US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Response to Changes in a Patient's Condition and Quality Reviews at the VA Greater Los Angeles Healthcare System in California

Healthcare Inspection | **24-03531-09** | **October 17, 2025**

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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 hotline inspection from October 29, 2024, through January 29, 2025, to assess care concerns and inadequate quality reviews related to a patient's death in spring of 2024 at the VA Greater Los Angeles Healthcare System (facility) in California. These concerns were identified during an unrelated OIG review in August 2024.

Brief Patient Case Summary

On a day in 2024 (day 1), a 72-year-old patient was admitted to the facility for further assessment after being discharged from a community hospital with back and hip pain and a lesion in the right femur and left lung.[1] Facility medical staff biopsied the right femur lesion and confirmed metastatic cancer. Over the next month, the patient had surgery on the right femur, developed delirium, and was moved to the geriatrics service on an acute medical surgical unit.

On day 31, the resident physician (resident) documented that the patient had "new left lower abdominal pain" of unclear etiology, an increasing white blood cell count, "and ongoing delirium will pursue further workup – Obtaining CT [computerized tomography] chest/abdomen/pelvis to further assess." The resident ordered laboratory tests and stat CT scans of the chest, abdomen, and pelvis and documented "infection" as the reason for the scans.[2] The patient's laboratory results showed significant abnormal bicarbonate, white blood cell, and platelet values.

That evening, the night nurse documented the patient started complaining of pain at 7:30 p.m. and administered pain medication. The night nurse noted the patient remained in pain and documented making several unsuccessful attempts to contact the night on-call provider. After seeking guidance from a nurse supervisor, the nursing team successfully contacted the medical officer of the day (MOD) who planned to notify the on-call provider to call the nurses. The next morning, at 12:24 a.m., the night nurse noted the patient was experiencing respiratory distress and called a rapid response. Radiology staff obtained a chest x-ray at 12:35 a.m. A radiologist interpreted the x-ray as showing a "marked gaseous distention [sic] of the stomach" and noted the possibility of gastric outlet obstruction or gastroparesis. The patient's condition declined, despite efforts to support breathing and circulation; the patient was pronounced dead shortly thereafter.

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

[2] The facility's Chief of Staff reported that a "stat" CT order should be completed within 24 hours.

Inspection Results

The OIG determined that clinical staff failed to rescue the patient as staff did not timely recognize, address, and further investigate changes in the patient's clinical condition to include new abdominal pain, abnormal laboratory results, and decreased oxygen levels.[3] Although the patient's outcome may not have changed, not recognizing an emerging condition suggestive of an evolving infectious or other acute process hindered clinical staff considering modifications to the plan of care and discussing the course of action with the patient and family.

By day 31, in addition to the patient's ongoing delirium and newly confirmed metastatic cancer, multiple indicators in the span of several days provided evidence that the patient's clinical status changed.[4] Several factors, outlined below, contributed to clinical staff not recognizing the changes that led to the patient's deterioration and intervening accordingly.

The OIG determined that although the resident placed an order for the patient's laboratory tests to be drawn on day 31, neither the resident nor the attending reviewed or acted upon the abnormal laboratory values recorded in the electronic health record (EHR) that afternoon. The results were suggestive of a significant clinical change in the patient's condition that warranted action.

The resident ordered stat CT scans to assess the patient's new abdominal pain and evaluate for infection; however, neither the resident nor the attending took action to ensure the CT scans were completed. The chief of hospital medicine learned the medical team ordered the CT scans to better understand the patient's condition and to further inform care but did not consider the scans to be emergent and were surprised by the patient's decompensation that evening. Further, nursing staff did not acknowledge the patient's stat CT scan orders in the EHR or make attempts to facilitate completion of the scan. The nurse manager reported following up with the day nurse to ask why the orders had not been acted on and said that the day nurse was unable to explain why this occurred. The OIG found the abnormal laboratory test results combined with the patient's delirium and undefined abdominal pain indicated the patient had a progressing acute process. As such, a complete workup should have been arranged and promptly completed.

The OIG determined on days 30 and 31, the patient's day and night nurse missed early warning signs of the patient's deteriorating clinical state. The nurses did not conduct National Early

[3] Joshua R. Burke, Candice Downey, and Alex Almoudaris, "Failure to Rescue Deteriorating Patients: A Systemic Review of Root Causes and Improvement Strategies," *Journal of Patient Safety* 18, no. 1, (January 2022): 140-155, https://doi.org/10.1097/pts.0000000000000720. Failure to rescue refers to "the failure to prevent inpatient deterioration and death resulting from a complication of medical care or underlying illness."

[4] Multiple indications signaling a change in the patient's condition included an elevated white blood cell count suggestive of an evolving infectious process; a decreased bicarbonate level highly suggestive of a buildup of lactic acid; unexplained, new abdominal pain; and decreased oxygen levels requiring supplemental oxygen support.

Warning Score (NEWS) assessments at the frequency and within the time frame required.[5] In addition, when NEWS scores were elevated, the nurses did not intervene as required. An expanded review of nursing NEWS documentation revealed similar deficiencies. The day nurse acknowledged being unaware of the NEWS assessment requirements when caring for the patient.[6] The night nurse believed the patient's pain was related to the current medical condition rather than a new or emergent condition and focused efforts on contacting the on-call provider for assistance managing the patient's pain. The OIG is concerned that inpatient nurses may not be fully aware of the critical value of the NEWS tool and nursing's role in utilization to timely recognize and respond to patients at risk of clinical deterioration.

The OIG concluded that the patient experienced several hours of persistent pain due to the nursing staff's inability to contact a provider as nurses did not have the correct contact information for either the on-call provider or MOD. Facility leaders and quality management staff completed a quality review of these communication barriers in late spring 2024 and identified multiple contributing factors, which included administrative delays in updating on-call provider information, nurses calling the wrong pager number for the on-call provider, and nurses initially calling a nonworking number when attempting to contact the MOD. Although facility staff began implementing corrective actions, at the time of this OIG inspection leaders had not yet completed planned actions to address communication barriers, including conducting audits to ensure accuracy and timeliness of on-call provider contact information and implementation of the facility's escalation procedure.

The OIG found none of the patient's nursing shift assessment notes (assessments) were completed within two hours, as required, and were typically completed near the end of the 12-hour shifts.[7] As EHR documentation is not visible until signed by the author, the patient's nursing assessment notes were not available to other healthcare providers during the entire shift. Further, the OIG found no evidence nurses documented reassessments during the patient's admission. The OIG noted an absence of nursing documentation in the patient's EHR for approximately 11 hours prior to death; as a result, real-time information about the patient's condition was neither recorded nor available to other nursing and provider staff involved in the patient's care.[8] When asked about assessment documentation requirements, both the day and

[5] NEWS is an assessment tool used to identify early warning signs of clinical deterioration in patients so that timely intervention such as increasing nursing attention, contacting a provider, or activating a rapid response, can be initiated.

[6] The day nurse informed the OIG that in December 2024 (following the OIG site visit in late October), nurses received NEWS assessment training and articulated information learned that aligned with VHA policy. The OIG did not independently verify whether NEWS training had been conducted.

[7] VHA-ONS-NUR-22-01, *VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)*, September 20, 2022, revised September 10, 2024.

[8] VHA-ONS-NUR-22-01.

night nurses reported being unsure of required time frames and identified similar practices of documenting an assessment once a shift near the end of the shift.

Facility leaders and staff did not conduct a comprehensive review of the care leading up to the patient's death. The OIG found systemic concerns—timely review of laboratory results, completion of stat CT scan orders, escalation of elevated NEWS scores to providers, and lack of completed and timely nursing documentation—that contributed to clinical staff not recognizing, relaying, and responding to early warning signs of the patient's clinical decline. Without a thorough analysis of these issues, the OIG is concerned that vulnerabilities persist for patient care.

In February 2025, following discussions with the OIG, facility leaders reported they planned to complete an institutional disclosure with the patient's family. When the OIG followed up in April 2025, the chief nurse, quality and safety reported that multiple attempts to reach the patient's family, including phone calls and registered mail, were unsuccessful.

The OIG made seven recommendations to the Facility Director related to comprehensive quality review processes of the circumstances surrounding the death of the patient, NEWS assessment training and associated nursing compliance, escalating patient care concerns processes, nursing assessments, and efforts to conduct an institutional disclosure.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). Based on information provided, the OIG considers recommendation 7 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

CT	computerized tomography
EHR	electronic health record
ICU	intensive care unit
k/uL	kilo per microliter
mg	milligram
mmHg	millimeters of mercury
mmol/L	millimoles per liter
MOD	medical officer of the day
NEWS	National Early Warning Score
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a hotline inspection from October 29, 2024, through January 29, 2025, to assess care concerns and inadequate quality reviews related to a patient's death in the spring of 2024 at the VA Greater Los Angeles Healthcare System (facility) in California. These concerns were identified during an unrelated OIG review in August 2024.

Background

The facility, part of Veterans Integrated Service Network (VISN) 22, includes a VA medical center located in West Los Angeles, two ambulatory care centers, and eight outpatient clinics. The Veterans Health Administration (VHA) classifies the facility as level 1a, high complexity, providing emergency, mental health, primary, and specialty care services.[1] The facility has 290 hospital operating beds. From October 1, 2023, through September 30, 2024, the facility served 86,711 patients.

Acute Hospitalization, Differential Diagnosis, and the Plan of Care

Patients who are acutely admitted to a hospital for care require stabilization of disease or medical condition (presenting medical condition). However, during hospitalization, a patient's presenting medical condition may become unstable or new illnesses may emerge requiring new interventions, therapies, and discussions with the patient and family about how the care should change. Providers rely on the most current laboratory tests, studies, and ongoing clinical assessments to determine the plan of care.[2] Without timely review and assessment of evolving clinical data throughout a patient's hospitalization, medical staff have limited means to analyze worsening issues or identify emerging concerns.

Providers formulate a list, called a differential diagnosis, for a patient when there are several possible diagnoses to consider. The diagnoses may change as the patient's symptoms and conditions change, or new clinical concerns develop. New symptoms and conditions require investigation to assess the criticality of emerging issues. A differential diagnosis helps the provider formulate an accurate diagnosis through review of the most up-to-date clinical data, which may include laboratory tests, studies, consults, and medical team meetings. The endpoint

[1] "Data Definitions: VHA Facility Complexity Model," VHA Office of Productivity, Efficiency, and Staffing, https://dvagov.sharepoint.com/sites/VHAOPES/Pages/Facility-Complexity-Model.aspx. (This website is not publicly accessible.) The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex.

[2] The OIG uses the term *studies* to include, but not limited to, radiological images, invasive and non-invasive procedures, biopsies, urine output, telemetry, and electrocardiograms.

of an accurate diagnosis is to apply appropriate, timely interventions and treatments to lessen severity of symptoms and prevent further complications or death.

Hospital providers formulate a plan of care to address the diagnosis by

- determining the stability of conditions for which the patient was admitted,
- assessing clinical changes for the emergence of new conditions,
- evaluating results of completed laboratory tests and studies, and
- following up on laboratory tests and studies ordered as results become available.

Hospital providers utilize VHA enterprise-wide monitoring tools for continuous assessment of patients, expected communication about clinical changes, and timely initiation of required actions, to formulate a plan of care to address the diagnosis.

Failure to Rescue

Failure to rescue refers to "the failure to prevent inpatient deterioration and death resulting from a complication of medical care or underlying illness."[3] In 2007, the US Agency for Healthcare Research and Quality recognized the failure to rescue rate, inpatient deaths deemed to be avoidable or preventable, as a hospital patient safety indicator. That same year, the United Kingdom's National Safety Agency reported that 11 percent of hospital patient deaths were the "result of inaction or a lack of recognition of [the patient's] deterioration."[4]

Over the years, there have been significant efforts toward identifying and mitigating deficiencies that contribute to "failure to rescue," as well as strategies and interventions for timely recognition and response to patients at risk of clinical deterioration. Tools have been developed and implemented to rectify known overt errors, such as administering the wrong medication. However, recognizing and remediating errors related to actions and steps not taken are less obvious but equally important. These omissions could be in the form of a test that was not ordered, laboratory results not reviewed or acted on, not recognizing or escalating changes in a patient's condition, incomplete or delayed assessments, or untimely documentation.[5] Timely recording of clinical data in a patient's electronic health record (EHR) serves as the mechanism

[3] Joshua R. Burke, Candice Downey, and Alex Almoudaris, "Failure to Rescue Deteriorating Patients: A Systemic Review of Root Causes and Improvement Strategies," *Journal of Patient Safety* 18, no. 1 (January 2022): 140-155, https://doi.org/10.1097/pts.0000000000000720.

[4] Burke, Downey, and Almoudaris, "Failure to Rescue Deteriorating Patients: A Systemic Review of Root Causes and Improvement Strategies."

[5] Richard Kremsdorf, MD., "What Really Ails Us?: Part I - Failure to Rescue and Errors of Omission," July 1, 2005, Patient Safety and Quality Healthcare, accessed March 11, 2025, https://www.psqh.com/analysis/what-really-ails-us-part-i-failure-to-rescue-and-errors-of-omission/.

to communicate information so staff can make informed decisions to support care.[6] Delays in entering data or entering inaccurate information into a patient's EHR may introduce patient safety risks as information gaps may impair staff's ability to make accurate and timely medical decisions.[7]

Recognizing and Responding to Early Warning Signs of Deterioration

Medical research has shown that physiologic abnormalities typically occur 8–24 hours before unplanned intensive care unit (ICU) transfers or deaths.[8] The time to "rescue" patients is often in this interval, and early indicators have been developed to detect if an intervention may be necessary.[9]

Nurses play a critical role in "'failing to rescue' through early recognition, escalation, and intervention of subtle changes [in patients] signaling complications. Upstream strategies, such as the use of early warning sign indicators, structured communication, and teamwork, shift the discourse from failure to rescue, to processes in nursing practice of good catch events."[10] The National Early Warning Score (NEWS) is an assessment tool used to identify early warning signs of clinical deterioration in patients so that timely intervention such as increasing nursing attention, contacting a provider, or activating a rapid response, can be initiated.[11] The NEWS tool assigns a numeric value on a point scale to a patient's physiological parameters to derive a composite score for the patient's level of risk for deterioration.[12]

---

[6] Ayse Gedikci Ondogan, Mehmet Sargin, and Kadir Canoz, "Use of electronic medical records in the digital healthcare system and its role in communication and medical information sharing among healthcare professionals," *Informatics in Medicine Unlocked* 42, (October 2023), https://doi.org/10.1016/j.imu.2023.101373.

[7] Dan Fraczkowski, Jeffrey Matson, and Karen Dunn Lopez, "Nurse workarounds in the electronic health record: An integrative review," *Journal of the American Medical Informatics Association* 27, no. 7 (July 11, 2020): 1149-1165, https://doi.org/10.1093/jamia/ocaa050.

[8] Mejalli Al-Kofahi et al., "National Early Warning Score Deployment in a Veterans Affairs Facility: A Quality Improvement Initiative and Analysis," *America Journal of Medical Quality* 38, no. 3 (May/June 2023): 147-153, https://doi.org/10.1097/JMQ.0000000000000123. Physiological abnormalities may include changes in systolic blood pressure, heart rate, respiratory rate, oxygen saturation, use of supplemental oxygen, and altered mental status.

[9] Jane Mushta, Kathy L. Rush, and Elizabeth Andersen, "Failure to rescue as a nurse-sensitive indicator," *Nursing Forum* 53, (2018): 84-92, https://doi.org/10.1111/nuf.12215.

[10] Jane Mushta, Kathy L. Rush, and Elizabeth Andersen, "Failure to rescue as a nurse-sensitive indicator."

[11] Al-Kofahi et al., "National Early Warning Score Deployment in a Veterans Affairs Facility: A Quality Improvement Initiative and Analysis."; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together; VHA-ONS-NUR-22-01, *VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)*, September 20, 2022, revised September 10, 2024.

[12] Inyong Kim et al., "Use of the National Early Warning Score for predicting in-hospital mortality in older adults admitted to the emergency department," *Journal of Clinical and Experimental Emergency Medicine* 7, no. 1 (July 9, 2019): 61-66, https://doi.org/10.15441/ceem.19.036.

Prior OIG Report

An August 17, 2022, OIG report reviewed allegations related to the facility's (VA Greater Los Angeles Healthcare System's) community living center's nursing staff's failure to assess a patient who was complaining of pain, properly document assessments, and follow and implement a provider's order.[13] The OIG found that a day charge nurse's assessment of the patient was delayed and incomplete; further, the charge nurse did not properly document the patient's reassessments, treatments, and interventions. The OIG determined that following the patient's death, facility staff failed to conduct a comprehensive review of the events leading up to, and contributing to, the patient's death, and delayed completion of an institutional disclosure. The OIG made recommendations related to nursing practice and documentation policies, pain assessments, provider orders, handoff communication, and patient care reviews and disclosures.[14] As of April 4, 2023, all recommendations were closed.

Concerns

While conducting a review in August 2024, an OIG Healthcare Facility Inspection team identified concerns related to a patient's care and inadequate quality reviews following the patient's death at the facility. The OIG opened a hotline inspection to evaluate the care provided to the patient and the quality reviews.

Scope and Methodology

The OIG conducted an on-site visit October 29 and 30, 2024, with additional virtual interviews from November 7, 2024, through January 29, 2025. The OIG interviewed facility leaders; providers, including attending physicians (attendings) and resident physicians (residents); nurses; and staff with knowledge of the patient's care or related facility processes.[15] The OIG reviewed relevant VHA and facility policies, email correspondence, staff schedules, a quality review, an accreditation standard, and other documents related to the patient's care and subsequent death. The OIG also reviewed the patient's EHR related to the inpatient hospitalization.

[13] VA OIG, *Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California*, Report No. 21-03595-219, August 17, 2022.

[14] VA OIG, *Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California*.

[15] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. The directive delineates that supervising practitioners (attendings) are licensed independent physicians (or other medical practitioners) who have been approved by the facility and the affiliated institutions training program to supervise residents. A resident is an individual in an accredited graduate medical training program who participates in the provision of patient care under the direction of a supervising practitioner.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, 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

On a day in the spring of 2024 (day 1), a 72-year-old patient, who had liver disease, type 2 diabetes, and heart disease presented to the facility's emergency department with generalized weakness and a recent fall. The patient was recently discharged from a community hospital for back and hip pain and found to have a lesion in the right femur and left lung. Facility medical staff admitted the patient for further assessment and biopsied the right femur lesion to confirm metastatic cancer.

On day 8, the patient experienced an episode of symptomatic hypotension, which subsequently responded to fluid administration and a blood transfusion. The patient had surgery two days later to strengthen the right femur and was transferred to the surgical ICU post-operatively. Following the procedure, the patient was less responsive; a neurologist assessed the patient's decreased responsiveness to be toxic metabolic encephalopathy and delirium. The patient remained in the surgical ICU for two additional days. On day 15, the patient was described as "doing well" though continued to display symptoms of delirium. The patient reported hip pain, but denied other complaints, and was transferred to the geriatric service on an acute medical surgical unit. On day 21, an oncologist documented the patient's overall poor health status.

On day 25, the geriatric team resident (resident) documented the patient reported feeling "fine" but "continued with deficits in orientation/mentation … still with delirium." The next day, the resident noted the patient "feels well this am," vital signs were normal, and while the patient's abdomen was described as "mildly distended," the patient denied abdominal pain.

On day 27, the geriatric team attending (attending) documented the patient denied abdominal pain, was "alert," and the patient's delirium was "improving each day."

On day 30, a nursing assistant documented that, beginning at 8:30 a.m., the patient was restless and "in and out of sleep making sound of pain," the patient's stomach was upset, and the patient was in "lots of pain" by 12:30 p.m. At 10:15 a.m., the resident saw the patient and documented

the patient "feels well" with "no issues" and assessed that delirium was still present and the patient could not follow instructions consistently. The resident documented an increase in the patient's white blood cell count from 3.98 to 9.4 kilo per microliter (k/uL), with abnormally high neutrophils at 8,010 per microliter (uL), and a decrease in CO2 (bicarbonate) to 19.6 millimoles per liter (mmol/L). At mid-day, the patient's blood pressure was 91/55 millimeters of mercury (mmHg) and pulse oximetry was 99 percent on room air.[16] A nurse documented the patient's NEWS score as a 2. By evening, the patient's NEWS score increased to 6; the patient's pulse oximetry was 92–93 percent with supplemental oxygen, and systolic blood pressure remained in the 90s.

The next day, day 31, the resident documented the patient endorsed "some stomach pain that has not been going on for a while" and had "mild tenderness in the left lower quadrant." The resident's assessment was of "new left lower abdominal pain" of unclear etiology, an increasing white blood cell count, "and ongoing delirium, will pursue further workup – Obtaining CT [computerized tomography] chest/abdomen/pelvis to further assess." The resident ordered stat CT scans of the chest, abdomen, and pelvis at 10:45 a.m.[17] The resident documented infection as the reason for the CT scans. At 9:26 a.m., a nurse documented the patient's NEWS score as a 5, reflecting changes in vital signs of a high pulse, blood pressure of 92/52, and use of supplemental oxygen.

Late afternoon on day 31, the attending documented the patient's abdomen was "soft." The attending noted the patient's delirium may have been slightly worse than the prior day and that the patient's episode of oxygen desaturation to 88 percent, which required supplemental oxygen earlier that day, was resolved. The attending wrote "Labs today" that included a white blood cell count of 4 k/uL and a normal bicarbonate level of 23 mmol/L; however, at 2:06 p.m., laboratory results drawn at 1:22 p.m. showed the patient's bicarbonate level was low at 13.9 mmol/L, elevated bands (immature neutrophils) at 37.3 percent (0 to 3 percent is normal), and low platelets at 85 k/uL.

The evening of day 31, the night nurse documented the patient started complaining of pain at 7:30 p.m. The night nurse administered pain medication as prescribed (oxycodone 5 milligrams (mg) and acetaminophen 500mg) but noted the patient remained in pain. The night nurse documented making several unsuccessful attempts to contact the night-float (on-call) provider

[16] A normal blood pressure for most adults is under 120/80 mmHg. However, low blood pressure is below 90/60 mmHg. *Cleveland Clinic*, "Blood Pressure," accessed January 28, 2025, https://my.clevelandclinic.org/health/diagnostics/17649-blood-pressure; A good oxygen saturation number is "over 90-92%." *American Lung Association*, "Pulse Oximetry," accessed January 28, 2025, https://www.lung.org/lung-health-diseases/lung-procedures-and-tests/pulse-oximetry."

[17] The facility's Chief of Staff reported that a "stat" CT order should be completed within 24 hours.

about the patient's pain.[18] "After another hour of the patient repeatedly moaning and complaining of pain," the charge nurse also attempted to contact the night float "to no avail." After seeking guidance from a nurse supervisor, the nursing team successfully contacted the medical officer of the day (MOD) who planned to "get in touch with the night float to call us [nurses] back."

On day 32, at 12:24 a.m., shortly after contacting the MOD, the nurse noted the patient was experiencing respiratory distress (rapid respiratory rate greater than 28 breaths per minute and low oxygen saturation of 76 percent) and called a rapid response. When the rapid response team arrived, the patient's oxygen saturation had improved to the mid-90s although the patient was breathing rapidly. A chest x-ray obtained a few minutes later was interpreted as showing a "marked gaseous distention[sic]of the stomach" and noted the possibility of gastric outlet obstruction or gastroparesis. The patient was transferred to the ICU for acute hypoxic respiratory failure. The patient initially responded to respiratory therapy treatments but then stopped breathing, became pulseless, and was intubated. A venous blood gas showed a worsening metabolic acidosis. Cardiopulmonary resuscitation was started approximately two hours later but was unsuccessful; the patient was pronounced dead shortly thereafter. A provider informed the family of the patient's death; the family declined an autopsy.

Inspection Results

Indications of the Patient's Clinical Deterioration

By day 31, in addition to the ongoing delirium and newly confirmed metastatic cancer, in the span of several days, multiple indicators provided evidence that the patient's clinical status changed. The indicators included

- an elevated white blood cell count suggestive of an evolving infectious process;
- a decreased bicarbonate level from 25.6 to 13.9, highly suggestive of a buildup of lactic acid;
- unexplained, new abdominal pain;
- decreased oxygen levels requiring supplemental oxygen support; and
- elevated NEWS assessment scores indicating the patient was at risk of deterioration.

[18] VHA Directive 1400.01. The night float refers to a resident physician assigned to cover evening or night shifts as the primary provider for assigned patients. Supervision of night floats is often provided by a medical officer of the day (MOD). VHA Directive 1101.04, *Medical Officer of the Day,* February 14, 2024. VHA defines the MOD as a physician responsible for the care of all medical inpatients when regular medical staff are not on duty, such as nights or weekends, to ensure continuous medical supervision.

Considering the changes to the patient's clinical status, a new or modified differential diagnosis could have been warranted.

1. Staff Did Not Recognize and Respond to Changes in the Patient's Condition

The OIG determined that clinical staff "failed to rescue," as staff did not timely recognize, address, and further investigate changes in the patient's clinical condition. As a result, clinical staff's differential diagnosis was limited to existing conditions instead of an emerging condition, which may have been addressed sooner. Although the patient's ultimate outcome may not have changed, not recognizing the emerging condition hindered clinical staff from considering modifications to the plan of care and determining the course of action with the patient and family.[19]

Multiple factors contributed to clinical staff not recognizing the patient's clinical deterioration and intervening accordingly, including not reviewing current laboratory results, completing a stat CT scan, escalating elevated NEWS scores to a provider, and completing timely nursing assessments. Improved patient outcomes rely on continually assessing and recognizing changes in physiologic parameters so that interventions can be initiated earlier to prevent further decline.

Laboratory Results Were Not Reviewed

The OIG determined that although the resident placed an order for the patient's laboratory tests to be drawn on day 31, neither the resident nor the attending reviewed or acted upon the abnormal laboratory values recorded in the EHR that afternoon. The laboratory results were suggestive of a significant clinical change in the patient's condition; consequently, neither the resident nor the attending initiated appropriate clinical action.

VHA policy states the ordering providers "maintain responsibility for all test results they order" and for "initiating timely and appropriate clinical action and follow up" for the orders they place.[20] Laboratory results provide objective data to assess clinical stability or concerns. When significant changes are revealed in laboratory results, clinical staff have the responsibility to reexamine the differential diagnosis and modify care plans accordingly. Medical decision making is based on using available data to support or refute a diagnosis, which guides a plan of care for the patient.

For this patient, who had multiple serious conditions, providers obtained laboratory tests to assess the status of disease. According to the patient's EHR, laboratory staff were unsuccessful in drawing the patient's blood in the morning of day 31; therefore, no morning laboratory

[19] For the purposes of this report, clinical staff include attending physicians, residents, and nurses.

[20] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 30, 2024.

samples were obtained. The resident placed a repeat laboratory draw order at 12:51 p.m., and staff obtained blood samples from the patient at 1:22 p.m. The day 31 laboratory results were reported in the patient's EHR at 2:06 p.m. and 4:03 p.m.

The resident saw the patient prior to the laboratory results and did not acknowledge the results when they were available that afternoon. The attending saw the patient in the afternoon of day 31 and incorrectly documented the patient's laboratory values as "Today's labs" in the progress note, which the attending signed at 4:06 p.m. Neither the resident's nor the attending's day 31 EHR documentation contained the patient's actual laboratory results from day 31.

The patient's day 31 laboratory results ultimately showed significant abnormal bicarbonate, white blood cell, and platelet values. These abnormal laboratory parameters supported a differential diagnosis that included acute infection, ischemia, sepsis, or septic shock. The abnormal laboratory parameters, each in isolation, may represent change in a patient's condition, but having several abnormal results should support an acute process that requires immediate attention and evaluation.

The OIG interviewed facility physician leaders, who had reviewed the EHR, to obtain their perspective of the patient's evolving clinical status. The chief of hospital medicine reported the patient's laboratory results demonstrated that "something bad is happening" and felt that, "in retrospect, it's easy to look back and say … this is a clear red flag"; however, the chief of hospital medicine stated that at the time, this was not apparent to the medicine team. The Chief of Staff said it was evident there was a change in the patient's clinical status on day 31 with new pain that escalated throughout the evening and laboratory studies suggestive of an acute bacterial infection.

The patient had delirium and undefined origin of abdominal pain, underscoring the need to follow up on objective data in assessing clinical status. The OIG concluded that acute changes of several laboratory results within two days were indicative of clinical deterioration and should have resulted in a new differential diagnosis and more timely care management decisions.

Uncompleted Stat CT Scans

The OIG determined that, although the resident ordered stat CT scans on day 31, at approximately 10:40 a.m., to assess the patient's new abdominal pain and evaluate for infection, neither the resident nor attending viewed the patient's condition as urgent and did not take action to ensure the CT scans were completed promptly. Further, nursing staff did not acknowledge the patient's stat CT scan orders in the EHR or make attempts to facilitate the scans completion.

VHA policy requires ordering providers to initiate "timely and appropriate clinical action and follow-up for any test orders that they have placed." If ordering providers are unavailable, they must assign a qualified provider to receive the test results.[21]

During an OIG interview, the resident recalled ordering stat CT scans after noting that the patient was less talkative, more lethargic, and experiencing new abdominal pain. Although the patient appeared to be relatively stable, the resident was concerned about the source of the patient's condition and ordered CT scans stat so the scans would be completed that day but could not recall whether actions were taken to facilitate the scans completion.[22] The attending could not recall whether discussion occurred to order the CT scans stat or routine but reported the patient was relatively stable and did not believe the CT scan order to be urgent.

The chief of hospital medicine reported being initially concerned that the stat CT scans were not completed that day but, after talking with the medical team, learned the team ordered the scans to better understand the patient's condition and to further inform care. The medical team did not consider the scans to be emergent and were surprised by the patient's decompensation that evening. The chief of hospital medicine reported understanding that the standard time frame for a stat CT order to be completed was within 24 hours. The Chief of Staff stated the expectation for the completion of a stat CT imaging study would be "within 24 hours at most, at the outset," and added that although 24 hours had not passed, there was still the question of whether the care was appropriate or sufficient. The Chief of Staff explained "stat can mean 24 hours, that's the general consensus, but I think you could say stat should mean today … if it's [ordered in] the morning stat means today, if it's 8:00 p.m., stat could mean the next morning." The Chief of Staff offered, "… we can do a better job of defining what that means to order something stat."

Through review of the patient's EHR and interviews, the OIG found nursing staff did not process the CT scan orders so that scheduling of the scans would be arranged with radiology. The nurse manager reported following up with the day nurse to ask why the orders had not been acted on but said that the day nurse was unable to explain why this occurred. The nurse manager hypothesized that because the day nurse missed the CT scan orders, it was unlikely that the day nurse would have alerted the night nurse of the pending orders during handoff. The nurse manager reported nursing staff were informed to review patient charts for new orders at least two to three times per shift and would expect nurses to act as soon as possible to facilitate the completion of a stat CT scan order.

The OIG concluded that the patient had an acute process that was progressing. The laboratory tests provided several indicators of decline and combined with the patient's delirium and undefined abdominal pain, a workup to include the CT scans ordered should have been arranged

[21] VHA Directive 1088(1).

[22] The resident shared that it was common practice to enter inpatient orders as stat and said that routine orders take longer to complete.

and promptly completed.

Insufficient Assessments and Actions on Early Warning Signs of Clinical Deterioration

The OIG determined on days 30 and 31, the patient's day and night nurse missed early warning signs of the patient's deteriorating clinical state. The nurses did not conduct NEWS assessments at the frequency and within the time frame required and intervene accordingly. Further, the OIG identified similar NEWS deficiencies in the EHR throughout the course of the patient's hospitalization.

VHA inpatient nurses utilize the NEWS assessment tool to recognize and respond to early signs of clinical deterioration in patients.[23] Nurses must complete NEWS assessments within two hours of a patient's "admission, transfer, change of shift or caregivers, and with any clinical deterioration." Additionally, when the level of risk increases, the NEWS assessment must be completed more frequently to closely monitor and respond to changes in a patient's status. When the level of risk is considered medium, the nurse must contact a provider, and when the level of risk is considered high, nurses must immediately activate the rapid response team.[24] VHA's minimum required nursing interventions associated with the level of risk are outlined in Table 1.

Table 1. Interventions by NEWS Score and Level of Risk

NEWS Score	Risk Level	Interventions
0–4	Low	Continue to monitor, per VA medical facility's clinical algorithms.[25]
5–6	Medium	**Patient is at risk to deteriorate rapidly.** [Emphasis by VHA.] Increase vital signs to every two hours for three times (next six hours total); reassess NEWS with each vital sign set. Contact VA health care provider, site specific nursing resources, and follow local VA medical facility's algorithms. Document actions and interventions taken, patient status, and event synopsis for scores of 5 or greater.

[23] Al-Kofahi et al., "National Early Warning Score Deployment in a Veterans Affairs Facility: A Quality Improvement Initiative and Analysis."

[24] VHA-ONS-NUR-22-01.

[25] VHA-ONS-NUR-22-01. VHA policy advises VA medical centers to develop NEWS algorithms based on local resources but notes that "facility processes/algorithms can be more stringent but cannot contradict or lessen the minimum standard interventions set forth in this SOP [standard operating procedures]." At the time of the OIG site visit, a patient safety manager reported the facility had not developed NEWS standard operating procedures.

NEWS Score	Risk Level	Interventions
7 or Greater	High	**Immediate action is needed.** [Emphasis by VHA.] Notify charge nurse and primary team immediately, activation of rapid response team, follow local VA medical facility's clinical algorithm. Continuous monitoring is recommended. Document actions and interventions taken, patient status, and event synopsis.

Source: VHA-ONS-NUR-22-01.

The OIG found no evidence nurses completed the following required actions:

- Contacted the provider, and documented related actions or interventions taken, patient status, and event synopsis for scores of 5 or higher.
- Repeated NEWS assessments and vital signs after the day 30 score of 6, when due at 8:52 p.m., 10:52 p.m., and 12:52 a.m.[26]
- Repeated NEWS assessments and vital signs after the day 31 score of 5, when due at 11:26 a.m. and 1:26 p.m.
- Completed additional NEWS assessments on the patient during the approximately 10-hour period preceding the day 32 rapid response shortly after midnight.

The OIG interviewed the day and night nurses who provided care to the patient from day 30 to day 32, about the NEWS assessments and care provided. The day nurse acknowledged that when caring for the patient, being unaware of the requirement to repeat the patient's vital signs and NEWS assessments every two hours when NEWS scores were 5 or above.[27] The night nurse informed the OIG of beginning the shift on day 31 at 7:30 p.m. Having also cared for the patient the previous night, the night nurse explained being familiar with the patient and the patient's medical condition. Outside of the patient complaining of pain, the night nurse did not believe there was a new or emergent condition occurring until several hours later when the patient was in respiratory distress and the night nurse called a rapid response. When asked if the night nurse was aware that the patient had respiratory distress requiring oxygen and had a pain level of 7–10 earlier that day, the night nurse said, "I didn't know any of that." Additionally, when asked about the patient's elevated NEWS score that day, the night nurse did not recall being made aware of issues.

[26] The OIG found that the patient's vital signs were not reassessed for over nine hours after the medium risk NEWS score of 6.

[27] The day nurse informed the OIG that in December 2024 (following the OIG site visit in late October) nurses received NEWS assessment training and articulated information learned that aligned with VHA policy. The OIG did not independently verify whether NEWS training had been conducted.

The OIG interviewed nursing leaders about the patient's NEWS assessments on days 30 and 31.[28] Nursing leaders identified concerns with the nurses' actions in response to the patient's elevated NEWS scores, including contacting a provider or initiating a rapid response earlier, and lack of documentation recording the patient's status and of nursing actions taken. At the time of the interview, the OIG learned the Associate Director for Patient Care Services was not aware of facility efforts to track compliance with nursing requirements related to NEWS assessments.

Because of the nursing NEWS assessments and intervention deficiencies in the days preceding the patient's death, the OIG reviewed nursing NEWS documentation in the patient's EHR related to the hospitalization and found similar deficiencies. Specifically, the OIG reviewed 31 nursing shifts and found that 16 (52 percent) of the shifts had no NEWS assessment documented, and 33 percent of the documented NEWS assessment notes were not completed within the required two hours.

In conclusion, the OIG found that nurses did not utilize the NEWS assessment and corresponding interventions as a critical tool in evaluating the patient's risk of deterioration as required. The OIG is concerned the nurse's lack of understanding of the purpose of NEWS resulted in the nurse not utilizing assessment tools to collect relevant clinical data to identify changes in the patient's condition, that may have allowed for earlier intervention before the patient experienced rapid decline. As these deficiencies were identified throughout the patient's course of treatment, the OIG has concerns whether inpatient nurses possess the knowledge of VHA NEWS standards and are fully aware of the critical value of the tool and their role in utilization to timely recognize and respond to patients at risk of clinical deterioration.

Inability to Contact a Provider

The OIG determined that over an approximate five-hour period on day 31, nursing staff made multiple unsuccessful attempts to contact the on-call provider to treat the patient's persistent pain.

The Joint Commission requires facility staff to coordinate "the patient's care, treatment, and services within a time frame that meets the patient's needs."[29] VHA strives to provide high quality "health care that is patient-centered, effective, timely, efficient, equitable, and safe."[30]

[28] Nursing leaders interviewed included the Associate Director of Patient Care Services, a nurse manager, and an assistant nurse manager.

[29] The Joint Commission, *Standards Manual E-dition*, PC.02.02.01, August 1, 2024.

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

In interviews, the night nurse and charge nurse shared making multiple, unsuccessful attempts over several hours to contact the patient's on-call provider for assistance in managing the patient's pain.[31] Specifically, staff informed the OIG that the night nurse

- reviewed the patient's EHR and found two different names listed as the on-call provider. Unsure of which provider to call, paged both numbers, but did not receive a return call;
- enlisted assistance from the charge nurse who also attempted to contact the on-call provider without success;
- contacted the off-tour nurse supervisor who provided the phone number for the MOD;
- contacted the MOD via telephone;
- paged the night float but did not receive a return call; and
- called a rapid response when the patient's condition deteriorated.[32]

The night nurse told the OIG of feeling very frustrated and upset about the inability to contact a provider. In an effort to facilitate coordination between the night float and the night nurse, the MOD reported calling the night float and advising the night float to contact the nurse directly. After learning that the night float never called the night nurse, the MOD reported providing direct feedback to the night float regarding expectations.[33] During an interview, the night float explained receiving a large volume of pages from throughout the hospital, which the night float was working to prioritize.

Facility leaders and quality management staff reviewed the nurses' inability to contact the on-call provider. Leaders told the OIG of multiple contributing factors, including delays in updating on-call provider information and nurses calling the wrong pager number; further, nurses did not have the correct contact information for the MOD and were initially calling a nonworking number. The patient safety manager shared facility efforts, including audits to ensure contact information is correct and education to ensure nurses know how to access the correct contact information for on-call providers.

[31] The OIG reviewed email communication that suggested nursing attempts to contact the on-call providers began at 7:30 p.m.

[32] The chief of hospital medicine confirmed in an interview that the nurse initially made attempts to contact the MOD on a nonworking system. Per nursing staff interviewed, the provider team listed in a patient's EHR indicates which covering provider was caring for the patient and who should be contacted for orders. The OIG found that after nurses were able to contact the MOD, the MOD provided the correct night float pager information. The OIG reviewed email communication that confirmed, through call logs, the attempted calls to the MOD occurred at 11:35 p.m. and 11:37 p.m. A little after midnight on day 32, the night float placed an order in the patient's EHR for a one-time dose of intravenous pain medication, but the night nurse reported not being contacted by the night float and the pain medication was not administered.

[33] The MOD reported functioning as a resource when needed by the night float; the night float was typically the first line provider responsible to treat the patient.

The Chief of Staff said it "is troublesome when a nurse can't reach a provider to escalate care for pain management" and relayed that nursing staff should feel comfortable contacting providers along the chain of command when unable to contact an on-call provider. Both the Chief of Staff and patient safety manager reported the facility was in the process of finalizing an escalation policy.

Following the site visit, the OIG was concerned that leaders had not completed planned actions to address barriers in communication. After an OIG inquiry in mid-May 2025, facility staff confirmed an escalation standard operating procedure was finalized. The procedure was for situations, such as unresolved patient care concerns, that require escalating the concern "through established organizational channels of communication."[34] The procedure was signed by the chief of quality and safety on May 28, 2025, the same day it was provided to the OIG. The OIG noted that the escalation procedure did not outline a clear pathway for nurses to escalate patient care concerns, and it is unknown how facility leaders planned to disseminate the procedural information to providers and nursing staff.[35] Although identified as an important intervention to mitigate future patient care delays by providing a pathway to escalate patient care concerns through nursing and medicine services to receive a timely response, facility leaders did not finalize the escalation procedure until the OIG sent an inquiry, nearly seven months later.

The OIG concluded that the patient experienced several hours of persistent pain due to the nursing staff's inability to contact a provider as nurses did not have the correct contact information for either the on-call provider or MOD. Further, a facility escalation policy or procedure is a necessary tool in helping facility and clinical service line leaders establish and standardize escalation processes and algorithms that are easily accessible to and understood by nursing and medicine service staff who may be initiating or responding to escalation processes.

Lack of Timely and Complete Nursing Assessments

The OIG determined nurses did not complete and document nursing shift assessments in the patient's EHR within the time frame and at the frequency required. The OIG noted an absence of nursing documentation in the patient's EHR for approximately 11 hours prior to death; as a result, real-time information about the patient's condition was neither recorded nor available to other nursing and provider staff involved in the patient's care.

VHA requires nursing documentation that "is factual, accurate, complete, sequential, timely," and "recorded [in the EHR] and signed immediately after the care event or the observation has

[34] VA Greater Los Angeles Healthcare System SOP-00-QM-100, "Clinical and Administrative Escalation Process," (standard operating procedure), May 28, 2025.

[35] VA Greater Los Angeles Healthcare System SOP-00-QM-100, "Clinical and Administrative Escalation Process."

taken place."[36] Timely nursing assessments are a critical form of interdisciplinary communication that promotes continuity of care, identification of changes in condition, opportunities for intervention, and decreased risk of adverse events.[37]

VHA requires nurses to complete and document a nursing assessment on each patient within two hours of beginning their shift. Thereafter, nurses must reassess each patient every four to eight hours, based on the patient's acuity, and "whenever there is a significant change in the patient's condition or diagnosis."[38]

Delays in Documenting Nursing Shift Assessments

The OIG reviewed all nursing shift assessments documented in the patient's EHR from day 16 through day 32 and found that no assessments were completed within the required two-hour time frame. Rather, the assessments were often not completed until near the end of the 12 hour shifts. As EHR documentation is not visible until signed by the author, the patient's nursing assessment notes were not available to other healthcare providers for most of the 12-hour shifts. For example, on day 31, the day nurse signed the assessment note at 6:04 p.m. The night nurse did not document in the EHR until the next day at 2:03 a.m. and did not document any assessments or reassessments. Further, it is unknown whether the nursing assessments reflected the patient's condition at the beginning or end of the shift or anytime in between.

When asked about assessment documentation requirements, both the day and night nurses reported being unsure of required time frames and identified similar practices of documenting an assessment once a shift near the end of the shift or after other duties. The night nurse told the OIG of completing an assessment of the patient but not documenting the assessment due to having a "really busy night" with many tasks to complete.

In interviews, a nurse manager and assistant nurse manager acknowledged awareness of nurses not documenting in the EHR timely as required. The assistant nurse manager reported being previously advised by a quality management staff member that nurses need to document in real-time. However, the assistant nurse manager felt nurses sometimes cannot chart in real-time and that the time frame is not followed throughout the facility.

The OIG also found no evidence nurses documented reassessment notes for any of the shifts, resulting in EHR documentation gaps of up to 18 hours between assessments. When asked about the lack of reassessment notes, the assistant nurse manager explained the expectation is for the

[36] VHA-ONS-NUR-22-01. The policy sets requirements for standardized nursing documentation across VHA inpatient acute care settings with specifications for required frequency of assessments and timeliness of documentation.

[37] American Nurses Association, *ANA's Principles for Nursing Documentation Guidance for Registered Nurses*, November 2010, https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/ana-principles/.

[38] VHA-ONS-NUR-22-01.

assessment note to be completed, but added, "to be honest, we don't have time to [document] reassessment[s]."

Although the OIG recognizes nursing time constraints with the provision of patient care and timely assessment documentation, the failure to document timely results in a lack of real-time patient care information being available. The OIG concluded that nurses' lack of timely and complete nursing shift assessments may negatively affect interdisciplinary communication, continuity of care, and patient safety. The OIG is concerned that these nursing documentation issues may be indicative of a larger system issue.

2. Inadequate Quality of Care Reviews and Lack of Institutional Disclosure

Inadequate Quality of Care Reviews

The OIG determined that following the patient's death, facility leaders and staff did not conduct a comprehensive review of the events leading up to and contributing to the patient's death. The OIG found multiple systemic concerns, as identified throughout this report, contributed to clinical staff not recognizing, relaying, and responding to early warning signs of the patient's clinical decline. Although facility staff conducted a root cause analysis, the review and corrective actions were narrowly focused and did not address other concerns.

VHA quality and patient safety programs initiate reviews to ensure "quality health care that is patient-centered, effective, timely, efficient, equitable and safe."[39] VHA uses several processes for evaluating deaths and unexpected outcomes. These well-established processes are part of the VA healthcare system that is focused on learning from poor outcomes. The root cause analysis is one such review tool.[40] Other quality reviews include service level reviews, peer reviews for quality management, mortality reviews, or other interdisciplinary team reviews. Irrespective of how a review is completed, the analysis should be thorough in VA's framework of a high reliability organization.[41] The results should produce an endpoint of solutions that mitigate the underlying root causes found. In quality reviews, if causes are not identified correctly or thoroughly, problems are not mitigated effectively.

Facility staff conducted a root cause analysis that focused on aspects of the patient's care. When asked how the focus of the review was determined and whether other system issues, such as the timeliness of interventions, were reviewed, the patient safety manager stated that the system issues were not considered. The patient safety manager also shared that the evaluation team was under a time constraint to complete the review and had to condense the review into a one- to two-week time frame because of a team member's limited availability.

For this patient, the OIG identified multiple systemic concerns that contributed to clinical staff not recognizing the patient's clinical decline. However, the OIG learned facility leaders did not complete comprehensive reviews that addressed the multiple systemic concerns, including stat CT scan orders, timely review of laboratory results, escalating elevated NEWS scores to providers, and lack of completed and timely nursing documentation.

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

[40] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, March 2024. VHA states that the root cause analysis team is responsible for "continuing to gather data until the team establishes a clear understanding of the event and the existing factors that led up to it."

[41] VHA, *VHA High Reliability Organization (HRO) Reference Guide*, v4.0, September 2024.

The OIG acknowledges facility leaders' and staff's efforts in conducting a root cause analysis but notes the limited focus and corresponding actions address only one of many systemic concerns. The OIG concluded that facility leaders did not identify and review contributing factors related to the patient's care concerns to allow for broader process improvement.

Lack of an Institutional Disclosure

The OIG found that facility leaders were aware of the patient's persistent untreated pain, uncompleted CT scans, and undiagnosed abdominal condition but did not consider the issues as adverse events that may meet criteria for an institutional disclosure and, therefore, did not inform the patient's family.

VHA policy states that an institutional disclosure "is a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury."[42]

The OIG found, through interviews and review of email communication, that leaders discussed whether an institutional disclosure was warranted after the patient's death and determined a disclosure was not required based on a belief that the on-call provider's delay in returning the nurse's call did not have a direct effect on the patient's death. In an OIG interview, a risk manager agreed that the delay in pain management could be considered an adverse event, although reported the risk manager's earlier analysis of the event concluded a disclosure was not needed because the delay did not cause the patient's death.

During discussions with the OIG, the Chief of Staff acknowledged that an institutional disclosure could have taken place. The Chief of Staff stated that a completed CT scan would not have affected the patient's outcome but may have provided information about the patient's developing condition and prompted discussions regarding the plan of care with the patient and the patient's family. In February 2025, following discussions with the OIG, facility leaders reported to the OIG a plan to complete an institutional disclosure with the patient's family. In April 2025, the chief of quality and safety reported that multiple attempts to reach the patient's family, including phone calls and registered mail, were unsuccessful.

The OIG concluded that a timely disclosure to the patient's family would have provided an additional opportunity for leaders to identify, notify, and discuss unresolved care concerns with the patient's family.

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

Conclusion

The OIG determined that clinical staff did not timely recognize, address, and further investigate changes in the patient's clinical condition. The patient had complex diagnoses that included metastatic cancer, liver disease, and heart conditions, then developed delirium after surgery. Delirium may complicate the assessment of existing and emerging conditions and often, providers rely on current laboratory results, studies, and ongoing clinical assessments. Although the patient's ultimate outcome may not have changed, not recognizing the emerging condition hindered clinical staff from considering modifications to the plan of care and determining the course of action with the patient and family.

The resident and the attending did not review the patient's completed laboratory tests, and therefore, did not initiate clinical action in response to abnormal results. The OIG concluded the acute and significant changes of several laboratory results within two days of death were indicative of clinical deterioration and should have resulted in a new differential diagnosis and more timely care management decisions.

Since the resident and attending did not view the patient's condition as urgent, neither ensured the stat CT scans were completed the same day. Further, nursing staff did not acknowledge the patient's stat CT scan orders in the EHR and did not facilitate completion of the scans. The OIG concluded that prompt CT scans may have alerted clinical staff to the patient's source of clinical decline and provided possibilities for interventions, including earlier transfer to a higher level of care, and discussion with the patient and family regarding goals of care.

Further, the patient's day and night nurse missed early warning signs of the patient's deteriorating clinical state by not conducting NEWS assessments at the frequency required and intervening accordingly. The OIG is concerned that the nurses' lack of understanding of the purpose of NEWS resulted in the nurses not utilizing assessment tools to identify changes in the patient's condition, which may have allowed for earlier intervention before the patient experienced rapid decline.

The OIG concluded that the patient experienced several hours of persistent pain while nursing staff were unable to contact the on-call provider due to incorrect phone numbers and nonworking technology. Although facility leaders finalized an escalation standard operating procedure in May 2025, the OIG found the document did not outline a clear path through the chain of commands, and procedural information had not been disseminated to providers and nursing staff.

For all shifts throughout the patient's admission to the medical surgical unit, nurses did not document assessments timely. The OIG concluded this resulted in real-time information about the patient's condition that was neither recorded nor available to other clinical staff involved in the patient's care. Nurses' failure to complete required assessments and document timely in the EHR may negatively affect interdisciplinary communication, continuity of care, and patient

safety. The OIG is concerned that nursing documentation issues may be indicative of a larger system issue.

Facility leaders and staff failed to conduct a comprehensive review of the events leading up to and contributing to the patient's death. Although leaders completed a root cause analysis, the review and corrective actions were narrowly focused and did not address other related concerns. Following discussions with the OIG, facility leaders determined an institutional disclosure was appropriate and reported making multiple efforts to contact the patient's family to conduct a disclosure.

Recommendations 1–7

1. The VA Greater Los Angeles Healthcare System Director considers conducting peer reviews for the clinical staff involved in the patient's care from day 30 through day 32, to identify opportunities to strengthen clinical practices and improve the quality of patient care.

2. The VA Greater Los Angeles Healthcare System Director ensures that inpatient nurses receive training on the National Early Warning Signs assessment related to the assessment's administration, intervention, escalation, and documentation; establishes a process to monitor inpatient nurses' adherence; and conducts audits to ensure improved and sustained compliance.

3. The VA Greater Los Angeles Healthcare System Director ensures nursing staff have knowledge of and timely access to the accurate names and contact numbers for patients' on-call provider teams and the medical officer of the day, and addresses and closely monitors discrepancies as warranted.

4. The VA Greater Los Angeles Healthcare System Director reviews [Standard Operating Procedure] SOP-00-QM-100, *Clinical and Administrative Escalation Process*, May 28, 2025; ensures the procedure meets facility and service-line needs; and confirms information is disseminated to relevant leaders, providers, and nursing staff.

5. The VA Greater Los Angeles Healthcare System Director ensures nursing shift assessments electronic health record documentation is completed, timely, and at frequencies required by Veterans Health Administration's nursing policies and procedures; takes corrective action as indicated; and establishes a process to monitor for improved and sustained compliance.

6. The VA Greater Los Angeles Healthcare System Director evaluates the circumstances surrounding the death of the patient to ensure completion of comprehensive quality review process(es) in alignment with Veterans Health Administration standards on patient safety and high reliability that identify root causes and provide actions that enhance patient safety and mitigate similar events.

7. The VA Greater Los Angeles Healthcare System Director confirms that facility staff made reasonable efforts to conduct an institutional disclosure with the patient's family.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date:

From: Interim Network Director, Desert Pacific Healthcare Network (10N22)

Subj: Department of Veterans Affairs (VA) Office of Inspector General (OIG) report, Review of Response to Changes in a Patient's Condition and Quality Reviews at the VA Greater Los Angeles Healthcare System in California

To: Director, Office of Healthcare Inspections (54HL03)
Chief Integrity and Compliance Officer (10OIC)

1. We sympathize with this Veteran's family and loved ones in this time of loss. I have reviewed and concur with the findings, recommendations and submitted action plans of the Greater Los Angeles Healthcare System.

2. As a high reliability organization, we are committed to ongoing improvement and a review of processes, to ensure we deliver the highest quality of care in the safest manner to our Veterans. These recommendations give us the opportunity to do that.

3. Should you need further information, please contact the VISN 22 Quality Management Officer.

(*Original signed on August 19, 2025, by:*)

Stephanie Young, MHA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on September 11, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date:

From: Director, VA Greater Los Angeles Healthcare System (691)

Subj: Department of Veterans Affairs (VA) Office of Inspector General (OIG) report, Review of Response to Changes in a Patient's Condition and Quality Reviews at the VA Greater Los Angeles Healthcare System in California

To: Director, Desert Pacific Healthcare Network (10N22)

1. We sympathize with this Veteran's family and loved ones in this time of loss. We appreciate the opportunity to review and comment on VA OIG report, Review of Response to Changes in a Patient's Condition and Quality Reviews at the VA Greater Los Angeles Healthcare System in California.

2. VA Greater Los Angeles Healthcare System concurs with the findings and will take appropriate actions as recommended.

3. Should you need further information, please contact the Chief, Quality and Patient Safety.

(*Original signed on August 20, 2025, by*:)

Robert C. Merchant, FACHE

[OIG comment: The OIG received the above memorandum from VHA on September 11, 2025.]

Facility Director Response

Recommendation 1

The VA Greater Los Angeles Healthcare System Director considers conducting peer reviews for the clinical staff involved in the patient's care from day 30 through day 32, to identify opportunities to strengthen clinical practices and improve the quality of patient care.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

Department of Veterans Affairs (VA) Greater Los Angeles Healthcare System (VAGLAHS) initiated peer review for all clinical staff involved in the patient's care from day 30 through day 32, in accordance with VHA Directive 1190(1), Peer Review for Quality Management. The Peer Review Coordinator will report the results of the peer reviews to VAGLAHS Peer Review Committee. The appropriate stakeholders will address and refer identified system and process issues to strengthen clinical practice and improve the quality of patient care. The Medical Executive Council will review the completed report and include it in their regular processes.

Recommendation 2

The VA Greater Los Angeles Healthcare System Director ensures that inpatient nurses receive training on the National Early Warning Signs assessment related to the assessment's administration, intervention, escalation, and documentation; establishes a process to monitor inpatient nurses' adherence; and conducts audits to ensure improved and sustained compliance.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

VAGLAHS will ensure inpatient nurses receive training on the National Early Warning Score (NEWS) assessment, establish a process to monitor adherence, and conduct audits for sustained compliance.

From December 2024 to May 2025, VAGLAHS provided education to nursing staff on all tours in the medical surgical telemetry units. VAGLAHS also provided education on the VA Approved Enterprise Standard (VAAES) Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP) (SOP VHA-ONS-NUR-22-01, revised September 10, 2024), which includes the NEWS assessment. VAAES is also incorporated in Nursing New Employee Orientation. A tool has been established to monitor compliance with assessment, appropriate documentation, and escalation based on the NEWS score.

To demonstrate compliance, the Nursing Service will report monthly through the Quality and Patient Safety Council. Compliance will be measured by monitoring staff who have received education on the NEWS assessment and have documented appropriate responses to NEWS scores. The compliance goal is 90%.

Recommendation 3

The VA Greater Los Angeles Healthcare System Director ensures nursing staff have knowledge of and timely access to the accurate names and contact numbers for patients' on-call provider teams and the medical officer of the day and addresses and closely monitors addressing discrepancies as warranted.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

VAGLAHS will ensure nursing staff know how to contact the patients' on-call provider teams and the Medical Officer of the Day (MOD). Training for contacting the provider team is also incorporated into Nursing New Employee Orientation. To demonstrate compliance, the Nursing Service will report monthly to the Quality and Patient Safety Council. Compliance will be measured through completion of training and monitoring of discrepancies in contacting the on-call provider or MOD. The compliance goal is 90%.

Recommendation 4

The VA Greater Los Angeles Healthcare System Director reviews [Standard Operating Procedure] SOP-00-QM-100, *Clinical and Administrative Escalation Process*, May 28, 2025; ensures procedure meets facility and service-line needs; and confirms information is disseminated to relevant leaders, providers, and nursing staff.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

VAGLAHS adopted a new SOP titled "Clinical and Administrative Escalation Process" (SOP-00-QM-100), effective June 9, 2025. This SOP establishes a process for escalating clinical and administrative issues to ensure timely responses to patient care needs.

The review process for the new SOP involved collaborating with various departments to gather input and feedback, evaluating existing procedures to identify areas for improvement, and integrating best practices to enhance the escalation process. Developed with input from key stakeholders, including Quality and Patient Safety, Nursing, and Executive Leadership, the SOP outlines steps for escalating issues, defines staff roles and responsibilities, and sets timelines and communication protocols.

At the Quality and Patient Safety Council meeting on July 18, 2025, the Chief Nurse of Research, Innovation, and Development and the Deputy Chief, Quality and Patient Safety announced the SOP. On August 5, 2025, Nursing Education emailed a Clinical Practice Alert with the full SOP to all leaders, providers, and nursing staff, and it is now included in the New Employee Orientation. To ensure compliance, the Patient Safety Manager will report monthly to the Quality and Patient Safety Council on training completion and the timeliness of documentation. The compliance goal is 90%.

Recommendation 5

The VA Greater Los Angeles Healthcare System Director ensures nursing shift assessments electronic health record documentation is completed, timely, and at frequencies required by Veterans Health Administration's nursing policies and procedures; takes corrective action as indicated; and establishes a process to monitor for improved and sustained compliance.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

VAGLAHS will implement training for inpatient nursing staff on timely nursing shift assessments in accordance with VAAES and the SOP (VHA-ONS-NUR-22-01, revised September 10, 2024), which includes the NEWS assessment. VAGLAHS will establish a process to monitor compliance and sustain documentation. Corrective action will be taken as indicated. To demonstrate compliance, the Nursing Service will report monthly to the Quality and Patient Safety Council to monitor training completion and assessment of documentation timeliness. The compliance goal is 90%.

Recommendation 6

The VA Greater Los Angeles Healthcare System Director evaluates the circumstances surrounding the death of the patient to ensure completion of comprehensive quality review process(es) in alignment with Veterans Health Administration standards on patient safety and high reliability that identify the root causes and provide actions that enhance patient safety and mitigate similar events.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

VAGLAHS will convene an interdisciplinary team from Medicine, Nursing, and Quality and Patient Safety to thoroughly review the circumstances surrounding the Veteran's death. The review will follow the High Reliability Organization framework to ensure a comprehensive evaluation and process improvement. The team will conduct a thorough systematic review and develop actions to enhance patient safety and ensure a just culture. Upon completion, the interdisciplinary team will present a summary report on findings, conclusions, lessons learned, and recommendations to the Quality and Patient Safety Council. VAGLAHS will establish a plan for implementing recommended changes to mitigate similar events.

Recommendation 7

The VA Greater Los Angeles Healthcare System Director confirms that facility staff made reasonable efforts to conduct an institutional disclosure with the patient's family.

_X _Concur

____Nonconcur

Target date for completion: July 31, 2025

Director Comments

VAGLAHS confirms that staff made reasonable efforts to contact the Veteran's family for Institutional Disclosure; however, these attempts were not successful, and the disclosure could not be scheduled. All actions were carried out in accordance with VHA Directive 1004.08, Disclosure of Adverse Events to Patients.

VAGLAHS consulted with the Office of Medical Legal Risk Management and the Office of General Counsel regarding the efforts to contact the Veteran's family. VAGLAHS completed

documentation of the attempts to contact the Veterans' family in compliance with VHA Directive 1004.08, Disclosure of Adverse Events to Patients.

Considering the reasonable attempts, VAGLAHS requests the closure of this recommendation prior to publication based on supporting evidence provided as an enclosure.

OIG Comments

The OIG considers this recommendation closed.

Glossary

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

acetaminophen. An analgesic drug "that reduces pain and fever."[1]

adverse event. "Untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers."[2]

blood pressure. "The amount of force [the] blood uses to get through [the] arteries … Blood pressure that's too high raises [the] risk for heart disease. But blood pressure that's very low can also cause issues."[3]

cardiopulmonary resuscitation. An emergency lifesaving procedure delivering chest compressions and breaths performed when the heart stops beating.[4]

charge nurse. A nurse who oversees operations of a "specific nursing unit" and ensures that nursing functions "run smoothly."[5]

CO2 (bicarbonate). An electrolyte that indicates the level of carbon dioxide [CO2] in the blood. It helps maintain acid-base balance in the body and prevents the blood from becoming too acidic.[6]

computerized tomography (CT) scan. "A type of imaging that uses X-ray techniques to create detailed images of the body."[7]

delirium. "An altered state of consciousness, characterized by episodes of confusion, that can develop over hours or days."[8]

---

[1] *National Cancer Institute*, "Acetaminophen," accessed February 11, 2025, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/acetaminophen.

[2] VHA Directive 1050.01(1).

[3] *Cleveland Clinic*, "Blood Pressure," accessed July 2, 2025, https://my.clevelandclinic.org/health/diagnostics/17649-blood-pressure.

[4] *American Heart Association*, "What is CPR?," accessed January 28, 2025, https://cpr.heart.org/en/resources/what-is-cpr.

[5] *American Nurses Association*, "Charge Nurse vs. Nurse Manager: What's the Difference," accessed January 8, 2025, https://www.nursingworld.org/content-hub/resources/nursing-resources/charge-nurse-vs-nurse-manager/#:~:text=how%20they%20differ.-,What%20Is%20a%20Charge%20Nurse%3F,department%20run%20smoothly%20and%20efficiently.

[6] *Cleveland Clinic*, "Basic Metabolic Panel (BMP)," accessed July 2, 2025, https://my.clevelandclinic.org/health/diagnostics/22020-basic-metabolic-panel-bmp;National Kidney Foundation, "Metabolic Acidosis," accessed July 2, 2025, https://www.kidney.org/kidney-topics/metabolic-acidosis.

[7] *Mayo Clinic*, "CT Scan," accessed December 18, 2024, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

[8] *Johns Hopkins Medicine*, "Delirium," accessed January 28, 2025, https://www.hopkinsmedicine.org/health/conditions-and-diseases/delirium.

femur. "The proximal bone of the hind or lower limb that extends from the hip to the knee;" also called the thigh bone.[9]

gastric outlet obstruction. "A condition where the passageway between [the] stomach and small intestine gets blocked, preventing food from leaving [the] stomach," preventing digestion, causing discomfort, and may lead to complications.[10]

gastroparesis. "A condition in which the muscles in the stomach don't move food as they should for it to be digested."[11]

hypotension. "Abnormally low blood pressure."[12]

hypoxic respiratory failure. A condition where there is not enough oxygen in the tissues of the body (hypoxia) or when too much carbon dioxide is in the blood (hypercapnia), often described as "acute hypoxemic respiratory failure."[13]

institutional disclosure. "A formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[14]

metabolic acidosis. "A condition in which acids build up in [the] body," which can be caused by the loss of bicarbonate and results in symptoms of increased heart rate, confusion, and fatigue.[15]

neutrophils. "The most common type of white blood cell" that help the "immune system fight infections and heal injuries." "The normal range of neutrophils is between 2,500 and 7,000 per microliter of blood."[16]

---

[9] *Merriam-Webster.com Dictionary*, "femur," accessed February 24, 2025, https://www.merriam-webster.com/dictionary/femur.

[10] *Cleveland Clinic*, "Gastric Outlet Obstruction," accessed January 28, 2025, https://my.clevelandclinic.org/health/diseases/gastric-outlet-obstruction.

[11] *Mayo Clinic*, "Gastroparesis," accessed June 23, 2025, https://www.mayoclinic.org/diseases-conditions/gastroparesis/symptoms-causes/syc-20355787.

[12] *Merriam-Webster.com Dictionary*, "hypotension," accessed January 29, 2025, https://www.merriam-webster.com/dictionary/hypotension.

[13] *Cleveland Clinic*, "Respiratory Failure," accessed January 28, 2025, https://my.clevelandclinic.org/health/diseases/24835-respiratory-failure.

[14] VHA Directive 1004.08.

[15] *Cleveland Clinic*, "Metabolic Acidosis," accessed January 28, 2025, https://my.clevelandclinic.org/health/diseases/24492-metabolic-acidosis.

[16] *Cleveland Clinic*, "Neutrophils," accessed April 15, 2025, https://my.clevelandclinic.org/health/body/22313-neutrophils.

nurse manager. Nurses in upper management positions who typically hold advanced degrees and provide supervision, support, and oversight.[17]

oxycodone. An opioid pain-relieving medication administered orally.[18]

oxygen saturation. The blood oxygen level showing the amount of oxygen circulating in the blood.[19]

peer review for quality management. A confidential, nonpunitive peer evaluation focusing on critical review of the care provided by individual clinicians within a selected episode of care to identify opportunities for practice improvement.[20]

platelets. Blood cells to help blood clot. A low platelet count is "fewer than 150,000 platelets per microliter." Low platelet counts could lead to life threatening internal bleeding.[21]

pulse oximetry. A device used to measure oxygen (saturation) level of the blood. A good saturation number "would be over 90–92%."[22]

rapid response. Used to summon a team of providers to the bedside of a patient, demonstrating signs of imminent clinical deterioration, to provide immediate assessment and treatment with the goal of preventing further deterioration.[23]

root cause analysis. A process "for identifying the basic causal factor(s) underlying system failures" that may lead to adverse events.[24]

sepsis. "A life-threatening medical emergency caused by [the] body's" immune system response to an infection that "can lead to tissue damage, organ failure, and even death."[25]

shock. A life-threatening condition occurring when the body is not getting enough blood flow to carry oxygen and nutrients to cells and organs. The main types of shock include cardiogenic, hypovolemic, anaphylactic, and septic.[26]

---

[17] *American Nurses Association*, "Charge Nurse vs. Nurse Manager: What's the Difference."

[18] *Mayo Clinic*, "Oxycodone (oral route)," accessed February 11, 1015, https://www.mayoclinic.org/drugs-supplements/oxycodone-oral-route/description/drg-20074193.

[19] *Cleveland Clinic*, "Blood Oxygen Level," accessed January 8, 2025, https://my.clevelandclinic.org/health/diagnostics/22447-blood-oxygen-level.

[20] VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

[21] *Cleveland Clinic*, "Platelet Count," accessed February 3, 2025, https://my.clevelandclinic.org/health/diagnostics/21782-platelet-count.

[22] *American Lung Association*, "Pulse Oximetry."

[23] Patient Safety Network, Agency for Healthcare Research and Quality, US Department of Health and Human, *Rapid Response Systems*, 2019, accessed June 24, 2025, https://psnet.ahrq.gov/primer/rapid-response-systems.

[24] VHA National Center for Patient Safety, *Guide to Preforming Root Cause Analysis,* v14, March 2024.

[25] *Cleveland Clinic*, "Sepsis," accessed January 8, 2025, https://my.clevelandclinic.org/health/diseases/12361-sepsis.

[26] National Institutes of Health, *Medline Plus*, "Shock," accessed April 15, 2025, https://medlineplus.gov/ency/article/000039.htm.

toxic metabolic encephalopathy. A brain dysfunction caused by either organ dysfunction or organ failure. Early signs and symptoms affect cognitive functioning and may include confusion and disorientation.[27]

venous blood gas. "A measurement of how much oxygen and carbon dioxide are in [the] blood," from an artery blood sample.[28]

vital signs. "Measure the basic functions of [the] body" including "body temperature, blood pressure, pulse, and respiratory (breathing) rate." Normal ranges of vital signs vary by age and other factors.[29]

white blood cell count. A test that counts the five types of white blood cells. White blood cells circulate through the blood stream and are a part of the immune system that respond to injury or illness. A high white blood cell count may indicate infection.[30]

[27] *Cleveland Clinic*, "Metabolic Encephalopathy," accessed January 28, 2025, https://my.clevelandclinic.org/health/diseases/metabolic-encephalopathy.

[28] Mount Sanai, *Health Library*, "Blood gases," accessed January 28, 2025, https://www.mountsinai.org/health-library/tests/blood-gases.

[29] *Cleveland Clinic*, "Vital Signs," accessed January 8, 2025, https://my.clevelandclinic.org/health/articles/10881-vital-signs.

[30] *Cleveland Clinic*, "White Blood Cells," accessed January 28, 2025, https://my.clevelandclinic.org/health/body/21871-white-blood-cells.

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Stacy DePriest, Director, MSW, LCSW Erin Butler, LCSW Ashley Dobrovech, MJ, RN Sheena Mesa, MSN, RN Thomas Wong, DO
Other Contributors	Jennifer Baptiste, MD Jennifer Christensen, DPM Debbie Davis, JD Christopher D. Hoffman, LCSW, MBA Natalie Sadow, MBA

Report Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Public and Intergovernmental Affairs
Veterans Health Administration
Director, Desert Pacific Healthcare Network (10N22)
Director, VA Greater Los Angeles Healthcare System (691)

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: Alex Padilla, Adam B. Schiff
US House of Representatives: Pete Aguilar, Nanette Barragán, Julia Brownley, Ken Calvert, Salud Carbajal, Gil Cisneros, Lou Correa, Judy Chu, Vince Fong, Laura Friedman, Robert Garcia, Jimmy Gomez, Sydney Kamlager-Dove, Young Kim, Ted Lieu, Jay Obernolte, Jimmy Panetta, Luz Rivas, Linda Sánchez, Brad Sherman, Mark Takano, Norma Torres, Derek Tran, Maxine Waters, George T. Whitesides

OIG reports are available at www.vaoig.gov.