US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care Failures for a Patient with Alcohol Withdrawal at the Hampton VA Medical Center in Virginia

Healthcare Inspection | **24-02232-87** | **March 26, 2025**

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a referral from Representative Jen Kiggans regarding the care of a patient who was admitted for alcohol withdrawal and later died at the Hampton VA Medical Center (facility) in Virginia.

Synopsis of Patient's Care

In late summer 2023, a 65-year-old patient presented to the facility's emergency department for alcohol detoxification (hospital day 1). The patient reported relapsing the week prior after being sober for several months. The patient had a significant history of alcohol dependence with multiple admissions for alcohol withdrawal, including a prior episode of withdrawal-related seizure activity and delirium tremens (delirium).[1] The patient was placed on a Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) protocol to monitor and assess the severity of the alcohol withdrawal. A provider initiated a regimen of benzodiazepines based on the facility CIWA-Ar protocol and the patient was admitted to the intensive care unit (ICU). During the hospital stay, the patient became progressively more agitated and restless, pulling at peripheral intravenous lines, trying to get out of bed, and exhibiting tremors. As a result, in addition to benzodiazepines, the patient was intermittently given dexmedetomidine infusions and placed in physical restraints (restraints). On hospital day 9, a nurse found the patient in cardiac arrest and initiated the advanced cardiac life support protocol. Facility staff intubated and, ultimately, resuscitated the patient. However, after the cardiac arrest, the patient was ventilator dependent and remained unresponsive. After consulting with a neurologist, the patient's spouse elected to withdraw life support and the patient died on hospital day 14.

Failure to Recognize and Treat Alcohol Withdrawal Symptoms

Nursing Staff's Improper Assessment and Treatment of Alcohol Withdrawal Symptoms

The OIG identified nursing staff failures related to compliance with the facility CIWA-Ar protocol. CIWA scores represent the severity of alcohol withdrawal based on a nurse's observation and a patient's input regarding agitation and disorientation. Higher scores indicate more severe withdrawal, which warrants more frequent reassessments and pharmacotherapy interventions and may result in administration of higher doses of benzodiazepines "to prevent progression to severe withdrawal." The facility CIWA-Ar protocol provides nursing staff with

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

guidance for the assessment and reassessment of CIWA scores specifying the amount of lorazepam, a benzodiazepine, to administer based on the score.

The OIG found that the patient's CIWA-Ar scores were inconsistent with nursing staff's electronic health record (EHR) documentation of the patient's clinical presentation and behaviors. For example, in one nursing note, documentation reflected that the patient was agitated exhibiting behaviors of restlessness and decreased orientation but was predominantly given CIWA-Ar scores of zero. Furthermore, the OIG determined nursing staff delayed EHR documentation of CIWA-Ar scores, including high scores, by approximately three to seven hours after completed assessments. The OIG also found nursing staff did not consistently reassess the patient within the time frames specified in the facility CIWA-Ar protocol. On multiple occasions, nursing staff's reassessments were delayed at least one hour after the expected time. Each delayed entry may affect information available for use by providers in patient care decision-making. Additionally, nursing staff did not consistently follow facility protocol when administering lorazepam to the patient. Specifically, nursing staff administered lorazepam without a CIWA-Ar score and in dosages that did not align with those outlined in the protocol. The OIG also noted incidences when no lorazepam was administered despite a high CIWA-Ar score. These inconsistencies may have affected the information providers used when making clinical decisions and influenced the overall management of the patient, contributing to the patient's deteriorating clinical status and worsening of alcohol withdrawal symptoms.

Veterans Health Administration (VHA) policy strongly recommends VA medical facilities offer "training specific to management of [substance use disorder] to all clinically active staff engaged in the treatment or care of Veterans diagnosed with a [substance use disorder]." One substance use disorder training is the CLE-118 Withdrawal Assessment CIWA/Clinical Opiate Withdrawal Scale (COWS). At the facility level, nurse managers are responsible to ensure that staff are knowledgeable of the alcohol withdrawal protocol. All ICU staff were provided training on the CIWA-Ar protocol. However, the CIWA training provided to ICU staff was ineffective given the variability with accuracy and timeliness of CIWA assessments as well as inconsistent adherence to CIWA-Ar protocol. In addition, the training did not include competency assessments to ensure CIWA scoring was completed accurately, and that staff consistently followed CIWA-Ar protocol. The lack of competency assessments may have contributed to the training's ineffectiveness.

Furthermore, two weeks after the facility had updated their Alcohol Withdrawal Management standard operating procedure (SOP), VHA Notice 2024-09 was issued "to standardize and improve alcohol withdrawal management across the VA healthcare system." The OIG reviewed the new SOP and identified gaps between the content and expectations outlined in the VHA notice.

Providers' Failure to Recognize and Address the Patient's Complex Alcohol Withdrawal Symptoms

The OIG determined that facility providers failed to recognize the severity of the alcohol withdrawal when managing this complex patient. The patient was considered high risk for developing delirium based on past admissions for alcohol withdrawal and previous reports of a seizure related to withdrawal. According to The American Society of Addiction Medicine, delirium can be effectively treated with benzodiazepines such as lorazepam and chlordiazepoxide.

On hospital day 1, the patient was started on a CIWA-Ar protocol including a regimen of benzodiazepines. On hospital day 7, a provider (provider 1) ordered dexmedetomidine, an adjunctive medication that may have helped treat the autonomic symptoms for the patient's extreme agitation. Unlike lorazepam (and other benzodiazepines), dexmedetomidine has not been shown to prevent seizure activity or delirium in alcohol withdrawal. Provider 1 told the OIG that a nursing staff member reported lorazepam injectable was in short supply. Although the OIG received conflicting information from nursing and pharmacy staff whether there was an actual shortage of lorazepam injections during the patient's hospital stay, the OIG's review of the facility's inventory of lorazepam injectable during the period of the patient's care confirmed that lorazepam injectable was available for use in the ICU. The OIG is concerned that provider 1's failure to clarify and confirm the availability of lorazepam injectable in the ICU likely affected the provider's clinical decision to use dexmedetomidine rather than lorazepam.

EHR documentation throughout the admission described a patient who was not improving and had an ongoing need for ICU care. Another provider's (provider 2) EHR documentation described that the patient was experiencing ongoing agitation and needed restraints on numerous occasions. Provider 2 documented symptoms suggestive of severe alcohol withdrawal but failed to identify the presence of several risk factors of severe withdrawal including continued delirium and severe agitation. On hospital day 8, provider 2 documented that the agitation may not have been due to alcohol withdrawal but rather a different cause and discontinued the CIWA-Ar protocol, including the orders for benzodiazepines. This determination resulted in provider 2 not considering higher or more frequent lorazepam dosing and not using additional clinical resources available on-site, such as intensivists, to assist in managing the patient's care. The OIG concluded that the clinical decisions made by provider 1 and provider 2 likely resulted in the patient not being provided evidence-based care for severe alcohol withdrawal and prevention of delirium.

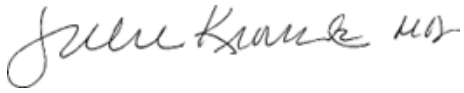
Facility Review of the Care Provided to the Patient

The OIG concluded that, in completing an institutional disclosure, root cause analysis, and peer reviews related to the patient's cardiac arrest and clinical care, the facility followed VHA guidance for administrative actions and quality management reviews of clinical care.

The OIG made seven recommendations to the Facility Director related to compliance with facility CIWA-Ar protocol, CIWA assessment, and the management of alcohol withdrawal syndrome.

VA Comments and OIG Response

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



JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Executive Summary i

Abbreviations vi

Introduction 1

Scope and Methodology 5

Patient Case Summary 6

Inspection Results 9

1. Failure to Recognize and Treat Alcohol Withdrawal Symptoms 9

2. Facility Review of the Care Provided to the Patient 19

Conclusion 20

Recommendations 1–7 22

Appendix A: CIWA-Ar Scale 24

Appendix B: VISN Director Memorandum 26

Appendix C: Facility Director Memorandum 27

Glossary 32

OIG Contact and Staff Acknowledgments 36

Report Distribution 37

Abbreviations

ASAM	The American Society of Addiction Medicine
CIWA-Ar	Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised
EHR	electronic health record
ICU	intensive care unit
OIG	Office of Inspector General
RASS	Richmond Agitation-Sedation Scale
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a referral from Representative Jen Kiggans regarding the care of a patient who was admitted for alcohol withdrawal and later died at the Hampton VA Medical Center (facility) in Virginia.

Background

The facility, part of Veterans Integrated Service Network 6 (VISN), serves six counties in eastern Virginia and nine counties in northeastern North Carolina and is affiliated with the Eastern Virginia Medical School. The facility provides primary and specialty outpatient care and acute inpatient medical care with 129 operating inpatient beds, including 5 medical intensive care unit (ICU) beds.[1] From October 1, 2022, through September 30, 2023, the facility served 68,633 patients. During the same time frame, there were 48 admissions to the ICU for alcohol withdrawal care.

The OIG published a national review of inpatient management of alcohol withdrawal in January 2024. The OIG completed the review in response to prior inspections, which identified adverse clinical outcomes that were attributed to inadequate assessment and management of alcohol withdrawal severity. The review revealed a lack of facility and national guidance for inpatient management of alcohol withdrawal and training of inpatient staff on assessment of alcohol withdrawal severity. The OIG made three recommendations to the Under Secretary for Health.[2]

Alcohol Withdrawal Syndrome

Alcohol withdrawal syndrome is a set of symptoms that occur after cessation or reduction of long-term, heavy alcohol consumption. Alcohol withdrawal symptoms may initially present within hours or up to several days after the last alcohol drink.[3] Signs and symptoms of alcohol withdrawal may include elevated blood pressure, fast heart rate, anxiety, and hallucinations. According to The American Society of Addiction Medicine (ASAM), the most serious outcomes

[1] In addition to the five medical ICU beds, the facility has three surgical ICU beds.

[2] VA OIG, *Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal*, Report No. 21-01488-44, January 4, 2024. Two of the three recommendations remain open.

[3] Psychiatry Online, *Substance-Related and Addictive Disorders*, accessed September 8, 2024, https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders; Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome," *CNS Drugs*, no. 28 (April 30, 2014): 401-410, https://link.springer.com/content/pdf/10.1007/s40263-014-0163-5.pdf.

that may occur are seizures, delirium tremens (delirium), and even death.[4] The main goals of alcohol withdrawal management are the reduction of withdrawal symptoms and prevention of serious outcomes such as delirium.[5] Severe alcohol withdrawal may prolong a hospitalization and may be fatal without appropriate and frequent medication administration.[6] Complications from delirium are associated with a worse prognosis and may lead to death in up to 5 percent of patients with alcohol withdrawal.[7] According to *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*, "Studies have shown standardized protocols to be effective at reducing the incidence, duration, and frequency of delirium among hospitalized patients."[8] However, while clinical practice guidelines and protocols provide a good baseline for the treatment of alcohol withdrawal management, in cases when a patient is not improving, clinicians must customize care according to the individual patient's needs.

Medication Management

Benzodiazepines, such as lorazepam and chlordiazepoxide, are medications that are considered first-line therapy to treat alcohol withdrawal symptoms. The utility of this drug class is well-documented and has the "best evidence base" effectiveness for reducing signs and symptoms of alcohol withdrawal, including seizures and delirium.[9] The VA/Department of Defense (DoD) Clinical Practice Guideline for the Management of Substance Use Disorders recommends using benzodiazepines with adequate monitoring for the treatment of moderate to severe alcohol withdrawal.[10] For patients who are experiencing more severe alcohol withdrawal, providers

[4] The American Society of Addiction Medicine (ASAM), *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*, January 23, 2020; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[5] Ildikó Katalin Pribék, Ildikó Kov?cs, Bettina Kata K?d?r, Csenge S?ra Kov?cs, Mara J. Richman, Zolt?n Janka, et al., "Evaluation of the Course and Treatment of Alcohol Withdrawal Syndrome with the Clinical Institute Withdrawal Assessment for Alcohol-Revised: A Systematic Review-Based Meta-Analysis," *Drug and Alcohol Dependence* 220 (2021), https://doi.org/10.1016/j.drugalcdep.2021.108536.

[6] Tessa L. Steel et al., "Research Needs for Inpatient Management of Severe Alcohol Withdrawal Syndrome: An Official American Thoracic Society Research Statement," *American Journal of Respiratory and Critical Care Medicine*, 204:7 (October 21, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8528516/.

[7] Marc A. Schuckit, "Recognition and Management of Withdrawal Delirium (Delirium Tremens)," *The New England Journal of Medicine* (2014) 371:2109-13; Ildikó Katalin Pribék et al., "Evaluation of the course and treatment of Alcohol Withdrawal Syndrome with the Clinical Institute Withdrawal Assessment for Alcohol – Revised: A systematic review-based meta-analysis."

[8] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management.*

[9] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; Shivanand Kattimani and Balaji Bharadwaj, "Clinical management of alcohol withdrawal: A systemic review," *Industrial Psychiatry Journal* 22, no. 2 (July–Dec 2013): 100-108, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4085800/.

[10] VA and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders* 4.0, August 2021.

should ensure that a therapeutic dose of benzodiazepine has been administered.[11] If, while taking a benzodiazepine, symptoms are not managed as needed, providers should consider increasing the dose of the benzodiazepine.[12] Patients whose symptoms do not respond to management by benzodiazepines alone may require the addition of an adjunctive medication such as dexmedetomidine, which helps treat the symptoms but does not address the underlying cause of the symptoms.[13]

Alcohol withdrawal management involves early identification of at-risk patients and symptoms using a valid tool such as the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar).[14] The CIWA-Ar relies on the patient's ability to self-report (communicate) symptoms and should not be used to assess patients with delirium or impaired communication. The Richmond Agitation-Sedation Scale (RASS) is an alternative assessment tool used for patients with delirium or impaired communication.[15] The CIWA-Ar scores the severity of alcohol withdrawal using the patient's self-report for the presence and degree of nausea, tremor, autonomic hyperactivity, anxiety, agitation, perceptual disturbances [auditory, tactile, and visual hallucinations], headache, and disorientation (see appendix A). Nine of the items are scored from zero to seven and the 10th is scored zero to four; higher scores indicate more severe withdrawal (see table 1). Individuals with previous seizures or delirium due to alcohol withdrawal warrant frequent and repetitive assessments of symptom severity to inform timely pharmacotherapy interventions "to prevent progression to severe withdrawal."[16]

[11] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.
[12] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management.*
[13] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."
[14] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."
[15] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.
[16] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

Table 1. ASAM Alcohol Withdrawal Severity

Severity category	Associated CIWA-Ar range	Symptom description
Mild	CIWA-Ar < 10	Mild or moderate anxiety, sweating, and insomnia, but no tremor
Moderate	CIWA-Ar 10–18	Moderate anxiety, sweating, insomnia, and mild tremor
Severe	CIWA-Ar ≥ 19	Severe anxiety and moderate to severe tremor, but not confusion, hallucinations, or seizure
Complicated	CIWA-Ar ≥ 19	Seizure or signs and symptoms indicative of delirium–such as an inability to fully comprehend instructions, clouding of the sensorium or confusion–or new onset of hallucinations

Source: The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management.

Prior OIG Reports

The OIG published a report on June 28, 2022, on failures in test result follow-up for a patient diagnosed with prostate cancer. The OIG made seven recommendations to the Facility Director related to communication of abnormal test results, entering radiology orders, urology consults, and quality reviews. All recommendations have been closed.[17]

The OIG published another report on September 29, 2023, on the delay in diagnosis and treatment for a patient with a new lung mass. The OIG made seven recommendations to the Facility Director concerning care coordination agreements, compliance with Veterans Health Administration (VHA) patient care aligned team policies, VHA cancer registry, and root cause analysis and institutional disclosures. As of December 6, 2024, all recommendations are closed.[18]

The OIG published a third report on July 23, 2024, on the facility's mismanagement of surgical privileging actions and the deficient surgical service quality management processes. The OIG made 11 recommendations to the Facility Director regarding focused clinical care reviews, privileging actions, state licensing board reporting, professional practice evaluations, and quality review processes. The OIG also made one recommendation to the VISN Director. As of February 27, 2025, nine recommendations remain open and three are closed.[19]

[17] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, Report No. 21-03349-186, June 28, 2022.

[18] VA OIG, *Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia*, Report No. 22-02800-225, September 29, 2023.

[19] VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, Report No. 23-00995-211, July 23, 2024.

Request for Review and Related Concerns

On April 30, 2024, the OIG received correspondence from the office of Representative Jen Kiggans requesting a review of the care of a patient who was admitted to the facility in fall 2023 for alcohol withdrawal syndrome and died. After a review of the patient's electronic health record (EHR), the OIG opened a healthcare inspection to assess the management of the patient's alcohol withdrawal. Additionally, the OIG evaluated facility leaders' review of the quality of care provided to the patient.

Scope and Methodology

The OIG initiated the healthcare inspection on May 22, 2024, and conducted a virtual site visit July 15 through 18, 2024. The OIG conducted additional virtual interviews through September 4, 2024.

The OIG interviewed the VISN 6 Quality Management Officer; a facility executive leader; quality management service chief and staff; ICU service leaders; as well as providers, nurses, and other clinical staff who cared for, or consulted on the care of, the patient during the admission.

The OIG reviewed *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; relevant VHA and facility policies, procedures, and guidelines relating to the management of alcohol withdrawal syndrome, reporting of adverse events, and reviews of clinical care; provider and clinical staff credentialing and privileging documents; CIWA-Ar nurse training records; quality management reviews specific to the patient's care; facility Critical Care Committee meeting minutes dated from September through October 2023; and Medical Executive Council meeting minutes for July 2023, October 2023, January 2024, and April 2024.[20] In addition, the OIG reviewed relevant aspects of the patient's care in the EHR.

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

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

[20] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

In late summer 2023 (hospital day 1), a 65-year-old patient with a history of alcohol dependence and post-traumatic stress disorder presented to the facility's emergency department and requested detoxification. The patient reported being sober following detoxification several months earlier but relapsed a week prior. On examination the patient was intoxicated but alert, oriented, and in no acute distress, with an elevated blood pressure of 158/90 millimeters of mercury (mm Hg), heart rate of 102, and slurred speech. The patient's serum ethanol level was 310 milligrams per deciliter (mg/dL).[21] The patient reported starting "drinking heavily" at age 16 and had multiple prior admissions for alcohol withdrawal, including to the ICU. The patient also reported previously experiencing withdrawal-related seizure activity and delirium. The patient variably listed daily alcohol use as "0.5 bottle of whiskey." In the emergency department, staff placed the patient on CIWA-Ar protocol to monitor and assess the severity of alcohol withdrawal. A provider initiated a regimen of benzodiazepines: chlordiazepoxide 25 mg capsules every eight hours in combination with symptom triggered lorazepam dosing, administered either orally or intravenously, as determined by CIWA-Ar score.[22]

Following initial evaluation in the emergency department, the patient was admitted to the ICU fully oriented and ambulatory but with an unsteady gait. During hospital day 2, the patient became progressively more agitated and restless, pulling at lines, trying to get out of bed, and was tremulous. In addition to receiving lorazepam per CIWA-Ar protocol, the patient was also

[21] University of Rochester Medical Center, "Ethanol (Blood)," accessed September 27, 2024, https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=167&contentid=ethanol_blood. A person may feel slight intoxication with a serum ethanol level of 30 mg/dL, is legally drunk in the United States at 80 mg/dL, typically unconscious at 300 mg/dL, and likely in a coma or dead at 400 mg/dL.

[22] Benzodiazepines are the preferred treatment in patients at risk of developing severe or complicated alcohol withdrawal because of their well-documented effectiveness in reducing the signs and symptoms of withdrawal, including the incidence of seizure and delirium; CIWA-Ar protocol specified lorazepam, oral or injection, in doses of 1 mg (for CIWA score of 8–10), 2 mg (CIWA score 11–14), 3 mg (CIWA score 15–24), 4 mg (CIWA score 25 or greater).

started on dexmedetomidine infusion.[23] The next day, the patient remained on CIWA-Ar protocol and dexmedetomidine infusion and was drowsy but with stable vital signs. On hospital day 4, the patient continued to have "shakes" and was also complaining of right shoulder and hip pain. The chlordiazepoxide regimen was increased to 50 mg by mouth every six hours and the dexmedetomidine infusion was discontinued. By mid-day the patient was confused, restless, and trying to get out of bed. Due to worsening withdrawal symptoms, dexmedetomidine infusion was resumed at 6:00 p.m. On hospital day 5, the patient was "less shaky" and reported feeling better. Dexmedetomidine infusion was again stopped. The patient continued to complain of pain in the right hip and shoulder regions. A magnetic resonance imaging of the lumbar spine revealed severe neuroforaminal stenosis and a neurologist advised a tapering dose of methylprednisolone and evaluation by physical therapy and occupational therapy.

That afternoon, occupational therapy staff saw the patient and noted an elevated blood pressure of 186/120 mm Hg, upper extremity tremors, confusion, and tangential thoughts. During the overnight shift, the patient was extremely agitated, removed medical devices, and remained confused. A provider (provider 1) assessed the patient to be in "severe alcohol withdrawal" and in need of physical restraints (restraints). On the morning of hospital day 6, the patient remained confused, was making multiple attempts to get out of bed; and had removed a urinary catheter, telemetry monitoring leads, and attempted to pull out a peripheral intravenous line. Staff placed the patient in restraints. On hospital day 7, provider 1 observed that the patient continued with severe alcohol withdrawal symptoms and described the patient as agitated, confused, disoriented, attempting to remove devices, not following instructions, and having to be restrained multiple times during the night. Provider 1 justified the continued need for restraints due to disorientation, delirium, attempts to remove medical devices, and self-protection. Provider 1's EHR entry stated:

> Per [nurse of the day] [intravenous] [[lorazepam] is in] a short supply. Patient unable to tolerate [oral] medications. Hence, [dexmedetomidine] [infusion] was started to help with withdrawal symptoms.

During the early hours of hospital day 8, nurse 1 described the patient as having "severe agitation, attempting to bite, hit, and kick nursing staff, and pull at medical devices." Nurse 1 justified the continued use of restraints based on the patient's confusion, disorientation, verbal threats, attempts to remove medical devices, and being "assaultive." EHR documentation describes the patient as having ongoing delirium and requiring restraints during the afternoon, evening, and night of hospital day 7, and the morning of hospital day 8. Per the EHR, the patient did not receive lorazepam or chlordiazepoxide during this period.

[23] Dexmedetomidine should not be used alone to prevent or treat withdrawal-related seizures or delirium.

Another provider (provider 2) saw the patient mid-day on hospital day 8 and noted the patient was confused, with mild sweatiness, agitated, fighting the staff, and kicking, and had required 4-point restraints during the night. Provider 2 also noted the patient had a congested cough but described a normal effort of breathing and normal breath sounds. A chest x-ray was obtained and revealed "no acute cardiopulmonary process." Provider 2 assessed the patient to have "alcohol use disorder with withdrawal" but stated:

> Doubt [the patient's] agitation is due to alcohol withdrawal at this time but may be due to the initiation of [methylprednisolone]. Will discontinue [chlordiazepoxide], CIWA-Ar protocol and symptom-triggered [lorazepam].

Provider 2 described the patient as "a harm to self as [the patient] is trying to get out of bed while on [dexmedetomidine] [infusion]" concluding that the patient was still meeting the criteria for restraints. Provider 2 proceeded to wean the patient off dexmedetomidine and indicated that the patient could receive haloperidol as needed for agitation.

During the evening of hospital day 8, nurse 2 described the patient as being confused and needing frequent orientation. The patient remained in bilateral wrist restraints. The next morning, nurse 3 noted the continued need for restraints due to "confusion, self-protection, marked agitation, attempts to remove medical devices and prevent injury." A physical therapist saw the patient at 12:07 p.m. who noted, pre-session, the presence of a left wrist restraint, an elevated blood pressure of 159/109 mm Hg, and "a small rectangular erythema" on the left side of the patient's low back. The physical therapist described the patient as only oriented to self, that standing balance was unsteady, and that the patient needed cueing and redirection. Following the session, the physical therapist reapplied the left wrist restraint and noted the patient's blood pressure had increased to 185/112 mm Hg. Provider 2 then observed that the patient "has a rash on [the patient's] lower back from the Lidoderm patch" and that hypertension was "uncontrolled." At 12:33 p.m., provider 2 assessed the patient to have decreased agitation and planned to remove restraints, discontinue haloperidol, and begin amlodipine for elevated blood pressure. The next EHR entry was at 4:11 p.m. when nurse 3 documented the patient to be "obtunded and turning blue." The patient was initially found to be in cardiac arrest and staff conducted cardiopulmonary resuscitation per advanced cardiac life support protocol (code). Following intubation, a return of spontaneous circulation was achieved. After the code, the patient remained unresponsive and ventilator dependent.[24] On hospital day 12, after an extensive discussion with a neurologist, the patient's spouse elected to withdraw life support and place the patient in a comfort care status. The patient died on hospital day 14.

[24] When attempting intubation, a certified registered nurse anesthetist discovered "a long white gauze" lodged in the patient's airway and after removal, was able to secure the airway with an endotracheal tube. The circumstances that led to the foreign object becoming lodged in the patient's airway will not be addressed in this inspection as VA OIG's Office of Investigations reviewed and closed this matter.

Inspection Results

1. Failure to Recognize and Treat Alcohol Withdrawal Symptoms

In reviewing the quality of care provided to the patient, the OIG identified deficiencies in actions taken by nursing staff and the primary providers caring for the patient who was withdrawing from alcohol.

Nursing Staff's Improper Assessment and Treatment of Alcohol Withdrawal Symptoms

The OIG determined that nursing staff failed to accurately and timely assess the patient's alcohol withdrawal symptoms and consistently administer medications in adherence with the facility's CIWA-Ar protocol. These failures may have affected the overall management of the patient's alcohol withdrawal symptoms.

Failure to Follow Facility CIWA-Ar Protocol

The facility's nursing service Alcohol Withdrawal Monitoring standard operating procedure (SOP) provides a protocol for nursing staff related to CIWA-Ar assessment scores, reassessments, monitoring of vital signs, thresholds for provider notification, and the administration of symptom-triggered lorazepam.[25] Based on the CIWA-Ar score, the facility protocol specifies the amount of lorazepam nursing staff are to administer, how often CIWA-Ar assessments are required, and provider notification thresholds for ICU patients (see table 2).[26] Nursing staff's reassessment of a patient's alcohol withdrawal symptoms using a validated withdrawal severity scale, such as the CIWA-Ar scale,

> should ensure that signs and symptoms are not worsening, that patients are responding as expected to medication if provided, and that signs and symptoms are not persisting beyond the expected timeline of withdrawal. Any of these indicate the need to reassess a patient's treatment plan and/or level of care.[27]

[25] Facility, Acute Care Nursing Services, "Alcohol Withdrawal Monitoring," Standard Operating Procedure, September 27, 2021; ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*. Provider orders pertaining to nursing staff tasks and medication administration are similar; therefore, the OIG will utilize the CIWA-Ar protocol outlined in the SOP as a reference point.

[26] Facility, "Alcohol Withdrawal Monitoring."

[27] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

Table 2. CIWA-Ar ICU Protocol

ICU			
CIWA-Ar score	**Lorazepam dose**	**Frequency of assessment**	**Monitoring**
5–7	None	Every 4 hours while awake	Assess vital signs after each lorazepam dose: Intravenous: 5–15 minutes Oral: 30–60 minutes If respiratory rate less than 12 breaths per minute, hold lorazepam dose and contact provider. Oral route preferred if patient could tolerate. If no intravenous access, administer intramuscularly.
8–10	1 mg oral or intravenous	Every 4 hours while awake	
11–14	2 mg oral or intravenous	Every 2 hours while awake	
15–25	3 mg oral or intravenous	Every 1 hour while awake and notify provider	
≥25	4 mg intravenous	Every 1 hour while awake and notify provider	
If CIWA-Ar score 11–14 on two consecutive assessments OR 15–24 on one assessment, notify provider for either a one-time extra dose of benzodiazepine OR initiation of dexmedetomidine.			

Source: Facility, Acute Care Nursing Services, SOP, "Alcohol Withdrawal Monitoring," September 27, 2021.

From hospital day 6 until the patient's cardiac arrest on hospital day 9 the patient required multiple forms of interventions, including use of restraints and two adjunctive medications, dexmedetomidine and haloperidol, to reduce agitation and restless behaviors described by nursing staff.[28]

The OIG noted nursing staff's EHR documentation of the patient's clinical and behavioral status appeared to be consistent with worsening alcohol withdrawal symptoms. However, the CIWA-Ar assessment scores did not reflect the same behaviors as described in nursing staff documentation. As an example, on hospital day 8, nurse 4 documented the patient's behavior as sedated and scored the patient's alcohol withdrawal symptoms as predominantly zero except for one score of four. However, during the same period, nurse 4 documented the patient continued to be intermittently medicated for agitation and was in restraints for behaviors such as agitation, restlessness, mumbling vocal responses, and decreased orientation status.[29] Given the clinical and behavioral assessments of the patient documented in the EHR, a conservative clinical

[28] Facility Memorandum No. 116 A-07, *Restraint and Seclusion Policy*, July 08, 2021.

[29] Merck Manual, Professional Version, "Examination of Mental Status," accessed August 27, 2024, https://www.merckmanuals.com/professional/neurologic-disorders/neurologic-examination/how-to-assess-mental-status. Determination of a patient's orientation status includes testing the patient's awareness of their person (self), time (date), and place (location).

assessment of the patient's described behaviors utilizing only two of the CIWA-Ar symptoms (agitation and orientation) may have led to a more accurate total CIWA-Ar score of at least seven or eight.

The OIG also found nursing staff did not consistently reassess the patient's alcohol withdrawal symptoms within the allotted time frames based on the patient's assessment scores, as described within the CIWA-Ar protocol (see table 3). Per the protocol, when a patient's CIWA-Ar assessment score is equal to or greater than 11, the frequency of assessments is increased from every four hours to every two hours. For scores equal to or greater than 15, the frequency of assessments is every one hour.[30]

Table 3. Lack of Timely CIWA-Ar Assessments

Hospital day	Time of assessment	CIWA-Ar score	Based on score, expected time of next assessment per protocol	Actual time of reassessment by nurse	Comments
Day 2	4:00 p.m.	13	6:00 p.m.	8:00 p.m.	Two hours after expected time
Day 5	12:00 p.m.	13	2:00 p.m.	8:00 p.m.	Six hours after expected time
Day 5	8:00 p.m.	12	10:00 p.m.	12:00 a.m.	Two hours after expected time
Day 7	2:00 a.m.	14	4:00 a.m.	5:00 a.m.	One hour after expected time
Day 7	5:00 a.m.	17	6:00 a.m.	8:00 a.m.	Two hours after expected time

Source: OIG analysis of delayed CIWA-Ar assessments from the patient's EHR.

As shown in table 3, at noon on hospital day 5, the patient's CIWA-Ar assessment score was a 13; however, the following reassessment was not documented as completed in the EHR until 8:00 p.m. If the patient's status did not improve, the gap of eight hours led to as many as three CIWA-Ar assessments being either undocumented or not completed. In another instance, on hospital day 7, the patient's CIWA-Ar assessment score was documented at 5:00 a.m. as a 17, which requires reassessment one hour later; however, the reassessment was not completed for three hours, at 8:00 a.m.

Table 4 summarizes the OIG's review of the patient's EHR showing instances when nursing staff were not consistent with the administration of lorazepam based on the patient's CIWA-Ar assessment score as outlined in the CIWA-Ar protocol. In some instances, nursing staff

[30] Facility, "Alcohol Withdrawal Monitoring."

administered lorazepam to the patient without a corresponding CIWA-Ar assessment score. For example, on hospital day 5, the patient's EHR did not reflect CIWA-Ar assessment scores for eight hours; however, during this time frame, the patient received two doses of lorazepam. Contrarily, the OIG found other occasions when nursing staff documented a CIWA-Ar assessment score that indicated the need for symptom-triggered lorazepam yet the patient did not receive the medication to address worsening signs and symptoms of alcohol withdrawal.

Table 4. Inconsistent Administration of Lorazepam Based on CIWA-Ar Protocol

Hospital day	Time of CIWA-Ar assessment	CIWA-Ar score	Based on score, dose to be administered per protocol	Actual dose administered	Time of administration	Comments
Day 5	-	-	-	2 mg	3:50 p.m.	No CIWA-Ar assessment
Day 5	-	-	-	1 mg	5:47 p.m.	No CIWA-Ar assessment
Day 6	2 a.m.	10	1 mg	-	-	No dose administered
Day 6	9 a.m.	9	1 mg	-	-	No dose administered
Day 7	-	-	-	2 mg	4:43 a.m.	No CIWA-Ar assessment
Day 7	5 a.m.	17	3 mg	-	-	No dose administered
Day 7	10 a.m.	8	1 mg	-	-	No dose administered
Day 8	12 a.m.	9	1 mg	-	-	No dose administered

Source: OIG analysis of CIWA-Ar assessments and lorazepam administration from the patient's EHR.

The OIG determined that, based on the CIWA-Ar score, or lack thereof, the amounts of lorazepam administered did not align with the CIWA-Ar protocol. Systematic reassessment and administration of lorazepam may have decreased, or eliminated, the need for additional interventions such as haloperidol and restraints.

The OIG concluded that there was a lack of accuracy and timeliness in nursing staff's CIWA-Ar assessments of the patient's alcohol withdrawal symptoms and a lack of consistency in the administration of symptom-triggered lorazepam. These failures may have affected the overall management of the patient and contributed to the deterioration of the patient's clinical and behavioral status and worsening of the patient's alcohol withdrawal symptoms.

Lack of Timely Documentation of CIWA-Ar Scores

In addition to concerns regarding nursing adherence to the CIWA-Ar protocol, the OIG is concerned about the timeliness of nursing staff's EHR documentation of CIWA-Ar assessment scores. Delayed entries of assessment scores may affect information available for use by providers in patient care decision-making.

VHA nursing documentation guidelines specify nursing staff enter accurate and complete EHR documentation immediately after the care of a patient and in response to interventions.[31] Nursing staff are instructed to notify the provider when the patient's CIWA-Ar assessment scores are between 11–14 for two consecutive assessments or for any score of 15 or greater. While nursing staff documentation of provider notification is not explicitly required per the facility SOP, documentation in the EHR is an important tool for communicating patient information to other clinicians caring for the patient.

The OIG found some nursing staff documented CIWA-Ar assessment scores within the EHR approximately three to seven hours after the assessments were completed. In one instance, on hospital day 5, nurse 6 documented a CIWA-Ar assessment score after the provider evaluated the patient and determined the daily plan of care. In that case, nurse 6 completed the CIWA-Ar assessment at 8:00 a.m., resulting in a score of 10, but did not enter documentation of that score into the EHR until 1:38 p.m. In the meantime, provider 2 documented evaluating the patient at 10:38 a.m., noting the 4:00 a.m. CIWA-Ar assessment score of 1, the last score documented at that time in the EHR. Provider 2 subsequently discontinued the patient's scheduled lorazepam and noted anticipating discharge within a few days.

Additionally, the OIG found instances when nursing staff delayed documentation of consistently elevated CIWA-Ar assessment scores within the EHR. On hospital day 4, at 3:16 p.m., nurse 3 documented CIWA-Ar scores as 11 at noon, 10 at 1:00 p.m., 11 at 2:00 p.m., and 11 at 3:00 p.m. On day 6, nurse 5 documented three consistently elevated CIWA-Ar scores (12, 10, 11) from midnight to 4:00 a.m., but did not enter any of these scores into the EHR until approximately 4:40 a.m. (4:38–4:45 a.m.).

[31] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)." VHA-ONS-NUR-22-01, September 20, 2022, revised September 10, 2024, https://dvagov.sharepoint.com/sites/vhanursing/StdNsgDcmnt/Published%20SOPs/Forms/All%20ONS%20SOPs.aspx?id=%2Fsites%2Fvhanursing%2FStdNsgDcmnt%2FPublished%20SOPs%2FVAAES%20Nursing%20Admission%20Screen%2C%20Assessment%2C%20and%20Standards%20of%20Care%20SOP%2Epdf&parent=%2Fsites%2Fvhanursing%2FStdNsgDcmnt%2FPublished%20SOPs. (This website is not publicly accessible). If a nurse is unable to document patient care actions or observations within a patient's EHR during the tour of duty, the guidelines allow adjustment of the time the interventions occurred. A late EHR documentation entry should clearly indicate the documentation is a late entry and the reason why the documentation was entered late.

Accurate and timely documentation of the patient's CIWA-Ar scores may have provided information affecting the provider's clinical decision-making and affording the patient greater symptom control and a better chance of recovery from alcohol withdrawal.

Providers' Failure to Recognize and Address the Patient's Complex Alcohol Withdrawal Symptoms

As mentioned earlier, delirium is a severe form of alcohol withdrawal that can be life-threatening.[32] Risks factors for delirium include

- "history of alcohol withdrawal delirium or alcohol withdrawal seizure,"
- "numerous prior withdrawal episodes in the patient's lifetime," and
- "long duration of heavy and regular alcohol consumption."[33]

Patients who have a CIWA-Ar score of at least 10 are considered at risk for severe alcohol withdrawal.[34] Early detection of signs and symptoms of alcohol withdrawal allows providers to initiate treatment that may help decrease the risk of developing delirium.[35]

According to the ASAM, delirium can be effectively treated with benzodiazepines such as lorazepam and chlordiazepoxide. If a patient's signs and symptoms are not adequately assessed to determine if their CIWA-Ar score allows administration of symptom-triggered benzodiazepines, the risk to the patient is increased symptoms that may lead to delirium and possibly death.[36]

Failure to Identify Severity of Withdrawal and Utilize Clinical Resources

The OIG determined that provider 2 failed to identify the severity of the alcohol withdrawal symptoms in this complex patient case. As a result, the provider did not utilize clinical resources to assist in managing the patient's care.

Based on the patient's medical history of multiple incidences of alcohol withdrawal including a report of an alcohol withdrawal seizure, as well as very heavy alcohol consumption over an extended period, the patient was at increased risk for delirium.[37]

---

[32] VA and DoD, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders 4.0*.

[33] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[34] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[35] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[36] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[37] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; Marc A. Schuckit, "Recognition and Management of Withdrawal Delirium (Delirium Tremens)."

Per EHR documentation, on hospital day 4, the patient began exhibiting signs of high blood pressure readings and CIWA-Ar scores of greater than 10. On hospital days 6 and 7, documentation indicated that the patient's symptoms continued to worsen. Provider 1, saw the patient on both hospital days and documented assessments in the EHR stating that the patient was in severe alcohol withdrawal requiring restraints. The patient was noted to have been

> Extremely agitated removing medical devices . . . need restraints . . . . Remains confused and agitated at times. Patient continues to have severe withdrawal symptoms, agitated, confused, disoriented, attempting to remove devices.

On hospital day 8, provider 2 assessed the patient as having "alcohol use disorder with withdrawal," confusion, and "mild sweatiness." Despite this assessment, provider 2 discontinued the chlordiazepoxide, symptom-triggered lorazepam orders, and CIWA-Ar protocol stating, "doubt [the patient's] agitation is due to alcohol withdrawal."

With the presence of several risk factors for severe alcohol withdrawal and documented signs and symptoms suggestive of alcohol withdrawal including continued delirium, severe agitation, the need for restraints, and ICU-level care in a patient who was not improving, the OIG would have expected provider 2 to consider a higher dose or more frequent dosing of lorazepam, as recommended in the ASAM guidelines or consult with a facility intensivist as needed.

During an interview with the chief of medicine, the OIG learned that hospitalists are the primary providers for patients in the ICU but there are intensivists at the facility who are available for consultation. Additionally, intensivists are available through the telecritical care program. According to facility policy and a statement by the chief of medicine, intensivists, when consulted, will see a patient daily and help direct care as well as treatment plans.[38] The OIG asked provider 2 about consulting with the intensivists and learned that they are consulted but not that often and when they are, consults are usually requested for patients who are intubated or experiencing worsening respiratory status.[39] Provider 2 told the OIG the intensivists were not contacted because the patient "was not considered a difficult patient to manage." In written correspondence with the OIG, provider 2 recounted not having been "notified that [the patient's] behavior was difficult to manage or that [the patient] was agitated" adding if that was the case, an intensivist consult would have been requested.

The OIG found this response was contrary to provider 2's documentation within the EHR on hospital day 8, noting the patient was "fighting the staff and kicking," remained on dexmedetomidine "due to agitation," and continued haloperidol as needed for agitation. Additionally, provider 2 documented that the patient met the criteria for continued use of

[38] Facility Memorandum 111-22, *Intensive Care Unit Policy*, January 13, 2022.

[39] Provider 2 was also asked about utilization of the telecritical care program. Provider 2 would consult with the facility intensivists before using telecritical care program and did not contact them about the patient's case.

restraints citing "Confusion, Assaultive, Self protection." The next day, provider 2 documented the patient's assessment to include a "decrease [in] agitation today." In addition to provider 2's references to agitation, provider 1 and nursing staff documented in the EHR multiple periods of the patient being agitated beginning on hospital day 6, two days prior to discontinuing the CIWA-Ar protocol, through hospital day 9.

The OIG concluded that provider 2's failure to recognize the patient's symptoms as related to the withdrawal of alcohol likely led to making the clinical decision to discontinue orders to treat the withdrawal and not consult with available clinical resources. This failure likely contributed to the patient not being afforded evidence-based care for severe alcohol withdrawal and prevention of delirium.

Failure to Confirm Availability of Injectable Lorazepam

Although provider 1 documented that nursing staff reported a short supply of lorazepam injectable, the OIG found that there was not a shortage of lorazepam injectable at the time of the patient's care. In addition, provider 1's failure to confirm the availability of the medication likely changed the course of treatment for the patient's alcohol withdrawal symptoms on hospital day 7.

On hospital day 6, according to EHR documentation, the patient's alcohol withdrawal symptoms worsened, and the patient became "extremely agitated." Provider 1 noted that according to a nursing staff member, the facility had a short supply of lorazepam injectable, and the patient was unable to take medication by mouth. Therefore, on hospital day 7, provider 1 ordered dexmedetomidine instead, to help manage the severity of alcohol withdrawal symptoms.

In an interview with the OIG, provider 1 explained that the nurse of the day indicated there was a short supply of lorazepam injectable at that time and provider 1 did not consider it available for use. As a result, provider 1 started the patient on dexmedetomidine instead. Additionally, provider 1 reported that if lorazepam injectable had been available, a higher dose of the lorazepam injectable would have been considered. According to the EHR, the patient did not receive any doses of lorazepam injectable after the initiation of dexmedetomidine on hospital day 7, or at any time thereafter prior to the patient's cardiac arrest on hospital day 9.

The OIG received conflicting information from the nurse of the day, ICU nurses, and pharmacy staff regarding the shortage of lorazepam injectable during the patient's admission. In written correspondence with the OIG, the nurse of the day acknowledged awareness of intravenous lorazepam availability at the time of the patient's admission but shared an understanding that due to supply issues, priority use should be given "for active seizures and severe [alcohol] withdrawals." The OIG was told by some ICU nursing staff that the shortage of lorazepam injectable had been an ongoing issue, while others said it was never out of stock and always available for use. Pharmacy staff acknowledged periodic shortages of lorazepam injectable but reported to the OIG that it was available for use during the time of the patient's inpatient care

and has always remained available in the ICU. A nurse manager also told the OIG that there was not a shortage of lorazepam injectable in the ICU during the time of the patient's care. The OIG reviewed the facility's inventory of lorazepam injectable during the period of the patient's care and confirmed that the ICU medication dispensing unit was stocked with lorazepam injectable available for use.

Based on the medication dispensing records, the OIG determined that lorazepam injectable was available for use. The OIG is concerned that provider 1's failure to clarify and confirm the availability of lorazepam injectable in the ICU likely affected the provider's clinical decision-making. As a result, the patient was given dexmedetomidine, a medication that does not treat delirium or prevent seizures, instead of lorazepam infusion as an option per facility CIWA-Ar protocol for delirium.[40]

Contributing Factor to the Mismanagement of Care

Lack of Training Effectiveness

The OIG determined that nursing staff caring for patients going through alcohol withdrawal had training on the use of CIWA-Ar and their facility SOP, including the CIWA-Ar protocol; however, the education provided to facility nursing staff did not include a competency assessment to ensure consistency and accuracy across staff utilizing the CIWA-Ar assessment tool.

The OIG national review, discussed earlier, addressed the need to ensure clinicians are competent to perform CIWA-Ar assessment scales and manage patients with alcohol withdrawal. Within this review, the VHA National Hospital Medicine Program Director stated that "due to the subjectivity in scales such as [CIWA-Ar,] healthcare systems should train staff to ensure consistent utilization and scoring."[41]

ASAM states clinicians utilizing the CIWA-Ar scale need training to administer it reliably and should be aware of limitations of the assessment tool.[42] According to The Joint Commission,

[40] ASAM recommends dexmedetomidine "as an adjunct to benzodiazepine therapy to control autonomic hyperactivity and anxiety when these signs are not controlled by benzodiazepines alone.;" Ankur Sachdeva, Mona Choudhary, and Mina Chandra, "Alcohol Withdrawal Syndrome: Benzodiazepines and Beyond," *Journal of Clinical and Diagnostic Research* 9, no. 9 (September 2015): VE01–VE07. https://doi.org/10.7860%2FJCDR%2F2015%2F13407.6538; Facility, "Alcohol Withdrawal Monitoring."

[41] VA OIG, *Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal*.

[42] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

competent clinicians require the "knowledge, technical skills, and ability" to "correctly perform technical tasks" and "deliver safe care."[43]

VHA policy strongly recommends VA medical facilities offer "training specific to management of [substance use disorder] to all clinically active staff engaged in the treatment or care of Veterans diagnosed with a [substance use disorder]." One substance use disorder training is the CLE-118 Withdrawal Assessment CIWA/Clinical Opiate Withdrawal Scale (COWS).[44] Facility policy in place at times relevant to this review, required the CIWA-Ar tool be used to assess and evaluate all patients at risk for alcohol withdrawal. Nurse managers were responsible for ensuring that staff were knowledgeable of the alcohol withdrawal protocol.[45]

The OIG found that prior to this patient's admission, ICU staff were trained through a unit-wide training when CIWA-Ar was implemented. Staff hired after that training took place were trained on the CIWA-Ar in new employee orientation. During an interview, the unit nurse educator indicated that the education provided was directed toward the information within the SOP and documentation of the CIWA-Ar assessment score within the EHR.

The OIG found that at times relevant to this review, 86 percent of ICU nursing staff completed CLE-118 Withdrawal Assessment CIWA/Clinical Opiate Withdrawal Scale (COWS) training. The ICU nurse manager told the OIG that ICU nurses are "100 percent comfortable" utilizing the CIWA-Ar assessment and SOP. The nurse leader reported the ICU staff frequently provide care for patients experiencing alcohol withdrawal symptoms and are updated on changes to the SOP, and that because they use the CIWA-Ar so frequently, it is not included in annual nurse refresher training or competency assessments. However, in interviews with nursing staff, the OIG heard responses concerning the required time frames for CIWA-Ar assessments and how to assess sedated patients that were varied and inconsistent with the protocol. The nurse educator stated that outside of the education specific to documentation, a competency for CIWA-Ar assessment scoring is not included in the annual skills fair as it is "not a skill per se" and could not be demonstrated by the nursing staff in the skills fair setting.

On August 13, 2024, near the end of the inspection period, VHA Notice 2024-09, *Alcohol Withdrawal Management*, was issued "to standardize and improve alcohol withdrawal management across the VA healthcare system."[46] The notice included content required for inclusion in facility SOPs. The notice states "All staff involved in ordering and implementing

[43] The Joint Commission, *Competency Assessment vs Education and Training, What is the difference between education, training and competency assessment?*, August 23, 2019, revised September 8, 2022, https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/human-resources-hr/000002254/#:~:text=Competency%20(see%20HR.01.06.01)%20differs%20from%20education%20and.

[44] VHA Directive 1160.04, *VHA Programs for Veterans with Substance Use Disorders,* December 8, 2022.

[45] Facility, "Alcohol Withdrawal Monitoring."

[46] VHA Notice 2024-09, *Alcohol Withdrawal Management*, August 13, 2024.

alcohol withdrawal care must be trained on their facility's alcohol withdrawal SOP …, including clinical components of the severity scale." And, "All staff administering, interpreting, and applying the validated alcohol withdrawal severity scale used by their facility (e.g., CIWA-Ar) must complete standardized training to ensure accurate and consistent use."

On August 1, 2024, two weeks before the issuance of VHA Notice 2024-09, facility leaders updated the facility's SOP. The OIG reviewed the facility's new SOP and identified gaps between the content and expectations outlined in the VHA notice.

The OIG is concerned that the CIWA-Ar training provided to nursing staff prior to this patient's care was ineffective given the variability found in this patient case with the accuracy and timeliness of the CIWA-Ar assessments and inconsistent adherence to CIWA-Ar protocol for medication administration. The recent VHA notice provides facility leaders with the opportunity to review the facility SOP and to update training according to the newly stated expectations. Conducting interrater reliability between nursing staff conducting clinical assessments that are subjective in nature may help ensure accurate and consistent scoring and tracking of a patient's alcohol withdrawal and providing accurate CIWA-Ar scoring to providers in support of their clinical decision-making.

2. Facility Review of the Care Provided to the Patient

VHA provides guidance to the field on administrative and quality management actions to take following adverse events to patients. The OIG found that the facility took administrative action and completed quality management reviews related to the patient's cardiac arrest and clinical care, as required by VHA.

VHA requires facilities to disclose harmful or potentially harmful adverse events to patients or their personal representative.[47] Adverse events that cause death warrant an institutional disclosure as soon as possible, preferably within 72 hours.

The OIG confirmed that the Chief of Staff conducted an institutional disclosure with the patient's representative detailing circumstances surrounding the patient's cardiac arrest.

VHA facilities charter and conduct a root cause analysis when an adverse event occurs.[48] According to VHA, a root cause analysis is "required for any event that has been given an actual or potential safety assessment code of 3 (catastrophic), including any sentinel event."[49] A root cause analysis "is interdisciplinary in nature, identifies system vulnerabilities of risks and their potential contributions to the adverse event. . . and identifies changes that can be made in

[47] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[48] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[49] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, Version 16.

systems to improve performance and reduce the risk of event recurrence."[50] The root cause analysis team, which includes a subject matter expert, conducts interviews, collects data, performs a cause-and-effect analysis, and formulates an action plan based on their findings.[51]

Following the patient's cardiac arrest, a staff member entered a patient safety event report into the Joint Patient Safety Reporting System.[52] The patient safety manager told the OIG the report was presented to the executive leadership team and a root cause analysis was recommended to be conducted. The OIG confirmed that the final root cause analysis was presented to the executive leadership team but that the root cause analysis was not yet finalized and approved.

Per VHA, the peer review for quality management (peer review) process is an evaluation of the "care provided by individual clinicians within a selected episode of care" to determine if the provider's clinical decision-making and actions met the standard of care.[53] The peer review process "is intended to promote confidential and non-punitive assessments of care at the individual clinician level" with the intent of identifying opportunities for improvement in clinical practice.[54] Peer review for quality management may be completed in situations when a patient experiences an unexpected or negative outcome that may be related to care provided or when leaders have concerns related to the quality of care provided to a patient.[55]

The OIG learned that, based on executive concern, six peer reviews were completed to review the medication management, nursing care, and clinical decision-making in the care of this patient prior to the cardiac arrest.

The OIG concluded that, in completing an institutional disclosure, root cause analysis, and peer reviews related to the patient's cardiac arrest and clinical care, the facility followed VHA guidance for administrative actions and quality management reviews of clinical care.

Conclusion

Failures by nursing staff to adhere to the facility CIWA-Ar protocol were identified. Nursing staff's EHR documentation of the patient's clinical and behavioral status appeared to be consistent with worsening alcohol withdrawal symptoms. However, the CIWA-Ar assessment

[50] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis.*

[51] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[52] VHA Directive 1050.01(1). "A patient safety event is an event, incident or condition, directly associated with care or services provided to a patient, that could have resulted, or did result in unintentional harm."

[53] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018. VHA defines standard of care as "a diagnostic and/or treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance. It is how similarly qualified clinicians would have managed the patient's care under the same or similar circumstances."

[54] VHA Directive 1190.

[55] VHA Directive 1190.

scores did not reflect the same behaviors as described in nursing staff documentation. Nursing staff did not consistently reassess the patient's alcohol withdrawal symptoms within the allotted time frames based on the patient's prior CIWA-Ar assessment score. Further, there were times when the entry of the EHR CIWA-Ar score was delayed. Additionally, nursing staff were not consistent with the administration of lorazepam based on the patient's CIWA-Ar assessment score. In some instances, nursing staff administered lorazepam to the patient without a corresponding CIWA-Ar assessment score. Contrarily, on other occasions nursing staff documented a CIWA-Ar assessment score that indicated the need for symptom-triggered lorazepam, yet the patient did not receive the medication to address worsening signs and symptoms of alcohol withdrawal. The failure to systematically reassess the patient, document assessment scores, and administer lorazepam accordingly may have affected the overall management of the patient and contributed to the deterioration of the patient's clinical and behavioral status and worsening of the patient's alcohol withdrawal symptoms.

Provider 2's documentation within the EHR described an agitated patient who was difficult to manage; criteria the provider indicated would lead to consulting an intensivist. The patient had several risk factors for severe alcohol withdrawal. Additionally, EHR documentation noted signs and symptoms suggestive of alcohol withdrawal including continued delirium, severe agitation, the need for restraints, and ICU-level care in a patient who was not improving. Despite this, provider 2 failed to identify the severity of the alcohol withdrawal symptoms in this complex patient case. As a result, the provider did not utilize clinical resources to assist in managing the patient's care or consider a higher or more frequent dose of lorazepam. These failures likely contributed to the patient not being afforded evidence-based care for severe alcohol withdrawal and prevention of delirium.

The nurse of the day, ICU nurses, and pharmacy staff provided conflicting information regarding the shortage of lorazepam injectable from during times relevant to this review. Based on the medication dispensing records, there was not a shortage of lorazepam injectable at the time of the patient's care. However, provider 1's failure to confirm the availability of lorazepam when treating the patient likely affected the provider's clinical decision-making and resulted in a medication being ordered for the patient that does not treat delirium or prevent seizures.

Prior to this patient's admission, ICU staff received unit-wide training on the facility Alcohol Withdrawal Monitoring SOP and how to document CIWA-Ar scores within the EHR. However, given the importance of accurate CIWA-Ar scoring as a support for clinical decision-making, the OIG identified a concern that the CIWA-Ar training provided was ineffective given the variability found with the accuracy and timeliness of the CIWA assessments and inconsistent adherence to CIWA-Ar protocol for medication administration. Additionally, the issuance of VHA Notice 2024-09 provides an opportunity for facility leaders to review the facility SOP and update training according to the new stated expectations.

The facility, in completing an institutional disclosure, root cause analysis, and peer reviews

related to the patient's cardiac arrest and clinical care, followed VHA guidance for administrative actions and quality management reviews of clinical care.

Recommendations 1–7

1. The Hampton VA Medical Center Director directs nursing leaders to review records of medical intensive care unit patients with Clinical Institute Withdrawal Assessment of Alcohol Scale protocol orders to confirm that medical intensive care unit nurses document Clinical Institute Withdrawal Assessment of Alcohol Scale scores consistent with patient's documented behavior and symptoms and takes actions to address any deficiencies that are identified.

2. The Hampton VA Medical Center Director confirms that nursing leaders complete review of records of medical intensive care unit patients with Clinical Institute Withdrawal Assessment of Alcohol Scale protocol orders to determine the extent with which administration of medication is in adherence with the protocol and take actions to address any deficiencies that are identified.

3. The Hampton VA Medical Center Director ensures that a review of records of medical intensive care unit patients with Clinical Institute Withdrawal Assessment of Alcohol Scale protocol orders is completed by nursing leaders to (a) assess the degree of compliance with completing Clinical Institute Withdrawal Assessment of Alcohol Scale assessments based on the last assessment score, as outlined in the protocol, and (b) review the actual time Clinical Institute Withdrawal Assessment of Alcohol Scale is completed in comparison to the time it is documented in the electronic health records to identify significant delays, if any, and based on analysis of findings, takes action to address deficiencies that are identified.

4. The Hampton VA Medical Center Director works with the facility Chief of Staff to ensure medical intensive care unit providers have reviewed a clinical practice guideline specific to management of alcohol withdrawal from an accredited source, such as The American Society of Addiction Medicine.[56]

5. The Hampton VA Medical Center Director confirms completion of a review to assess the current process for communicating unit-based medication shortages and how staff can confirm the availability of shortage medications when use of the medication is key to the patient's treatment, and updates the process as warranted.

[56] The American Society of Addiction Medicine "is a professional medical society representing over 7,000 physicians, clinicians and associated professionals in the field of addiction medicine." The group provides industry practice guidelines on alcohol withdrawal management recognized by VHA leaders from the Office of Mental Health and Suicide Prevention and the National Hospital Medicine Program.

6. The Hampton VA Medical Center Director ensures that the facility's Alcohol Withdrawal Management standard operating procedure aligns with requirements for a standard operating procedure outlined in Veterans Health Administration Notice 2024-09.

7. The Hampton VA Medical Center Director confirms that training requirements specified in Veterans Health Administration Notice 2024-09 are completed, training attendance is tracked, and a process is in place to monitor accurate and consistent use of the alcohol withdrawal scale identified in the facility standard operating procedure.

Appendix A: CIWA-Ar Scale

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ **Date:** _____ **Time:** _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ **Blood pressure:**_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

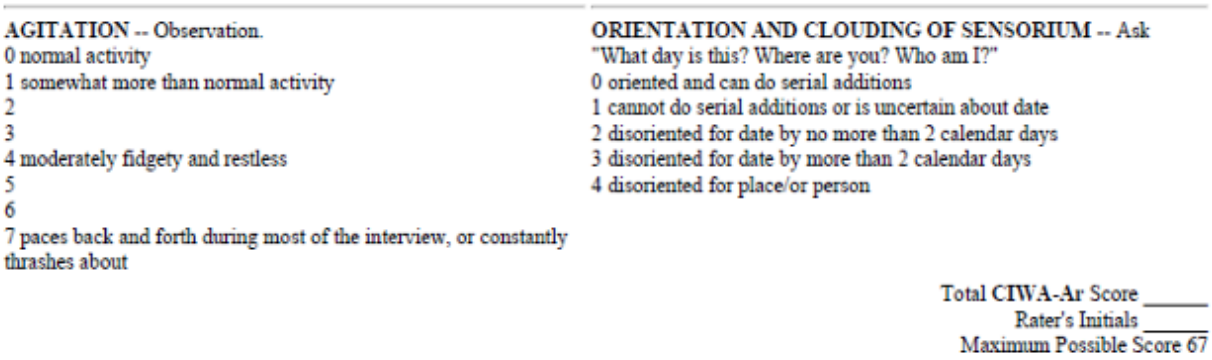
AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe



AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total CIWA-Ar Score _____
Rater's Initials _____
Maximum Possible Score 67

Figure A.1. *CIWA-Ar Scale, Revised*
Source: Facility, *Alcohol Withdrawal Monitoring.*

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 19, 2025

From: VA Mid-Atlantic Health Care Network Director, VISN 6 (15N6)

Subj: Healthcare Inspection—Care Failures for a Patient with Alcohol Withdrawal at Hampton VA Medical Center in Virginia

To: Office of Healthcare Inspections (54HL05)
Executive Director, Office of Integrity and Compliance (10OIC)

1. We are deeply saddened by the loss of this patient. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values, including leadership commitment, sensitivity to operations, and deference to expertise. We appreciate the opportunity to review and comment on the Office of Inspector General (OIG) report, Care Failures for a Patient with Alcohol Withdrawal at Hampton VA Medical Center in Virginia.

2. I have reviewed and concur with the OIG recommendations and the action plans submitted by the Hampton VA Medical Center. As we remain committed to ensuring our Veterans receive exceptional care, Veterans Integrated Services Network (VISN) 6 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

3. I would like to thank the Office of Inspector General for their thorough review, and if there are any questions regarding responses or additional information required, please contact the VISN 6 Quality Management Officer.

(*Original signed by:*)

Paul S. Crews, MPH, FACHE

[OIG comment: The OIG received the above memorandum from VHA on February 26, 2025.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 18, 2025

From: Acting Executive Director, Hampton Department of Veterans Affairs (VA) Medical Center (00)

Subj: Healthcare Inspection—Care Failures for a Patient with Alcohol Withdrawal at Hampton VA Medical Center in Virginia

To: Network Director, Veterans Integrated Service Network 6 (VISN 6)

1. Thank you for the opportunity to review and respond to the Office of Inspector General's (OIG) draft report, Care Failures for a Patient with Alcohol Withdrawal at Hampton VA Medical Center in Virginia.

2. Our deepest condolences go out to the Veteran's family and friends during this difficult time. In response to this unfortunate event, our organization took swift actions to review the circumstances surrounding the incident, notify appropriate representatives, and determine opportunities for improvement. The Hampton VA Medical Center concurs with the recommendations and submits the attached action plan. The findings outlined in the OIG report reflect a thorough evaluation.

3. Should you need further information, contact the Chief of Quality & Patient Safety.

(*Original signed by*:)

Michael Harper

[OIG comment: The OIG received the above memorandum from VHA on February 26, 2025.]

Facility Director Response

Recommendation 1

The Hampton VA Medical Center Director directs nursing leaders to review records of medical intensive care unit patients with Clinical Institute Withdrawal Assessment of Alcohol Scale protocol orders to confirm that medical intensive care unit nurses document Clinical Institute Withdrawal Assessment of Alcohol Scale scores consistent with patient's documented behavior and symptoms and takes actions to address any deficiencies that are identified.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Hampton Department of Veterans Affairs (VA) Critical Care Nursing leadership will initiate refresher training to all medical intensive care unit nurses on the documentation requirements for the Clinical Institute Withdrawal Assessment of Alcohol Scale protocol. Nursing leadership will conduct reviews on medical intensive care unit patients to verify Clinical Institute Withdrawal Assessment (CIWA) score documentation is consistent with the patient's documented behavior and symptoms. Compliance will be monitored and reported monthly to the Associate Director for Patient Care Services (ADPCS) as a standing agenda item at the Patient Care Services Council. Based on the findings, leadership will conduct additional training for all medical intensive care unit nurses. Monitoring will continue until 90% compliance is met for six consecutive months.

Recommendation 2

The Hampton VA Medical Center Director confirms that nursing leaders complete review of records of medical intensive care unit patients with Clinical Institute Withdrawal Assessment of Alcohol Scale protocol orders to determine the extent with which administration of medication is in adherence with the protocol and take actions to address any deficiencies that are identified.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Hampton VA Critical Care Nursing leadership will initiate refresher training for all medical intensive care unit nurses on the medication administration requirements for the Clinical Institute Withdrawal Assessment of Alcohol Scale protocol. Nursing leadership will conduct reviews on

medical intensive care unit patients to verify administration of medication follows the protocol. Compliance will be monitored and reported monthly to the ADPCS as a standing agenda item at the Patient Care Services Council. Monitoring will continue until 90% compliance is met for six consecutive months.

Recommendation 3

The Hampton VA Medical Center Director ensures that a review of records of medical intensive care unit patients with Clinical Institute Withdrawal Assessment of Alcohol Scale protocol orders is completed by nursing leaders to (a) assess the degree of compliance with completing Clinical Institute Withdrawal Assessment of Alcohol Scale assessments based on the last assessment score, as outlined in the protocol, and (b) review the actual time Clinical Institute Withdrawal Assessment of Alcohol Scale is completed in comparison to the time it is documented in the electronic health records to identify significant delays, if any, and based on analysis of findings, takes action to address deficiencies that are identified.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Hampton VA Critical Care Nursing leadership will initiate refresher training to all medical intensive care unit nurses on the assessment and reassessment requirements for the Clinical Institute Withdrawal Assessment of Alcohol Scale protocol. Nursing leadership will conduct reviews on medical intensive care unit patients to validate assessments and reassessments are documented timely in the electronic health record according to the CIWA score. Compliance will be monitored and reported monthly to the ADPCS as a standing agenda item at the Patient Care Services Council. Monitoring will continue until 90% compliance is met for six consecutive months.

Recommendation 4

The Hampton VA Medical Center Director works with the facility Chief of Staff to ensure medical intensive care unit providers have reviewed a clinical practice guideline specific to management of alcohol withdrawal from an accredited source, such as The American Society of Addiction Medicine.

_X _Concur

____Nonconcur

Target date for completion: March 2025

Director Comments

All medical intensive care unit providers will be trained on the American Society of Addiction Medicine Clinical Practice Guideline on Alcohol Withdrawal Management (2020). These guidelines will be available for all providers to access on the department's SharePoint and included in new provider's orientation. Providers will sign an attestation memo indicating they have reviewed the clinical practice guideline and are able to access the document on the SharePoint by March 2025. The Chief, Medicine Attestation will monitor and reported to the Chief of Staff as an agenda item at the Medical Executive Council until closed.

Recommendation 5

The Hampton VA Medical Center Director confirms completion of a review to assess the current process for communicating unit-based medication shortages and how staff can confirm the availability of shortage medications when use of the medication is key to the patient's treatment and updates the process as warranted.

_X _Concur

____Nonconcur

Target date for completion: April 2025

Director Comments

The Hampton VA Pharmacy leadership team identified opportunities to enhance the process for communicating the availability of shortage medications to all staff. A single repository that captures the current availability of medications is being established with accessibility by all health care providers on the facility's SharePoint. Once this repository is developed, a formal Standard Operating Procedure (SOP) to define the communication process and responsibilities of management and employees will be created. To ensure staff are knowledgeable and able to access the repository, all staff will sign an Attestation Memo indicating they have reviewed the SOP and are able to access the repository located on the facility's SharePoint by April 2025. The Chief, Pharmacy will review attestation compliance and report to the Pharmacy and Therapeutics Committee monthly until 90% compliance is achieved.

Recommendation 6

The Hampton VA Medical Center Director ensures that the facility's Alcohol Withdrawal Management standard operating procedure aligns with requirements for a standard operating procedure outlined in Veterans Health Administration Notice 2024-09.

_X _Concur

____Nonconcur

Target date for completion: March 2025

Director Comments

In December 2024, a multidisciplinary team of leaders (Chief, Medicine, Chief Nurse of Acute Care, Chief of Mental Health, Chief, Mental Health Residential, Assistant Chief of Medicine, Chief, Primary Care and Chief, Mental Health Nurse) developed the Standard Operating Procedure (SOP), Facility Alcohol Withdrawal Management to align with requirements outlined in VHA Notice 2024-09. All clinical staff will be trained on this SOP by March 2025.

Recommendation 7

The Hampton VA Medical Center Director confirms that training requirements specified in Veterans Health Administration Notice 2024-09 are completed, training attendance is tracked, and a process is in place to monitor accurate and consistent use of the alcohol withdrawal scale identified in the facility standard operating procedure.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

Service level leadership developed the SOP, Facility Alcohol Withdrawal Management to be in alignment with requirements outlined in VHA Notice 2024-09. All clinical staff will be trained on this SOP by March 2025. Leadership will track training attendance and conduct reviews to monitor accurate and consistent use of the alcohol withdrawal scale by clinical staff. Compliance will be monitored and reported monthly to the Quality and Patient Safety Council (QPSC) as a standing agenda item. Monitoring will continue until 90% compliance is met for six consecutive months.

Glossary

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

adverse event. "Untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers."[1]

amlodipine. A calcium channel blocker used to treat high blood pressure and decrease the workload of the heart.[2]

autonomic. Refers to involuntarily actions.[3]

benzodiazepine. A group of medications used to treat seizures and anxiety by slowing down activity in your nervous system.[4]

cardiopulmonary resuscitation. A procedure designed to restore normal breathing after cardiac arrest.[5]

chlordiazepoxide. A medication used to the treat alcohol withdrawal symptoms, such as anxiety. It is also considered a benzodiazepine.[6]

Clinical Institute Withdrawal Assessment of Alcohol Scale Revised (CIWA-Ar). A tool used to "assess and diagnose the severity of alcohol withdrawal."[7]

delirium tremens. Occurs one to three days after someone with moderate or severe alcohol use suddenly stops drinking. Symptoms may include tremors or shakes, confusion, agitation or anxiety, bouts of heavy sweating, and seizures.[8]

---

[1] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[2] Mayo Clinic, "Amlodipine (Oral Route)," revised September 1, 2024, accessed October 1, 2024, https://www.mayoclinic.org/drugs-supplements/amlodipine-oral-route/description/drg-20061784?p=1.

[3] *Merriam-Webster.com Dictionary*, "autonomic," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/autonomic.

[4] Cleveland Clinic, "Benzodiazepines (Benzos)," medically reviewed January 3, 2023, accessed August 5, 2024, https://my.clevelandclinic.org/health/treatments/24570-benzodiazepines-benzos.

[5] *Merriam-Webster.com Dictionary*, "cardiopulmonary resuscitation," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/cardiopulmonary%20resuscitation.

[6] Mayo Clinic, "Chlordiazepoxide hydrochloride (oral route)," accessed September 19, 2024. https://www.mayoclinic.org/drugs-supplements/chlordiazepoxide-hydrochloride-oral-route/description/drg-20072246.

[7] American Addiction Centers, "CIWA-AR Assessment for Alcohol Withdrawal," accessed September 27, 2024, https://americanaddictioncenters.org/alcohol/rehab-treatment/ciwa-ar-alcohol-assessment.

[8] Cleveland Clinic, "Delirium Tremens," accessed December 11, 2024. https://my.clevelandclinic.org/health/diseases/25052-delirium-tremens.

dexmedetomidine. An alpha2-adrenergic agonist and can be used in alcohol withdrawal patients "as an adjunct to benzodiazepine therapy to control autonomic hyperactivity and anxiety when these signs are not controlled by benzodiazepines alone."[9]

erythema. Abnormal redness of the skin or mucous membranes due to capillary congestion, such as inflammation.[10]

first-line therapy. Considered to be the first, and best, treatment for a condition.[11]

haloperidol (Haldol). A first-generation antipsychotic that rebalances dopamine to improve thinking, mood, and behavior. The medication is also used to treat behavioral problems such as agitated behavior.[12]

hospitalist. A physician who specializes in providing and managing the care and treatment of hospitalized patients.[13]

institutional disclosure. A process where medical center leaders share information with a patient, or their representative, regarding an event of harm or potential harm that occurred during care of the patient.[14]

intensivist. A physician who specializes in the care and treatment of patients in the intensive care unit.[15]

intubation. The introduction of a tube into the trachea to maintain an open passage.[16]

magnetic resonance imaging. A noninvasive diagnostic technique based on nuclear magnetic resonance of atoms within the body triggered by radio waves and produces computerized images of internal body tissues.[17]

---

[9] *ASAM Clinical Practice Guideline on Alcohol Withdrawal Management,* accessed May 28, 2024, https://www.asam.org/quality-care/clinical-guidelines/alcohol-withdrawal-management-guideline.

[10] *Merriam-Webster.com Dictionary*, "erythema," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/erythema.

[11] NIH National Cancer Institute, "first-line therapy," accessed October 8, 2024, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/first-line-therapy.

[12] American Association of Psychiatric Pharmacists, *Medication Fact Sheet: Haloperidol*; Curry, Malas, Mroczkowski, Hong, Nordstrom, and Terrell, "Updates in the Assessment and Management of Agitation."

[13] *Merriam-Webster.com Dictionary*, "hospitalist," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/hospitalist.

[14] VHA Directive 1004.08.

[15] *Merriam-Webster.com Dictionary*, "intensivist," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/intensivist.

[16] *Merriam-Webster.com Dictionary*, "intubation," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/intubation.

[17] *Merriam-Webster.com Dictionary*, "magnetic resonance imaging," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/magnetic%20resonance%20imaging.

methylprednisolone. A steroid medication used to decrease inflammation by slowing down an overactive immune system or by replacing cortisol normally made within the body.[18]

neuroforaminal stenosis. A narrowing where a spinal nerve exits the spine, which may place pressure or damage the nerve causing symptoms in the body parts that rely on the nerve connection to the brain.[19]

obtunded. A state of consciousness where a patient has a decreased interest in their surroundings, a delayed response to stimuli, and is drowsy.[20]

pharmacotherapy. The use of drugs to treat disease.[21]

physical restraints. "The involuntary application of manual method of restricting the patient's freedom of movement, physical activity, or normal access to his or her body with or without patient's permission. This includes items used to restrict freedom of movement such as… cloth limb holders."[22]

Richmond Agitation-Sedation Scale (RASS). A commonly used scale to determine a patient's sedation level and measures the severity of agitation and sedation.[23]

root cause analysis. A comprehensive investigation that reviews systems-level issues related to adverse events and close calls.[24]

sentinel event. An event resulting severe or permanent harm to a patient, or death, that is "not primarily related to the natural course of patient's illness or underlying condition."[25]

serum ethanol. The level of alcohol in a person's blood.[26]

---

[18] Cleveland Clinic, "Methylprednisolone Tablets," 2024, accessed October 1, 2024, Methylprednisolone (Medrol): Uses & Side Effects (clevelandclinic.org).

[19] Cleveland Clinic, "Foraminal Stenosis," medically reviewed March 28, 2023, accessed October 1, 2024, https://my.clevelandclinic.org/health/diseases/24856-foraminal-stenosis.

[20] Suzie C. Tindall, "Level of Consciousness," chap. 57 in Clinical Methods: The History, Physical, and Laboratory Examinations, 3rd ed., eds. Walker HK, Hall WD, Hurst JW (Boston: Butterworths, 1990).

[21] *Merriam-Webster.com Dictionary,* "pharmacotherapy," accessed October 1, 2024, https://www.merriam-webster.com/dictionary/pharmacotherapy.

[22] Facility Memorandum No. 116 A-07, *Restraint and Seclusion Policy*.

[23] Kengo Imai, Tatsuya Morita, Naosuke Yokomichi, Masanori Mori, Akemi Shirado Naito, Toshihiro Yamauchi, et al., "Association of the RASS Score with Intensity of Symptoms, Discomfort, and Communication Capacity in Terminally Ill Cancer Patients Receiving Palliative Sedation: Is RASS an Appropriate Outcome Measure?," *Palliative Medicine Reports* 3, no. 1 (April 8, 2022):47–54, https://doi.org/10.1089/pmr.2021.0087.

[24] VHA Directive 1050.01(1).

[25] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[26] *Merriam-Webster.com Dictionary*, "serum," accessed September 27, 2024, https://www.merriam-webster.com/dictionary/serum; University of Rochester Medical Center, "Ethanol (Blood)," accessed September 27, 2024, https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=167&contentid=ethanol_blood.

symptom-triggered. An approach where patients are monitored through a structured alcohol withdrawal scale, such as CIWA-Ar, and given different amounts of benzodiazepine medication based on the patient's score. The score can also determine the frequency in which reassessments of the score are done and further medication dosing that is needed.[27]

telecritical care. "An advanced Telehealth program which is designed to enhance the quality of care by adding an additional layer of monitoring to standard care through increased access to intensive care expertise and consultation."[28]

tremulous. Having body movements such as tremors or shaking.[29]

[27] *ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[28] VA, Press Release*, Bay Pines VA Implements TeleCritical Care in ICU*, November 22, 2022, accessed October 1, 2024, https://www.va.gov/bay-pines-health-care/news-releases/bay-pines-va-implements-telecritical-care-in-icu/.

[29] Merriam-*Webster.com Dictionary,* "tremulous," accessed October 3, 2024, https://www.merriam-webster.com/dictionary/tremulous.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Susan Tostenrude, OT, MS, Director Tina Cha, PharmD Michelle Ernzen, MSN, RN Andrew Waghorn, JD
Other Contributors	Jennifer Baptiste, MD Jennifer Christensen, DPM Christopher D. Hoffman, LCSW, MBA Ronald Penny, BS Natalie Sadow, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Mid-Atlantic Health Care Network (10N6)
Director, Hampton VA Medical Center (590)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
North Carolina: Ted Budd, Thom Tillis
Virginia: Tim Kaine, Mark R. Warner
US House of Representatives
North Carolina: Donald Davis, Greg Murphy
Virginia: Jen Kiggans, Jennifer McClellan, Bobby Scott, Robert Wittman

OIG reports are available at www.vaoig.gov.