with Shands and the County EMS and documented a plan to send letters to each agency.

According to the Chief of Quality Management, apology letters were sent to Shands and County EMS; however, when asked to supply the letters for review, the Facility Director's Executive Assistant explained in a written statement that neither letter had been sent. The Executive Assistant noted that the Facility Director made the decision not to send letters and added that the Facility Director and the Facility Chief of Staff met informally with the Shands College of Medicine Dean on July 13, 2020, and with the EMS District Chief on August 27, 2020, to discuss the incident. The action item status did not reflect any of the above information and the status was marked "ongoing" on the action plan.

Emergency Department EMS Radio and Ambulance Bay Video Camera

The AIB noted that the Emergency Department's EMS radio system malfunctioned and was not reliable. Although the EMS radio system's functionality was not a factor in the patient incident, Emergency Department staff and EMS responders noted this to be a known, longstanding issue. Although noted as an action item in July 2020 and marked as "complete" as of November 16, 2020, the OIG found the status to be incomplete as facility staff initiated temporary measures that partially resolved the radio issue. As of January 6, 2021, facility leaders had not installed an Emergency Department EMS radio system capable of communicating with surrounding County EMS departments. On February 24, 2021, the Chief of Quality Management updated the OIG by email relaying that the Emergency Department was utilizing two radios to communicate with all surrounding EMS counties, with future plans to install a permanent desk-set radio system to provide communication with all surrounding County EMS.

To address the AIB concern of no video camera in the ambulance bay, the Police Service was tasked with evaluating the need for and placement of a video camera. Nearly six months later, on January 28, 2021, the video camera was installed and reported to be viewable by facility police services. In response to multiple status requests from the OIG, the quality management team provided several explanations of why action items were delayed or incomplete, including challenges with contracting and installation of equipment. Upon review, the OIG found the primary contributing factors to be a lack of planning, subject matter knowledge, communication, coordination, and follow-up.

Culture Prioritizing Patient Identification and Eligibility Over Patient Care

To address the AIB finding that identified a culture among Emergency Department and AOD staff that prioritized patient identification and eligibility over patient care, facility leaders developed an action item to conduct simulation activities "to ensure staff perform according to EMTALA guidance." Facility leaders charged the facility's Director of Simulation and Education with developing and implementing EMTALA simulation trainings.

The Director of Simulation and Education told the OIG that simulation trainings included presenting different scenarios of non-veteran patients presenting for care in the Emergency Department, followed by a discussion with staff about the management of the patient. The OIG reviewed the training sign-in records and noted EMTALA simulation trainings occurred during multiple shifts in August, September, and December of 2020. Emergency Department physicians, as well as nursing and AOD staff, attended the EMTALA simulation training. The Acting Emergency Department Nurse Manager added that there was an additional training in January and another was planned for April of 2021. The Director of Simulation and Education reported being unaware if staff attendance at the EMTALA simulation training was monitored by the service lines and added that no one had asked for verification of staff attendance except for the facility's performance improvement office. When questioned how the facility was monitoring compliance and evaluating effectiveness, both the Director of Simulation and Education and the Acting Emergency Department Nurse Manager reported that there was no competency verification or process in place to assess the simulation training's effectiveness.

The OIG found that EMTALA simulation trainings were implemented and attended by interdisciplinary staff; however, facility leaders did not track staff attendance, create an avenue for feedback about the trainings, evaluate the training for effectiveness, or monitor staff's compliance with EMTALA regulations. Although not required, the failure to ensure staff receive the necessary training and monitor EMTALA compliance demonstrates facility leaders' failure to effectively address ongoing EMTALA-related issues.

Lack of Staff Accountability for Delay of Patient Care and No Medical Care Provided (EMTALA-Related VHA Policy Violation)

The OIG determined that the Facility Director's decision to rescind the recommended discipline of the Emergency Department staff, while not a violation of policy, potentially compromised patient safety in the Emergency Department. The OIG found that the Facility Director's decision to reverse the proposed removals appeared to be based on disputes of facts within the AIB findings that were not material to the failure of staff to provide emergency medical care to the patient in lieu of prioritizing the identification of the patient.[38]

To address the AIB finding of a delay in patient care and that no medical care was provided, the Section Chief of Labor and Employee Relations was tasked to evaluate the information gathered during the AIB and consider appropriate disciplinary actions for employees involved in the patient incident, up to and including removal.[39] Following the review, the Section Chief of Labor and Employee Relations proposed the removal of the Emergency Department nurses involved for the "Failure to perform emergency procedures to include assessment and treatment for a patient who presented via ambulance for VA Emergency Department Care," and administrative staff for the "Dereliction of duties and inappropriate conduct." Prior to advancing these actions, the Section Chief of Labor and Employee Relations consulted with the Office of the General Counsel to ensure that the actions and supporting evidence were legally sufficient. The proposed actions were submitted to the employees' service chiefs who reviewed the actions and issued disciplinary action letters to the employees.

After receiving employee responses to the actions, the Facility Director, the deciding official on removal actions, and the Section Chief of Labor and Employee Relations met with each employee, referred to by VA policy as an oral reply, to give them an opportunity to share their perspective before rendering a final decision.[40] After listening to the facility staff's oral arguments and re-reviewing the evidence, the Facility Director issued a decision letter to the facility staff that rescinded the proposed removals, authorized the return to duty in the Emergency Department, and directed the employees to "be mindful that the duty to assess and

[38] VA Handbook 0700, *Administrative Investigations*, July 31, 2002. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Handbook 0700, *Administrative Investigation Boards and Factfindings,* August 17, 2021. Both handbooks contain the same or similar language regarding material evidence. "Evidence is "material" to an investigation if the matter it tends to prove or disprove is logically connected to an issue of the investigation and it does not unnecessarily duplicate other evidence tending to prove or disprove the same matter."

[39] Facility leaders determined it necessary to conduct an institutional disclosure with the patient's family; the facility's Chief of Staff and Associate Director of Patient Care Services conducted an institutional disclosure during summer 2020. Pending the completion of the investigation, select Emergency Department nursing and administrative staff involved with the incident were detailed out of their service to non-patient care areas.

[40] VA Directive 5021, *Employee Management/Relations,* April 15, 2002; VA Handbook 5021/21, *Employee Management Relations,* February 19, 2016.

evaluate a patient's clinical condition supersedes the need for obtaining identifying information or Veteran status." In two of the employee decision letters, the Facility Director acknowledged the fact that, "The agency was already made aware prior to the patient's arrival that the patient name was unknown."

A documented review of the facts, findings, and conclusions written and forwarded to the OIG by the Facility Director noted the areas challenged during oral arguments that led to his dispute of the AIB's conclusion that there was an inappropriate delay and denial of patient care. In the document, the Facility Director cited that the incident was not an EMTALA violation because the EMS "driver pulled [the] patient away before a full assessment could be performed or completed."

During an interview with the OIG, the Facility Director outlined the factors that influenced the decision to rescind the proposed removals. The Facility Director was aware that EMS responders were asked multiple times and by multiple facility employees for the patient's identifying information and stated that EMS personnel became agitated and angry. Further, the Facility Director stated that the nurses reported, and he believed, that the nurses had no control over the patient, that no facility staff refused to take the patient, and that EMS had full control of the situation and put the patient back into the ambulance. The Facility Director relayed that the nurses informed him that the patient's medical condition was not as critical as EMS responders had reported; the patient was not intubated and was only using a nasal cannula to breathe, and two of the nurses said the patient did not look like a GCS score of 8.

When asked, the Facility Director stated that he did not discuss with the Office of General Counsel any of the discrepancies between the information relayed in the oral reply meetings he conducted and the AIB findings.

According to an email written by the Section Chief of Labor and Employee Relations to and at the request of the VISN human resources representative, each of the involved Emergency Department nurses and administrative staff met with the Facility Director and the Section Chief of Labor and Employee Relations on August 17, 2020, to provide their oral arguments.[41] Within the email, the Section Chief of Labor and Employee Relations notes the most compelling points made by the nurses in their oral argument, one of which included:

> Each of the Nurses, some of whom are long term employees, with critical care or emergency experience, pointed out that there was NO SENSE OF URGENCY [Emphasis in original text]. No one was rushing around. The patient was breathing and was not struggling to breathe.

[41] The VISN human resources representative requested, via email, that the facility's Section Chief of Labor and Employee Relations describe the actions management wanted to take against the employees and the advice provided by the facility's human resources department.

Per the Section Chief of Labor and Employee Relations email, "It was my advice that given all the inconsistencies that the Nurses had pointed out that were validated, that it would be almost impossible to sustain these actions before a DAB [Decision Appeal Board]. The Director went through his deliberative process, and made the decision to mitigate to a LOI [letter of instruction]…"[42]

VA policy provides that the deciding official (the Facility Director) will give consideration to the employee's reply and all evidence of record, and if the charge is sustained must give consideration to the table of offenses and penalties.[43] The policy provides that the Facility Director has the discretion to rescind proposed discipline if it is determined to be procedurally defective to the "detriment of the employee's substantive rights."[44] The OIG found that the Facility Director's decision to reverse the proposed removals, however, was based on reports from the interviewed staff that were disputed by others involved. In addition, the information on which the Director relied was not material to the failure of staff to provide medical care to the patient.[45] Instead, the Facility Director relied on disputed facts, such as the criticality of the patient's medical status and confusion in the ambulance bay. The OIG found that the Facility Director's decision to rescind the proposed disciplinary actions relied on the employees' oral replies in lieu of the AIB's findings, which involved procedural safeguards including the objectivity of the board, the sworn testimony of witnesses, and the ability of the board to hear from 20 live witnesses. Further, the Office of General Counsel's review, which found legal sufficiency of the proposed actions, took into consideration the disputes in fact and found them to be negated because of the inaction by the staff, which was the material evidence the OIG found the Director should have focused on. The OIG concluded that the Facility Director's decision to rescind the discipline of the Emergency Department staff, while not a violation of policy, potentially impacted patient safety in the Emergency Department.

Continued Delays in Emergency Care

Although facility leaders implemented actions to address concerns identified in the AIB, the OIG determined that the actions have not been effective in preventing the occurrence of additional patient incidents.

[42] The letter of instruction refers to the decision letters mentioned earlier in this report.

[43] VA Handbook 5021/21.

[44] VA Handbook 5021.

[45] VA Handbook 0700, *Administrative Investigations*, July 31, 2002. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Handbook 0700, *Administrative Investigation Boards and Factfindings,* August 17, 2021. Both handbooks contain the same or similar language regarding material evidence. "Evidence is "material" to an investigation if the matter it tends to prove or disprove is logically connected to an issue of the investigation and it does not unnecessarily duplicate other evidence tending to prove or disprove the same matter."

The OIG learned through interviews, emails, and document reviews that there continue to be delays in the provision of emergency care to patients in the Emergency Department due to inefficient registration processes and practices. An Emergency Department nurse reported that in late 2020, a non-veteran patient came to the Emergency Department after experiencing a reaction to a COVID-19 vaccination. The nurse shared that the patient's care was delayed because AOD staff took approximately 45 minutes to register the patient. According to the nurse, facility leaders reportedly did not contact the Emergency Department nurse to obtain additional information about the incident. The facility's Chief of Quality Management provided a memorandum to the OIG regarding the late 2020 incident that was signed on February 4, 2021, by an Emergency Department nurse manager. The nurse manager had reviewed the incident, completed a summary of findings, and confirmed a registration delay of 48 minutes. The nurse manager documented having a conversation with the Assistant Chief of Patient Processing regarding the event, stating that registration should not exceed five minutes. The OIG found no evidence of further actions taken by facility leaders regarding this incident.

During an interview with the OIG, the Acting Emergency Department Nurse Manager described additional incidents that required intervention to prevent AOD staff from sending patients out of the Emergency Department to the registration office prior to receiving a medical evaluation. When questioned how recently this occurred, the Acting Emergency Department Nurse Manager stated as recently as last week (the week prior to the OIG interview) and described a specific incident involving an unregistered veteran patient arriving to the Emergency Department with leg pain to receive emergency care. Rather than registering the patient in the Emergency Department to facilitate a timely medical assessment, the AOD attempted to send the patient to the registration office. The Acting Emergency Department Nurse Manager intervened to ensure that the patient remained in the Emergency Department to receive an assessment and care. The Director of Simulation and Education who worked several shifts in the Emergency Department beginning in December 2020 identified this pattern and reported it to the Chief of the Emergency Department in an email. The Director of Simulation and Education noted in the email that one to two times per shift, Emergency Department patients were not registered onsite but rather sent out of the Emergency Department for registration prior to receiving a medical assessment.

When questioned about interdisciplinary Emergency Department and Medical Administration Services collaboration to address registration processes, the Acting Emergency Department Nurse Manager stated they held a one-time meeting to review the late 2020 patient incident but acknowledged this was not enough to fully address the issue. The Acting Emergency Department Nurse Manager opined that an additional meeting that included "the right people" may have allowed them to identify deficiencies before having another incident.

When questioned about the continuation of incidents, the Chief of Emergency Services acknowledged awareness and referenced a recent email received from the Director of Simulation and Education that had been sent to the Facility's Chief of Staff, Chief of Medical

Administration Services, Quality Management, and Emergency Department leaders. The email outlined recent observations and patient registration process concerns within the Emergency Department and included a recommendation to address these concerns in the ongoing simulation trainings. The Director of Simulation and Education informed the OIG team that neither facility nor service line leaders responded to the email.

The OIG found facility leaders' efforts to address the concerns of the AIB were ineffective based on continued incidents. The OIG concluded that the lack of oversight, interdisciplinary coordination and communication, accountability, and evaluation have resulted in failed past and current resolution of patient care delays and denials of medical care in the Emergency Department. Had facility leaders implemented effective action items and provided adequate oversight of the action plan, the recurrence of subsequent incidents, including the patient incident on June 7, 2020, may not have occurred.

Conclusion

The OIG determined that facility Emergency Department nurses failed to provide emergency care to a patient who arrived at the facility by ambulance. Despite having been informed of the limited patient identifying information EMS personnel had prior to arrival, Emergency Department nurses and an AOD wasted critical time by continuing to concentrate efforts on patient identification instead of focusing on patient care. The Emergency Department nurses' failure to prioritize medical intervention resulted in EMS personnel reloading the patient into the ambulance and transporting the patient to Shands where the patient died approximately 10 hours after admission.

The OIG determined that facility Emergency Department nurses failed to recognize and accurately assess the patient's emergency medical condition. Although informed by EMS personnel they were to receive a critical patient arriving by ambulance, Emergency Department nurses dismissed the reported criticality of the patient's condition based on their own inaccurate visual assessment of the patient. The OIG found EMS and Shands evaluations of the patient's critical medical condition to be consistent. The critical nature of the patient's medical condition was confirmed by the patient medical evaluations, the need for immediate life-saving interventions upon arrival to Shands Emergency Department, and the cause of death noted on the patient's death certificate. The OIG concluded that facility Emergency Department nurses disregarded EMS personnel's patient status reports, failed to recognize the patient's emergency medical condition, and inaccurately assessed the patient's condition as less critical. As a result of these findings, the OIG questioned the Emergency Department nurses' competence to treat patients seeking emergency care and reviewed select nurses' competencies and competency folders. The OIG identified deficiencies in the completion, validation, and oversight of Emergency Department nursing competencies and competency folders and had concerns regarding the replication of Ongoing Nursing Competency Assessments.

The OIG determined that the Facility Director's decision to rescind the recommended discipline of the involved facility staff, while not a violation of policy, potentially compromised patient safety in the Emergency Department. The Facility Director's decision to reverse the proposed removals were based on disputes in fact that were not material to the failure of staff to provide medical care.

Although facility leaders implemented actions to address concerns identified in the AIB, the OIG determined that since implementation, the actions have not been effective in preventing the occurrence of additional patient incidents. Despite the simulation education and interventions, the OIG learned through interviews, emails, and document reviews that there continue to be delays in the provision of emergency care to patients in the Emergency Department due to inefficient registration processes and practices.

The OIG made five recommendations.

Recommendations 1–5

1. The VA Sunshine Healthcare Network Director ensures a review of the patient incident is conducted to determine whether further administrative action or reporting to state licensing board(s), or both, is warranted for facility staff involved in the incident, and takes action as appropriate.

2. The Malcom Randall VA Medical Center Director ensures that Emergency Department nurses and Administrative Officers of the Day prioritize patient care before patient eligibility status when patients present with an emergency medical condition, holds staff accountable when violations occur, and monitors for ongoing compliance.

3. The Malcom Randall VA Medical Center Director ensures that Emergency Department nurse competencies are current, complete, and validated as required, and monitors for ongoing compliance.

4. The Malcom Randall VA Medical Center Director conducts an internal review of the Emergency Department Nurse Educator's replication of the 2019 Ongoing Competency Assessments and attestation of competency completion to determine whether administrative action is warranted and takes action as appropriate.

5. The Malcom Randall VA Medical Center Director evaluates the status of action plans referenced in this report and monitors the implementation and efficacy of action items to closure.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 3, 2022

From: Acting Director, VA Sunshine Healthcare Network (10N8)

Subj: Healthcare Inspection—Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure at the Malcom Randall VA Medical Center in Gainesville, Florida

To: Director, Office of Healthcare Inspections (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with the response provided by the Executive Director of the Malcom Randall VA Medical Center regarding the OIG's report, Healthcare Inspection-Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care.

2. I would like to thank the Office of Inspector General for their thorough review of this case and recommendations on process improvements. VISN 8 appreciates the opportunity to partner with the OIG on our high reliability journey. We remain steadfast in our commitment to zero harm.

3. If you have additional questions or need further information, please contact the VISN 8 Chief Nursing & Quality Management Officer.

(*Original signed by*:)

Edward P. Cutolo, Jr., M.D.
Acting VISN 8 Network Director

VISN Director Response

Recommendation 1

The VA Sunshine Healthcare Network Director ensures a review of the patient incident is conducted to determine whether further administrative action or reporting to state licensing board(s), or both, is warranted for facility staff involved in the incident, and takes action as appropriate.

Concur.

Target date for completion: September 30, 2022

Director Comments

The VA Sunshine Healthcare Network will have an external review team evaluate the patient incident to determine whether further administrative action or state licensing board reporting is feasible. Any new and/or previously unavailable information and/or evidence will be used in this review and if warranted, further action will be taken as appropriate.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 3, 2022

From: Executive Director, North Florida/South Georgia Veterans Health System (573)

Subj: Healthcare Inspection—Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure at the Malcom Randall VA Medical Center in Gainesville, Florida

To: Executive Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed the attached report and recommendations. I appreciate the Office of Inspector General's recommendations and look forward to closing them timely. Our sacred mission at VA reminds us all how important it is to continually focus on improvement, and we value the roles that our oversight partners have. We are committed to our journey of high reliability with a focus on zero harm.
2. The Malcom Randall VA Medical Center will focus on implementing activity based high reliability actions which cultivate and promote a Just and Accountable culture. Our High Reliability Organization principles – preoccupation with failure, sensitivity to operations, reluctance to simplify, commitment to resilience, and deference to expertise will drive our way forward. These principles help to frame the behaviors and actions we want to see in all employees.
3. If you have additional questions or need further information, please contact Chief, Office of High Reliability.

(*Original signed by*:)

David Isaacks
Executive Director

Facility Director Response

Recommendation 2

The Malcom Randall VA Medical Center Director ensures that Emergency Department nurses and Administrative Officers of the Day prioritize patient care before patient eligibility status when patients present with an emergency medical condition, holds staff accountable when violations occur, and monitors for ongoing compliance.

Concur.

Target date for completion: September 30, 2022

Director Comments

The Malcom Randall VA Medical Center will ensure that the first formal interaction for all patients which present to the Emergency Department will be with a registered nurse (RN). This RN will prioritize patient care for all patients at the entrance to the Emergency Department prior to any determination of eligibility status. Compliance for staffing this RN position will be monitored through the daily high reliability huddles and Acustaf, the tool used to determine staffing and assignments in the Emergency Department.

The Malcom Randall VA Medical Center has provided training on Emergency Severity Index (ESI) triage to each RN in the Emergency Department. This is the gold standard for triage endorsed by the Emergency Nurses Association (ENA). Additionally, all staff in the Emergency Department, including administrative personnel, have received training on EMTALA outlining the importance of prioritizing patient emergency care before any other activity such as determination of eligibility status, requirement for a medical screening evaluation, and our duty to provide humanitarian treatment to non-Veterans. Between June 2020 and April 2022 the facility has treated 239 humanitarian patients and there have been no instances of any individual (humanitarian or Veteran) being turned away or refused care.

To ensure sustainment of improvements and promote patient safety, the facility will implement a daily leader led high reliability huddle (HRH). This huddle will focus on daily patient prioritization, safety concerns, and encourage reporting. A standard work tool will be developed to address Safety, Methods, Equipment, Supply, Staffing (SMESS) concerns. Leader led high reliability huddles will be monitored monthly with a 90% compliance goal for use of the standard tool and staff participation in the huddles. The Malcom Randall VA Medical Center has also developed simulation training which allows Emergency Department staff the opportunity to apply the EMTALA training to scenarios of patients arriving to the Emergency Department for care. Simulation allows staff to apply knowledge to realistic situations, work through decision making, ask questions, and clarify expectations. Simulations will be conducted quarterly with a goal of 1 per quarter. So far 8 simulations have been completed across all shifts since June 2020.

Encouraging and promoting incident reporting will remain a top priority and be reenforced through daily huddles. With a focus on increased reporting the facility will measure its success by reducing actual patient safety events and increasing reports of close call or near misses. Incidents will be monitored for compliance by the Patient Safety Office and be tracked in the Department of Veterans Affairs Joint Patient Safety Reporting medical quality assurance system. All incidents will be reviewed against the VA National Center for Patient Safety Just Culture Decision Support Tool and if appropriate staff will be held accountable.

Recommendation 3

The Malcom Randall VA Medical Center Director ensures that Emergency Department nurse competencies are current, complete, and validated as required, and monitors for ongoing compliance.

Concur.

Target date for completion: September 30, 2022

Director Comments

As an organization focused on zero harm, we know that competency among the staff who are performing the work is foundational. Competencies in healthcare are ongoing and dynamic. Since the OIG's review, a requisite review of all Emergency Department nursing competencies was chartered on April 21, 2022. The facility has ensured all nursing staff in the Emergency Department have had competencies reviewed and that they are current, complete, and validated as required. Two additional requisite reviews will occur; one in May 2022 and one in June 2022. Following these three consecutive months of reviews, a monthly standard process will be developed and implemented. To ensure sustainment a yearly review of each nurse's competencies will become part of the standard process included with annual performance expectations. Each year the chief nurse over the emergency department will certify that all competencies are current, complete, and validate as required. Any nurse with competencies found to be incomplete or outdated, will immediately be removed from clinical care until competencies are updated.

Recommendation 4

The Malcom Randall VA Medical Center Director conducts an internal review of the Emergency Department Nurse Educator's replication of the 2019 Ongoing Competency Assessments and attestation of competency completion to determine whether administrative action is warranted and takes action as appropriate.

Concur.

Target date for completion: July 30, 2022

Director Comments

This recommendation infers that during the Office of Inspector General's investigation that potentially inappropriate conduct occurred regarding the replication of the 2019 Ongoing Competency Assessments and attestation of competency completion. Considering this recommendation and new evidence was previously unknown to the Malcom Randall VA Medical Center, a fact finding will be completed. A fact finding was chartered on April 22, 2022 with a completion target of June 1, 2022. At the conclusion of that fact finding, the Executive Director will determine whether administrative action is warranted and take action as appropriate.

Recommendation 5

The Malcom Randall VA Medical Center Director evaluates the status of action plans referenced in this report and monitors the implementation and efficacy of action items to closure.

Concur.

Target date for completion: September 30, 2022

Director Comments

As a part of our journey towards high reliability we will continue to focus on building a culture of safety and a culture of continuous process improvement. Identified actions and action plans will be documented and monitored through completion. To ensure high visibility of these action plans, they will be added to the Executive Leadership Committee and tracked to ensure completion and sustainment of improvements.

Glossary

To go back, press "alt" and "left arrow" keys.

anoxic brain. Anoxic and hypoxic are used interchangeably in the medical literature. An injury that occurs when the brain is deprived of oxygen for more than five minutes.[46]

anticoagulation. The process that prevents blood from clotting.[47]

atrial fibrillation. Rapid, uncoordinated contractions of the heart chambers that results in unsynchronized heartbeat and pulse.[48]

benign prostatic hypertrophy. An enlarged prostate gland that causes uncomfortable urinary symptoms, such as blocking the flow of urine out of the bladder. The terms hypertrophy and hyperplasia are used interchangeably. The term hypertrophy will be used for the purposes of this report.[49]

cardiac arrest. A condition that occurs when the heartbeat stops temporarily or permanently.[50]

cellulitis. "A common skin infection caused by bacteria."[51]

chronic kidney disease. A condition characterized by the gradual loss of kidney function resulting in the buildup of wastes in blood.[52]

chronic obstructive pulmonary disease. A common lung disease that makes it hard to breathe.[53]

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[46] Cleveland Clinic, "Cerebral Hypoxia," accessed February 8, 2021, https://my.clevelandclinic.org/health/articles/6025-cerebral-hypoxia.

[47] *Merriam-Webster.com Dictionary*, "anticoagulation," accessed January 25, 2021, https://www.merriam-webster.com/medical/anticoagulation.

[48] *Merriam-Webster.com Dictionary*, "atrial fibrillation," accessed January 13, 2021, https://www.merriam-webster.com/medical/atrial%20fibrillation.

[49] Mayo Clinic, "Benign prostatic hyperplasia (BPH)," accessed February 7, 2021, https://www.mayoclinic.org/diseases-conditions/benign-prostatic-hyperplasia/symptoms-causes/syc-20370087?p=1. University of Rochester, Medical Center, "Benign Prostatic Hyperplasia (BPH)," accessed January 25, 22, https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=85&ContentID=P01470.

[50] *Merriam-Webster.com Dictionary*, "cardiac arrest," accessed February 7, 2021, https://www.merriam-webster.com/dictionary/cardiac%20arrest.

[51] MedlinePlus, "Cellulitis," accessed January 13, 2021, https://medlineplus.gov/ency/article/000855.htm.

[52] National Kidney Foundation, *Chronic Kidney Disease (CKD),* accessed April 27, 2021, https://www.kidney.org/atoz/content/about-chronic-kidney-disease.

[53] Medline Plus, *Chronic obstructive pulmonary disease*, accessed January 13, 2021, https://medlineplus.gov/ency/article/000091.htm.

computerized tomography scan. A cross sectional or three-dimensional image of an internal body part used for diagnostic purposes.[54]

coronary artery bypass. A procedure that creates a new passage around blockages for blood and oxygen to reach the heart.[55]

coronary artery disease. A disease that causes narrowing of blood vessels that supply the heart with blood and oxygen.[56]

diabetes. A disease that occurs when the body cannot effectively process sugar (glucose) due to producing little or no insulin (a hormone that regulates blood glucose) or not using insulin well. Type 2 diabetes, the most common type, is when patients do not make or use insulin well.[57]

diastolic. Describes the left ventricle's inability to relax and allow the inflow of blood in preparation for the next heartbeat.[58]

electrocardiogram. "A test that measures the electrical activity of the heartbeat."[59]

heart failure. A condition that occurs when the heart is unable to pump blood at an adequate rate or volume.[60]

Hemophilia A. An inherited bleeding disorder that slows the blood from clotting. Acquired Factor VIII deficiency is a form of Hemophilia A which occurs when the body makes autoantibodies that attack and disable Factor VIII, a clotting factor.[61]

hyperkalemia. The condition of having abnormally high potassium in the blood. Normal potassium levels are between 3.6 and 5.2 millimoles per liter (mmol/L) while levels higher than 6.0 require immediate treatment as it can be dangerous.[62]

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[54] *Merriam-Webster.com Dictionary*, "Medical Definition of CT scan," accessed February 7, 2021, https://www.merriam-webster.com/dictionary/CT%20scan#medicalDictionary.

[55] Medline Plus, *Heart bypass surgery,* accessed January 27, 2021, https://medlineplus.gov/ency/article/002946.htm.

[56] Medline Plus, *Coronary heart disease,* accessed January 24, 2021, https://medlineplus.gov/ency/article/007115.htm.

[57] National Institute of Diabetes and Digestive and Kidney Disease, *What is Diabetes,* accessed January 13, 2021, https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes.

[58] Baptist Health, *Diastolic heart failure*, accessed June 14, 2021, https://www.baptisthealth.com/services/heart-care/conditions/diastolic-heart-failure.

[59] American Heart Association, *Electrocardiogram (ECG or EKG),* accessed April 26, 2021, https://www.heart.org/en/health-topics/heart-attack/diagnosing-a-heart-attack/electrocardiogram-ecg-or-ekg.

[60] *Merriam-Webster.com Dictionary*, "heart failure," accessed January 13, 2021, www.merriam-webster.com/dictionary/heart%20failure.

[61] MedlinePlus, *Hemophilia,* accessed January 27, 2021, https://medlineplus.gov/genetics/condition/hemophilia/#synonyms.

[62] The Mayo Clinic, "High Potassium (hyperkalemia)," accessed February 8, 2012, https://www.mayoclinic.org/symptoms/hyperkalemia/basics/definition/sym-20050776.

hyperlipidemia. Elevated levels of fats in the blood.[63]

hypertension. Also known as high blood pressure. A condition where blood pressure consistently ranges higher than 140 (systolic) over 90 (diastolic) millimeters of mercury (mmHg) documented over time.[64]

intubation. A procedure where a tube is placed into the trachea through the mouth to assist with breathing.[65]

leukopenia. A decrease in white blood cells which may have a number of causes including infection.[66]

lymphedema. Swelling, generally in one of the arms or legs, resulting from blockage in the lymphatic system.[67]

multifocal pneumonia. An infection in more than one area in one or both lungs.[68]

nasal cannula. A cannula that delivers low-flow oxygen to the nostrils.[69]

obesity. When the body has too much fat and which may increase the risk for chronic and serious health problems.[70]

oxygen saturation. The amount of oxygen in the blood, or more specifically the extent to which hemoglobin, found in red blood cells, is saturated with oxygen.[71]

pneumonia. An infection in the lungs.[72]

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[63] *Merriam-Webster.com Dictionary*, "Medical definition of hyperlipidemia," accessed January 29, 2021, https://www.merriam-webster.com/dictionary/hyperlipidemia.

[64] World Health Organization, "Hypertension" accessed January 25, 2022, www.who.int/news-room/fact-sheets/detail/hypertension.

[65] *Merriam-Webster.com Dictionary*, "intubation," accessed February 7, 2021, https://www.merriam-webster.com/dictionary/intubation.

[66] MedlinePlus, "CBC blood test," accessed February 8, 2021, https://medlineplus.gov/ency/article/003642.htm.

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[68] *Merriam-Webster.com Dictionary*, "multifocal*,"* accessed January 25, 2021, https://www.merriam-webster.com/dictionary/multifocal.

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[70] MedlinePlus, *Obesity Screening*, accessed February 16, 2021, https://medlineplus.gov/lab-tests/obesity-screening/.

[71] MedlinePlus, *Blood Oxygen Level*, accessed January 25, 2022, https://medlineplus.gov/lab-tests/blood-oxygen-level.

[72] Medline Plus, *Pneumonia*, accessed February 7, 2021, https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=pneumonia&_ga=2.261061645.1016256933.1547309418-1340738343.1505832622.

pulse. The number of times the heart beats per minute.[73]

pyelonephritis. When one or both kidneys is infected.[74]

respiratory failure. A condition that occurs acutely or slowly when there is not enough oxygen passing from the lungs into the blood to help the body work well or the lungs are unable to remove carbon dioxide (a waste gas) for the blood which can harm the body [75]

respiratory rate. The number of breaths per minute.[76]

sepsis. A systemic inflammatory response syndrome usually caused by a bacterial infection or bacterial toxins.[77]

septic shock. A life-threatening severe form of sepsis.[78]

triage. The process of sorting patients (as in an emergency room) according to the urgency of their need for care.[79]

venous stasis. "An abnormal slowing or stoppage of the flow of blood in a vein."[80]

vital signs. Measurements taken to assess general health including, blood pressure, pulse, breathing rate, and body temperature.[81]

[73] Cleveland Clinic, *Vital Signs*, accessed January 25, 2021, https://my.clevelandclinic.org/health/articles/10881-vital-signs.

[74] MedlinePlus, *Urinary tract infection – adults,* accessed January 25, 2021, https://medlineplus.gov/ency/article/000521.htm.

[75] National Heart, Lung and Blood Institute, *Respiratory Failure*, accessed February 7, 2021, https://www.nhlbi.nih.gov/health-topics/respiratory-failure.

[76] Cleveland Clinic, *Vital Signs*, accessed January 25, 2021, https://my.clevelandclinic.org/health/articles/10881-vital-signs.

[77] *Merriam-Webster.com Dictionary*, "sepsis," accessed on January 13, 2021, https://www.merriam-webster.com/dictionary/sepsis#medicalDictionary.

[78] *Merriam-Webster.com Dictionary*, "septic shock," accessed on January 13, 2021, https://www.merriam-webster.com/dictionary/septic%20shock#medicalDictionary.

[79] *Merriam-Webster.com Dictionary*, "triage," accessed on February 7, 2021, https://www.merriam-webster.com/dictionary/triage.

[80] *Merriam-Webster.com Dictionary*, "venous stasis," accessed on January 25, 2021, https://www.merriam-webster.com/medical/venostasis.

[81] Cleveland Clinic, *Vital Signs*, accessed on January 25, 2021, https://my.clevelandclinic.org/health/articles/10881-vital-signs.

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