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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia

HEALTHCARE INSPECTION | REPORT #21-01048-154 | MAY 12, 2022

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate the care of a patient who died at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia. Specifically, the OIG evaluated the adequacy of the patient's outpatient care in the months prior to surgery, preoperative care including surgical assessment and anesthesia evaluation, and postoperative care including alcohol withdrawal treatment.

In fall 2020, the patient underwent minimally invasive urologic surgery at the facility. On the same day as the surgery, the patient was admitted for orthostatic hypotension and physical deconditioning and subsequently suffered through alcohol withdrawal and declining health.[1] The patient died while on hospice in the intensive care unit (ICU) on postoperative day 13. The OIG determined that the surgical team completed all required elements of the preoperative assessment including surgical assessment and anesthesia evaluation. However, the OIG was concerned that the surgical team did not detect the patient's overall poor health, possibly compounding the primary care provider's (provider) and patient aligned care team (PACT) nurse's failures to intervene on the patient's behalf. The OIG found multiple deficiencies in the patient's primary care leading up to surgery and postoperative care.

PACT Care

The OIG determined that the provider failed to adequately address the patient's recurrent abnormal chest images, and facility staff failed to schedule and complete an ordered barium swallow test.[2] In the year preceding surgery, the patient had multiple abnormal chest images, and was prescribed four cycles of antibiotics for chest infections. The chest images showed signs of a chronic infectious or inflammatory process, possible aspiration, and pulmonary nodules. Despite two patient requests and a recommendation from a radiologist, the provider failed to consult a pulmonologist. The provider reported being aware of the patient's ongoing pulmonary issues and would have consulted a pulmonologist if the patient's treatment failed or condition worsened. The provider stated that the treatment plan was to repeat chest computed tomography (CT) scans, order a barium swallow and a bone density test, and prescribe cough syrup and antibiotics. The provider signed an order for a barium swallow test, four months before surgery, but the test was not scheduled or completed. Facility staff provided conflicting explanations for this failure and were unable to provide evidence to explain why this test was not scheduled. The provider did not order a bone density test.

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

[2] The barium swallow test was to look for muscle weakness, a possible cause of aspiration.

The OIG also determined that the provider failed to adequately address the patient's poor nutritional status. In the eight months leading up to surgery, the patient lost 27 pounds (20 percent of total weight), and the patient had multiple abnormal blood tests.[3] The provider failed to document the patient's weight loss, but addressed blood test abnormalities by repeating blood tests, offering dietary suggestions, instructing the patient to supplement with a sports drink, and suggesting the patient present to the Emergency Department if symptoms worsened. Three weeks before surgery, the provider received results for the patient's third abnormal blood test. The provider failed to communicate the blood test results to the patient within seven calendar days as required by Veterans Health Administration (VHA) policy.[4] The provider mailed the test results to the patient 13 days later, but failed to highlight the abnormalities or provide a plan of care.

Facility leaders reported no concerns with the provider's practice, and the provider successfully passed ongoing professional practice evaluations through May 2020.[5] However, the OIG was concerned about the quality of care provided by the provider to the patient in the months preceding surgery. The provider's failures most likely contributed to the patient's poor health going into the preoperative phase of care.

The OIG determined that a PACT nurse failed to adequately respond to the patient's request for assistance via secure message. Two days prior to surgery, the PACT nurse responded to a secure message that the patient sent the evening before, complaining of being weak and not able to keep "anything down." The PACT nurse did not alert a primary care provider, call the patient, schedule a same-day appointment for the patient, or note the provider's instructions from six days prior asking the PACT nurse to have the patient present to the Emergency Department if symptomatic. The PACT nurse could not recall why these deficiencies occurred.

Patient's Postoperative Alcohol Withdrawal Care

During the patient's post-surgical hospital stay, the OIG determined that medical-surgical nurses did not consistently assess the patient's alcohol withdrawal symptoms or administer medications according to the facility alcohol withdrawal treatment protocol (protocol) and physician orders.[6]

[3] The patient's starting and ending weights were 137 and 110 pounds, respectively.

[4] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[5] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. VHA uses ongoing professional practice evaluations to confirm the quality of care delivered by privileged clinicians to ensure patient safety.

[6] Mayo Clinic, "Alcohol use disorder," accessed June 24, 2021, https://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/symptoms-causes/syc-20369243. Alcohol withdrawal may occur from several hours to five days after a patient's alcohol use is significantly reduced or stopped after heavy prolonged use. Symptoms of alcohol withdrawal may include hallucinations, seizures, hand tremors, rapid heartbeat, nausea and vomiting, sweating, problems sleeping, restlessness, agitation, and anxiety.

For the less than 72 hours the patient was on the medical-surgical unit, five registered nurses (nurses 1–5) provided care.[7] At admission, a physician ordered initiation of the alcohol withdrawal protocol and included orders for assessments every four hours for the first 24 hours as well as benzodiazepines for moderate or severe alcohol withdrawal symptoms consistent with the facility's protocol.[8]

The OIG determined that all five nurses, who cared for the patient on the medical-surgical unit, failed to adequately assess and treat the patient's alcohol withdrawal symptoms and failed to follow the physician's orders regarding benzodiazepine administration. When interviewed, nurse 2 reported confusion regarding the orders and protocol and stated that the patient did not show signs of alcohol withdrawal during nurse 2's shift. Nurse 4 and nurse 5 had difficulty recalling the events outside of the information available in the patient's electronic health record (EHR). Nurse 1 no longer worked for VHA and did not respond to the OIG's interview request. During nurse 3's 12-hour shift, the patient was not assessed or provided benzodiazepines. Nurse 3, who has since moved to another VHA facility, told the OIG that a physician gave a verbal order to discontinue the patient's alcohol withdrawal treatment on the morning of nurse 3's shift. Not only did the EHR reflect no evidence of a verbal order to discontinue the patient's alcohol withdrawal treatment, the two physicians treating the patient at the time had documented in the patient's EHR to continue with the protocol and provide benzodiazepines as needed. In addition, over three hours prior to the end of the shift, nurse 3 verified duplicate orders for alcohol withdrawal treatment in the patient's EHR.

Patient's Postoperative Care: Incorrect Patient Positioning

During nurse 3's shift, at 10:15 a.m., a physical therapist noted the patient was confused, disoriented, and placed in a Trendelenburg position.[9] The note also indicated that a medical-surgical unit nursing assistant was present in the room and stated the positioning was to prevent the patient from trying to get out of bed. When interviewed by the OIG, nurse 3 was unable to recall that the patient was placed in this position. The OIG interviewed the medical-surgical unit nursing assistant assigned to the patient on the morning in question. The nursing assistant recalled seeing someone in the Trendelenburg position at around the start of a shift at 7:30 a.m. but could not recall the patient or day when this occurred. The nursing assistant confirmed this

[7] Facility registered nurses on the medical-surgical unit typically worked 12-hour shifts either at night or during the day from 7:30 a.m. to 8:00 p.m. and reportedly cared for three to five patients each while receiving support from nursing assistants.

[8] For the purposes of this report, the OIG uses assess, reassess, assessment, and reassessment to describe alcohol withdrawal assessments.

[9] Kathleen Rich, "Trendelenburg position in hypovolemic shock: A review," *Journal of Vascular Nursing, Clinical Column 37,* (March 2019): 71–73, accessed March 16, 2021, https://pubmed.ncbi.nlm.nih.gov/30954203. Trendelenburg refers to the positioning of a patient on the back with the head down and feet elevated. The risk for aspiration, one of the possible adverse outcomes of using this position, increases the longer the patient is in the position.

recollection was in the same half of the year as the patient's stay and matched the patient's general physical description. The OIG was unable to determine who placed the patient in the Trendelenburg position or for how long. The medical-surgical unit nurse managers informed the OIG that inpatient nursing staff will be re-educated about the risks of using the Trendelenburg position. Facility leaders concurred that patients should not be placed in the Trendelenburg position for patients' restlessness or as a form of restraint.

Medical-Surgical Unit Nurse Training and Oversight

Given the failures in medical-surgical unit nursing care, the OIG reviewed the training records of the five nurses and questioned nursing managers about oversight of the quality of nursing care. The OIG determined that medical-surgical unit nursing leaders did not have adequate training or quality controls in place to ensure the provision of safe and effective alcohol withdrawal nursing care in the medical-surgical unit. Facility leaders required that medical-surgical unit nurses complete initial and annual alcohol withdrawal training. Facility nursing leaders reported not having evidence of alcohol withdrawal training for the five nurses for the two years prior to the patient's death. Alcohol withdrawal care competency validation was also required for the five nurses upon hire. Facility nursing leaders were only able to provide three of five nurses' competency assessments from the years prior to the patient's death. Nurse 3's competency assessment showed that nurse 3 needed supervision when providing alcohol withdrawal care. Nurse 2 and nurse 5's competency assessments showed independent proficiency in providing alcohol withdrawal care; however, this was during their 2012–2013 review period. The OIG concluded that the lack of nurse training and competency assessment likely contributed to deficiencies in alcohol withdrawal care in this case.

In addition, the medical-surgical unit nurse manager did not conduct periodic chart reviews of documentation to monitor the quality of nursing care. The OIG determined that additional reviews, such as routine chart reviews, may assist the medical-surgical unit nurse manager in more adequately assessing the quality of care provided by medical-surgical unit nurses and may aide managers in identifying deficiencies in nursing care.

Additional Concern: Facility Alcohol Withdrawal Protocol

During the inspection, the OIG determined that the facility's alcohol withdrawal protocol could be discontinued by nursing staff prior to the onset of a patient's withdrawal symptoms. The facility protocol instructed nurses to discontinue alcohol withdrawal assessment and treatment when patients had three consecutive assessments, exhibited only mild withdrawal symptoms, and assessments were performed eight hours apart. This guidance could lead nurses to discontinue alcohol withdrawal assessment and treatment only 16 hours into a patient's hospital admission.

The onset of alcohol withdrawal typically occurs one–five days after cessation or reduction in alcohol use.[10]

The OIG made one recommendation to the Veterans Integrated Service Network Director to review the provider's care of the patient. The OIG made nine recommendations to the Facility Director related to same-day care access, communication of test results and treatment plans, assigned surrogates, preoperative care including quality reviews, medical-surgical unit nurses' patient care, Trendelenburg position usage and staff education, nursing competencies for alcohol withdrawal assessments and treatment, medical-surgical unit nurses' quality control oversight, and the facility's alcohol withdrawal treatment protocol.

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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[10] Mayo Clinic, "Alcohol use disorder," accessed June 24, 2021, https://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/symptoms-causes/syc-20369243.

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Abbreviations

CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol, revised
CT	computed tomography
EHR	electronic health record
ICU	intensive care unit
OIG	Office of Inspector General
PACT	patient aligned care team
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate concerns related to the assessment of a patient's preoperative health status and postoperative care at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia.

Background

The facility, part of Veterans Integrated Service Network (VISN) 7, offers a wide variety of inpatient and outpatient services in Augusta, Georgia, including surgical services. The Veterans Health Administration (VHA) classifies the facility as a complexity level 1b, high complexity.[1] From October 1, 2019, through September 30, 2020, the facility served 46,020 patients.

Prior OIG Reports

In the July 2019 report, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia,* the OIG identified concerns with facility staff not feeling supported by leaders, an inefficient hiring process, and inadequate communication of policies, among other administrative issues. The OIG made 27 recommendations, two of which remained open as of September 2, 2021.[2]

In the May 2020 report, *Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia*, the OIG outlined non-compliant practices and other deficits that contributed to adverse patient events and clinical outcomes. Due to the lack of consistent documentation, the OIG was unable to determine whether insufficient nurse staffing contributed to many of the patient events outlined in the allegations. The OIG identified concerns with compliance with VHA and facility requirements related to nursing practices documentation, evaluation of the circumstances surrounding the respiratory care for a patient, processes for securing sitters, and nurse staff assignment practices. The OIG made six recommendations, which were closed as of September 2, 2021.[3]

In the September 2020 report, *Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, the OIG identified that care deficiencies likely contributed to a patient's death. The OIG identified other concerns

[1] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing.

[2] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019.

[3] VA OIG, *Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-08296-118, May 12, 2020.

related to documentation, mismanagement of the patient's mental health needs, deficient Disruptive Behavior Committee processes and oversight, and facility leaders' insufficient review and response to the patient's death. The OIG made 18 recommendations, two of which remained open as of September 2, 2021.[4]

In the December 2020 report, *Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia*, the OIG identified deficiencies in care coordination between facility staff and telemedicine intensive care unit (ICU) staff after general surgery residents were removed by a university affiliate. However, the OIG was unable to determine that the absence of surgery residents resulted in deaths, injuries, or poor outcomes for patients identified in the complaint. The OIG found that facility leaders were aware of the removal of the residents but did not take actions to mitigate potential issues. The OIG identified other concerns related to communication and coordination, on-call processes, medicine and surgery staff responsibilities, patient safety reporting training, quality review collaboration processes, orientation and competency training, and coordination of patient care reviews. The OIG made eight recommendations, which were closed as of September 2, 2021.[5]

Concerns

During an OIG mortality review in December 2020, the OIG Office of Healthcare Inspections identified concerns with the primary care and preoperative and postoperative care of a patient who died at the facility. The patient underwent minimally invasive urologic surgery at the facility in fall 2020. After surgery, the patient was admitted and subsequently suffered alcohol withdrawal and declining health. The patient remained in the facility and died while on hospice in the ICU on postoperative day 13. The OIG opened a healthcare inspection in January 2021 to assess the adequacy of the patient's

- patient aligned care team (PACT) care in the approximately 20 weeks prior to surgery,
- preoperative outpatient care including surgical assessment and anesthesia evaluation, and
- postoperative care, specifically alcohol withdrawal treatment.

[4] VA OIG, *Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 19-08106-273, September 30, 2020.

[5] VA OIG, *Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 20-01480-31, December 16, 2020.

Scope and Methodology

The OIG initiated the inspection in January 2021 and conducted virtual interviews in March, April, and May 2021.[6]

Interviews included the Chief of Staff, Assistant Chief of Staff, Acting Associate Director of Patient Care Services, Acting Chief of Quality Management, Chief of Primary Care, numerous facility staff, and a family member of the patient.[7] The OIG also consulted with a VHA anesthesiologist and urologist, who were not affiliated with the facility, regarding the patient's anesthesia and urology surgical care.

The OIG reviewed VHA directives, handbooks, and memorandum; facility policies, procedures and training documents; credentialing documents; a patient safety report; committee meeting minutes between October 2019 and January 2021; and the patient's electronic health record (EHR) from November 2019 through November 2020.[8]

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).

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, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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[6] The interviews were conducted virtually due to the coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," March 11, 2020, accessed August 24, 2021, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. *Merriam-Webster.com Dictionary*, "Definition of pandemic," accessed August 24, 2021, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. The World Health Organization, Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It, accessed August 24, 2021, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[7] Numerous facility staff included the Patient Safety Coordinator, Risk Manager, an anesthesiologist, urologist, cardiologist, pulmonologist, neurologist, physical therapist, certified registered nurse anesthetist, a primary care nurse, current and acting nurse managers, primary care providers, medical-surgical unit nurses, and social workers.

[8] These included the Executive Council Medical Staff, Peer Review, Medical Records, Surgical Invasive Services, and Mortality Review Committees.

Patient Case Summary

The patient, who was in their 70s, received primary and specialty care at the facility since 1997.[9] The patient's medical history included Barrett's esophagus and low back pain from spinal stenosis requiring chronic pain medication.[10]

In early summer 2020, the patient called the assigned primary care provider (provider) to report multiple health concerns including weight loss. Two days later, the provider addressed the patient's health concerns via telephone and recommended the patient be evaluated in the Emergency Department but did not address the patient's complaint of weight loss. The same day, the patient presented to the facility's Emergency Department and was admitted the following day for treatment of abnormal electrolyte levels. The patient weighed 130 pounds on admission, down seven pounds from early 2020. The patient's weight in early 2020 had stayed within two pounds for approximately 18 months.

The patient was admitted to the facility and acknowledged drinking two to three beers daily. While hospitalized, two licensed clinical social workers provided alcohol use education and counseling to the patient, and the patient declined further treatment. The next day, the patient was discharged from the hospital in stable condition and instructed to follow up with the provider for repeat blood tests.

Approximately two weeks later, the provider telephoned the patient and discussed the patient's test results, including improved electrolyte levels, and a recent chest computed tomography (CT) scan showing signs of possible aspiration. The provider recommended and ordered a barium swallow test to look for evidence of aspiration and ordered antibiotics for the patient. The EHR showed no evidence that the barium swallow test was scheduled or completed.

In mid-summer 2020, the patient called the PACT clinic and spoke with a nurse regarding complaints of severe muscle spasms, similar to symptoms a month earlier. The nurse forwarded the message to the PACT physician who, 12 days later, acknowledged the message and ordered repeat blood tests. The patient's blood tests were completed the next day and showed abnormal electrolyte and protein levels. A few days later, the patient was notified of the abnormalities by letter and phone with instructions to treat the abnormalities by supplementing dietary intake using a sports drink (such as Gatorade).

At an outpatient appointment approximately two months later, the patient's recorded weight was 110 pounds. The same day, a repeat chest CT scan was ordered by the PACT physician that showed a waxing and waning pattern of pulmonary nodules "most consistent with a chronic

[9] The OIG uses the singular form of they (their) in this instance for privacy purposes.

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

infectious/inflammatory process."[11] The radiologist recommended the PACT physician consult a pulmonologist if one had not already been consulted. Repeat blood tests were completed that day and again showed abnormal electrolyte and protein levels; the provider was notified of the results the same day.

The next day, the patient underwent a urologic procedure (cystoscopy) for complaints of frequent and painful urination, and low urinary flow of four to five months duration. The procedure results showed an obstructing prostate. The urologist planned to perform a minimally invasive urologic surgery (surgery) 20 days later to treat an enlarged prostate.

Eight days before surgery, a urology physician assistant performed a preoperative evaluation, documented a general physical examination of the patient, and affirmed the plan for surgery. The attending urologist obtained consent for surgery from the patient. That same day, a nurse practitioner completed an anesthesia preoperative assessment for the patient including a review of systems, and documented a mouth, airway, and neck examination. The nurse practitioner noted the patient's late 2019 abnormal pulmonary function testing, and multiple abnormal chest images. An anesthesia care plan and consent for anesthesia was discussed with the patient. The patient was instructed to take a beta-blocker medication on the day of surgery. On the same day, the patient also completed a surgical patient education and pre-screening nursing visit. During that visit, the patient endorsed consuming one to two drinks of whiskey per day. Documentation on the discharge plan indicated that the patient planned to return home with transportation provided by the patient's significant other.

In the evening three days before surgery, the patient sent a secure message to the PACT team complaining of weakness and not being able to keep "anything" down.[12] The next morning, the PACT nurse answered the patient via secure message stating the patient "may" need to go to the Emergency Department because the provider was out of the clinic and no appointment was available for approximately two months. The patient requested to be seen sooner by another primary care provider. The PACT nurse notified the patient that the request would be forwarded to a medical support assistant. The EHR does not contain evidence that a PACT appointment was scheduled.

On the day of surgery, the patient presented to the facility as planned. A pre-procedure nursing assessment was completed; the patient denied taking beta-blocker medication that morning. The patient had a normal blood pressure reading, although slightly elevated from the patient's baseline; an elevated heart rate of 105; and a weight of 111 pounds. The patient's surgery was

[11] Waxing and waning indicates nodules that show regression, either with treatment or spontaneously, and appearance of new nodules at different sites on follow-up imaging.

[12] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. "Secure Messaging is a web-based, encrypted, secure communication tool" to facilitate patient and staff communication.

completed without complications with a plan to discharge home after the patient was able to urinate.

Postoperatively, the patient had difficulty urinating and orthostatic hypotension but was alert with no confusion. Given the patient's orthostatic hypotension and a concern for physical deconditioning, the urology service physicians admitted the patient to a medical-surgical unit at the facility with a plan for a medicine team physician's consultation, fluid rehydration, therapy, and rehabilitation placement or home health, as needed. Due to the patient's reported history of alcohol use, a urology physician had initiated the facility's alcohol withdrawal treatment protocol for the patient.

In the morning of postoperative day 1, a nurse documented the patient was alert but slow in responding. A urology physician noted that the patient had no active urologic concerns and could be discharged. A social worker wrote in the EHR the patient was appropriate for nursing home care but had refused. Although the social worker arranged home health services for the patient, ultimately the patient stayed in the hospital because the patient's driver declined to assume care of the patient.

In the afternoon of postoperative day 1, the patient was noted to be alert and appropriately answering questions. However, in the evening and into the early morning hours of postoperative day 2, the patient began to exhibit early signs of anxiousness, confusion, and agitation, which required treatment with medication per the alcohol withdrawal protocol.

Later that morning, a physical therapist entered an EHR note stating the patient was found to be confused and in the Trendelenburg position. The physical therapist wrote that the nursing assistant present in the room indicated the reason for the Trendelenburg positioning was the patient attempting to get out of bed.

On postoperative day 3 at 3:07 a.m., a nurse documented the patient was confused. The patient received medication per the alcohol withdrawal protocol. At 10:40 a.m., the medicine team physician noted the patient developed dropping oxygen levels, an increased heart rate, and low blood pressures. The medicine team physician additionally noted a brain CT scan, completed about an hour prior, had shown no new changes to explain the patient's sudden confusion, and the patient's new mental confusion seemed most consistent with alcohol withdrawal. A scan of the lungs showed no blood clots that would account for the rise in heart rate and low oxygen levels; however, an infection remained a possibility. The attending medicine physician documented the patient had "6-7 CT [scans] of the chest since last year" with the consideration of aspiration pneumonia. With declining oxygen levels and low blood pressure levels, the patient was transferred to the ICU for closer monitoring. Later that day, the patient was started on antibiotics for possible sepsis from pneumonia and urinary tract infection.

Over the next nine days, the patient's clinical condition deteriorated, and the patient was transitioned to inpatient hospice. The patient died the following day. An autopsy was not performed.

Inspection Results

1. Deficiencies in PACT Care

The OIG determined that PACT staff failed to provide sufficient care coordination and treatment in the months prior to the patient's surgery in mid-fall 2020.[13] Specifically, the provider failed to adequately address the patient's recurrent abnormal chest images and poor nutritional status, and failed to communicate blood test results to the patient in VHA's required time frame.[14] A PACT registered nurse (the PACT nurse) failed to adequately respond to the patient's request for assistance via secure message two days prior to surgery.

Inadequate Response to Abnormal Chest Images

The provider failed to adequately address the patient's recurrent abnormal chest images, and facility staff also failed to schedule and complete a barium swallow test. In the year preceding surgery, the patient had multiple abnormal chest images (CT scans and chest x-rays), and was prescribed four cycles of antibiotics for chest infections. The chest images showed signs of a chronic infectious or inflammatory process, possible aspiration, and pulmonary nodules. Despite two patient requests and a recommendation from a radiologist, the provider failed to consult a pulmonologist. VHA policy suggests PACT staff consult with specialty care when a patient requests "clinically appropriate consultation" or when the expertise of specialty care is needed to evaluate or treat complex health conditions.[15] PACT staff can request formal assistance from specialty care providers by placing a consult in the EHR.[16]

In the months preceding surgery, the provider failed to address two requests from the patient to discuss the possibility of a consult to a pulmonologist. In addition, three weeks before surgery, a radiologist recommended the provider consult a pulmonologist for persistent abnormalities seen on CT scans. The provider reported being aware of the patient's ongoing pulmonary issues, and would have consulted a pulmonologist if the patient's treatment failed or condition worsened. During an interview, the provider reported wanting to see the patient in person to determine if the treatment plan was failing. The EHR reflects that the provider spoke with the patient several times in the months prior to surgery; however, there were no documented attempts to see the patient in person. The provider informed the OIG that the treatment plan was to repeat chest CT scans, order a barium swallow and bone density test, and prescribe cough syrup and antibiotics. The provider did not order a bone density test. The EHR reflects the provider prescribed four cycles of antibiotics between late fall 2019 and mid-summer 2020. During a telephone

[13] VHA Handbook 1101.10(1); Patient Aligned Care Teams (PACTs) are comprised of healthcare professionals, such as physicians and nurses, along with administrative support staff, who provide patient-centered, accessible, timely, comprehensive, coordinated primary care in partnership with the patient.

[14] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[15] VHA Handbook 1101.10(1).

[16] VHA Handbook 1101.10(1).

appointment, four months before surgery, the provider recommended that the patient receive a barium swallow test, which would look for muscle weakness, a possible cause of aspiration. The provider signed an order for a barium swallow test, but the test was not scheduled or completed. Facility staff provided conflicting explanations for this failure and were unable to provide evidence to explain why this test was not scheduled.[17]

The OIG interviewed a facility pulmonologist who was involved in the patient's postoperative care. The pulmonologist reported that the provider could have called pulmonology to discuss the patient's case or place a consult. The pulmonologist confirmed that had a pulmonology consult been placed six or more months prior to surgery, testing and treatment could have been provided to diagnose, and possibly improve the patient's pulmonary status. The OIG determined that the provider's explanations for failure to consult a pulmonologist were inadequate.

Provider's Failure to Treat Patient's Poor Nutritional Status and Communicate Test Results

The OIG determined that the provider failed to adequately address the patient's poor nutritional status and failed to communicate blood test results to the patient in VHA's required time frame.[18] In the months leading up to surgery, the patient lost 27 pounds (20 percent of total weight), and the patient had multiple abnormal blood tests.[19]

Approximately four months prior to surgery, the provider failed to address the patient's request to discuss weight loss. The patient was subsequently briefly admitted to the facility in early summer 2020 with "significant electrolyte disorders" and the patient's recorded weight on admission reflected a seven-pound weight loss in four months. In the weeks following this admission, the provider ordered two blood tests for the patient and both were abnormal. The provider addressed these abnormalities by repeating the blood tests, offering dietary suggestions, instructing the patient to supplement with a sports drink (such as Gatorade), and suggesting the patient present to the Emergency Department if symptoms worsened.

During an outpatient specialty care appointment, three weeks before surgery, the patient's recorded weight showed an additional 20-pound loss.[20] When asked about the patient's weight loss, the provider responded that the patient was "not doing well at that time." The provider confirmed that the patient would have benefited from an in-person visit. The OIG acknowledged that at times the EHR reflected communication struggles between the patient and provider. For example, the patient refused to go to the Emergency Department, was noted to have resistance to

[17] Facility staff informed the OIG this study was not completed as the order was placed on hold by the provider because the patient wanted to wait. However, this was not supported by documentation in the EHR. The OIG also learned in an interview that the provider was waiting for the results of the barium swallow test.

[18] VHA Directive 1088.

[19] The patient's starting weight was 137 pounds and ending weight was 110 pounds.

[20] At this visit, the patient was 5 feet 6 inches tall and weighed 110 pounds. The patient's weight had previously been stable for over one year prior to this weight loss.

alternative medications, and was not receptive to medical advice. However, other EHR notes indicated that the patient repeatedly attempted to obtain medications, and did not receive a response from the provider for several days. In addition, the EHR reflected that the patient reported not receiving letters indicating test results and reported frustration with medications that the provider was "to mail" never arrived and were instead waiting for pick up at the facility pharmacy.

Three weeks before surgery, the provider ordered and received a third abnormal blood test. The provider failed to communicate the blood test results to the patient within seven calendar days as required by VHA policy.[21] The provider mailed the test results to the patient 13 days later, and failed to highlight the abnormalities or provide a plan of care. On the same day, the provider added the PACT nurse as a cosigner to a note in the EHR requesting that the nurse notify the patient by phone to take a sports drink (Gatorade) three times a day, repeat blood tests in one week, and report to the Emergency Department with any abnormal symptoms. The PACT nurse did not acknowledge the note until nine days later, at which time the patient had already been admitted to the facility.

The OIG determined that the PACT nurse was on unplanned leave the day the note was entered and did not return to the facility until six days later. VHA requires that facility staff establish contingency plans to ensure messages are communicated or assigned to covering PACT staff to ensure patients receive continuity of and access to care during staff absences.[22] The OIG found that a surrogate was not assigned for the PACT nurse while on leave. A facility nursing leader stated it was the responsibility of a nurse manager to ensure a surrogate was assigned for a nurse who was on unplanned leave. The two nurse managers on duty at the time were unable to explain why this failure occurred. Additionally, the provider did not contact the patient in the nurse's absence.

The OIG determined that the provider's documentation in the EHR and explanations regarding the patient's care were inadequate to address the patient's clinical needs. Facility leaders reported no concerns with the provider's practice, and the provider successfully passed ongoing professional practice evaluations through May 2020.[23] After the facility was informed of the OIG inspection, facility staff completed a peer review of the provider's care of the patient from June 2020 to October 2020 and found no concerns with the quality of care provided.

However, the OIG was concerned about the provider's quality of care given to the patient in the months preceding surgery. The provider's failure to consult a pulmonologist, follow up on a barium swallow test, timely communicate abnormal test results, and adequately treat the patient's poor nutritional status most likely contributed to the patient's poor health going into the

[21] VHA Directive 1088.

[22] VHA Handbook 1101.10(1).

[23] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. VHA uses ongoing professional practice evaluations to confirm the quality of care delivered by privileged clinicians to ensure patient safety.

preoperative phase of care. In addition, these failures may have impeded the surgical team's understanding of the magnitude of the patient's health conditions.

Inadequate Response to Patient's Request for Assistance

The OIG determined that the PACT nurse failed to adequately respond to the patient's request for assistance via secure message. Two days prior to surgery, the PACT nurse returned from leave and responded to a secure message that the patient sent the evening before, complaining of being weak and not able to keep "anything down." The PACT nurse did not alert a primary care provider, call the patient, schedule a same-day appointment for the patient, or note the provider's instructions from six days prior asking the PACT nurse to have the patient present to the Emergency Department if symptomatic. The PACT nurse responded with a secure message to the patient stating that the provider was out of the clinic, and the patient "may need to be evaluated in the emergency room" as the next available appointment with the provider was in two months. The patient requested to be seen sooner by another provider. The PACT nurse messaged the patient to explain that this appointment request would be sent to a medical support assistant, but a same-day or next-day appointment was not made.

VHA policy requires that a patient's request for health care is promptly evaluated by the PACT staff member who has the appropriate competency to do so.[24] "PACT staff must offer clinically indicated care to the patient that is respectful of the patient's preferences and appropriate for the safe delivery of care."[25] Secure messaging is a way for PACT staff and patients to exchange non-urgent health information.[26] If an in-person visit is required for the safe delivery of appropriate care, then VHA does not allow for substitution with other methods of care delivery.[27] VHA policy requires that all PACT physicians and nurses have same-day access for face-to-face or telephone encounters, providing the request for such is made when sufficient time is left in the workday.[28] VHA policy also outlines a hierarchy for PACT staff to follow when patients seek non-emergency care. The hierarchy ranges from a same-day appointment with the patient's assigned primary care provider to a next-day appointment with another PACT clinician.[29]

The PACT nurse could not explain why the term "may" was used to tell the patient to go to the Emergency Department. The PACT nurse was also unable to recall any details of this interaction, beyond the documented EHR notes, and was therefore unable to explain to the OIG why a same-day appointment was not made or why a primary care provider was not alerted. The PACT nurse offered that perhaps upon returning from leave the provider's message regarding the patient's abnormal blood test results was not easily visible in the EHR due to the amount of information

[24] VHA Handbook 1101.10(1).
[25] VHA Handbook 1101.10(1).
[26] VHA Handbook 1101.10(1).
[27] VHA Handbook 1101.10(1).
[28] VHA Handbook 1101.10(1).
[29] VHA Handbook 1101.10(1).

the PACT nurse was alerted to during leave. The PACT nurse reported rapidly reviewing the EHR but did not review the provider's recent message. The PACT nurse reported typically responding to calls with a return call and to secure messages with a secure message, although the PACT nurse could not recall why a call was not placed to the patient in this instance.

The OIG determined that the PACT nurse failed to adequately respond to the patient's request for assistance. The PACT nurse did not alert a primary care provider, call the patient, schedule a same-day appointment for the patient, or note the provider's instructions from six days prior asking the PACT nurse to have the patient present to the Emergency Department if symptomatic. Facility leaders acknowledged concerns with the PACT nurse's insufficient response to the patient's request for assistance. Facility staff completed a peer review of the PACT nurse's care of the patient and found that experienced clinicians would have managed the case differently. In response to these concerns, re-education was provided to the PACT nurse. Facility staff provided confirmation to the OIG that this education occurred. The PACT nurse's failures compounded the provider's failures to recognize and treat the patient's declining health prior to surgery.

2. Preoperative Care

The patient was scheduled for surgery in fall 2020. The OIG evaluated the patient's preoperative outpatient care including surgical assessment and anesthesia evaluation and determined that the surgical team obtained a consent for surgery and completed all required elements of a preoperative assessment.[30]

Surgical Assessment and Anesthesia Evaluation

VHA and facility policies require a physical examination and a discussion of the risks and benefits of surgery to allow patients to make an informed choice to proceed.[31] For surgeries that require anesthesia, this choice must be documented in a written consent form and signed by the patient.[32] The OIG found that the facility's surgical team examined the patient's urologic condition, documented a discussion of the risks and benefits of surgery, and determined a plan of care, and the patient signed the consent to proceed with surgery and anesthesia.

The OIG determined that the surgical team completed preoperative assessments and plans. VHA and facility policies required within the 30 days preceding surgery, completion of a comprehensive history and physical examination, a pre-anesthesia assessment, and the patient

[30] For the purposes of this report, the OIG considers the surgical team to include clinicians from anesthesiology and surgery including surgical nurses who were involved in the patient's care.

[31] VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009, amended January 4, 2021. Facility Policy 112-18-07, *Documentation and Completion of Health Records,* October 26, 2018.

[32] VHA Handbook 1004.01(4).

assigned an American Society of Anesthesiologists physical status score.[33] Eight days before surgery, the surgical team completed a history and physical exam, a pre-anesthesia assessment, reviewed complications or risks from previous anesthesia, and assigned an American Society of Anesthesiologists physical status score.

Alcohol Use Assessment and Discharge Planning

The OIG determined that the surgical team also assessed the patient's alcohol use. VA recommends that patients are screened annually for alcohol use, and if applicable, provided intervention.[34] Facility policy requires an assessment of suspected drug use during the preoperative evaluation process.[35] The patient reported no use of illegal drugs, a decrease in alcohol consumption on screenings in the months leading up to surgery, and just prior to surgery, reported only consuming one drink occasionally. A surgical team member explained that the potential for patients to minimize alcohol use is considered in the choice to perform surgery. The patient's family member informed the surgical team on the day of surgery that the patient's alcohol use was three to five drinks per day. The surgical team determined that this information did not prohibit the patient from having the minor surgical procedure.

The OIG determined that the surgical team formulated a discharge plan for the patient. VHA recommends discharge planning to be initiated at admission and include a multidisciplinary team approach along with the patient's input.[36] The surgical discharge plan, completed eight days before surgery, was for the patient to return home the same day as surgery with the patient's significant other providing transportation. The day before surgery, a facility nurse telephoned the patient to provide instructions for the surgery, including having a driver to return the patient home. On the day of surgery, a family member informed the surgical team that the patient lived alone and was having difficulty with self-care. In response, the surgical team entered a social work consult. A social worker met with the family member while the patient was in surgery and provided education on how to obtain home healthcare. After surgery, the family member declined to assume care of the patient as the family member was leaving the state in a few hours to return home.

Day of Surgery Assessments

The OIG determined that prior to surgery, the surgical team reassessed the patient, as required by VHA, before the induction of anesthesia.[37] Facility policy requires that within 24 hours prior to anesthesia, and based on the results of the pre-anesthesia assessment, a licensed independent

[33] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. Facility Policy 112-18-07.

[34] VA/DOD, *Clinical Practice Guideline for the Management of Substance Use Disorders*, December 2015.

[35] Facility Policy Memorandum No. 6022, *Assessment of Patients,* February 2, 2019.

[36] VA Care Management and Social Work, "Discharge Planning White Paper," December 2017.

[37] VHA Handbook 1907.01.

practitioner makes a determination if the patient is an appropriate candidate to undergo the planned anesthesia.[38] On the day of surgery, a certified registered nurse anesthetist reevaluated the patient and documented no significant change to the following: review of systems, airway, cardiopulmonary examination, and the patient's clinical information since the preoperative evaluation.

The OIG consulted with a non-facility VHA anesthesiologist and a urological surgeon regarding this patient's case. The two reported no concerns with the surgical team's choice to complete surgery or with the completion of the minimal elements required for a preoperative assessment. However, the OIG was concerned that although the surgical team met all required elements of preoperative assessment, the surgical team did not detect the patient's overall poor health, possibly compounding the provider's and PACT nurse's failures to intervene on the patient's behalf.

Although facility staff completed quality reviews of the patient's surgical care, the OIG determined that additional quality reviews may assist facility leaders in understanding areas for improvement.

3. Postoperative Care

The OIG determined that medical-surgical nurses did not consistently perform Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar) assessments or administer medications according to the facility alcohol withdrawal treatment protocol or according to physician orders. The OIG determined that medical-surgical unit nursing leaders did not have adequate training or quality controls in place to ensure the provision of safe and effective alcohol withdrawal nursing care in the medical-surgical unit.

Following surgery, the patient was admitted to the facility due to orthostatic hypotension and lack of a postoperative caregiver to assist with activities of daily living. From the evening of admission until transfer to the ICU in the afternoon of postoperative day 3, the patient was placed on the medical-surgical unit. In the early morning hours of postoperative day 2, the patient's condition declined and a physician noted that the patient's mental status was altered possibly due to alcohol withdrawal.

Alcohol Withdrawal Treatment Guidance

Alcohol withdrawal may occur from several hours to five days after a patient's alcohol use is significantly reduced or stopped after heavy, prolonged use.[39] Symptoms of alcohol withdrawal

[38] Facility Policy Memorandum No. 6022, *Assessment of Patients,* February 2, 2019.

[39] Mayo Clinic, "Alcohol use disorder," accessed June 24, 2021, https://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/symptoms-causes/syc-20369243.

include hallucinations, seizures, hand tremors, rapid heartbeat, nausea and vomiting, sweating, problems sleeping, restlessness, agitation, and anxiety.[40]

When medication to treat alcohol withdrawal is provided on a symptom-triggered schedule rather than a fixed one, VA recommends skilled staff frequently assess the severity of symptoms using a validated measure such as the CIWA-Ar.[41] VA recommends benzodiazepines as the preferred medications to treat moderate or severe alcohol withdrawal.[42] At the time of the OIG inspection, facility practice was for staff to use standard order sets to initiate symptom-triggered benzodiazepine administration.[43] Registered nurses used standardized nursing note templates that contained the CIWA-Ar questions to assess the patient's symptoms of alcohol withdrawal and assign a score that described the level of severity.[44] The facility CIWA-Ar note template included actions (protocol) for nurses to take depending on the total score:

- Scores less than 9 represented patients who had mild symptoms and only required reassessment in eight hours and discontinuation of assessments if the "score is less than 8 times three."
- Scores from 9–15 represented patients who had moderate symptoms and required administration of benzodiazepines and reassessment in two hours.
- Scores greater than 15 represented patients who had severe symptoms, required administration of benzodiazepines and reassessments every hour until the score was less than 12, and physician notification to transfer to the ICU.[45]

Admission and Postoperative Day 1

While on the medical-surgical unit, the patient was cared for by five registered nurses (nurses 1– 5).[46] At the time of admission, the physician ordered initiation of the protocol and included orders for CIWA-Ar assessments every four hours for the first 24 hours as well as

[40] Mayo Clinic, "Alcohol use disorder."

[41] VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, Version 3.0, 2015.

[42] VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders.

[43] VA Office of Information and Technology (OI&T), Computerized Patient Record System (CPRS), Technical Manual: List Manager Version, April 2021. Standard order sets are utilized to group like types of orders, such as admission, preoperative and postoperative orders, and in this case, the alcohol withdrawal order set.

[44] Soumitra S., et al., "A Symptom Triggered Benzodiazepine Protocol Utilizing SAS and CIWA-Ar Scoring for the Treatment of Alcohol Withdrawal Syndrome in the Critically Ill", *Annals of Pharmacotherapy*, 2017, Vol. 51(2): 101–110.

[45] The CIWA-Ar contains 10 scoreable items; the total score ranges from 0–67. Scores greater than 9 also required telemetry monitoring with continuous pulse oximetry monitoring; however, the patient was on both monitors continuously during this three-day stay, thus the OIG did not include these elements in the findings.

[46] Facility registered nurses on the medical-surgical unit typically worked 12-hour shifts either at night, or during the day from 7:30 a.m. to 8:00 p.m., and reportedly cared for three to five patients each while receiving support from nursing assistants.

benzodiazepines for moderate or severe alcohol withdrawal symptoms consistent with the protocol.[47]

The first nurse (nurse 1) initiated assessments and reassessed the patient approximately every four hours. On the morning of postoperative day 1, a second nurse (nurse 2) assumed care of the patient. Nurse 2 failed to assess the patient according to the physician's orders and only completed one assessment during the 12-hour shift. When interviewed, nurse 2 reported following the facility's protocol and not the physician's order for assessments of every four hours for the first 24 hours. Nurse 2 explained that as the assessment was negative three times, the protocol indicated assessments could be discontinued. The OIG reviewed the protocol and found this conclusion was incorrect; the protocol states that assessments should be discontinued if a patient has mild symptoms of alcohol withdrawal on three assessments eight hours apart. At the time, the patient had four assessments showing mild symptoms approximately four hours apart. Nurse 2 did not contact a physician to clarify the difference between the order and protocol. Nurse 2 reported that the patient was scheduled to be discharged and was not showing signs of alcohol withdrawal during this shift and therefore, did not require further assessment.

On the afternoon of postoperative day 1, the patient was prepared for discharge home, but the patient's driver declined to assume care of the patient. The patient remained in the hospital another night until transportation could be coordinated the next day. Overnight, the patient's condition declined, and the planned discharge was discontinued.

At 7:50 p.m. on postoperative day 1, nurse 1 resumed care of the patient and found the patient was disoriented and attempted to get out of bed. Nurse 1 assessed the patient and noted moderate alcohol withdrawal symptoms. However, nurse 1 delayed administering a benzodiazepine until 9:45 p.m., approximately two hours after the initial assessment. Nurse 1 reassessed the patient at 10:45 p.m. and documented the patient's symptoms were moderate; however, nurse 1 did not repeat the benzodiazepine as ordered and failed to reassess the patient in two hours.[48]

Table 1. Admission and Postoperative Day 1 Assessments and Benzodiazepines

Assessment Time	Nurse	Benzodiazepine Required	Benzodiazepine Administered	Reassessment Required in:	Reassessment Completed in:
8:45 p.m.	1	No	n/a*	4 hours	3.5 hours
12:15 a.m.	1	No	n/a	4 hours	4.5 hours
4:45 a.m.	1	No	n/a	4 hours	5.5 hours
10:15 a.m.	2	No	n/a	4 hours	9.5 hours

[47] For the purposes of this report, the OIG uses assess, reassess, assessment, and reassessment to describe CIWA-Ar assessments.

[48] The facility's protocol specifies reassessment of a patient two hours after giving a benzodiazepine for moderate symptoms to reassess for effectiveness.

Assessment Time	Nurse	Benzodiazepine Required	Benzodiazepine Administered	Reassessment Required in:	Reassessment Completed in:
7:50 p.m.	1	Yes	Delayed until 9:45 p.m.	2 hours	3 hours
10:45 p.m.	1	Yes	No	2 hours	3.25 hours

Source: OIG analysis of the patient's EHR.
** n/a indicates not applicable*

Postoperative Day 2

Nurse 1 assessed the patient at 2:00 a.m. and noted that the patient had mild symptoms. At 5:30 a.m., the patient's symptoms were moderate, and nurse 1 administered a benzodiazepine. At 7:50 a.m., the patient's symptoms were moderate; however, nurse 1 did not provide a benzodiazepine. The OIG was unable to ascertain the reason for nurse 1's failure to reassess and medicate the patient according to the protocol as indicated at the time of this inspection, nurse 1 no longer worked for VHA and did not respond to the OIG's interview request.

Nurse 3 assumed the patient's care from nurse 1 around 8:00 a.m. Nurse 3 also failed to follow the protocol, failed to follow the physician's orders, and was unable to provide a valid reason for these failures. During nurse 3's 12-hour shift, the patient was not assessed using CIWA-Ar or administered benzodiazepines. In addition, EHR notes during this time described the patient as confused.

Nurse 3 has since moved to another VHA facility but was available for interview. Nurse 3 reported that a physician gave a verbal order to discontinue the patient's alcohol withdrawal treatment on the morning of postoperative day 2. Nurse 3 could not provide the name of the physician who allegedly gave this verbal order and did not document this verbal order in the patient's EHR. Not only did the EHR reflect no evidence of a verbal order to discontinue the patient's alcohol withdrawal treatment, the two physicians treating the patient at the time had documented in the patient's EHR to continue protocol and provide benzodiazepines as needed. The OIG reached out to the two physicians charged with the patient's care and neither recalled providing a verbal order to nurse 3. In addition, another physician entered duplicate orders for alcohol withdrawal treatment at 4:25 p.m., and nurse 3 verified the orders at 4:38 p.m.; however, nurse 3 failed to reassess the patient or provide benzodiazepines.

Table 2. Postoperative Day 2 Assessments and Benzodiazepines

Assessment Time	Nurse	Benzodiazepine Required	Benzodiazepine Administered	Reassessment Required in:	Reassessment Completed in:
2:00 a.m.	1	No	n/a	8 hours	3.5 hours
5:30 a.m.	1	Yes	5:37 a.m.	2 hours	2.25 hours
7:50 a.m.	1	Yes	No	2 hours	24 hours

Source: OIG analysis of the patient's EHR.

During nurse 3's shift, at 10:15 a.m., a physical therapist noted the patient was confused, disoriented, and in the Trendelenburg position. The physical therapist's note also indicated that a medical-surgical unit nursing assistant was present in the room and stated the positioning was to prevent the patient from trying to get out of bed.[49]

According to the facility's Chief of Staff and a medical-surgical unit nurse manager, the Trendelenburg position is not an appropriate position to prevent a patient from trying to get out of bed. In addition, the risk for aspiration increases the longer the patient is in this position.[50] The OIG made facility leaders aware of these findings and the medical-surgical unit nurse managers reported inpatient nursing staff will be re-educated about the risks of using the Trendelenburg position. In addition, a medical-surgical unit nurse manager clarified that nurses need an order from a provider to place a patient in the Trendelenburg position if required for valid reasons (such as positioning during surgery). Facility leaders concurred that patients should not be placed in the Trendelenburg position for restlessness or as a form of restraint.

When interviewed by the OIG, nurse 3 was unable to recall that the patient was placed in this position. The OIG interviewed a medical-surgical unit nursing assistant assigned to the patient on the morning in question. The nursing assistant recalled seeing someone in the Trendelenburg position at around the start of a shift at 7:30 a.m.; however, could not recall the patient or day when this occurred. The nursing assistant confirmed this recollection was in the same half of the year as the patient's stay and matched the patient's general physical description. The OIG was unable to determine who placed the patient in the Trendelenburg position or for how long, and which nursing assistant was in the room with the patient.

The OIG interviewed several medical-surgical unit nursing assistants. One nursing assistant reported witnessing patients placed in the Trendelenburg position as a form of restraint; however, no one could provide the names of patients or staff involved. The nursing assistants also explained that although the medical-surgical unit had a no lift policy and had ceiling lifts in all

[49] The OIG was unable to determine the identity of the nursing assistant and therefore could not interview this person.

[50] Kathleen Rich, "Trendelenburg position in hypovolemic shock: A Review," *Journal of Vascular Nursing, Clinical Column 37,* (March 2019): 71–73, accessed March 16, 2021, https://pubmed.ncbi.nlm.nih.gov/30954203. Trendelenburg refers to the positioning of a patient with the head down and the feet elevated.

rooms (for repositioning of patients), nursing assistants sometimes used the Trendelenburg position to assist in repositioning patients toward the head of the bed.

Nurse 4 assumed care of the patient at the change of shift between 7:30 p.m. and 8:00 p.m. There were no nursing notes until after 3:00 a.m. (postoperative day 3), and no reassessment of the patient or administration of benzodiazepines until approximately 10 hours into nurse 4's shift. The patient was not provided with benzodiazepines to treat alcohol withdrawal symptoms for nearly 24 hours.

Postoperative Day 3

Between 3:00 a.m. and the end of shift at approximately 8:00 a.m., nurse 4 documented completion of one assessment (there was no documented time) and administration of one benzodiazepine to the patient at 5:19 a.m.[51] During these five hours, nurse 4 documented that the patient was alert but confused and still attempting to get out of bed without assistance. Nurse 4 documented speaking with a physician who instructed nurse 4 to follow the orders in the patient's chart to provide benzodiazepines as needed. Nurse 4 could not recall why the patient was not reassessed every two hours or provided with more than one benzodiazepine during the 12 hours that nurse 4 cared for the patient. Nurse 4 stated that based on the documentation in the EHR, the patient did not display symptoms of alcohol withdrawal and, therefore, nurse 4 did not initiate assessments until symptoms were present. Nurse 4 denied that this is normal practice if the protocol had already been initiated. When the protocol was active, nurse 4 told the OIG of having an expectation to get a handoff from the prior nurse at shift change. This handoff would have included the time of last assessment and projected time of reassessment. Nurse 4 could not recall if that occurred in this case, and stated that had it occurred, nurse 4 would have completed the assessments.

At 8:00 a.m., Nurse 5 assumed care of the patient and did not reassess the patient, but did document the patient was very confused, restless, and trying to get out of bed. Nurse 5 administered one benzodiazepine at 8:46 a.m. Nurse 5 could not recall why the patient was not reassessed every two hours or provided with more than one benzodiazepine during the approximately six hours that nurse 5 cared for the patient. Nurse 5 explained to the OIG that assessments were to be completed every four hours, and did not know why it was not documented.

At approximately noon, physicians documented that the patient "remains confused likely secondary to alcohol withdrawal," "may be aspirating," and noted improvement in the patient's cognition after the last benzodiazepine dose; and initiated the patient's transfer to the ICU. At 2:17 p.m. the patient was transferred to the ICU.

[51] Nurse 4 documented one assessment score at 8:10 a.m. and noted the full assessment template was inadvertently deleted; therefore, the exact time of assessment is unknown.

The OIG found that all five nurses charged with the patients care on the medical-surgical unit failed to adequately assess and treat the patient's alcohol withdrawal symptoms and failed to follow physician's orders. Given these failures, the OIG looked at the alcohol withdrawal training records of all five nurses in addition to questioning the medical-surgical unit nursing leaders about ongoing oversight of the quality of nursing care.

Medical-Surgical Nurses' Training

The OIG determined that medical-surgical unit nursing leaders did not have adequate alcohol withdrawal training in place to ensure the provision of safe and effective nursing care in the medical-surgical unit.

Facility leaders required medical-surgical unit nurses complete initial and annual alcohol withdrawal training. Facility nursing leaders reported not having evidence of alcohol withdrawal training for the five nurses for the two years prior to the patient's death. Facility nursing leaders also reported being unable to view the employee files of two nurses who were no longer employed at the facility.

Alcohol withdrawal care competency validation was also required for the five nurses upon hire and after October 1, 2020, competencies were required annually. Facility nursing leaders were only able to provide three of five nurses competency assessments from the years prior to the patient's death. Nurse 3's competency assessment showed that nurse 3 needed supervision when providing alcohol withdrawal care. A nursing leader informed the OIG that this supervision would have been provided by a shift charge nurse if requested by nurse 3. Nurse 2 and 5's competency assessments showed independent proficiency in providing alcohol withdrawal care; however, this was during the "2012-2013" review period. Facility nursing leaders reported being unable to locate any competency assessments for nurse 4. Facility nursing leaders reported being unable to view the employee file of nurse 1 who was no longer employed at the facility.

A facility nursing leader noticed alcohol withdrawal assessments were not documented appropriately in this patient's case and provided training to unit nurses in February 2021, a few weeks after the announcement of this OIG inspection. Of the five nurses, the three still employed at the facility attended the training. The OIG concluded that the lack of nurse training and competency assessment likely contributed to deficiencies in alcohol withdrawal care in this case.

Oversight of Medical-Surgical Nursing Care

The OIG determined that medical-surgical unit nursing leaders did not have adequate quality controls in place to ensure the provision of safe and effective alcohol withdrawal nursing care in the medical-surgical unit. The medical-surgical unit nurse manager stated that periodic EHR reviews of documentation to monitor the quality of nursing care were not conducted. The nurse manager instead made "rounds" on patients to assess patient satisfaction as a measure of nursing quality. Although not required by policy, a facility leader reported it is expected that nurse managers conduct random EHR reviews to assess the quality of care provided by nurses. The

OIG determined that additional reviews, such as routine EHR reviews, may assist a medical-surgical unit nurse manager in more adequately assessing the quality of care provided by medical-surgical unit nurses and may aide managers in identifying deficiencies in nursing care.

ICU Care

ICU staff treated the patient's alcohol withdrawal from postoperative day 3 through day 6 by providing benzodiazepines and reassessing symptoms using CIWA-Ars. The ICU nurse manager reported completing random chart reviews by looking at 72 hours of nursing documentation in 10 EHRs per review, reviewing the patient's care, and providing education to the ICU nurses within a few weeks of the initiation of the OIG's inspection. After reviewing the documentation, the OIG had no further concerns with the patient's ICU care.

Additional Concerns with the Protocol

During the inspection, the OIG determined that the facility's alcohol withdrawal protocol could be discontinued prior to the onset of a patient's withdrawal symptoms. The protocol instructed nurses to discontinue alcohol withdrawal assessment and treatment when patients had three consecutive assessments, exhibited only mild withdrawal symptoms, and assessments were performed eight hours apart. This guidance could lead nurses to discontinue alcohol withdrawal assessment and treatment only 16 hours into a patient's hospital admission. However, the onset of alcohol withdrawal occurs approximately one to five days after cessation or reduction in alcohol use.[52]

Conclusion

In the months prior to the patient's surgery, PACT staff failed to provide sufficient care coordination and treatment. Specifically, the provider failed to adequately address the patient's recurrent abnormal chest images and poor nutritional status, and failed to communicate blood test results to the patient in the required time frame. The PACT nurse failed to adequately respond to the patient's request for assistance via secure message two days prior to surgery. Additionally, facility staff failed to schedule and complete a barium swallow test.

The surgical team completed all minimally required elements of a preoperative assessment. However, the OIG was concerned that the surgical team missed an opportunity to detect the patient's overall poor health, possibly compounding the provider's and PACT nurse's failures to intervene on the patient's behalf. Although facility staff completed quality reviews of the patient's surgical care, the OIG determined that additional quality reviews may have assisted facility leaders in understanding areas for improvement.

[52] Mayo Clinic, "Alcohol use disorder," accessed June 24, 2021, https://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/symptoms-causes/syc-20369243.

During the patient's hospital stay, following surgery, the medical-surgical nurses did not consistently assess the patient's alcohol withdrawal symptoms or administer medications according to the facility alcohol withdrawal treatment protocol or according to physician orders. In addition, the OIG found that the facility's alcohol withdrawal protocol could be discontinued prior to the onset of withdrawal symptoms. The OIG determined that medical-surgical unit nursing leaders did not have adequate quality controls or training in place to ensure the provision of safe and effective alcohol withdrawal nursing care.

Recommendations 1–10

1. The Veterans Integrated Service Network Director reviews the primary care provider's care of the patient in the year prior to surgery and takes action as indicated.

2. The Charlie Norwood VA Medical Center Director ensures patient aligned care team nurses are aware of and comply with the Veterans Health Administration patient aligned care team policy including requirements for same-day access.

3. The Charlie Norwood VA Medical Center Director ensures patient aligned care team physicians are aware of and comply with the Veterans Health Administration directive regarding communication of test results to patients including time frames and communication of associated treatment plans.

4. The Charlie Norwood VA Medical Center Director ensures that surrogates are assigned for patient aligned care team nurses while they are on leave.

5. The Charlie Norwood VA Medical Center Director reviews the patient's preoperative care, including additional quality reviews, and takes action as indicated.

6. The Charlie Norwood VA Medical Center Director reviews medical-surgical unit nurses' care of the patient and takes action as warranted.

7. The Charlie Norwood VA Medical Center Director evaluates the use of the Trendelenburg position in inpatient areas and provides education to all facility nursing staff on the potential risks of and indications for use.

8. The Charlie Norwood VA Medical Center Director ensures that all medical-surgical unit nurses demonstrate competency to provide adequate alcohol withdrawal care and monitors for compliance.

9. The Charlie Norwood VA Medical Center Director implements controls to ensure care provided by medical-surgical unit nurses is of an acceptable quality.

10. The Charlie Norwood VA Medical Center Director ensures that the Charlie Norwood VA Medical Center alcohol withdrawal treatment protocol is specific, does not conflict with physicians' orders, and aligns with the probable onset of patients' alcohol withdrawal symptoms.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 23, 2022

From: Director, VA Southeast Network (VISN 7) (10N7)

Subj: Draft: Healthcare Inspection—Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia

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

1. I have had the opportunity to review the Draft Report: Healthcare Inspection-Deficiencies in the Care of a Patient who died at the Charlie Norwood VA Medical Center in Augusta, Georgia.

2. I concur with VISN 7 and Charlie Norwood VA Medical Center's action plan and ongoing implementation for recommendations 1-4, 6 and 9. I concur with Charlie Norwood VA Medical Center's request for closure of recommendations 5, 7-8 and 10.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by*:)

David M. Walker, MD, MBA
Director, VA Southeast Network VISN 7

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network Director reviews the primary care provider's care of the patient in the year prior to surgery and takes action as indicated.

Concur.

Target date for completion: March 31, 2022

Director Comments

The Veterans Integrated Service Network Director requested a management review of the Primary Care provider's care of the patient in the year prior to surgery by VHA Peer Review contractor. Actions needed will be addressed once the management review is completed.

OIG Comments

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

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 9, 2022

From: Medical Center Director, Charlie Norwood VA Medical Center (509/00)

Subj: Healthcare Inspection—Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia

To: Director, VA Southeast Network (10N7)

1. We at Charlie Norwood VA Medical Center thank the Office of Inspector General for evaluating and providing recommendations to strengthen our process as it relates to the adequacy of the patient's outpatient care in the months prior to surgery, preoperative care including surgical assessment and anesthesia evaluation, and postoperative care including alcohol withdrawal treatment.

2. Charlie Norwood VA Medical Center hereby submits the attached status update providing justification and documentation for closure of recommendations 5,7,8, and 10 and a pro-active action plan to complete and achieve closure of recommendations 2 through 4, 6 and 9 within six months.

3. If you have any questions or require further information, contact Executive Director, High Reliability Organization/Quality and Patient Safety.

(*Original signed by*:)

Robin E. Jackson, PhD
Medical Center Director, Charlie Norwood VA Medical Center

Facility Director Response

Recommendation 2

The Charlie Norwood VA Medical Center Director ensures patient aligned care team nurses are aware of and comply with the Veterans Health Administration patient aligned care team policy including requirements for same-day access.

Concur.

Target date for completion: July 1, 2022

Director Comments

The facility instituted a Patient Aligned Care Team (PACT) Opportunity map in February 2021 which is utilized to determine provider pen slot availability for same day access. All Veterans who call if for same day services are offered an appointment using the opportunity map if available or sent to the same day clinic. A comprehensive PACT Standdown and Reboot was conducted with several offering of blocked clinic time for training between June 7, 2021 through July 12, 2021 to ensure training of all staff. 62/62 RN/LPNS=100%-One hundred percent of Patient Aligned Care Teams were re-educated on the guidelines to VHA Handbook 1101.10 (1) Patient Aligned Care Teams and the and the use of same-day services to Veterans on August 24, 2021. An attestation memorandum was completed by the Chief Nurse Ambulatory Care. On December 15, 2021, the same day access clinic re-opened at the downtown division for additional access for Veterans. From December 15, 2021 to January 28, 2022, 482 Veterans have utilized the same day access clinic.

The PACT nurse manager will conduct audits of 30 charts monthly to assess for compliance with Directive including same-day access. The Chief Nurse Ambulatory Care will present the compliance rate during the monthly Primary Care Staff meeting. The Primary Care Committee will report the audits to the Health Care Delivery Council. The Health Care Delivery Council will report the audits up to the Executive Leadership Board monthly. Chart audits will continue until compliance of 90% or greater is reached for six consecutive months.

Recommendation 3

The Charlie Norwood VA Medical Center Director ensures Patient Aligned Care Team physicians are aware of and comply with the Veterans Health Administration directive regarding communication of test results to patients including time frames and communication of associated treatment plans.

Concur.

Target date for completion: July 1, 2022

Director Comments

A comprehensive PACT Standdown and Reboot was conducted with several offerings of blocked clinic time for training between June 7, 2021, through July 12, 2021 to ensure training of all staff. This training also included timeliness of test results. A refresher course attended by 100% of PACT providers was conducting regarding VHA Directive 1088, communication of test results, on January 19, 2022. An attestation memorandum was completed by the Deputy Chief of Staff, Uptown Division.

A random chart audit of 30 records per month will be completed to assess compliance with VHA Directive 1088 regarding the communication of test results and communication of an associated treatment plan of care. The Chief of Primary Care will present the audits to the Health Care Delivery Council. The Health Care Delivery Council will report the audits up to the Executive Leadership Board monthly. Chart audits will continue until compliance of 90% or greater is reached for six consecutive months.

Recommendation 4

The Charlie Norwood VA Medical Center Director ensures that surrogates are assigned for patient aligned care team nurses while they are on leave.

Concur.

Target date for completion: March 31, 2022

Director Comments

As of June 23, 2021, a PACT nurse surrogacy list is maintained in the Primary Care Management Module (PCMM) system. Primary and secondary surrogates are identified to facilitate PACT nurse coverage in the event of unplanned absences. Notification transfers and the assumption of care by the surrogate in the event of an absence is an automated process through CPRS [Computerized Patient Record System] by the My Health e-Vet coordinator. Surrogacy lists are updated by the nurse manager will all staffing changes. Notification of surrogacy list changes are communicated to the Chief Nurse Ambulatory Care. SOP 6103.509 dated November 9, 2020 titled View Alert Management outlines the process of maintain a surrogate.

Chief Nurse Ambulatory Care will conclude a retrospective cross reference audit of the surrogate list use will leave taken by PACT employees. Chart audits will continue until compliance of 90% or greater is reached for six consecutive months.

OIG Comments

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

Recommendation 5

The Charlie Norwood VA Medical Center Director reviews the patient's preoperative care, including additional quality reviews, and takes action as indicated.

Concur.

Target date for completion: Completed April 15, 2021

Director Comments

On October 23, 2020 a Joint Patient Safety Review (JPSR) was placed and incident was investigated per JPSR process. On December 17, 2020, a Surgical Morbidity and Mortality Review was completed. On January 7, 2021, the Veteran's case was reviewed by the Mortality Review Committee. Of that review, a recommendation to complete four protected peer reviews were initiated and concluded in accordance with VHA Directive 1190 Peer Review for Quality Management. The review yielding two identified opportunities for quality improvement. The quality improvement plans were completed on March 21, 2021 and April 15, 2021 respectively.

OIG Comments

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

Recommendation 6

The Charlie Norwood VA Medical Center Director reviews medical-surgical unit nurses' care of the patient and takes action as warranted.

Concur.

Target date for completion: July 1, 2022

Director Comments

On October 21, 2020 a clinic review was conducted on the medical-surgical nurses who took care of the Veteran. The review included a focus on relevant nursing assessments, interventions, and medication documentation. Those nurses whose actions did not meet the standard of care were provided education. Refresher training for CIWA via TMS [VA Talent Management System] was completed February 23, 2021 for the nurses who provided care for this Veteran.

The medical-surgical unit nurses (who cared for this Veteran) are being audited for appropriate care and to ensure education and training has been effective. The audits will be conducted until 90% compliance is achieved for six consecutive months. Three nurses are pending administrative action; one is no longer working for VA. VISN leadership is working to determine appropriate actions for the remaining nurse who transferred to another VA facility.

Recommendation 7

The Charlie Norwood VA Medical Center Director evaluates the use of the Trendelenburg position in inpatient areas and provides education to all facility nursing staff on the potential risks of and indications for use.

Concur.

Target date for completion: Completed February 9, 2022

Director Comments

As of April 2021, 100% of Medical surgical nurses were trained on the indication for use and risks of Trendelenburg position. An attestation memo has been completed to validate the training. Remaining facility nursing staff will be trained by February 2022 on the indication for use and risks of Trendelenburg position. The facility restraint and seclusion policy has been updated as of February 9, 2022, to include clarification that bed positioning should never be used as a restraint (e.g., Trendelenburg position). The updated policy was published on the policy SharePoint site and included in the Norwood Notes (facility newsletter), which was distributed to all nurses via the nurse managers. The updated policy was discussed during Medical Center Director's Fireside Chat February 9, 2022.

OIG Comments

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

Recommendation 8

The Charlie Norwood VA Medical Center Director ensures that all medical-surgical unit nurses demonstrate competency to provide adequate alcohol withdrawal care and monitors for compliance.

Concur.

Target date for completion: February 8, 2022

Director Comments

A standardized competency model (Donna Wright) was implemented June 2021. Implementation of annual CIWA protocol for medical-surgical unit nurses began February 2021. As of February 8, 2022, 100% all nursing staff have completed CIWA training, which included a test to validate learning and understanding. Annual refresher training on the CIWA protocol is assigned to nurses learning education requirements. CIWA training is given to new employees during nursing orientation.

From August 2021 through January 2022, electronic medical records of all Veterans on CIWA protocol were audited for nursing compliance. Components of all the audit including performance of CIWA assessments, medication administration, and post-intervention reassessment according to orders and protocol. Cumulative compliance of 93% or greater was reached for six consecutive months. Chart audits were reported to Chief Nurse, Hospital Services.

OIG Comments

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

Recommendation 9

The Charlie Norwood VA Medical Center Director implements controls to ensure care provided by medical-surgical unit nurses is of an acceptable quality.

Concur.

Target date for completion: July 1, 2022

Director Comments

The facility charged a formal program review March 30-31, 2021 to assess the current state and organizational effectiveness of the Hospital Education Program. A standardized competency model (Donna Wright) was implemented in June 2021. Re-organization of Hospital Education was outlined in a long-term plan. Evidence Based Practice (EBP) nurses and nurse educator have been hired who are providing ongoing education. Two EBP nurses are currently on board with two additional going through the boarding process. Daily huddles with Chief Hospital Service and unit nurse managers have included the incorporation of the review of safety events. Additionally, to stabilize and move nursing forward, the facility added a Nurse V Deputy Associate Director of Patient Care Services and Pathway to Excellence Coordinator to improve oversight and structure.

The electronic medical records of 10% of Veterans admitted to medical-surgical units began February 1, 2022. A standardized audit tool is used to assess the quality of nursing care provided. These audits will continue until 90% or greater compliance is achieved for six consecutive months. Chart audits will be reported to Chief Nurse, Hospital Services monthly.

Recommendation 10

The Charlie Norwood VA Medical Center Director ensures that the Charlie Norwood VA Medical Center alcohol withdrawal treatment protocol is specific, does not conflict with physicians' orders, and aligns with the probable onset of patients' alcohol withdrawal symptoms.

Concur.

Target date for completion: February 9, 2022

Director Comments

The Alcohol Withdrawal Monitoring and Treatment protocol has been revised by the Chief of Staff and Acting Associate Director for Patient care Services and education provided to staff on February 9, 2022. Protocol sent out in Norwood Notes, February 9, 2022. TEAMS meeting conducted by COS for applicable providers. Meeting recorded and sent to those providers not in attendance. The revised protocol factors onset time of patient's alcohol withdraw symptoms in accordance with evidence-based practice.

OIG Comments

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

Glossary

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

activities of daily living. "Fundamental skills that are required to independently care for oneself such as eating, bathing, and mobility."[53]

aspiration. The taking of foreign matter into the lungs.[54]

aspiration pneumonia. Pneumonia resulting from inhalation of foreign bodies (such as food particles).[55]

barium swallow. An imaging test used to diagnose conditions that affect the throat, esophagus, stomach, and first part the small intestine. The test involves drinking a chalky liquid containing barium. Barium makes parts of the body show up more clearly on imaging.[56]

Barrett's esophagus. "A condition in which the lining of the esophagus (the tube that carries food from the throat to the stomach) is replaced by tissue that is similar to the lining of the intestines. Although this change does not cause any specific signs or symptoms, it is typically diagnosed in people who have long-term gastroesophageal reflux disease."[57]

benzodiazepine. A medication that depresses (slows down) the central nervous system and can cause sedation, encourage sleep, reduce anxiety, and prevent seizures.[58]

beta blocker. Medications that can assist in treating essential tremor but are more commonly used to treat high blood pressure.[59]

bone density test. Assesses the amount of bone in the hip, spine, or other evaluated bones to estimate the density of bones and diagnose osteoporosis.[60]

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[53] Edemekong PF et. al, *Activities of Daily Living,* StatPearls [Internet], June 26, 2020, accessed July 6, 2021, https://pubmed.ncbi.nlm.nih.gov/29261878/.

[54] *Merriam-Webster.com Dictionary*, "Definition of aspiration," accessed June 15, 2021, https://www.merriam-webster.com/dictionary/aspiration.

[55] *Merriam-Webster.com Dictionary*, "Definition of aspiration pneumonia," accessed June 15, 2021, https://www.merriam-webster.com/dictionary/aspiration%20pneumonia.

[56] National Institute of Health, U.S. National Library of Medicine, Medline Plus, "Barium Swallow," accessed June 16, 2021, https://medlineplus.gov/lab-tests/barium-swallow/.

[57] National Institute of Health, National Center for Advancing Translational Sciences, Genetic and Rare Disease Information Center, "Barrett Esophagus," accessed February 10, 2021, https://rarediseases.info.nih.gov/diseases/20/barrett-esophagus.

[58] US Drug Enforcement administration, "Benzodiazepines," accessed June 24, 2021, https://www.dea.gov/factsheets/benzodiazepines.

[59] National Institute of Health, National Institutes of Neurological Disorders and Stroke, *Tremor Fact Sheet*, May 31, 2021, accessed June 16, 2021, https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Tremor-Fact-Sheet.

[60] National Osteoporosis Foundation, "Bone Density Exam /Testing," accessed June 24, 2021, https://www.nof.org/patients/diagnosis-information/bone-density-examtesting/.

computed tomography scan. A cross-sectional, three-dimensional picture of an internal body part primarily used for diagnostic reasons.[61]

cystoscopy. A procedure performed by a physician that allows examination of the lining of the bladder and the tube that carries urine out the body.[62]

electrolyte. Minerals in blood and body fluids that carry an electric charge and affect many body functions such as muscle function, acidity (pH) of the blood, and the amount of water in the body. Common electrolytes are sodium, potassium, phosphorus, magnesium, chloride, and calcium.[63]

orthostatic hypotension. "A drop in blood pressure that occurs when moving from a laying down (supine) position to a standing (upright) position."[64]

physical deconditioning. A loss of mobility due to periods of inactivity that results in muscle wasting.

pneumonia. "An infection that inflames the air sacs in one or both lungs," which may result in the air sacs filling with fluid causing difficulty in breathing. "A variety of organisms including bacteria, viruses, and fungi can cause pneumonia."[65]

pulmonary function test. A test that shows how well the lungs are working by measuring lung volume, capacity, gas exchange, and air flow.[66]

sepsis: "A potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues."[67]

spinal stenosis. A narrowing of the spaces within the spine, "which can put pressure on the nerves that travel through the spine."[68]

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[61] *Merriam-Webster.com Dictionary*, "Definition of Computed Tomography," accessed November 12, 2020, https://www.merriam-webster.com/dictionary/computed%20tomography.

[62] Mayo Clinic, "Cystoscopy," accessed November 19, 2020, https://www.mayoclinic.org/tests-procedures/cystoscopy/about/pac-20393694.

[63] National Institutes of Health, U.S. National Library of Medicine, MedlinePlus, "Electrolytes," June 2021, accessed June 30, 2021, https://medlineplus.gov/ency/article/002350.htm.

[64] National Institutes of Health, U.S. National Library of Medicine, MedlinePlus, "Orthostatic hypotension," August 2020, accessed June 16, 2021, https://medlineplus.gov/genetics/condition/orthostatic-hypotension/.

[65] Mayo Clinic. "Pneumonia," accessed November 20, 2020, https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204.

[66] Johns Hopkins Medicine, "Pulmonary Function Tests," accessed November 23, 2020, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/pulmonary-function-tests.

[67] Mayo Clinic, "Sepsis," accessed June 22, 2021, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214.

[68] Mayo Clinic, "Spinal Stenosis," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/spinal-stenosis/symptoms-causes/syc-20352961.

Trendelenburg. A position that involves the head of the bed being placed on a decline while the foot of the bed is on an incline. The patient is typically placed on the back.[69]

[69] Kathleen Rich, "Trendelenburg Position in Hypovolemic Shock: A review," *Journal of Vascular Nursing, Clinical Column 37,* (March 2019): 71–73, accessed March 16, 2021, https://pubmed.ncbi.nlm.nih.gov/30954203/.

OIG Contact and Staff Acknowledgments

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