VETERANS HEALTH ADMINISTRATION

# Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center

## Augusta, Georgia

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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to anonymous allegations involving multiple quality of care and leadership failures at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia. The OIG team found that while many of the allegations were largely unfounded, they nevertheless exposed a facility challenged by organizational division. Additionally, the OIG team identified leaders' failures to address a range of long-term problems.

The anonymous complainant provided specific allegations:

- Patient A went into cardiac arrest while waiting for an intensive care bed because the "crash bed" policy was inconsistently applied, and the subject nurse manager blocked the transfer of a stable intensive care patient contributing to the delay in Patient A's transfer to the intensive care unit.

- Nursing staff were taking care of four intensive care patients, which was dangerous for patient care.

- Nursing leadership had compromised patient care by placing patients who were on intravenous medications requiring hourly monitoring into stepdown beds where they were monitored every three hours.

- Patients were transferred from an intensive care bed to a stepdown bed without physician orders. Patient B, who had profuse rectal bleeding, was [transferred to a stepdown bed and] downgraded from hourly monitoring until dying from hemorrhage.

- Patients were transferred from the operating room to the critical care unit without a [hand-off] report.

- Patients were being admitted [to the facility] for neurosurgical care that could not be provided.

- A nurse manager (subject nurse manager) overlooked the inadequate performance of "allies," and intentionally "distorted" an interaction involving an employee's interaction with a patient "to settle a personal vendetta."

- A "personal vendetta of the nursing administration constantly blinds [the facility] from an honest assessment of any sentinel event," which had been the source of poor nursing and other challenges.

- "The institution is rapidly deteriorating. No one seems concerned. The veterans are suffering. The leadership does not care."

During the inspection, the OIG team identified additional concerns, many of which were long-term, unresolved, and revealing a lack of attention and urgency from facility leaders. These included the facility's weak response to a late 2018 sentinel event, deficits in completion and documentation of nurse competencies, challenges related to nurse (and other professional) hiring and staffing, and select problems adversely impacting emergency department operations. The complainant's allegations and other OIG findings are addressed in four report sections.

## Section I. Leadership Communication Style and Hiring/Staffing Challenges Setting the Stage for Deficiencies

The OIG team heard or read multiple accounts of the Facility Director publicly humiliating employees and found survey results supporting the perception of unproductive leadership communication styles. Further, in August 2018, the Executive Leadership Team (ELT) participated in a National Center for Organizational Development (NCOD) survey evaluating the group's strengths and challenges. The NCOD results showed that dialogue was not "particularly natural for this group" and that the group seemed "more inclined to use a challenging approach than a receptive one." One respondent from a separate manager-level survey wrote, "[w]e are trying to improve, but feedback should challenge us to get better, not belittle us." Results from this survey also reflected staff perceptions that decisions were not timely and were often confusing. The facility did not have a written plan of action to respond to the NCOD findings.

During interviews with facility staff, the OIG team was repeatedly told that hiring takes months, if not longer, and that the process is fraught with inefficiencies and challenges, some dating back several years. Interviewees used terms such as "awful," "extremely difficult," and "exquisitely problematic" to describe the hiring process. Multiple interviewees provided examples of their efforts to hire, with one person stating that the process for hiring required "a ridiculous level of impossible tasks." Several current facility leaders confirmed that the facility was in a "slow hire" campaign in 2017, apparently related to budgetary issues, and one of the managers responding to an NCOD survey in August 2018 stated, "[m]any decisions take way too long – especially disciplinary actions and other personnel issues. The process to bring on new employees is bogged down in paperwork and meetings rather than action."

Human Resource personnel explained the hiring steps and provided the OIG team with tracking information on the status of pending nurse hires. The tracking data, however, did not include all of the necessary dates and processing steps for the OIG to determine precisely where and why some delays occurred. Nevertheless, the OIG identified several steps in the hiring process that appeared to be redundant or otherwise inefficient, thereby contributing to delays or the perception of delays. A 2016 independent assessment of facility Human Resource operations identified that procedural changes were needed to streamline the recruitment and hiring process. Additionally, a 2018 Veterans Integrated Service Network (VISN) review of inpatient nurse staffing issues, which was requested by the Facility Director, suggested that the facility needed to

reduce hiring times to enhance the credibility of the existing staffing methodology. These problems continued to exist at the time of this inspection.

## Section II. Anonymous Allegations Related to Quality of Care Failures, the Subject Nurse Manager's Actions, and Leaders' Failure to Take Actions

The OIG team substantiated that in summer 2018, Patient A experienced a cardiac arrest event while waiting to be transferred to an intensive care bed in the critical care unit (CCU). The OIG did not substantiate that the subject nurse manager blocked the transfer of a stable intensive care patient (a transfer was needed to allow admission of a patient) or that Patient A likely would have survived had an intensive care bed been available. The OIG team determined that staff confusion over whether patients could use their home medical devices after admission to the medical facility contributed to the delay in transferring a medically stable patient from the CCU to the medical ward. The OIG team found no evidence that the subject nurse manager was involved in this transfer decision. Additionally, the earlier admission of a patient from the emergency department and CCU nurse staffing shortages contributed to the delay in Patient A's transfer to an intensive care bed. The OIG also determined that while the facility did not have an official "crash bed" policy, some staff members believed the policy existed while others acknowledged its previous existence but believed it was no longer applicable.

While awaiting transfer to the CCU, Patient A was attended by a clinical team of physicians and nurses. The OIG team determined that, even if an intensive care bed had been readily available, transfer to the intensive care unit would not likely have changed Patient A's course of treatment or outcome.

The OIG team substantiated that on a few occasions, nurses may have cared for more than one or two intensive care patients; however, the OIG did not find this to be a routine occurrence. The team found that, in general, nurse assignments followed the traditional 1:2 intensive care ratio and that staff absences occasionally resulted in nurses caring for more than two intensive care patients.

Patients on intravenous medications requiring titration were placed in stepdown beds on the CCU; however, the team did not find this to be a problematic practice. Because the facility's CCU stepdown beds were co-located with the intensive care beds, the nurses rotated assignments between the two areas. As a result, the nursing staff was expected to have the same intravenous medication management skills regardless of bed assignment. Therefore, the OIG team did not find that transferring patients with intravenous medications to a stepdown bed within the CCU compromised care.

The OIG team did not substantiate that patients were transferred from intensive care beds to stepdown beds without physician orders. The team reviewed the electronic health records for

patients transferred from an intensive care bed to a stepdown bed during a four-month timeframe in 2018, and found physician transfer orders were present almost 100 percent of the time. The team also did not substantiate that Patient B was downgraded from hourly monitoring or that the decision to transfer to a stepdown bed contributed to the patient's death. Physician orders to monitor Patient B hourly were present and remained in effect during the CCU stay (both intensive care and stepdown).

Based on available documentation, the OIG substantiated that there had been occasions when patients were transferred to the CCU without hand-off occurring prior to the patient's arrival. The team found multiple instances with insufficient documentation to confirm that the hand-off process had taken place. When hand-off communication is incomplete, not timely, or fails, patients are placed at risk for adverse outcomes.

The OIG team did not substantiate that patients were being admitted for neurosurgical care that could not be provided. The three patients identified by the complainant were not considered to be neurosurgical candidates at the times of their admissions. The OIG confirmed that the facility's neurosurgeon recommended two of the three patients be transferred to another hospital; however, those attempted transfers were not successful.[1] The one patient who underwent emergent surgery at the facility had a good outcome. Although the facility's neurosurgeon was privileged to perform neurosurgical surgeries, the facility's neurosurgical capacity was limited, and patients requiring more than basic neurosurgical procedures were referred to Augusta University Medical Center (AUMC).

The OIG team did not substantiate that the subject nurse manager overlooked inadequate performance in "allies." The OIG team reviewed the example provided by the complainant of a nurse that refused to take a patient for a computed tomography (CT) scan, which allegedly prolonged the patient's illness. While the nurse did not take the patient for the CT scan or notify the physician or CCU nurse manager about this decision, the team did not find that the delayed CT scan resulted in the patient's prolonged illness. Additionally, the OIG team concluded that although the nurse's failure was not addressed timely, the team could not determine with certainty where the breakdown occurred. Regardless, the OIG team found no evidence that the subject nurse manager failed to support an investigation because the nurse at issue was an "ally."

There was no evidence that the subject nurse manager "distorted" an employee's interaction with a patient or prevented nurses who were witnesses from providing information for the police report. The VA police officer who responded to the incident immediately deployed to the area, which reportedly did not allow time for the subject nurse manager to be briefed on the issue, intervene with witnesses, or influence their testimony.

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[1] Augusta University Medical Center did not have an intensive care unit bed to accommodate one patient, and the second patient was not a surgical candidate.

The OIG team did not substantiate that a personal vendetta of the nursing administration constantly blinded [the facility] from an honest assessment of any sentinel event. Because the allegation was vague, the OIG team reviewed whether processes were in place to identify and evaluate incidents. Eighty incidents entered into the facility's incident reporting system from October 1 through October 31, 2018, were evaluated in accordance with Veterans Health Administration (VHA) guidance. The team identified an adverse patient event in late 2018 that did not receive the appropriate safety assessment code (SAC) score, and therefore was not properly evaluated.

The OIG team confirmed through interviews that nursing morale in several areas was low. Nurses reported frustration at what they perceived as inadequate nurse staffing levels, lack of consistent guidance as communicated by leadership, and failure to hold poor performers accountable.

The OIG was unable to determine the validity of the complainant's allegations that "the institution is deteriorating, no one seems to be concerned, veterans are suffering, and the leadership does not care." Because the allegations were vague and subjective, the team examined some performance metrics to determine if any trends could be identified. While the facility's Strategic Analytics for Improvement and Learning (SAIL) performance data from 2013–2018 found improvement in some measures and decline in others, the facility had consistently underperformed with a "2-Star" ranking for about three years. Based on the ongoing underperformance in the measures reviewed, the OIG did not find that performance was deteriorating. In the domain of Patient Experience, the facility underperformed during fiscal year (FY) 2013–2016, improved during 2017, only to underperform again in FY 2018. Additionally, employee satisfaction survey results as evaluated through the Best Places to Work measure reflected that the facility substantially and consistently underperformed. The OIG team concluded that facility leaders were taking actions to address deficits within the facility, although the team did not evaluate the quality or prioritization of those actions. Improvements have been slow to take shape as evidenced by the facility's ongoing underperformance in SAIL quality metrics and poor satisfaction scores.

## Section III. OIG Identified Concerns Related to the Late 2018 Sentinel Event, Nurse Competencies, Hiring/Staffing, and Selected Long-Term Problems Impacting the Emergency Department

In late 2018, the facility had a sentinel event involving an incorrectly placed nasogastric (NG) tube. The OIG team determined that the event was not SAC-scored correctly (scored as a "2"),

and the facility did not conduct a root cause analysis in accordance with VHA guidance.[2] Additionally, there was no documented evidence that CCU nurses had completed annual competency assessments for routine or complex procedures performed in the CCU to include how to verify correct NG tube placement. The facility's proposed plan to update CCU nurse competencies lacked urgency and, given the serious nature of the event, and the requirement to appropriately evaluate the circumstances surrounding the event, the OIG found the facility's response to be less than vigorous.

In early 2018, a VISN 7 assessment of the facility's inpatient nurse staffing determined that "VHA's mandated staffing methodology process was in place" and there was "evidence of appropriate staffing levels for all inpatient units." The VISN report identified that although the overall nurse staffing full-time employee equivalent (FTE) for all nursing types was above the VA national average, inpatient registered nurse (RN) vacancy rates were below the national average. However, the OIG determined that as of February 28, 2019, CCU actual RN staffing was substantially below authorized levels. The team also found that staff absences frequently impacted the facility's ability to maintain safe CCU staffing levels and that unit managers failed to consistently use the available administrative actions to address unexcused staff absences.

Deficient nurse staffing had also been a long-term challenge in the emergency department. Reportedly, the facility used travel nurses to supplement emergency department staffing in the past, but the practice had been discontinued and there was no float pool of nurses to supplement staff. Inpatient nurses, without orientation to emergency department-specific procedures, were assigned to cover in the emergency department on at least one occasion. Assigning nurses, who did not have adequate training and orientation, to care for emergency department patients constituted a risk to patient safety. As of the end of February 2019, the facility's emergency department staffing issues had not been adequately addressed as evidenced by the continuing vacancies and ongoing concerns expressed by emergency department employees.

Inadequate emergency department security had been a long-term deficiency that continued to place patients and staff at risk. In spring 2017, an emotionally distraught patient was escorted to the emergency department by a VA police officer. The patient wrote in the comment section of the triage sheet about trying to self-harm by shooting. The Administrative Officer of the Day took the triage form and the patient to the triage area but reportedly neither the triage nurse nor the Administrative Officer of the Day read the form. The patient became restless and left the emergency department triage area through an unsecured door. The next morning, the patient suffered a self-inflicted gunshot wound. Because of this event, the facility made several

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[2] VHA requires facilities to evaluate every reported patient safety event and assign a Safety Assessment Code (SAC) score using a matrix that weighs the severity of harm incurred by the patient and the anticipated probability of recurrence of the incident. This SAC is graded from 1 (lowest safety risk) to 3 (highest safety risk). All events scored as a level 3 SAC must go through a root cause analyses process as this provides the means to critically assess an adverse event.

enhancements. However, as of January 2019, the contract for emergency department security upgrades was in the "executive office" awaiting signature and most of the emergency department doors remained unsecured.

Long-term staffing concerns in the laboratory had not been adequately addressed despite the Chief of Laboratory and Pathology Service's repeated efforts to secure resources, and cautions about the possible decrease in services if staffing was not improved. In December 2018 and January 2019, the laboratory was unable to staff its third shift on weekends, which resulted in reduced availability of some lab tests and emergency department staff's need to rely on point-of-care testing. AUMC contract providers, who covered many of the facility's emergency department shifts, expressed that the proposed changes were not in the interest of patients and compromised their [the providers'] ability to meet emergency care medical-legal standards. AUMC insisted that the situation be remedied, or the facility would have to make alternate arrangements for weekend emergency department physician coverage. The facility implemented an interim plan until additional laboratory technologists could be hired.

During the course of this inspection, the OIG was told of ongoing concerns related to the transport of patients between the facility and AUMC using a connecting pedestrian bridge. The failed communication surrounding the bridge transfer issue was a confusing and contentious problem for staff. The issue largely centered around the role of facility nurses in assisting with transport, and in mid-November 2018, an email from facility leaders to both facility and AUMC staff stated that the facility was ceasing the practice of using the bridge to transport patients and that the appropriate level of emergency medical transport should be used. While the OIG team's review of patient transfers via the connecting bridge did not find evidence of poor outcomes, emails from clinical staff reflected several close calls and substantial concerns about the potential for adverse events. After the OIG contacted facility leadership on November 26, 2018, interim guidance permitting use of the bridge under certain circumstances was communicated to relevant stakeholders on November 30, 2018, via email. However, on March 1, 2019, another transfer breakdown occurred, suggesting that some facility nursing staff were not informed of the interim guidance.[3]

The OIG was also told that contract transport services were not consistently timely, which made the use of the connecting bridge necessary in some situations. However, the Contracting Officer's Representative (COR) did not collect data regarding the timeliness of transports even though the contract required this surveillance. The COR confirmed that the vendor had difficulty accurately estimating times of arrival.

The facility did not have a contingency plan for mobilizing additional staff when patient care demands in the emergency department exceeded the available physician and nursing staffing, nor did the facility have a signed policy outlining expectations for managing patients who needed to

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[3] The breakdown occurred when a facility nurse did not meet an AUMC nurse, as agreed, to accept transfer of a patient.

remain in the emergency department pending admission to an inpatient unit (boarders). In the absence of such policies, emergency department patients were at risk for missed medications, treatments, or services.

In FY 2018, the facility's median time from emergency department check-in to hospital admission was 341 minutes (about 5 ½ hours) when VHA's goal is less than 240 minutes. Despite what was described as routine admission delays and data collected by the emergency department to evaluate patient flow (Emergency Medicine Management Tool) supporting this perception, the facility received relatively few complaints about this issue.

## Section IV. OIG Summary Concerns Related to Infrastructure Challenges and Quality Patient Care

The OIG found that despite the facility's surgical complexity designation of complex, various clinical services that were required to be available 24 hours-per-day, 7 days-per-week were periodically not available.

As noted previously, some laboratory services, primarily chemistry testing, were unavailable on several occasions between December 2018 and January 2019. The unavailability of these services was the predictable result of a long-standing staffing issue that was not adequately addressed. The OIG also learned that, due to inadequate staffing, ultrasonography would not be available on March 10 or March 31, 2019, and that vacant positions for diagnostic radiology technicians, some open for over a year, had the potential to compromise the radiology department's ability to continue to meet coverage demands. An email from the interim Chief of Emergency Department, sent on February 13, 2019, stated that no neurology coverage would be available from the date of the email to April 1, 2019. The email directed that non-ambulance patients with acute stroke that could require thrombolytic treatment should be stabilized and immediately transferred to AUMC's emergency department via the pedestrian bridge connecting the facility and AUMC.

While the identified service challenges are not evidence of large-scale infrastructure failures, they demonstrate a chaotic environment where emergency department providers, and potentially other facility providers, are expected to adjust their clinical practices and struggle to secure resources to compensate for the service lapse(s). These concerns, coupled with leadership and communication challenges, inefficient Human Resource and hiring practices, and significant staffing issues that reduce access to the emergency department and CCU, suggest that the facility may not be consistently prepared to manage emergent situations and provide safe, quality care.

The OIG made 27 recommendations including three recommendations to the VISN Director related to ELT communication, implementing NCOD recommendations, and assessing the facility's ability to provide consistent services and staffing for the safe and timely delivery of care. Recommendations to the Facility Director focused on hiring processes, staffing in the CCU and emergency department, developing and disseminating policies related to the CCU, inpatient

use of home medical devices, hand-off communications, nasogastric tube procedures, and boarders. Other areas of focus included neurosurgery privileges, SAIL data, patient/employee satisfaction, emergency department security, stakeholder notification of changes in services, and COR transport contract responsibilities.

## Comments

The VISN and Facility Directors concurred with the OIG's recommendations. The Directors reported that some of the conditions were resolved and documented that recommendations had been completed on dates in the past. The OIG did not agree with leaders that the deficient conditions had been addressed and resolved in those cases as the conditions continued to exist at the time of OIG's site visits in November and December 2018. (See appendixes C and D, pages 62–80 for the comments.) The OIG considers all recommendations open and will follow up through review of supporting documentation provided by the VISN and facility, as well as through a site visit to reassess conditions "on the ground."

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# Abbreviations

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| ADPNS | Associate Director for Patient and Nursing Services |
| AUMC | Augusta University Medical Center |
| CCU | critical care unit |
| COR | Contracting Officer's Representative |
| COS | Chief of Staff |
| CRRT | continuous renal replacement therapy |
| CT | computed tomography |
| DNR | do not resuscitate |
| EHR | electronic health record |
| EKG | electrocardiogram |
| ELT | Executive Leadership Team |
| EMMT | Emergency Medicine Management Tool |
| FTE | full-time employee equivalent |
| FY | fiscal year |
| LEAF | Light Electronic Action Framework |
| MCRC | Medical Center Resource Committee |
| NCOD | National Center for Organizational Development |
| NG | Nasogastric |
| OIG | Office of Inspector General |
| OR | operating room |
| PSB | professional standards board |
| RCA | root cause analyses |
| RN | registered nurse |
| SAC | Safety Assessment Code |
| SAIL | Strategic Analytics for Improvement and Learning |
| TJC | The Joint Commission |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to anonymous allegations involving multiple quality of care failures, a nurse manager's (subject nurse manager's) improper actions, and leaders' failure to take action despite "deterioration" at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia. During the course of the inspection, the OIG team identified or was told about additional clinical and administrative concerns. The purpose of the inspection was to assess the merit of the allegations and additional concerns.

## Background

The facility, part of Veterans Integrated Service Network (VISN) 7, is a two-division medical center providing tertiary care in medicine, surgery, neurology, psychiatry, rehabilitation medicine, and spinal cord injury. The facility operates three community based outpatient clinics located in Athens and Statesboro, Georgia, and Aiken, South Carolina. In fiscal year (FY) 2018, the facility served 45,949 patients and had a total of 407 hospital operating beds, including 215 inpatient beds, 60 domiciliary beds, and 132 community living center beds. The facility has sharing agreements with Eisenhower Army Medical Center at Fort Gordon, Georgia, and is affiliated with Augusta University (AU) Medical College of Georgia.

The facility's intensive care unit beds and stepdown beds are co-located in a joint critical care unit (CCU). Intensive care includes continuous monitoring and treatment of seriously ill patients using special medical equipment and services. Stepdown care is reserved for those patients requiring less care than standard intensive care but more than that which is available on the [medical] wards.[4] Thus, all stepdown unit beds have cardiac monitoring. The current CCU floorplan includes nine stepdown beds along one wall of a horseshoe-shaped unit and 11 intensive care beds along the back and opposite wall. In FY 2018, there were 1,543 admissions and transfers into the facility's CCU.

## Senior Leadership

Stable and effective leadership is central to the health of an organization. The facility has had five acting or permanent directors in the past five years. The current Facility Director became the Acting Facility Director in April 2017 and was permanently assigned to the position in April 2018. The facility had an Acting Chief of Staff (COS) from May 2017 to December 2018,

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[4] Medical Center Policy Memorandum No. 03-17-34, *Admission and Discharge Criteria: Step Down Unit*, May 24, 2017.

and two different Acting Associate Directors for Patient and Nursing Services (ADPNS) since February 2018.[5]

## Quality and Performance Measure Data

Veterans Health Administration's (VHA's) Office of Organizational Excellence developed the Strategic Analytics for Improvement and Learning (SAIL) model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. Based on the distribution of VHA facilities on the quality composite score, each facility is rated on a Star system. SAIL "estimates the 10th, 30th, 70th, and 90th percentile cut-offs of overall quality and assigns facilities 1- and 5-Star if their scores fall in the bottom and top 10th percentile, respectively. Facilities in the next bottom and top 20 percent of the distribution are assigned 2- and 4-Star. The remaining 40 percent of facilities are assigned 3-Star."[6]

After more than five years ranked as a "1-Star" in quality, the facility achieved an overall "2-Star" ranking as of June 30, 2015, which it largely maintained through September 30, 2016.[7] The facility achieved a "3-Star" ranking for one quarter in 2017 but subsequently dropped back to a 2-Star ranking for FY 2018.[8]

## Nurse Staffing

VHA Directive 1351 provides a standardized method for determining appropriate direct care nurse staffing.[9] This methodology incorporates staffing standards of nursing professional organizations and established VHA staffing models with the goal to ensure safe and effective nursing care. The Facility ADPNS or the Deputy ADPNS is responsible for ensuring that nurse staffing levels, skill mix, and assignments of nursing personnel are consistent with the provisions of the directive.

Staff scheduling is the process of assigning available nursing resources to meet patient care needs. Scheduling relies on the judgment of the nurse manager to identify what nursing resources are needed at different hours of the day or days of the week. The results of staff scheduling are the actual nursing hours [needed] per patient per day (NHPPD). The ability to reach NHPPD targets relies on available nursing resources.

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[5] The long term ADPNS was reassigned in February and retired in August 2018.

[6] VHA SAIL, Data Definitions. (The website was accessed on November 29, 2018.) This is an internal website that is not accessible by the public.

[7] In quarter 1 FY 2016, the facility achieved a 1-star ranking.

[8] Some employees described the June 30, 2017, uptick in performance as unsustainable because the facility lacked solid processes to maintain the improvements.

[9] VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017; direct care nursing is the delivery of patient-centered nursing activities to a patient.

## Nurse Competency

The American Nurses Association defines nursing competency as an "expected level of performance that integrates knowledge, skills, abilities, and judgement." Within the context of nursing practice, nurses are individually responsible and accountable for maintaining professional competence. The issue of staff competency is also addressed in The Joint Commission (TJC) Human Resource Standards.[10] Specifically, the standards state that the hospital will define the competencies for staff that provide patient care and assess and document staff competence at least once every three years, or more frequently, if required by hospital policy.[11]

## Allegations

On October 1, 2018, the OIG received an anonymous complaint alleging multiple quality of care failures, the subject nurse manager's improper actions relative to discipline and follow-up, and facility leaders' failure to take action despite the facility's "deterioration." Because the complainant was anonymous, the OIG was unable to obtain clarification of some of the allegations. In those cases, OIG team members relied on their experience and expertise, and on interviews with facility staff and past employees to determine the most likely concerns raised in the allegations. Allegations as provided by the complainant are listed below:

- Patient A went into cardiac arrest while waiting for an intensive care bed because the "crash bed" policy was inconsistently applied (a bed was not kept vacant) and the subject nurse manager blocked efforts to transfer a stable intensive care patient out of the CCU to free up a bed for Patient A. The complainant alleged that Patient A could have survived if an intensive care bed had been available.[12]

- "Lately," nursing staff are taking care of four intensive care patients [rather than one or two] in the CCU, which is dangerous for patient care.

- Nursing leadership has compromised patient care by placing patients who are on intravenous medications requiring hourly monitoring into stepdown beds where they are monitored every three hours, even if the [intravenous] drip is titrated (adjusted) many times.

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[10] TJC is an internationally accepted external validation organization. TJC standards require that processes are in place to ensure safe, high quality patient care. VHA requires all medical facilities and ambulatory programs to obtain and maintain compliance with TJC standards.

[11] Facility policy requires assessment of competence annually.

[12] The term "crash bed" refers to the practice of keeping an intensive care bed vacant in the event of an emergency.

- Patients are transferred from an intensive care bed to a stepdown bed without physician orders. Patient B, who had profuse rectal bleeding, was [transferred to a stepdown bed and] downgraded from hourly monitoring until dying from hemorrhage.

- Patients are transferred from the operating room (OR) to the CCU without a [hand-off] report.

- Patients are being admitted [to the facility] for neurosurgical care that cannot be provided. The facility's neurosurgeon has recommended that patients needing surgical intervention be transferred to another clinical setting. However, Patients C, D, and E were admitted with intracranial hemorrhages and experienced poor outcomes or death.

- The subject nurse manager overlooked inadequate performance of "allies." The complainant gave the example of a nurse who refused to take a patient for a computed tomography (CT) scan, and did not inform the physicians or the [former] CCU nurse manager. The delay in care resulted in the patient's "prolonged illness." While the [former] CCU nurse manager reportedly asked for the behavior to be investigated, the nurse was allegedly an ally of the subject nurse manager and the complaint was not pursued.

- The subject nurse manager "distorted" an employee's interaction with a patient "to settle a personal vendetta;" deliberately prevented nurses who were witnesses to the incident from providing information [for a police report]; and selectively told witnesses what should be entered into the police report.

- "A personal vendetta of the nursing administration constantly blinds [the facility] from an honest assessment of any sentinel event. This has been the source of our poor nursing morale, pitting nurse against nurse, and absolving laziness in nurses who are friends of the Nursing leadership."

- "The institution is rapidly deteriorating. No one seems concerned. The veterans are suffering. The leadership does not care."

During the course of the inspection, the OIG team identified or was told about additional concerns including leadership and Human Resource hiring process challenges; a sentinel event in the CCU, nurse competencies, and hiring and staffing issues; and deficient conditions impacting emergency department operations.

# Scope and Methodology

The OIG initiated the inspection on October 24, 2018, and conducted site visits November 13–16 and December 10–14, 2018.

Prior to the inspection, the OIG interviewed former and current facility leaders and managers. During the inspection, the OIG team interviewed the Facility Director, Acting COS, Acting Chief of Surgery, Acting ADPNS, Chief of Specialty Care, Chief of Human Resources, Chief of Neurosurgery, Chief of the Emergency Department, and Chief Nurse of Medicine and CCU; Quality Management, Human Resource, and Facilities Management staff; and CCU, emergency department, and medicine ward nurses as well as others with knowledge of the issues. The team also interviewed representatives from Augusta University Medical Center (AUMC).

The OIG's data review included selected documents from 2013 through February 2019. The OIG team reviewed VHA and facility data related to the tenure of facility leaders; quality and performance data and corrective actions; staffing and recruitment actions; and emergency department care, bed utilization, and patient complaint information. The OIG team also reviewed individual cases brought forward by the anonymous complainant and completed electronic health record (EHR) reviews of additional patient cases identified during the inspection. The team assessed patient transfer data and meeting minutes for the Code Committee, Pharmacy and Therapeutics Committee, Medical Center Resource Committee (MCRC), and the Quality Safety Value Council. The team toured the CCU and emergency department.

In this report, OIG has generalized narratives and case scenarios, and has de-identified protected patient and quality assurance information.

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

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

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 Summaries

## Patient A

The patient was in their mid-60s with a medical history that included end stage renal disease, coronary artery disease, and multiple cardiac stents. The patient also had an implantable cardioverter-defibrillator.[13]

In summer 2018, the facility was notified that the patient was in the emergency department of a community hospital complaining of chest pain. The treating community hospital physician described the patient as having intermittent chest pain, but otherwise stable for transfer to the facility. Based on information provided by the community physician, a facility physician accepted the patient for transfer and admission to the facility's general medicine ward. The patient arrived approximately five hours later (Day 1). Nursing admission documentation described the patient as "calm and cooperative" but complaining of left-sided chest pain. However, 45 minutes after arriving on the ward, the patient began complaining of "severe" chest pain and vomited a large amount of undigested food. The patient was treated with a variety of medications. When examined by the facility cardiologist in the early morning hours of the next day (Day 2), the patient did not appear to be in pain and serial electrocardiograms (EKGs) were unchanged.[14]

Less than two hours after the cardiologist's evaluation, the patient again began having chest pain. The facility's Rapid Response Team was called and determined that the patient needed to be transferred to the CCU. However, after learning there were no available intensive care beds, facility physicians contacted AUMC to discuss transferring the patient to its cardiac care unit. One AUMC physician reportedly said that the "patient's current situation was likely not cardiac," and with patient transfers expected within the facility's CCU, facility physicians decided that the patient would remain on the general medicine ward until an intensive care bed was available in-house (in the facility).

While waiting for an intensive care bed, the patient experienced an episode of pulseless electrical activity requiring cardiopulmonary resuscitation. The patient was attended by multiple members of the Rapid Response and Code Blue teams until an intensive care bed was available approximately two hours later. Following the patient's transfer to an intensive care bed in the facility CCU and over the next 24 hours (through Day 3), the patient experienced several additional cardiac arrest events. After multiple resuscitation efforts, CCU physicians discussed

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[13] The OIG uses the singular form of they for patient privacy purposes.

[14] Serial EKGs are EKGs done in succession and compared to one another so that changes in the heart can be recognized.

the patient's poor prognosis with the family. The family decided that further resuscitation efforts should not be attempted, and the patient died a short time later.

## Patient B

The patient was in their early 90s and had a history of coronary artery disease, peripheral vascular disease, peripheral neuropathy, and chronic obstructive lung disease.

In late summer 2017, the patient presented to the facility's emergency department complaining about passing a "large amount of blood" rectally that morning (Day 1). Although the emergency department physician documented the patient's condition as stable, the hemoglobin level was 9.6 grams per deciliter (g/dL) (normal range is 13.5 to 17.5 g/dL for men), a drop from the previous level done in spring 2017.

Following an evaluation in the emergency department, the patient was admitted to an intensive care bed in the CCU. After receiving a blood transfusion and additional fluids, the bleeding stopped and the patient's hemoglobin improved to 10.5 g/dL. The next day, a CT scan identified an aortic pseudoaneurysm. Concerned that a fistula between the patient's aorta and gastrointestinal tract was the source of the initial rectal bleeding, Gastroenterology and Vascular Surgery consults were requested. The gastroenterologist recommended "supportive care" and monitoring in the CCU. The vascular surgeon determined that the patient would "not tolerate" vascular interventions. A second CT scan on Day 3 failed to confirm the presence of an aorto-enteric fistula. A tagged red blood cell scan did not identify the source of bleeding within the gastrointestinal tract. Also on Day 3, the patient was transferred from an intensive care bed to a stepdown bed.[15]

On Day 4, the patient was transferred from a stepdown bed to the general medicine ward with a hemoglobin of 11.2 g/dL and no evidence of further bleeding. Three days after being transferred to the general medicine ward (Day 7), the rectal bleeding began again. A Rapid Response was called, and the patient was transferred back to an intensive care bed. Shortly after arrival on the CCU, the patient experienced a cardiac arrest event. Although resuscitation was initially successfully, the patient continued to experience blood loss. After discussions with the patient's family, the decision was made to discontinue further resuscitative efforts. The patient died later that day of shock secondary to acute blood loss.

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[15] The CCU attending physician caring for the patient told the OIG about not being initially notified [by the CCU resident] of the plan to transfer the patient to the stepdown bed. However, the orders authorizing the patient's transfer included the CCU attending physician's electronic signature.

# Inspection Results

The anonymous complainant made multiple allegations of which several involved facility leaders in general and the subject nurse manager in particular. The OIG team found that while many of the allegations were largely unfounded, they nevertheless exposed a facility challenged by organizational division and dysfunctional communications. Further, some clinical managers did not feel heard or supported by members of the leadership team, and failures to adequately address a range of long-term problems resulted in situations that angered staff, jeopardized relationships and partnerships, and placed patients at risk.

This report is organized into four sections, some involving multiple issues.

- Section I. Two underlying themes: (1) leadership communication style, and (2) hiring process challenges impacting staffing levels—that "set the stage" for many of the deficiencies described in this report.
- Section II. Anonymous allegations related to: (3) quality of care failures; (4) subject nurse manager's improper actions; and (5) leadership's failure to take [improvement] actions.
- Section III. Other concerns identified during the course of this inspection, including: (6) a 2018 sentinel event and the facility's response; (7) nurse competencies, and staffing and hiring matters; and (8) management of selected long-term problems impacting the emergency department.
- Section IV. OIG summary concerns about the facility's infrastructure challenges and its uncertain ability to consistently assure quality patient care in a safe manner.

# Section I—Underlying Themes

## Issue 1. Leadership Communication Style

Facility culture refers to the set of shared attitudes, values, goals, and practices that impact the way things are done organizationally. According to TJC, "[l]eaders establish the organization's culture through their words, expectations for action, and behavior" and "[l]eaders are the most powerful force in changing the organization's culture and in eliminating intimidating behavior."[16]

Some facility leaders' communication styles and responses were not consistently viewed as professional, positive, or oriented toward problem-solving. The OIG team heard or read multiple accounts of the Facility Director publicly humiliating employees and found survey results supporting the perception of unproductive leadership communication styles. In summer 2018, VA's National Center for Organizational Development (NCOD) deployed a Leadership Impact

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[16] Leadership in Healthcare Organizations. A Guide to Joint Commission Leadership Standards. A Governance Institute White Paper, Winter 2009.

Assessment to 54 managers and key stakeholders facility wide. In response to the statement, "[t]he ELT [Executive Leadership Team] makes it safe to speak up about concerns," 36 of the 54 respondents (67 percent) were neutral (9), dissatisfied (13), or very dissatisfied (14). In response to questions about how the ELT could make improvements, excerpts of responses included:

- "We are trying to improve, but feedback should challenge us to get better, not belittle us. I do not fear negative feedback, I want to improve. The way feedback is delivered, however, is often condescending and demoralizing."
- "Communication occurs but behaviorally is often [delivered] in a sarcastic, negative tone. Remarks to service line executives have been delivered with subordinates' present. Authority and respect have been undermined as well as effected *[sic]* the culture of safet[y]."

In response to a separate question, one manager wrote, "[m]y impression is that there is a lot of intimidation, undermining and disrespect being demonstrated by the ELT."

Further, in summer 2018, six members of the ELT participated in an NCOD survey evaluating the group's strengths and challenges in three specific areas: Vision, Alignment, and Execution. Results showed that, collectively, the group had a natural affinity for explaining rationales and initiating action.[17] However, the NCOD results also showed that dialogue was not "particularly natural for this group;" that the group seemed "more inclined to use a challenging approach than a receptive one;" and the group tended to be "more matter-of-fact" than encouraging."

In response to the statement, "[t]he ELT makes decisions in a timely manner," 42 of the 54 respondents (80 percent) were neutral (11), dissatisfied (19), or very dissatisfied (13). In response to questions about how the ELT could make improvements, one manager wrote, "[d]ecisions are not timely and [are] often confusing. Processes have to be continually redesigned and often work redone because a process wasn[']t completely though[t] out before it was implement[ed]. The rules always seem to be changing with minimum warning."

Based on the OIG's inspection and understanding of the issues, the team concluded that communication challenges, including some leaders' communication styles, were central to the findings discussed in the remainder of this report. The OIG team was told that the facility did not have a written action plan to respond to the NCOD findings.

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[17] Per NCOD, many of the facility's leaders were naturally inclined to lay out their rationale when explaining the group's vision, plan, or goals. Per NCOD, many of the facility's leaders were inclined to initiate action and "jump on new opportunities."

## Issue 2. Hiring Challenges

During interviews with facility staff, the OIG team was repeatedly told that hiring takes months, if not longer, and that the process is fraught with inefficiencies and challenges, some dating back several years.

Several current facility leaders confirmed that the facility was in a "slow hire" campaign in 2017, apparently related to budgetary issues, and one of the managers responding to NCOD's Leadership Impact Survey in summer 2018 stated, "[m]any decisions take way too long - especially disciplinary actions and other personnel issues. The process to bring on new employees is bogged down in paperwork and meetings rather than action." Another response was, "[s]ome critical needs, particularly with staffing, seem to be given lower priority when they should be based on the impact on patient care."

The OIG team interviewed managers and others with knowledge of the facility's historical and current hiring and staffing practices. Interviewees used terms such as "awful," "extremely difficult," and "exquisitely problematic" to describe the hiring process. Several interviewees provided examples of their efforts to hire, with one person stating that the process for hiring required "a ridiculous level of impossible tasks."

Human Resource personnel explained the hiring steps and, at the request of the OIG, provided the team with tracking information on the status of pending nurse hires.[18] The tracking data, however, did not include all of the necessary dates and processing steps for OIG to determine precisely where and why some delays occurred. Thus, much of the information about the hiring process is discussed in broad categories or is anecdotal. Nevertheless, the OIG identified several steps in the hiring process that appeared to be redundant or otherwise inefficient, thereby contributing to delays or the perception of delays. The OIG team used nurse, radiology, and laboratory staff hiring to illustrate the steps involved and/or the challenges encountered at various steps.

### Light Electronic Action Framework

The facility process to hire into a vacant position begins when the manager, using the Light Electronic Action Framework (LEAF) system, electronically submits a request to fill a position. The appropriate ELT member in the supervisory chain of command (for example, the ADPNS for nurse hires) can either agree or disagree that the position should be filled. If the ELT member approves, the request is annotated in LEAF and moves to the next step in the hiring process.

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[18] The OIG team specifically requested nurse hire information because several allegations referenced inadequate nurse staffing.

The OIG was provided an example of two vacant CCU positions that failed to progress timely through the LEAF system. The team learned that the two hiring actions were routed to the incorrect approving ELT member and it took several months for this administrative error to be discovered.[19] As the facility did not have a system or responsible person to identify and correct the routing error in a timely fashion, the two CCU positions were not presented to the MCRC timely.

## MCRC—Director's Approval

After approval by the responsible ELT member, the hiring request is submitted to the MCRC. The MCRC is responsible for reviewing and making recommendations to approve or disapprove requests to fill vacant positions. All requests for hire must be reviewed to ensure they are essential and meet the needs of the organization, facility priorities, and budgetary constraints. If the MCRC recommends approval of a hiring request, the Facility Director's signature on the approval memorandum allows Human Resource staff to announce the vacant position for hire. In addition to new hires, requests to fill vice positions ("vice" is a Human Resource term that refers to previously approved positions that were vacated, such as through an employee's retirement or promotion) were also required to be processed through the MCRC with the exception of Environmental Management Service, Nutritional Food Service, and Medical Support Assistants. The OIG team reviewed MCRC minutes and Facility Director's approval memorandums from December 2017 to November 2018.

Of the 13 completed sets of minutes and memorandums, the average elapsed time from the date of the MCRC recommendation to hire for a nursing position (as reflected in the minutes) to the Facility Director's signed approval memorandum was 19 business days, with a range of 11 to 43 business days.[20] The OIG team noted that direct patient care (nurse) vice positions were included in the timeliness data reviewed. The OIG found in a separate review of MCRC minutes that Radiology Service hiring requests also included vice positions. One vice position, an advanced diagnostic radiology technologist, had been slowly continuing through the hiring process for a year. Specifically, the request was sent to MCRC around March 2018, was listed on the department's July Strengths Report as "pending" the Facility Director's approval, and as of March 6, 2019, the position was annotated "awaiting completion of hiring process for [selectee] by HR [Human Resource]." While OIG acknowledges the Facility Director's prerogative to require the Director's approval for all hiring requests (rather than delegating this authority related to vice positions), delays in filling direct care and critical vice positions may require

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[19] The former CCU nurse manager who requested to fill the two positions also did not follow up to determine the status of the request. Had the former CCU nurse manager done so, the error could have been identified sooner.

[20] Five of the documents reviewed were missing dates and were excluded from OIG's analysis of the facility MCRC process.

existing staff to absorb the workload or cover shifts of the "missing" employee. This has the potential to adversely impact morale and place patients at risk.

The team was also told about occasions when the MCRC minutes had been inaccurately recorded, the corrections were not made timely, and the approval and hiring process was further delayed. For example, an error was made in a set of August 2018 MCRC minutes related to the number of laboratory technologists that were recommended for hire. As of November, an addendum correcting the August MCRC minutes was still pending.

## Human Resource Process

Once the Facility Director has approved a vacant position to be filled, Human Resource personnel are responsible for recruitment activities including posting the job announcement, validating the position, and generating a list of qualified applicants.[21] Applicants meeting VHA requirements and position-specific qualifications are referred to the hiring manager.

The OIG team reviewed 50 nurse hiring actions across multiple inpatient and outpatient units that were pending completion of some Human Resource recruitment activity as of December 31, 2018.[22] On average, the 50 hiring actions had been pending one of the Human Resource processing activities for almost 58 days, with some pending completion of certain activities for more than 240 days.

The OIG team reviewed 34 additional cases where the nurses had been selected for employment and Human Resource staff were overseeing completion of pre-employment activities including physical exams, fingerprinting, online credentialing (VetPro), and relevant professional standards board (PSB) approval. The OIG found that as of December 31, 2018, the 34 cases were pending one of the pre-employment processing activities for an average of nearly 58 days, with some pending completion of certain activities for more than 150 days. Another example of pre-employment processing delays involved two radiologists who were approved for hire on September 24, 2018, that were listed in Human Resource's weekly status update report on December 4 as "Pending pre-employment requirements (courtesy physical, fingerprints, eQIP [background investigation forms], credentialing, boarding, Market Pay Approval)." While the market pay review was reportedly completed in December 2018, and the radiologists credentialed on February 19, 2019, as of March 6, the Human Resource liaison had apparently

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[21] Position validation is the process Human Resources uses to ensure each hiring action packet includes all the required supporting documentation.

[22] For the purposes of this analysis, the OIG reviewed only registered nurse positions.

not sent letters of intent [to hire].[23] Although Human Resource personnel could not control some pre-employment activities, such as PSB review and approval, Human Resource did not have a method to track the timeliness of those activities such that process bottlenecks could be identified and addressed.

The OIG team also found that after applicant selection and final offer of employment, it took an average of 44 days for a nurse selectee to begin working. The OIG acknowledges that the lag time before new employees actually started could occur for a variety of reasons outside of Human Resource's or the facility's control, but nonetheless represented additional time to be factored in to the total elapsed days from position vacancy to the employee being on duty.

A 2016 independent assessment of facility Human Resource operations identified that procedural changes were needed to streamline the recruitment and hiring process. A 2018 VISN review of inpatient nurse staffing issues, which was requested by the Facility Director, suggested that the facility needed to reduce hiring times to enhance the credibility of the existing staffing methodology. Given the ongoing and recent concerns expressed by many interviewees, as well as staffing challenges discussed throughout this report, the OIG team concluded that opportunities to improve the hiring process continue to exist

**Recommendation 1.** The Veterans Integrated Service Network Director evaluates the quality and professionalism of Executive Leadership Team communications and takes action when indicated.

**Recommendation 2.** The Veterans Integrated Service Network Director requires the development of, and follow-through on, corrective action plans responding to relevant findings from the National Center of Organizational Development's 2018 site visits and reports.

**Recommendation 3**: The Charlie Norwood VA Medical Center Director develops a process to ensure that Light Electronic Action Framework hiring requests are tracked and processed timely.

**Recommendation 4**: The Charlie Norwood VA Medical Center Director reviews the facility's hiring processes to identify opportunities to improve the efficiency and timeliness of hiring actions, and takes corrective action, as needed.

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[23] On February 21, the Chief of Radiology requested the Human Resource specialist via email to "Please send out the firm letters of intent to both physicians by or before Wednesday, February 25, 2019. Both of these physicians are critical elements of our neuroradiology contract reduction, new mammography project and reinstating full nuclear medicine and PET [positron emission tomography]/CT services and decreasing contract costs in both areas, among other projects."

# Section II—Allegations

## Issue 3: Quality of Care Failures

### CCU

> ***Allegation***: *Patient A went into cardiac arrest while waiting for an intensive care bed because the "crash bed" policy was inconsistently applied (a bed was not kept vacant) and the subject nurse manager blocked efforts to transfer a stable intensive care patient out of the CCU to free up a bed for Patient A.[24] The complainant alleged that Patient A could have survived if an intensive care bed had been available.*

The OIG team substantiated that in summer 2018, Patient A experienced a cardiac arrest event while waiting to be transferred to an intensive care bed in the CCU. Details can be found in Patient A's case summary.

The OIG did not substantiate that inconsistent application of the crash bed policy delayed Patient A's transfer, that the subject nurse manager blocked the transfer of a stable intensive care patient to free a bed for Patient A, or that Patient A likely would have survived had an intensive care bed been available.

### Crash Bed Policy

The facility did not have a signed crash bed policy. As described by staff, a "crash bed" is an intensive care bed that remains available should a patient in another department require transfer within the facility for intensive care. The OIG team requested a copy of this policy and was provided with an unsigned copy of a document entitled "Crash Bed Availability and Assignment," dated March 2016. Although this document suggested that a single bed would remain available and be considered a "crash bed," it also described the procedure to follow in the event the designated bed was unavailable. Specifically, when no intensive care bed was available:

- Emergency department patients requiring intensive care would either be transferred to a non-VA hospital or, if indicated, remain in the emergency department until an intensive care bed was available.
- Inpatients requiring intensive care would be transferred once an intensive care bed became available, contingent upon a stable intensive care patient being moved to either a stepdown bed or to a designated bed on medical ward 5D.

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[24] The term "crash bed" applies to the practice of keeping an intensive care bed vacant in the event of an emergency.

During interviews with staff who would likely have knowledge of current facility policies, the OIG heard conflicting information on the existence of a specific "crash bed" policy. Some staff members believed the policy existed while others acknowledged its previous existence but believed it was no longer applicable. Additionally, interviewees repeatedly told the OIG that although having a designated intensive care bed had been a historical practice, it was their understanding that a bed should not be held in anticipation of its possible need.

To further understand the factors that potentially contributed to challenges transferring Patient A to an intensive care bed from the inpatient unit, the OIG team reviewed CCU staff bed assignments for Day 1 and 2 of the patient's hospitalization.[25] The team also reviewed the applicable EHR documentation for Patient A and another patient admitted to the CCU early in the morning on Day 2:[26]

- From almost midnight on Day 1 until 7 a.m. on Day 2, six CCU nurses were available to provide patient care; eight CCU staff nurses were the minimum required to have all intensive care and stepdown beds open and available.
- A critically ill emergency department patient was admitted to the CCU at 4:04 a.m., thereby taking the last available staffed bed.[27]
- Patient A experienced severe chest pain, the facility Rapid Response Team was called at 4:59 a.m., and the patient was subsequently admitted to the CCU at 7:50 a.m. after dayshift nurses came on duty.

The OIG team concluded that the earlier admission of a patient from the emergency department and CCU nurse staffing shortages contributed to the delay in Patient A's transfer to an intensive care bed. Additionally, the absence of an approved and widely understood written CCU bed management policy may have contributed to the complainant's perception that the crash bed policy was applied inconsistently.

## Subject Nurse Manager's Actions

The OIG team did not substantiate that the subject nurse manager had a role in the decision to keep the allegedly stable patient in the CCU rather than transferring the patient to another ward to free up a bed for Patient A. In summer 2018, one of the CCU physicians documented a plan to transfer a patient who no longer required intensive care to the general medicine ward. A different

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[25] The applicable staff assignment sheets covered Day 1 at 7:30 p.m. to Day 2 at 7:00 a.m. Patient A experienced the cardiac arrest event in the early morning hours of Day 2. The OIG team acknowledges the limitations of reviewing and accurately interpreting the staff and patient assignment sheets.

[26] For this facility, 7:30 a.m. concludes the tour of duty for nurses working the night shift.

[27] The admission of this patient occurred approximately 55 minutes prior to the call to the facility's Rapid Response team in response to Patient A's complaint of severe chest pain.

CCU physician documented that because the patient needed to use a home BiPAP device, being transferred to the general medicine ward would place the patient "at risk."[28] Approximately three hours later, a third CCU physician documented that the patient was stable for transfer to the general medicine ward and could use the home BiPAP at night, intermittently during the day, and during naps.

The OIG heard conflicting information on whether the facility allowed patients to use their home BiPAP devices during an inpatient admission. One CCU nurse told the OIG that there was an issue with the general medicine ward taking patients on BiPAP but was unsure of the exact nature of the issue. A different nurse believed the general medicine floors were not able to care for patients on BiPAP. Nurse managers from different general medicine wards told the OIG that patients could use their home BiPAP if the device has been cleared through the Biomedical Engineering Department. No one the OIG spoke with could locate a facility policy or any other documentation that provided clear guidance on a patient's use of home BiPAP or other medical devices while hospitalized. Although the facility Medical Equipment Management Plan identified the Biomedical Engineering Department as responsible for maintaining a written management plan for the effective and safe use of medical equipment, the plan was silent on how patient home medical devices were to be handled.

The OIG concluded that although the patient appeared to be stable for transfer, the transfer was not readily accomplished because of confusion surrounding the permissibility of using the home BiPAP on the medical ward. The team found no evidence that the subject nurse manager was involved with the decision.[29]

## Patient A's Outcome

The OIG did not substantiate that Patient A would have survived if an intensive care bed had been available. The facility's decision to accept Patient A for admission was based on medical evidence of clinical stability.[30] After Patient A suffered a cardiac arrest and facility providers determined that an intensive care bed was not readily available and attempted to arrange a transfer to AUMC. Patient A was not accepted for transfer to AUMC and facility physicians made the decision to keep the patient on the general medical ward until an intensive care bed was available.

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[28] VHA provides veterans with respiratory equipment and mechanical devices to be used at home in support of prescribed medical treatment. It is not uncommon for patients to request to use a personal device (in this case, the patient's home BiPAP device) during an inpatient admission. Allowing the use of patient-owned equipment may place the facility at risk because the facility has never had control over the equipment's use or evidence of its proper maintenance, repair, or storage.

[29] The patient was transferred to the general medical ward the next day and discharged home three hours later.

[30] For the purposes of this inspection, the designation clinical stability was based on the professional evaluation of the patient's EKG, relevant laboratory studies, and overall presentation. This evaluation was completed by the medical staff caring for the patient at the community hospital and the facility's admitting physician.

While awaiting transfer to the CCU, Patient A was attended by a clinical team of physicians and nurses. The OIG team determined that, even if an intensive care bed had been readily available, transfer to the intensive care unit would not likely have changed Patient A's course of treatment or outcome.

> *Allegation:* *"Lately," nursing staff are taking care of four intensive care patients [rather than one or two] in the CCU, which is dangerous for patient care.*

The OIG team substantiated that on a few occasions, nurses may have cared for more than one or two intensive care patients; however, the OIG did not find this to be a routine occurrence. Nurse staffing requirements in a critical care setting depend on a variety of factors, and staffing assignments are made based on the needs of the patients. The OIG team was told that in the facility's CCU, patients requiring continuous renal replacement therapy received 1:1 nursing care, meaning that the nurse did not care for other patients at the same time. Beyond this specific scenario, though, the facility did not have an official pre-established nurse to intensive care patient ratio. While the historical staffing model for the facility's intensive care beds had been one nurse caring for two patients (1:2), VHA does not mandate specific ratios.

The OIG reviewed the critical care daily patient assignments for a four-month time frame in 2018 and found five occasions when nurses had bed assignments with more than two actual or potential intensive care patients. The team found that, in general, the nurse assignments followed the traditional 1:2 intensive care ratio and that staff absences occasionally resulted in nurses caring for more than two patients.

## Intravenous Medications

> *Allegation:* *Nursing leadership has compromised patient care by placing patients who are on intravenous medications requiring hourly monitoring into a stepdown bed where they are monitored every three hours, even if the [intravenous] drip is titrated many times.*

The OIG team substantiated that patients on intravenous medications requiring titration were placed in stepdown beds on the CCU; however, the team did not find this to be a problematic practice. Facility policy requires "all medication and fluids administered must be given in compliance with the protocols and practice guidelines specific to the areas where medications and fluids are administered." [31] Facility policy also outlines admission criteria for a stepdown bed, and while it includes patients requiring continuous intravenous infusion, it does not delineate how often monitoring and titrating of intravenous medications can or should occur. [32]

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[31] Medical Center Policy Memorandum No. 03-15-18, *Administration of Intravenous Medication and Fluids,* November 30, 2015.

[32] Medical Center Policy Memorandum No. 03-17-34, *Admission and Discharge Criteria: Step Down Unit,* May 24, 2017.

The OIG team was told that because the stepdown beds are co-located with the intensive care beds, the nurses rotated assignments between the two areas. As a result, the nursing staff was expected to possess the same intravenous medication management skills regardless of their bed assignment. Based on the available information and considering that any transfer from one level of care to another is based on a provider's clinical judgment, the OIG team did not find that transferring patients with intravenous infusions to a stepdown bed within the CCU compromised care. Nurse assignments should be based on the complexity and needs of individual patients to assure safe patient care; these assignments may not always follow traditional nurse to patient ratios.

## Transfers Within the CCU

*Allegation*: *Patients are transferred from intensive care beds to stepdown beds without physician orders; Patient B who had profuse rectal bleeding, was downgraded from hourly monitoring until dying from hemorrhage.*

The OIG team did not substantiate that patients were transferred from intensive care beds to stepdown beds without physician orders. The team also did not substantiate that Patient B was downgraded from hourly monitoring until the patient died.

The transfer of a patient from one level of care to another is at the discretion of the physician(s) caring for the patient. It is a medical decision based on the patient's needs and made in collaboration with nurses and other healthcare professionals. According to the facility's Medical Staff By-Laws, "[w]hen a patient is transferred from one level of care to another, [physician] orders must be written for the new level of care."

The OIG team reviewed more than 100 EHRs of patients transferred from an intensive care bed to a stepdown bed during a four-month time frame in 2018. The team found physician transfer orders were present almost 100 percent of the time. Patient B also had a written order for transfer from an intensive care bed to a stepdown bed.

Physicians are responsible for coordinating the patient's medical care, writing orders for implementation by nursing staff, and documenting their clinical decision making. The physician retains ultimate responsibility for ensuring that all aspects of the patient's plan of care are consistent with clinical needs.

The OIG team determined that physician orders to monitor Patient B hourly were present and remained in effect for the duration of the patient's stay in the CCU (both intensive care and stepdown).

## Inter-Ward Transfers Between Patient Care Units

*Allegation*: *Patients are transferred from the OR to the CCU without a [hand-off] report.*

The OIG substantiated that there had been occasions when patients were transferred to the CCU without a hand-off occurring prior to the patient's arrival. A hand-off is the transfer of patient care from one caregiver or team member to another. The hand-off report involves the communication of patient specific information that ensures continuity of care. Facility policy requires the use of hand-off communication for "patients transferred in or out of any clinic, unit, or department who have received nursing care" and "following any procedure or operation from one nursing area to another." This policy also states that although the preferred hand-off report is "face-to-face," telephonic communication is acceptable. The policy is silent on when the hand-off report should take place or how to document compliance with the policy.

A member of the CCU nursing staff told the OIG team, "the CCU staff are usually aware that a patient is coming from the OR; however, at times they [patients] will just show up." The OR nurse manager also acknowledged that on occasion, patients were transferred to the CCU prior to completing a telephonic hand-off report. According to the OR nurse manager, this occurred if the CCU nurse assigned to take the patient was busy or unavailable to take a telephonic report. However, once the patient reached the CCU, OR staff did not leave the patient's bedside until a verbal hand-off report was given.

In the absence of facility guidance on how to ensure compliance with the hand-off process, the OIG team relied on documentation within the EHR. Specifically, the team reviewed the EHRs of patients transferred from the OR to CCU and between the CCU and other patient care units for a four-month time frame in 2018 for evidence of nursing documentation of hand-off communication between caregivers. In this limited study, the OIG team found multiple instances where there was insufficient documentation to confirm that the hand-off process had taken place. The OIG team concluded that when hand-off communication is incomplete, not timely, or fails, patients are placed at risk for adverse outcomes. Therefore, opportunities exist for the facility to improve the hand-off communication process to include the minimum documentation requirements.

## Neurosurgical Care

> *Allegation: Patients are being admitted [to the facility] for neurosurgical care that cannot be provided. The facility's neurosurgeon has recommended that patients needing surgical intervention be transferred to another clinical setting. However, Patients C, D, and E were admitted with intracranial hemorrhages and experienced poor outcomes or death.*

The OIG did not substantiate the allegation that patients *were being admitted for* neurosurgical care that could not be provided. Patients C, D, and E were not considered to be neurosurgical candidates at the times of their admissions. The OIG confirmed that the facility's neurosurgeon recommended two of the three patients be transferred to another hospital; however, those attempted transfers were not successful. Patient C, who developed an emergent condition after

admission, underwent surgery at the facility and had a good outcome. Patients D and E, who were not surgical candidates, died after providers discussed their respective conditions with their families and decisions were made to limit care to comfort measures only.

### Patient C

The patient was in their mid-80s with a past medical history that included cirrhosis, liver cancer, and thrombocytopenia. In early 2018, the patient presented to the facility's emergency department after falling. A CT scan of the head revealed bilateral subdural hematomas. The neurosurgeon's EHR entry stated, "[f]ortunately does not seem like surgery is needed, because[the patient] is not a surgical [candidate] thus all that can be offered is medical management." The patient was admitted to an intensive care bed and the following day, a repeat head CT revealed an increase of bleeding with a midline shift. The neurosurgeon recommended transfer to AUMC noting the facility did "not have capabilities for intracranial surgery." However, there were no intensive care beds available at AUMC. After discussion with the patient and family, the decision was made to perform a surgical procedure to remove the hematoma. The patient recovered and subsequent CT scans revealed no new intracranial hemorrhage. The patient was discharged to a skilled nursing facility approximately two weeks after surgery.

The OIG found that the patient was admitted to the facility for medical management. Only after the signs and symptoms worsened and transfer to another hospital could not be arranged did the facility's neurosurgeon perform a surgical procedure to relieve the pressure on the patient's brain. This was done with the patient and family's understanding that should symptoms worsen, no further surgery would be possible, and the patient could die. The OIG team determined that the neurosurgery care for this patient was appropriate.

### Patient D

The patient was in their 90s and had a past medical history of atrial fibrillation, bradycardia, dementia, blindness, and multiple falls. The patient, who resided at a community nursing care facility, was evaluated in the facility emergency department after falling. A CT scan of the head showed an acute subdural hematoma, a subarachnoid hemorrhage, and multiple frontal bruises. The emergency department physician consulted the neurosurgeon, who recommended supportive care as no neurosurgical intervention was indicated. The emergency department physician documented the family's decision to forgo surgery and request for a Do Not Resuscitate (DNR) order. The family requested that the patient remain at the facility. The patient was admitted to a stepdown bed for close observation and hourly neurological checks, with a plan for urgent neurosurgical consultation if the patient's condition worsened. Comfort care was initiated. Three days after admission, the patient was transferred to a community hospice facility and died nine days later. The OIG team determined that the patient's evaluation, care, and disposition were appropriate medically and consistent with the patient's and family's wishes.

## Patient E

The patient was in their early 60s and had a past medical history of congestive heart failure, diabetes, and renal failure requiring dialysis. The patient presented to the emergency department in early 2018 with speech difficulties and right arm weakness. A CT scan revealed a hematoma and the patient was admitted to the CCU. Neurosurgery Service recommended transferring the patient to AUMC. However, after discussion with AUMC physicians, the medical team determined the patient was not a surgical candidate due to medical complexity. The patient's medical condition subsequently deteriorated and palliative care and a DNR order were recommended. The CCU team discussed the situation with the family and the patient was placed on DNR status and comfort care. A hospice consult was initiated. The patient was transferred from the CCU to ward 6D and died later that day. The OIG concluded that the patient's death was caused by a massive hemorrhagic stroke occurring in the setting of major pre-existing comorbidities.

## Facility's Neurosurgical Capacity

Transfer of patients requiring access to specific providers and services not available through the facility is often necessary to ensure quality of care and patient safety.[33] The OIG confirmed that the facility's neurosurgical capacity was limited, and the team was told that patients requiring anything more than basic neurosurgical procedures were referred to AUMC.

VHA requires that clinical privileges be granted within the scope of the VHA facility's mission. Only privileges for procedures provided by the VHA facility may be granted to a provider. The facility had one neurosurgeon on staff; this neurosurgeon performed 27 surgeries in FY 2018, averaging two cases per month. While the neurosurgeon was privileged to perform intracranial and spinal surgeries, the neurosurgery OR workload included one intracranial case and no complex spinal cases. The neurosurgeon confirmed to OIG that the facility does not, and should not, perform cranial procedures because the facility lacks neurosurgical residents, physician assistants, and equipment to support those efforts. Rather, the neurosurgeon told OIG that the facility sends patients to AUMC because that was the most prudent thing to do when there is a small service and no neurosurgery intensive care unit. Privileging providers to perform procedures that the facility cannot support places patients at risk.

**Recommendation 5.** The Charlie Norwood VA Medical Center Director ensures development and broad dissemination of a written critical care unit bed management policy that clearly states the process to be followed when an inpatient requires intensive care and a critical care unit bed is unavailable.

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[33] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

**Recommendation 6.** The Charlie Norwood VA Medical Center Director ensures development and broad dissemination of a written policy regarding patient-owned medical devices and equipment that clearly outlines restrictions and acceptable uses when the patient is hospitalized.

**Recommendation 7.** The Charlie Norwood VA Medical Center Director ensures development and broad dissemination of a standardized method for documenting and ensuring compliance with the internal hand-off communication policy.

**Recommendation 8.** The Charlie Norwood VA Medical Center Director ensures that neurosurgery privileges are amended to include only procedures which facility infrastructure can support.

## Issue 4: Nursing Leaders' Actions

> *Allegation*: The subject nurse manager overlooked inadequate performance in "allies." The complainant gave the example of a nurse who refused to take a patient for a CT scan, and did not inform the physicians or the [former CCU] nurse manager. The delay in care resulted in the patient's "prolonged illness." While the [former] CCU nurse manager reportedly asked for the behavior to be investigated, the nurse was allegedly an ally of the subject nurse manager and the complaint was not pursued.

### Subject Nurse Manager—Follow-Up of CT Incident

The OIG team did not substantiate that the subject nurse manager overlooked inadequate performance in "allies." The OIG confirmed that a nurse did not take a patient for a CT scan, nor did the nurse notify the patient's physicians or the CCU nurse manager about the reasoning behind this decision.

The former CCU nurse manager notified Human Resource staff about the issue the day after the event in early 2018, but did not include the nurse's supervisor (subject nurse manager) on the email string. The former CCU nurse manager told the OIG team that hard-copy, and possibly electronic (via email), documentation and witness statements were subsequently provided to Human Resource staff to advance the investigation and possible disciplinary action. The Human Resource representative and the subject nurse manager, however, both denied receiving those documents, either hard-copy or electronically. The OIG's email search for the relevant time frame did not find evidence that the former CCU nurse manager sent electronic copies of supporting documentation to Human Resource staff or the subject nurse manager. The former CCU nurse manager sent an email to Human Resource staff in late March 2018 inquiring about the status of the case, but no apparent action was taken.

The Human Resource specialist told the OIG in February 2019 that while action could still be taken, the case was weakened by the elapsed time from the incident. Thus, while the OIG team confirmed that the nurse's actions were not timely investigated, the team could not determine

with certainty where the breakdown occurred. Regardless, the OIG team found no evidence that the subject nurse manager failed to support an investigation because the subject nurse was an "ally."

### Impact on Patient's Outcome

The OIG team did not substantiate the allegation that the delayed CT scan resulted in a patient's prolonged illness. The patient presented to the emergency department in early 2018 (Day 1) for chest pain and was admitted for hydration and further assessment. On Day 2, the patient was markedly tachycardic and hypotensive, and was becoming hypoxemic, with worsening abdominal pain. A CT scan of the abdomen and pelvis that day revealed possible duodenitis. On Day 4, the patient was intubated due to worsening respiratory distress. An endoscopy performed that day had findings suggestive of acute esophageal necrosis. The patient remained in an intensive care bed for medical management. An EHR entry on Day 7 noted the plan to continue supportive care and consider a surgery consult if the patient decompensated or the "clinical picture" worsened.

The patient's condition subsequently deteriorated and a CT scan of the thorax was ordered in the morning on Day 8 to be completed as soon as possible to rule out esophageal perforation. The assigned nurse did not take the patient for the CT scan and did not notify the physicians or CCU nurse manager of the reason for this decision. The patient had the CT scan of the thorax completed on Day 9, which showed an esophageal perforation.

The OIG physician determined that a CT scan of the thorax should have been obtained on Day 8 per the "as soon as possible" order. However, the CT scan was obtained the following day and the Cardiothoracic Surgery Service proceeded with an esophagectomy on Day 11. The patient was subsequently discharged to a nursing home on Day 36. While the failure to obtain the CT scan as ordered delayed the decision as to whether surgery was necessary, the OIG found no conclusive evidence that the one-day delay in obtaining the CT scan prolonged the patient's illness.

## Subject Nurse Manager—Alleged Distortion of an Employee's Interaction

> *Allegation: The subject nurse manager "distorted" an employee's interaction with a patient "to settle a personal vendetta;" deliberately prevented nurses who were witnesses to the incident from providing information [for a police report]; and selectively told witnesses what should be entered into the police report.*

The OIG team did not substantiate any elements of the allegation. The OIG evaluated the police report and witness testimony, and interviewed the investigating VA police officer and several of the witnesses independently. The OIG team did not find evidence of "distortion." While witness testimony was variable, the type of incident in question warranted an investigation and the

facility would have been remiss had the incident not been thoroughly reviewed. Further, the OIG team found no evidence that the subject nurse manager had a role in reporting the incident or alleged influencing of witness testimony. The responding VA police officer told OIG that upon receiving the complaint, the officer immediately deployed to the incident location and took witness testimony; there was no time for the subject nurse manager to be briefed on the issue and intervene with witnesses to influence their testimony. The former CCU nurse manager, who reported the incident to VA Police, denied feeling intimidated or coerced to make a statement that was not true, and did not think that other witnesses were being coerced. The OIG team found documentation and testimony of the incident to be straightforward and devoid of language that could signal distortion. Based on this evidence, the OIG determined that the facility conducted the investigation in good faith and without influence by the subject nurse manager.

## Nursing Administration's Alleged Failure to Assess Sentinel Events

*Allegation: "A personal vendetta of the nursing administration constantly blinds [the facility] from an honest assessment of any sentinel event. This has been the source of our poor nursing morale, pitting nurse against nurse, and absolving laziness in nurses who are friends of the Nursing leadership."*

The OIG team did not substantiate that a *personal vendetta* of nursing administration had the effects described by the complainant. However, the team did identify leadership communication styles as discussed in Section I that could negatively impact staff members' comfort in reporting "bad news." The team also confirmed poor nurse morale in some areas.

As the anonymous complaint lacked details and examples, the OIG team interviewed nurses and other personnel, and relied on OIG team members' experience and expertise, to identify the most likely meaning of the allegations. The OIG team acknowledges the limitations of this approach.

### Personal Vendetta

While the OIG team heard complaints about various nursing leaders, the team did not learn of any specific, verifiable evidence that a nursing leader took an action because of a personal feud with, or hostility against, a specific employee or group of employees. Further, the OIG team did not find evidence that nursing leaders intentionally failed to address the poor performance of nurses who were "friends."

### Assessment of Sentinel Events

Although the OIG did not find evidence that a personal vendetta affected the facility's assessment of sentinel events, the team determined that a sentinel event occurring in late 2018 was not assessed according to VHA guidelines. That event is discussed in detail in Section III, Issue 6 of this report. Beyond this example, OIG was not told about nor did the team identify sentinel events that were not properly assessed.

Sentinel events are a type of adverse event defined by TJC as "unexpected occurrences involving death, serious physical or psychological injury, or risk thereof."[34]

To determine whether the facility had processes in place to assess sentinel events, the OIG team evaluated 80 incident reports entered into the Joint Patient Safety Reporting system for a one-month time frame in 2018.[35] VHA requires facilities to evaluate every reported patient safety event and assign a safety assessment code (SAC) score using a matrix that weighs the severity of harm incurred by the patient (or reasonable "worst case" if the incident is a close call) and the anticipated probability of recurrence of the incident. This SAC is graded from 1 (lowest safety risk) to 3 (highest safety risk). All events scored as a level 3 SAC must go through a root cause analyses (RCA) process as this provides the means to critically assess an adverse event by asking many "whys." The OIG team found that the 80 incidents reviewed were generally evaluated and scored according to VHA's SAC matrix. Further, the OIG team evaluated seven RCAs conducted between October 2017 and September 2018 and determined they were completed in accordance with VHA guidelines.[36]

## Nurse Morale and Lack of Accountability

The OIG team confirmed through interviews that nursing morale in several areas was low. Nurses reported frustration at what they perceived as inadequate nurse staffing levels, lack of consistent guidance as communicated by leadership, and failure to hold poor performers accountable. Those concerns are discussed in various sections of this report.

**Recommendation 9**. The Charlie Norwood VA Medical Center Director ensures that the nurse's failure related to the computed tomography (CT) event outlined in this report is evaluated and administrative action is taken, as indicated.

## Issue 5: Performance Measure Data and Leadership Actions

> *Allegation(s):* *"The institution is rapidly deteriorating. No one seems concerned. The veterans are suffering. The leadership does not care."*

The OIG was unable to determine the validity of the allegations because they were vague and subjective. Lacking examples and details, the OIG team assessed (a) the facility's SAIL performance from 2013–2018 to determine whether SAIL data reflected overall deterioration related to the quality domains, and (b) whether facility leaders were taking steps to evaluate deficiencies and develop and implement actions to address conditions within the facility.

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[34] VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011.

[35] Joint Patient Safety Reporting is the standardized system VHA uses to report safety-related incidents and issues to patient safety professionals.

[36] Generally, the RCAs were compliant with requirements for multidisciplinary teams, leadership representation, process focused, vulnerability focused, and improvement focused.

## Select Performance Metrics

While the OIG team noted intermittent improvement in some measures and decline in others, in the aggregate, the facility had consistently underperformed with a "2-Star" ranking for about three years. Based on the ongoing underperformance in the measures reviewed, the OIG did not find that performance was deteriorating.

The OIG also reviewed patient and employee satisfaction as these measures are integral to the health of an organization.

The Patient Experience domain is a composite measure comprised of patient survey responses related to both inpatient and outpatient care encounters. Survey questions relate to access, communication, and care coordination, among other areas. Aggregate data reflected that, in general, the facility underperformed in the Patient Experience domain in FYs 2013–2016, improved somewhat in FY 2017, and underperformed again in FY 2018.

Employee Satisfaction is reported, in part, through the Best Places to Work measure. Completed annually, the VA All Employee Survey is VA's internal feedback tool from employees to management about how staff experience the VA workplace, including job satisfaction, psychological safety, work/life balance, and engagement, among others. Employee feedback gained through the All Employee Survey results is used to calculate a Best Places to Work composite score ranging from 0–100 points. Data reflected that the facility substantially underperformed in the Best Places to Work measure from FYs 2013–2018.

## Facility and Leadership Actions

The facility submitted action plans quarterly to the VISN for the top 10 SAIL priorities, which in quarter 3 FY 2018, included quality measures and elements of Patient Experience and Employee Satisfaction.[37] According to one of the facility's SAIL coordinators, a work team and process champion developed action plans for each priority, and starting in October 2018, status updates were provided to the ELT monthly. However, the facility was unable to provide evidence of formal oversight committee processes where SAIL action plans and improvements were reviewed and discussed.

The Acting Chief of Employee Engagement and Veteran Experience (Acting Chief) told OIG that the facility had been in a "funk" for a long time, and thought that unstable leadership, lack of employee recognition programs, and inadequate supervisor training contributed to the condition. The Acting Chief described several activities to improve employee engagement including an all

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[37] The VISN defines the top priorities as those metrics in the lower performing and deteriorated metric value box and/or metrics in the 4th and 5th quintiles. SAIL recognizes that some measures have a narrow range across facilities and the relative ranking of those measures' scores may not effectively differentiate performance among facilities. Therefore, instead of ranking facilities on numeric order, SAIL assesses a facility's performance by its quintile designation.

employee Fall Festival, monthly Town Hall meetings, and regular video messaging from the Facility Director. The Acting Chief also reported that staff have complained that facility leaders did not round enough, and in response, a new rounding schedule had been implemented to include two random locations monthly. This arrangement would allow staff to directly communicate with leaders. The facility was also tracking patient complaint data and taking actions including Own the Moment and Service Level Champion training throughout Primary Care, and was meeting with Primary Care and Pharmacy leaders to streamline service recovery.[38]

Changing the underlying reasons for the facility's underperformance is a large-scale endeavor that begins with knowledge of the existing culture and problems. As noted previously, facility leadership engaged NCOD in summer 2018, which was an appropriate step for leaders to understand the facility's culture, strengths, and weaknesses. The OIG also learned that the facility was revising its governance structure and was implementing a new operations approach. Based on this information, the OIG team concluded that facility leaders were taking actions to address deficits within the facility, although the team did not evaluate the quality or prioritization of those actions. In any event, improvements have been slow to take shape as evidenced by the facility's ongoing underperformance in SAIL quality metrics, and patient and employee satisfaction scores.

**Recommendation 10.** The Charlie Norwood VA Medical Center Director enhances processes to document Strategic Analytics for Improvement and Learning related improvement actions.

**Recommendation 11.** The Charlie Norwood VA Medical Center Director continues efforts to improve patient and employee satisfaction.

# Section III—Additional Concerns

Section III discusses additional concerns the OIG team identified during the course of this inspection. After reviewing the basic history and sequence of events, the OIG found leaders' response to several issues lacked attention and urgency. Several of the concerns should have prompted more robust and timelier problem-solving, but corrective actions were sluggish. Section III covers:

- The facility's response to a late 2018 sentinel event,
- Deficits in completion and documentation of nurse competency assessments,
- Long-standing challenges related to nurse staffing, and

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[38] Own the Moment is a one of the national initiatives (from Patient Experience) that trains staff on owning the moment.  It helps staff have "a set of related solutions that will support VHA facilities in providing a consistent, exceptional experience that along with great clinical care, rebuilds the trust and confidence of Veterans and their families."  For instance, if a patient presents to an employee with a concern, that employee will own it and assist the person at that moment.

- Selected problems adversely impacting emergency department operations.

## Issue 6: Sentinel Event and Facility Response

The facility's assessment of a late 2018 sentinel event in the CCU was not consistent with VHA policy. The response lacked urgency and robustness, and as a result, the facility may have missed opportunities to improve patient care and safety.

### Sentinel Event: Patient Y

During the OIG's second site visit, the team was told that a CCU patient (Patient Y) suffered an adverse event as the result of medication administration through an incorrectly positioned nasogastric (NG) tube. The team was also told that a nurse repositioned the NG tube but did not check for appropriate placement. A second nurse reportedly used the NG tube to administer a physician-ordered dose of potassium and water. Patient Y immediately experienced respiratory distress necessitating intubation. During intubation, it was discovered that the NG tube was in the patient's lung.

The following day a hospice care physician evaluated Patient Y and at the family's request, Patient Y's life support was withdrawn, and comfort care was initiated. Patient Y died nine days later.

The OIG determined that the timing of the respiratory distress just after the potassium administration indicated a high likelihood that the NG tube was positioned in the lung and not the stomach. While Patient Y's existing cardiopulmonary problems of pneumonia, congestive heart failure, and low cardiac output were a clinical scenario that was suboptimal, they were survivable. The misplaced NG tube with potassium administered via this tube likely was the major contributor to the patient requiring intubation and diminished chances for recovery from the conditions that initiated the hospitalization. Patient Y's case summary is located in Appendix A.

### Facility Response

The facility immediately initiated a focused review of the event, and an initial SAC score of 2 was assigned.[39] The Patient Safety Manager told OIG inspectors that the score of 2 was assigned (rather than a 3) because Patient Y had a history of aspiration and decreasing oxygen saturation, and given Patient Y's underlying condition and that Patient Y died ten days after the incident, it [the event] was serious but not catastrophic. The OIG team disagreed with this explanation.

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[39] A focused review addresses specific issues of major consequence to patient care processes and outcomes or specific incidents usually involving a discrete episode of care.

Although an x-ray showed evidence of aspiration pneumonia, Patient Y was well-oxygenated with levels that were sustained above 93-percent with nasal oxygen. Patient Y required intubation due to acute respiratory distress less than an hour after the potassium administration through the NG tube. As Patient Y's pulmonary status was already compromised, the administration of potassium through the misplaced NG tube likely impeded recovery and contributed to a death that was not part of the natural course of a preexisting conditions.

By assigning a SAC score of 2, the facility was not required to complete an RCA. Per VHA guidelines, however, if a death occurs that was not part of the patient's natural course, the SAC score would be rated at the highest level (3) regardless of the likelihood of a recurrence. With a SAC score of 3, an RCA should have been completed. When questioned, the Patient Safety Manager told OIG that the facility did not think an RCA would yield further information than that identified through the focused review.

The OIG determined that an RCA may have identified contributing factors to the event that were not readily apparent from the focused review and could have included analyses of other opportunities, such as:

- The adequacy of nursing education for NG tube procedures including insertion, checking initial placement, dislodgement, and checking placement prior to administration of medications,
- Whether there were better methods to secure the NG tube in place,
- Whether indications for the NG tube use needed to be reassessed,
- Whether there were alternate methods to confirm NG tube placement other than x-ray, and whether the NG tube procedure needed better standardization of placement confirmation.

Given the serious nature of the event and the requirement to appropriately evaluate the circumstances surrounding the event, the OIG found the facility's response to be less than vigorous.

**Recommendation 12.** The Charlie Norwood VA Medical Center Director ensures prompt evaluation of sentinel events, to include root cause analyses, in accordance with Veterans Health Administration requirements.

## Issue 7: Nurse Competencies and Staffing

### Nurse Competencies

The facility failed to follow its policy when completing nursing competency assessments, and as a result, nurses were providing care to CCU patients without documentation of their competency to do so. The sentinel event noted above illustrates the importance of nursing competency assessments.

## CCU Nurse Competencies—NG Tubes

Neither of the two nurses involved in the event related to the NG tube dislodgement and subsequent medication administration had documented competencies in NG tube placement.[40] The Acting CCU nurse manager provided copies of the "education" provided to CCU nurses pertaining to NG tubes; the sign-in sheet reflected that both nurses read the Enteral Nutrition Policy in September 2018. An attachment to that policy entitled "Tube Feeding Safety 101" reflected that providers should "ALWAYS ensure tube placement by x-ray." An updated Enteral Nutrition policy, dated October 26, 2018, similarly stated, "Verification of tube placement: X-ray verification will be completed prior to first use of tube for feeding or medication unless placement has been accomplished via fluoroscopy or by IR [Interventional Radiology]. Verification will be documented in the medical record under the radiology report section." The policy was silent, however, on requirements and methods to confirm correct repositioning when the NG tube had been partially dislodged but did not require reinsertion.

The OIG team interviewed both nurses involved in this event. The first nurse described the steps taken in this case to reposition Patient Y's NG tube the morning in question, including checking the placement of the tube by pushing air through a syringe and listening via stethoscope for air entry. The first nurse further reported being unaware that an x-ray was needed as the NG tube had not been pulled out completely. Additionally, the OIG team found that the first nurse did not document the dislodgment or repositioning of the NG tube.

The second nurse told OIG inspectors about not having a stethoscope and not following the normal practice of pushing air into the NG tube and listening for sounds of air entering the abdomen. Instead, the second nurse reported attempting to "aspirate air" to determine if the NG tube was properly positioned, which the OIG team noted was not an acceptable method for determining that the NG tube was in the stomach and not in the lungs. Further, the team found that the second nurse did not document care provided on this date even though facility policy requires nurses to reassess CCU patients and document at a minimum every shift not to exceed 12 hours.

Both nurses appeared to rely on their nursing experience to "test" the positioning; however, professional literature reflects the unreliable and inconclusive nature of tests other than x-ray verification. Improper positioning of an NG tube is a main risk factor for aspiration, and when enteral formulations or medications enter the lung through an NG tube inadvertently positioned in the respiratory tract, the result could be catastrophic as it was in Patient Y's case.

After the sentinel event involving Patient Y, the facility developed a plan to assure that CCU nurses were competent to place NG tubes; it did not include expectations for repositioning. The

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[40] The first nurse started at the facility in spring 2018 but the acting CCU nurse manager could not locate a competency file. The first nurse told the OIG team of completing CCU orientation and competency assessment as required.

OIG team also found the facility's planned completion date reflected a lack of urgency. According to the Acting CCU nurse manager, the online training module for NG tube placement was to be completed by the end of February 2019. As of February 14, eight CCU nurses had completed the online training module. However, despite multiple verbal and written requests, as of March 14, the facility had not provided the OIG team with evidence that all of the CCU nurses had completed the online NG training module. The Acting CCU nurse manager was also responsible for ensuring that nurses completed a mandatory hands-on skills lab to include NG tube insertion and how to confirm placement by April 19, 2019. The OIG team requested a copy of the syllabus and agenda for the hands-on skills lab competency training, but as of March 14, the requested information had not been provided.

## CCU Nurse Competencies—General

The facility could not produce evidence that most CCU nurses had completed annual competency assessments for routine or complex procedures performed in the CCU. Facility policy requires that each employee's competency in "skills specific to their assignment" be verified within 365 days of their last assessment. Each Service is required to maintain a current copy of the competence assessment checklist for each employee covered by the facility's competency policy.

The OIG team reviewed the nurse competency folders for 42 current and former staff. Two of the folders reviewed contained documentation of current skills-specific competence assessments. The remaining folders did not contain evidence of current skills-specific competencies, and in several of the folders, the most recent competency documentation dated back to 2012. Staff told the OIG that the competencies had been completed but could not provide documentation to support this assertion.

To assess whether competency or knowledge deficits may have contributed to adverse outcomes, OIG reviewed over 200 CCU-specific patient safety event reports for the period October 15, 2015, to January 22, 2019. The OIG did not find clear examples of poor care or adverse outcomes directly attributable to inadequate nursing skills or competencies. However, any clinical mishap, such as a medication error, could be rooted in nurse knowledge deficits or failure to follow policy.

The subject nurse manager and the Acting CCU nurse manager told OIG that they would be prioritizing the completion of CCU competencies. According to the written annual competency monthly training plan provided to the OIG team, CCU nurses would be required to complete priority annual competencies by May and the remaining competencies by July 31, 2019. The OIG team found that the approximately five-month timeline from the time it was learned that the CCU competencies were largely missing to the proposed completion of prioritized nurse competencies lacked urgency, particularly in the context of the NG tube failures by two nurses presumed to have the appropriate skill sets.

**Recommendation 13.** The Charlie Norwood VA Medical Center Director evaluates the documentation failures related to Patient Y, and takes appropriate action, as indicated.

**Recommendation 14.** The Charlie Norwood VA Medical Center Director ensures the development of policy addressing the appropriate method for confirming and documenting nasogastric tube placement prior to administration of medications or tube feedings, including actions that should be taken when a nasogastric tube is partially dislodged.

**Recommendation 15.** The Charlie Norwood VA Medical Center Director requires the Associate Director for Patient and Nursing Services to ensure that all registered nurses assigned to work in critical care units promptly complete assessments for missing unit-specific competencies.

**Recommendation 16.** The Charlie Norwood VA Medical Center Director requires the Associate Director for Patient and Nursing Services to enhance processes to ensure that nursing competency skills assessments are specific to individual duty assignments and completed in accordance with Veterans Health Administration and facility policy.

## Nurse Staffing in Selected Areas

In early 2018, a VISN assessment of the facility's inpatient nurse staffing determined that "VHA's mandated staffing methodology process was in place" and there was "evidence of appropriate staffing levels for all inpatient units." Additionally, the VISN report identified that although the overall nurse staffing full-time employee equivalent (FTE) for all nursing types was above the VA national average, inpatient registered nurse (RN) vacancy rates were below the national average. The OIG team reviewed organizational charts that provided information on current authorized and actual RN FTE data for selected nursing units.[41] This section of the report discusses CCU and emergency department nurse staffing because most of the complaints OIG heard were centered on these areas. See Table 1 for details.

**Table 1. Authorized versus Actual RN FTE as of February 28, 2019**

| Nursing Unit | Authorized FTE | Actual FTE | Vacancies |
|---|---|---|---|
| CCU | 52.5 | 41.4 | -11.1 |
| Emergency Department | 36.0 | 30.2 | -5.8 |

*Source: Facility Unit Managers*

### CCU Nurse Staffing

The sickest patients in the hospital are admitted to intensive care units such as the facility's CCU. The availability or non-availability of CCU beds often drives patient flow through the

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[41] As of February 28, 2019, ward 6D authorized RN FTE was 28, and actual RN FTE was 24. Ward 5D authorized RN FTE was 28.3, and actual FTE was 18.35.

emergency department, as well as impacts a facility's need to go on ambulance diversion and/or transfer emergency department patients to community hospitals. Optimal nurse staffing is central to keeping CCU beds operational. As of February 28, 2019, facility CCU actual RN staffing was substantially below authorized levels. During on-site interviews, the OIG team heard that in addition to insufficient staffing levels, unexcused nursing absences adversely impacted the CCU's ability to fully staff nursing shifts.[42]

The CCU minimum-per-shift staffing requirement was five nurses for 11 intensive care beds and three nurses for nine stepdown beds. To determine if the number of CCU staff required to provide safe patient care was consistently available, the OIG team reviewed CCU staff assignment sheets from August 1 to November 30, 2018.[43] Based on this information, it appeared that on August 18, 22, and 23, and November 26, 2018, staff absences (excused and unexcused) exceeded 30 percent. On August 30, 2018, staff absences reached 50 percent. In these cases, the nursing supervisor would discuss staffing options with the CCU nurse manager, attempt to call in additional staff, or increase the nurse to patient ratio for the stepdown unit. The final option would be to not take more patients until staffing improved.

In early 2019, however, a nurse on the stepdown unit was assigned to care for five patients for about an hour in the late morning. The nurse started the shift with four assigned patients, one of whom was scheduled to start continuous renal replacement therapy (CRRT) later that afternoon. At about 10:00 a.m., a patient with myasthenia gravis transferred in from a medical ward, but the CRRT patient was not reassigned to another nurse until about 11:00 a.m. The patient with myasthenia gravis did not receive needed medications at the appropriate dosing times because the nurse was caring for other patients; one of the other patients was critically ill.[44]

VHA's standardized nurse staffing methodology requires ongoing analysis of staffing plans when significant changes occur, when there is unusually high staff turnover, or when audit activities suggest that [patient] outcomes may be impacted by staffing levels. [45] Additionally,

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[42] Staff absences can happen for a variety of reasons. If a staff absence is not approved in advance, VHA describes the event as an "unexcused absence." Unexcused absences are often referred to as "call outs." Excused absences have been previously approved by the employee's supervisor and include requests for annual or sick leave.

[43] The CCU assignment sheets were a working tool used by nurse managers to identify staffing needs. The OIG acknowledges certain limitations associated with the retrospective review of this type of document when determining the appropriateness of staffing levels.

[44] The medical ward nurse caring for the patient with myasthenia gravis documented a 9:00 a.m. dose was held because the patient had an order for nothing by mouth. The patient actually had an order for a full liquid diet; however, the patient had been complaining of abdominal pain and nausea. The CCU nurse did not administer the 1:00 p.m. dose of medication (pyridostigmine bromide) to the patient, documenting that it was "unavailable" at 2:48 p.m. A dose was administered at 4:48 p.m., with accompanying documentation stating, "delayed by care of other critically ill patients and missing dose. Med[ication]s not brought from previous nursing unit." The patient was subsequently intubated; contributing causes to the intubation were the missed and delayed medication doses.

[45] As identified earlier in the report, staffing within the CCU was a factor in the timely transfer of Patient A.

when unit managers calculate the number of required staff, they must also account for staff absences.[46] VHA and facility policy allow managers to administratively address staff attendance issues. However, the OIG team found documentation that CCU leadership had initiated staff counseling and monitoring of staff attendance only one time in 2018. The OIG concluded that CCU nurse staffing was not consistently adequate to assure safe care and maintain the CCU's 20-bed capacity. The OIG also concluded that CCU managers failed to address staff unexcused absences that continued to impact safe staffing levels.

## Emergency Department Nurse Staffing

Despite emergency department leaders' multiple requests for resources, deficient nurse staffing had been a long-term challenge in the emergency department. General emergency department nurse responsibilities include frequent monitoring of vital signs, administration of medications and intravenous fluids, and educating patients and their family members.

In January 2017, nursing leadership was notified that the emergency department was repeatedly challenged to provide 1:1 observation of patients due to an insufficient number of "sitters." Nursing leadership was asked to consider a nursing float pool, among other options, to improve coverage as the emergency department was often in "crisis mode" trying to prevent an untoward outcome.

In February 2018, an email to the [former] ADPNS about the emergency department read, "[w]e really struggle at night without transporters, sufficient aides and sufficient nurses." The email stated that a physician was taking specimens to the laboratory and transporting patients to radiology, two intensive care patients were being boarded [pending bed availability], and other patients were receiving 1:1 observation. It further reflected that the Facility Director agreed to "push for" seven approved RNs to be hired as soon as possible, and that the writer had communicated the need for a nursing float pool. The former ADPNS responded that the nursing positions had been submitted as "critical hires," which had required multiple meetings to achieve.

As of late October 2018, an email to leadership outlined that emergency department nurse staffing was "critically low," and "[t]his insufficient nurse staffing reduces our emergency department to a 12 bed emergency department, but since we can't leave sick patients in the waiting room, the only real choice is to overload the nursing staff creating an unsafe environment of care…just slightly less unsafe than leaving them in the waiting room," and "given this staffing, we are in absolutely no condition to board patients." It further reported limited nursing assistants and technicians for 1:1 observations and to transport specimens.

Despite the history of nurse staffing and float pool requests, emergency department nursing staff told the OIG team in December 2018 that short staffing, unexcused nursing absences, and lack of

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[46] VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017.

a nursing float pool negatively impacted their ability to provide quality patient care. Interviewees noted that they used emergency department nurses' overtime to provide patient care, as well as pull CCU nurses [to provide emergency department care] when the emergency department was short-staffed.

According to the emergency department nurse manager, as of the end of February 2019, the facility's emergency department had 36 authorized staff RN positions, with 30.2 RNs currently on staff and five vacancies. Further, RNs "called out" (resulting in staff absences) a total of 97 shifts (731 hours) from October 1, 2018, through February 28, 2019.

The OIG concluded that emergency department nurse staffing issues had not been adequately addressed as evidenced by the continuing vacancies and ongoing concerns expressed by emergency department staff.

**Recommendation 17.** The Charlie Norwood VA Medical Center Director ensures that critical care unit staffing decisions include contingencies for staff absences.

**Recommendation 18**: The Charlie Norwood VA Medical Center Director continues efforts to recruit and hire for critical care unit and emergency department nurse vacancies, and ensure that until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

**Recommendation 19**. The Charlie Norwood VA Medical Center Director ensures that unexcused nursing absences are managed in accordance with relevant Human Resource guidelines.

## Issue 8: Management of Long-Term Problems Impacting the Emergency Department

Failures to adequately address several long-term problems resulted in confusion and anger among staff, jeopardized relationships and academic affiliate partnerships, and potentially placed emergency department patients at risk.

Access to appropriate emergency services is the cornerstone of VA health care. VHA Directive 1101.05 (2) requires that the emergency department is staffed and equipped to provide initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and mental health disorders, regardless of the level of severity. In FY 2018, the facility's emergency department treated approximately 24,900 patients.

In addition to emergency department nurse staffing issues discussed in the previous section of this report, the OIG team learned of multiple emergency department-related issues that had the potential to affect patient care and safety. Managers initiated efforts to improve the conditions, but relevant stakeholders, administrative services, and facility leaders were not consistently

working toward the same goals. As described below, the facility's efforts at problem-solving had not always been timely, effective, or sustained:

- The emergency department had multiple doors that were not secured against unauthorized access or unsafe egress.
- Inadequate laboratory technician staffing during weekend night shifts resulted in a temporary change to the availability of laboratory services, resulting in the emergency department having to perform more point-of-care testing.
- The policy and expectations for transporting patients over a pedestrian bridge to AUMC were unclear, placing patients at risk and creating discord among nurses and physicians, and between the facility and AUMC.
- The emergency department lacked a contingency plan when patient volume and care needs exceeded the emergency department's resources, and the policy for managing emergency department boarders had not been signed or adequately communicated, resulting in confusion among the staff.[47]

## Emergency Department Security

Inadequate emergency department security had been a long-term deficiency that continued to place patients and staff at risk at the time of the OIG site visit(s). VHA's emergency department directive specifies that the emergency department be designed to provide a safe environment for patients and staff while making access convenient.[48]

The emergency department included two sections, Side A and Side B, that shared common hallways. Side A consisted of nine acute beds, five hallway stretcher spaces, a psychiatric intervention room, and the triage area. Side B provided care for stable Emergency Severity Index (ESI) 3, 4, and 5 patients.[49] Side B included four standard examination rooms, one gynecological room, and two fast track rooms. The OIG was told that when multiple patients were admitted to the facility but awaiting a bed, those patients were moved to Side B of the emergency department

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[47] Medical Center Policy Memorandum 21-18-08, *Emergency Department Boarding and Virtual Inpatient Status*, March 29, 2018.

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

[49] A psychiatric intervention room is where seriously disturbed, agitated, or intoxicated patients may be taken for rapid medical and psychiatric evaluation. The ESI is a five-level emergency department triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. https://www.ahrq.gov/professionals/systems/hospital/esi/index.html. (The website was accessed on May 2, 2019.)

to facilitate caring for these virtual inpatients.[50] The emergency department area could be accessed directly through at least six doors that exited to public areas.

Emergency department security had reportedly been a concern for at least five years. The Chief Facilities Engineer told OIG team members that the original project request began in 2013 but funding for lockdown security for the emergency department was inadvertently omitted from the request.[51] Over the next few years, additional delays occurred related to funding, infrastructure, and contract challenges.

In April 2017, an emotionally distraught patient was escorted to the emergency department by a VA police officer. The patient wrote in the comment section of the triage sheet about trying to self-harm by shooting. The Administrative Officer of the Day (AOD) took the triage form and the patient to the triage area but reportedly neither the triage nurse nor the AOD read the form. The patient became restless and left the emergency department triage area through an unsecured door. The next morning, the patient suffered a self-inflicted gunshot wound. This event prompted the facility to make changes to several emergency department processes:

- A Nurse First position was implemented. The Nurse First evaluates patients, determines the need for immediate intervention and assigns an initial ESI level, and performs continuous rounds on waiting room patients. By rounding on patients, the nurse can continually assess changes in patients' conditions and keep patients updated on expected wait times and delays.
- The triage area was remodeled to give patients with mental health concerns a safe environment in which to wait.
- A badge-activated lock was installed at the front entrance to Side A; a badge was required to enter the emergency department through this door but not to exit.

Another recommended action was to install badge access for all emergency department doors contingent upon funding availability. A request was sent to VISN 7 in June 2017 seeking more than $320,000 to provide security measures for the emergency department "which were inadvertently omitted from the design drawings." The memorandum stated, "The lockdown security is required to protect patients and staff."

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[50] Emergency department patients are not generally considered to be "inpatients." When patients are boarded in the emergency department pending admission, their status is changed to "virtual" inpatients to allow receipt of inpatient medications, special diets, and other support services, as indicated.

[51] Lockdown security includes cameras, electronic door controls, remote monitoring stations, and emergency power. The original project was for construction renovation to correct security assessment deficiencies. In a November 2017 email responding to a design modification request, a VISN 7 project engineer wrote, "If they [the facility] left out a critical issue (which is deemed within the scope), then it would be considered a design omission. They missed it. Not good planning…"

Another request was made in an October 2018 memorandum to add a project on emergency department security upgrades to the FY 2019 Non-Recurring Maintenance plan. The memorandum stated, "[t]his project will upgrade the emergency department security system to meet the current security requirements. The current emergency department has multiple places that can be entered without having to be allowed in or checking in with staff."

The OIG team was told that as of January 29, 2019, the contract [for emergency department security upgrades] was in the executive office awaiting signature.[52] The OIG observed that most of the emergency department doors remained unsecured and, in some cases, propped open. Further, VA Police Service was unable to provide continuous emergency department coverage due to insufficient staff.[53] The OIG team interviewed multiple emergency department employees who reported feeling unsafe due to the security challenges.

**Recommendation 20.** The Charlie Norwood VA Medical Center Director ensures that the emergency department security system is upgraded to meet current security requirements and to provide a safe environment for patients and staff.

## Laboratory Staffing and Services

Long-term staffing concerns in the laboratory had not been adequately addressed despite the Chief of Laboratory and Pathology Service's repeated efforts to secure resources and cautions about the possible decrease in services if staffing was not improved.

During this inspection, the OIG was told that ongoing concerns related to laboratory staffing had led to the recent curtailment of some testing on several weekend shifts. The facility's failure to adequately address laboratory staffing over a period of years had also resulted in the facility being cited twice by the College of American Pathologists.[54]

To ensure timely and high-quality emergency care, VHA requires sufficient laboratory staff be on-site and capable of performing critical tests 24-hours-per-day, 7-days-per-week. Additionally, VHA has determined that for 24-hour emergency departments, specific laboratory tests, including point-of-care testing, should be available.[55]

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[52] In this report, the Executive Office refers to the suite of offices occupied by the leadership team.

[53] VHA recognizes the emergency department as a high-risk area and recommends that all facilities with an emergency department consider stationing police or security officers in or around the emergency department 24-hour-per-day, 7-day-per-week when feasible.

[54] The College of American Pathologists Accreditation Program accredits the entire spectrum of laboratory test and testing procedures. VHA requires all laboratory testing performed on-site at VA laboratories meet College of American Pathologists requirements.

[55] Point-of-care testing refers to tests performed near the patient's location and outside the facility's clinical laboratory.

In early January 2019, the OIG team received information that the facility had been "closing the laboratory" during the 11:00 p.m. to 7:00 a.m. shift (third shift) on Friday and Saturday nights.[56] Specifically, only one technician was available for an 8-hour period and the emergency department was expected to use the point-of-care testing machine for tests that would normally be completed in the laboratory by laboratory personnel. Additionally, because of these changes, AUMC was refusing to provide emergency department coverage on those shifts.

Emails between the Chief of Laboratory and Pathology Service or the Laboratory Manager and various clinical and administrative leaders reflected concerns about Human Resource support, slow approvals to hire, laboratory staff members' long-term volunteerism (to cover shifts for pay), and caution about the potential decrease in laboratory-based services due to inadequate staffing dating back to 2017:

- A November 15, 2017, email indicated "…many of our 3rd and 2nd shifts are being filled through volunteerism…"
- A January 11, 2018, email indicated "[t]he Director approved [seven] lab positions on December 4, 2017…" but "HR [Human Resource] has done nothing…", and that "[a]necdotal conversations with the lab's HR specialist suggest that she is "too busy" to address the lab's needs." The email further stated that shifts were being filled by lab personnel who volunteered, but that, "[i]t is personally distasteful to continually tell my techs [technologists] to "hang on" and "help is coming" when in fact, help is nowhere in sight."
- A January 11, 2018, email referenced the "critical hire situation in the lab that has been ongoing essentially since January 2017 and unquestionably since March 2017…", that volunteerism was declining, and that the Chief of Laboratory and Pathology Service was considering closing the chemistry section on the night shift.
- A March 26, 2018, email referenced a meeting with Human Resource staff in January but that the lab was "… no further along in that process as compared to day one."
- An April 26, 2018, email referenced the January warning that the [laboratory] third shift was going to have to close "at some point because of the lack of onboarding."[57] It further stated that lab staff "keep bailing us out with excessive volunteerism. The risk has become too great and now the HR [Human Resource] situation is super critical."

Laboratory and Pathology Service was able to hire several technologists in summer 2018, but reportedly because of attrition in the laboratory and the long-standing delays in getting new

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[56] The laboratory's first shift was 7:00 a.m. to 3:00 p.m., second shift was 3:00 p.m. to 10:00 p.m., and third shift was 11:00 p.m. to 7:00 a.m. The third shift is often referred to as the night shift.

[57] Onboarding refers to the final process for verifying an applicant's documents, eligibility for hire, and participation in new employee orientation.

vacancies filled during parts of 2017 and 2018, the new hires did not substantially improve the Service's ability to staff the third shift.

By December 2018, continued staffing shortages would only allow for one laboratory technician to cover the third shift. The Chief of Laboratory and Pathology Service sent an email to multiple clinical service chief, nurse manager, and administrative group email accounts on December 6, 2018, notifying these groups of reduced laboratory testing availability during the third shift December 8 (into the morning of December 9). The Chief of Laboratory and Pathology Service proposed to offset the decrease in laboratory services during this shift by increasing the use of point-of-care testing in the emergency department. This proposal stated that specific STAT (immediate) tests would continue to be available, any blood samples that were collected and not tested would have priority for testing at 7:00 a.m. the following morning, and that the Chief of Laboratory and Pathology Service would be available to address any circumstances needing "special attention."

On January 14, 2019, AUMC representatives and facility clinical leaders met to discuss a variety of joint issues, including laboratory service changes.[58] Follow-up emails reflected that AUMC did not support the point-of-care testing plan, which was described as "… NOT in the best interest of patients." Additionally, AUMC physicians felt the proposed changes in available laboratory services compromised their ability to meet emergency care medical-legal standards, and they stated that the situation needed to be remedied or AUMC could not provide weekend physician coverage. On January 17, AUMC leaders sent a letter to facility leaders objecting to the change, and wrote, "[w]e view the lack of prior notice of this critical change to be a failure to act in good faith in building and maintaining a partnership for quality of care to Veterans."

In reply, the facility's new COS wrote that laboratory services had not been discontinued and that safe practices had been maintained.[59] Further, in response to AUMC's charge that they were not given timely notification of the change, the facility COS wrote, "At the beginning of this year, without notice, there was a reduction in the laboratory staffing that effected [*sic*] the Friday and Saturday 11pm to 7am work shift." The facility COS went on to write that the "enhanced" point-of-care testing addressed the third shift laboratory issue, and that participants in the January 14 meeting agreed that the point-of-care testing was a "reasonable approach." Subsequent email exchanges revealed that AUMC did not agree with the point-of-care testing approach [in lieu of laboratory-based testing].

In a January 30th interview with the Facility Director and three senior clinicians who attended the January 14 meeting with AUMC, the OIG team was told that changes in the availability of

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[58] AUMC provides the facility with emergency department physician services covering multiple shifts starting Sunday morning through Saturday night.

[59] The COS assumed this position in December 2018.

laboratory services [during the period when there was only one laboratory technologist on the weekend third shift] had not occurred.[60] Facility leaders said that, nevertheless, third shift laboratory staffing would (as of the upcoming weekend) return to its previous levels through volunteerism until new technologists could be hired.

### OIG's Concerns Relative to the History of Laboratory Staffing and the Facility's Subsequent Communications with AUMC

The OIG team found that the Chief of Laboratory and Pathology Service repeatedly communicated concerns about critical laboratory vacancies. In some cases, the Chief of Laboratory and Pathology Service was given approval to hire several employees; however, the process to complete the hiring actions was cumbersome and fraught with inefficiencies, such as an omission on the MCRC minutes resulting in a months-long delay getting the Facility Director's approval. When the Chief of Laboratory and Pathology Service was given authority to hire staff outside of the MCRC process, the newly hired staff were not immediately independent in the laboratory because of orientation and training needs.[61] Facility leaders' lack of urgency in responding to the laboratory staffing issues, as well as what appeared to be an insistence on following a time-consuming and inefficient Human Resource process for what was described as critical hires, contributed to the laboratory-related issues noted above.

The OIG team also found the divergent perceptions of the January 14 meeting and what was "agreed to" to be a reflection of communication challenges described earlier in this report. Further, the team found the facility's apparent effort to characterize the long-term laboratory staffing issues as having just occurred, *without notice*, to be disingenuous. The Chief of Laboratory and Pathology Service repeatedly told leadership about the staffing issues and the increasing likelihood that laboratory staff would not be able to perform the full range of laboratory tests on the weekend third shift. Further, the formal notice of curtailed laboratory services was sent to a broad range of facility clinical leaders on December 6, 2018, contradicting the statement that the problem occurred "at the beginning of this year." Of note, the Chief of Laboratory and Pathology Service resigned on January 31, 2019, to protest the "recalcitrant failure of the leadership to adequately address the critical short staffing in the clinical lab over a protracted period of time."

Although the OIG team acknowledges the facility's inherent authority to make changes to laboratory services based on available resources, the team agreed with AUMC that the reduction in laboratory-based testing and the increase in the need for point-of-care testing in the emergency

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[60] The facility stated that it had over 700 different laboratory tests, 600 of which were readily available. Additionally, the emergency department had the capability of performing 31 point-of-care tests.

[61] At the facility, positions categorized as "critical hires" could bypass the MCRC and be presented directly to the Facility Director for approval.

department presented challenges and had the potential to increase patient risk in some areas.[62] The facility also failed to communicate early with AUMC managers and leaders about the change in the availability of specific laboratory services and the plan going forward, which contributed to AUMC's sense that their concerns were not being heard, and potentially strained the professional relationship.

**Recommendation 21.** The Charlie Norwood VA Medical Center Director continues efforts to recruit and hire for critical laboratory staff vacancies, and ensures that until optimal staffing is attained, alternate methods are consistently available that meet patient care needs.

**Recommendation 22.** The Charlie Norwood VA Medical Center Director ensures that before policy changes are made that impact the delivery of quality patient care, broad discussion with all key stakeholders takes place and written guidance is widely disseminated.

## Facility-AUMC Bridge Transfers

During the course of this inspection, the OIG was told of ongoing concerns related to the transport of patients between the facility and AUMC using a connecting pedestrian bridge. The failed communication surrounding the bridge transfer issue was a confusing and contentious problem for staff and placed patients at risk.

Medical Center Policy 02-14-41, *Inpatient Transport To and From the Georgia Regents Medical Center*, dated January 29, 2014, outlined the type of patient appropriate for transport across the bridge and the steps necessary to accomplish the transport.[63] The policy stated, among other things, that "[a]t the agreed upon date/time, the patient will be transported by the appropriate [facility] staff" to AUMC via the crosswalk connecting the two buildings. The policy was signed by the Facility Director.

An August 2016 AUMC policy, developed jointly by facility and AUMC staff over several months in 2016, included the statement "[i]n most cases transport will occur by utilization of the 2nd floor crosswalk that links both institutions." The meeting minutes from the joint planning sessions reflected that concerns about VA nurses' responsibilities and potential liabilities were discussed.[64] This policy was signed by an AUMC representative. It was unclear how and when the policy was communicated to VA staff.

In September 2016, the Chief Nurse for Surgery sent an email to the ADPNS, COS, and Quality Manager detailing an event the previous evening when a nurse was instructed to take a patient to

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[62] Areas of concern include the lack of drug level testing for medications such as acetaminophen given the number of patients who have suicide attempts; and the likely increase in the use of imaging studies (as work-arounds) and empiric treatment with medications, such as antibiotics, until confirmatory laboratory test results are available.

[63] Georgia Regents Medical Center is now AUMC.

[64] Federal employment rules allow VA nurses who are licensed in one state to practice in any state. The concerns appeared to center around whether a VA nurse who did not possess a Georgia license could be held professionally liable for a negative patient event occurring during transport off federal property.

AUMC for an urgent radiology exam but was not met by an AUMC employee on the other side of the bridge and later spent several hours in AUMC's emergency department waiting for the patient to obtain the scan. The Chief Nurse for Surgery expressed concerns about the lack of emergency response on the bridge and the safety of patients, and requested that the facility "…widely disseminate a cease and desist with this practice until a fully safe process is identified and [providers appropriately] trained and if necessary [concurrence achieved] by all appropriate parties at both facilities." It was unclear whether any actions were taken at that time to address the Chief Nurse for Surgery's concerns.

An April 5, 2017, letter from AUMC to the outgoing COS copied to the Acting Facility Director and the ADPNS at the time, outlined concerns that while the facility and AUMC had jointly developed a policy regarding transfers and use of the crosswalk, "…there has been a lack of good faith on the part of VA to follow the agreed upon approach." It went on to state, "[t]he repeated incidents of misinformation on this issue strains the credibility of those in leadership positions at the [facility] and suggest a lack of good faith to continue further work on this issue."

Emails from early November 2018 reflected that the concerns had not been resolved, and one facility physician wrote, "[w]e have been dancing around this issue for about 3 years." The Acting ADPNS (who was the Chief Nurse for Surgery in 2016) wrote that the bridge "… enters their [AUMC's] building in a non-patient care area and PRESUMES our employees know the geography and may function as a registered nurse when escorting a patient in another facility. This is dangerous. I do not support it and will not require my nursing staff to escort a patient to another facility."

A November 15, 2018, email from facility leaders to both facility and AUMC staff stated that the facility was ceasing the practice of using the bridge to transport patients and that the appropriate level of emergency medical transport should be used. The email also stated "If, in your clinical judgement, the safest/fastest/most efficacious method of transport is to go by the bridge, then go by the bridge." Some providers, however, responded with recent examples of patients requiring transfer to AUMC for cardiac or trauma care, but when they attempted to complete the transfer via the bridge, were told that nursing staff could not assist. Comments from the involved providers appeared to question the feasibility of a policy that supported the use of a provider's clinical judgment when determining the type of transport, but did not allow nurses to assist in the process. One provider summarized by writing, "As a group, we can decide to use it [bridge transport] whenever we want to but without nursing assistance on the transfers, it's chaos."

The OIG contacted facility leadership on November 26, 2018, to determine the facility's expectations and plan for addressing the ongoing confusion. The facility issued interim guidance, signed by the Acting COS and Acting ADPNS, the same day. The guidance authorized emergency transport of certain patients, with COS approval, and outlined staffing and equipment expectations. The interim guidance permitting use of the bridge under certain circumstances was communicated to relevant staff on November 30, 2018, via email. However, on March 1, 2019,

another transfer breakdown occurred, suggesting that some facility nursing staff were not informed of, or did not recall, the interim guidance.

To evaluate whether confusion about transports via the connecting bridge has been problematic, the OIG reviewed transport information on 63 patients that, according to the facility, were transported via the connecting bridge during a seven-month timeframe in 2018. The OIG did not find evidence of poor outcomes but emails from clinical staff reflected several close calls and substantial concerns about the potential for adverse events.

**Recommendation 23.** The Charlie Norwood VA Medical Center Director ensures that policies and procedures regarding the appropriate transfer of critically ill patients are developed in conjunction with key stakeholders and that the process is widely disseminated to relevant staff.

## Contracted Transport Services

During interviews with emergency department staff, the OIG was told that contract transport services were not consistently timely, which made the use of the connecting bridge necessary in some situations. The November 15, 2018, email from facility leaders instructed providers to use emergency medical services, rather than the connecting bridge, to transport patients to AUMC. Providers, however, reported that using the emergency medical (911) or contract ambulance transport services was unreliable and could be unsafe for some patients.

One provider documented, "EMS in this county is quite poor. 911 response times are slow, and in the downtown area, will nearly always be without a paramedic. We could end up waiting 30-60 minutes to hand off a sick patient" to a basic emergency medical technician to drive the patient across the street. Another provider wrote about transporting a trauma patient, "[t]o avoid the hours of delay in getting an ambulance to drive [the patient] across the street during Black Friday, I pushed [the patient] across the crosswalk myself along with one of our residents. Otherwise it would have likely taken 2 to 3 hours to get [the patient] across the street."

Emergency (911) transportation is generally provided through the city of Augusta. However, the facility contracts with a local transportation company (the vendor) for 24 hour-per-day, 7 day-per-week non-emergent ambulance service consisting of Basic and Advanced Life Support as well as stretcher van transport services.

The facility's COR is responsible for "technical administration of the contract and shall assure government surveillance of the contractor's performance." Per the contract, several performance measures relate to timeliness. The COR told OIG team members that data was not collected regarding the timeliness of transports even though the contract required this surveillance.[65] The COR stated that after the original contract expired, a series of short-term contracts were initiated until the contract could be rebid. The current vendor would not be eligible to bid for the new

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[65] The COR reported that a previous supervisor, who has since retired, declined to "dock" the vendor for sub-par performance.

contract, and in the COR's opinion, the vendor became less-reliable at that time. The COR confirmed that the vendor had difficulty accurately estimating times of arrival.

**Recommendation 24.** The Charlie Norwood VA Medical Center Director ensures the Contracting Officer's Representative responsible for the technical administration of the transportation contract conducts surveillance of the contractor's performance and provides oversight of the contractual agreements.

## Emergency Department Contingency Plan and Boarder Policy

During the course of this inspection, the OIG was told of concerns that the emergency department did not have a contingency plan for staffing during high-volume times and the "boarder" policy was not signed or adequately communicated, resulting in confusion among staff about expectations and responsibilities.

The VHA Emergency Medicine Directive requires that appropriately educated and qualified emergency care professionals must be present in the emergency department during all hours of operation. VA medical facilities must have contingency plans in place to rapidly mobilize additional staff in cases where patient care demands exceed the current available physician and nurse staffing resources. Patients who wait in the emergency department for an inpatient bed for four or more hours after the decision to admit is made are called "boarders," and boarding patients represent additional workload for emergency department staff.

In March 2018, the facility issued a draft policy entitled, *Emergency Department Boarding and Virtual Inpatient Status*. This policy states that the emergency department Charge Nurse will assign emergency department staff to be primary nurses for boarding patients per safe staffing availability. During interviews, emergency department staff indicated that while emergency department nurses appeared to manage workload during regular operations, existing emergency department nurses could not safely assume care of all boarding patients at very high-volume times. In fact, emergency department nurse staffing was such that nursing triage could not be started until 11:00 a.m.

In interviews with emergency department staff, OIG was told that the facility did not have a contingency plan in place to rapidly mobilize additional staff in cases where patient care demands exceeded the current available nurse staffing resources. Reportedly, the facility used travel nurses to supplement emergency department staffing in the past, but the practice was discontinued by the Facility Director. Further, there was no float pool of nurses to supplement staff. At least once in late 2018, inpatient nurses were assigned to the emergency department to care for emergency department boarding patients. The inpatient nurse manager(s) was not informed of this decision. The nurses who were pulled from acute care units did not have an emergency department orientation to familiarize them with emergency department-specific policies and procedures, the location of supplies and equipment, and other emergency

department-related operations. Floating nurses to the emergency department without training and/or orientation constituted a patient safety risk.

When patients are boarded in the emergency department pending admission, they are considered to be in "virtual" inpatient beds and arrangements must be made to obtain inpatient medications, special diets, and other support services, as indicated. Coordinating the delivery of inpatient care services in an outpatient setting can be complicated and requires a well-written policy that relevant inpatient and outpatient staff are familiar with. In the absence of such policy, patients are at risk for missed medications, treatments, or services needed to manage or treat the reason for their admission. At the time of the OIG site visit, the facility did not have a clear contingency plan for managing patients at high-volume times and Memorandum 21-18-08, *Emergency Department Boarding and Virtual Inpatient Status,* remained unsigned and in draft status.

**Recommendation 25.** The Charlie Norwood VA Medical Center Director ensures contingency plans are in place to rapidly mobilize staff when emergency department patients' care demands exceed the current staffing resources.

**Recommendation 26.** The Charlie Norwood VA Medical Center Director ensures there is a signed boarder policy, which is broadly disseminated.

## Emergency Department Timeliness Performance Data

Given emergency department staffing challenges, the OIG reviewed Emergency Medicine Management Tool (EMMT) Improvement Dashboard data for patients seen in the emergency department in FY 2018. While the facility met the overall Length of Stay metric that measures the elapsed time from when the patient checks in to the emergency department to the time of disposition, the facility was close to exceeding VHA's performance threshold related to the timeliness of admission. Specifically, VHA's goal from emergency department check-in to hospital admission was less than (<) 240 minutes, with a threshold not to exceed 360 minutes. In FY 2018, the facility's median time from emergency department check-in to hospital admission was 341 minutes (about 5 ½ hours). Emergency department staff cited lack of inpatient beds as a cause of emergency department delays.

Despite what was described as routine admission delays and EMMT data supporting this perception, the facility received relatively few complaints about this issue. The OIG reviewed the facility's Patient Advocate Tracking System data for the period October 1, 2016, through November 13, 2018.[66] Of the 69 emergency department-related complaints, four were specific to emergency department waiting times and one concerned a delayed admission. Facility staff addressed the complaints.

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[66] The Patient Advocate Tracking System is used to document, track, and report patient-related issues including patient complaints.

# Section IV—Summary Concerns

With the exception of the neurosurgery cases discussed in Section II, the OIG did not review Surgery Service. However, the facility's surgical complexity designation is complex, meaning that it requires the highest level of facility infrastructure and various clinical services must be available 24 hours-per-day, 7 days-per-week including basic laboratory and radiology services.[67] These infrastructure requirements apply throughout the facility, not just to the surgery program.

Some laboratory services, primarily chemistry testing, were not available on three occasions in December 2018–January 2019, requiring emergency department staff to rely on point-of-care testing. While the facility may choose to use point-of-care testing, it was designed to improve patient outcomes in the emergency department and not be the default position in lieu of having the appropriate staffing. Further, the curtailment of some laboratory services on those three occasions was the predictable result of a long-standing staffing issue that was not adequately addressed.

The OIG team learned that ultrasounds were also not available at the facility on February 17, 2019, and emergency department staff were instructed to use AUMC for ultrasound tests. On February 19, AUMC received an email from the facility's interim emergency department Chief stating, "[w]hen calling to get an after-hours ultrasound, please make sure you contact the on-call chief of radiology. After you get approval, YOU will need to contact the ultrasound tech[nologist]. If this process is not possible and you decide to send the patient to AU for the procedure, make sure you complete all appropriate paperwork." The Chief of Radiology told the OIG that the facility would not be able to assure ultrasonography on March 10 or 31, either, and that due to inadequate ultrasound technologist staffing, the facility had never been able to reliably provide 24 hour-per-day, 7 day-per-week ultrasound coverage.

The Chief of Radiology reported that the department had been able to provide CT scans in-house in accordance with complexity guidelines (weekday dayshift and on-call 24/7 within 30 minutes). However, one CT and five diagnostic radiology technologist positions had reportedly been vacant for over a year, which compromised the department's ability to continue to meet coverage demands as existing staff were working overtime and were getting stressed.

Per complexity guidelines, specialty consults, including neurology, must be available 24 hours-per-day, 7 days-per-week within 15 minutes by phone or 60 minutes in person. The team learned that on February 13, 2019, the interim emergency department Chief sent an email to emergency department providers stating, "[t]here will be no neurology coverage from today

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[67] VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures,* May 6, 2010. This Directive requires that VA medical facilities with an inpatient Surgical Program have: "(1) surgical complexity designation of either standard, intermediate, or complex based upon the facility infrastructure; and (2) that the scheduled (non-emergent) surgical procedures performed are not to exceed the infrastructure capabilities of the facility."

until April 1, 2019," and went on to state that stroke patients being transported by ambulance that could require thrombolytics should be diverted. The email further stated that non-ambulance patients with acute stroke that could require thrombolytic treatment should be stabilized and immediately transferred to AUMC's emergency department via the pedestrian bridge connecting the facility and AUMC. Instructions reflected that a physician and a nurse were required to accompany the patient. If the need for transfer occurred "in the middle of the night," providers were cautioned not to leave the emergency department "uncovered." The interim emergency department Chief wrote, "[c]all the hospitalist or admitting senior resident to transfer the patient or watch the emergency department, whatever is felt to be the lower of the two acuities."

While the service challenges noted above are not evidence of large-scale infrastructure failures, they do demonstrate a chaotic environment where emergency department providers, and potentially other facility providers, are expected to adjust their clinical practices and struggle to secure resources to compensate for the service lapse(s). These concerns, coupled with leadership and communication challenges, inefficient Human Resource and hiring practices, and significant staffing issues that reduce access to the emergency department and CCU as noted in previous sections of this report, suggest that the facility may not be consistently prepared to manage emergent situations and provide safe, quality of care.

**Recommendation 27.** The Veterans Integrated Service Network Director completes an assessment of the facility's ability to assure consistent availability of services and staffing to support providers' professional practice and the safe and timely delivery of care, and takes action as necessary.

# Conclusion

While the OIG team did not substantiate most of the allegations made by the anonymous complainant, evaluation of the allegations exposed a facility challenged by organizational division, inefficient processes, and leadership failures to adequately address a range of long-term problems. The OIG team perceived a collective frustration on the part of many employees that the facility continued to struggle with the same problems year after year, making little headway in improving operational efficiency and performance.

Leadership communication style and hiring and staffing challenges were the common underpinning for many of the deficiencies identified by the OIG team. Interviewees' testimony, as well as NCOD survey results, supported the perception that some leaders' communication styles were insensitive and unproductive, and that leadership decisions were not consistently timely or clear. Further, hiring and staffing was inefficient and cumbersome, resulting in months-long delays to hire in some areas, as well as insufficient staffing in others.

As noted, the OIG team did not substantiate most of the allegations related to CCU policies and patient care failures or the actions of the subject nurse manager; however, the team confirmed that CCU nurse staffing could be problematic, and that communication about, and understanding

of, certain policies was inadequate. The team confirmed poor nursing morale in several areas, which interviewees attributed to inadequate nurse staffing levels, guidance, and accountability. The team did not identify adverse patient outcomes in the cases reviewed. Overall, the OIG team could not conclude that the facility was deteriorating, primarily because it had been underperforming for years. And while leaders were taking actions, deficient conditions persisted as evidenced by the facility's ongoing underperformance in SAIL quality metrics and poor satisfaction scores.

In late 2018, the facility had a sentinel event involving an incorrectly positioned NG tube; however, the evaluation of the event was inadequate. Further, although there was no documented evidence that CCU nurses had completed annual competency assessments for routine or complex procedures performed in the CCU, including how to verify correct NG tube positioning, the facility's plan to update CCU nurse competencies lacked urgency.

Almost uniformly, service level hiring managers reported that the hiring process was exceedingly difficult, and OIG confirmed nurse staffing challenges in the emergency department and CCU, as well as technologist staffing issues in the laboratory and radiology areas. Some of the interim actions to address staffing shortfalls, such as floating nurses to the emergency department despite them not having appropriate orientation and training in this area, were not ideal. In addition to not having a contingency plan for mobilizing additional staff when patient care demands exceeded the available physician and nursing staffing, the emergency department did not have a signed boarder policy outlining staff responsibilities for the care of these patients. These policy failures placed patients at risk.

Inadequate emergency department security had been a long-term deficiency that continued to place patients and staff at risk. While the facility made several enhancements to emergency department services and the emergency department environment after an adverse event in 2017, as of January 2019, the contract for emergency department security upgrades was incomplete and most of the emergency department doors remained unsecured.

Failed communication surrounding the use of a connecting bridge between the facility and AUMC was a confusing and contentious problem for staff of both institutions. While a joint workgroup developed criteria and a plan for patient transfers via the bridge, the plan was not consistently followed. AUMC representatives expressed significant concerns about the facility's revised plan to use emergency transport services (which were described as inadequate), fearing that the process would delay care in critical cases. While the OIG team's review of patient transfers via the connecting bridge did not find evidence of poor outcomes, emails from clinical staff reflected several close calls and substantial concerns about the potential for adverse events.

Despite the facility's complex designation, a multitude of services were periodically reduced or unavailable—these services included some laboratory testing, ultrasonography, and neurology. While the identified service challenges were not evidence of large-scale infrastructure failures, they challenged the emergency department providers, and potentially other facility providers, to

secure resources and compensate for the service lapse(s). These concerns, coupled with leadership and communication challenges, inefficient Human Resource and hiring practices, and significant staffing issues that reduce access to the emergency department and CCU, suggest that the facility may not be consistently prepared to manage emergent situations and provide safe, quality care.

# Recommendations 1–27

1. The Veterans Integrated Service Network Director evaluates the quality and professionalism of Executive Leadership Team communications, and takes action when indicated.

2. The Veterans Integrated Service Network Director requires the development of, and follow-through on, corrective action plans responding to relevant findings from National Center for Organizational Development's 2018 site visits and reports.

3. The Charlie Norwood VA Medical Center Director develops a process to ensure that Light Electronic Action Framework hiring requests are tracked and processed timely.

4. The Charlie Norwood VA Medical Center Director reviews the facility's hiring processes to identify opportunities to improve the efficiency and timeliness of hiring actions, and takes corrective action, as needed.

5. The Charlie Norwood VA Medical Center Director ensures development and wide dissemination of a written critical care unit bed management policy that clearly states the process to be followed when an inpatient requires intensive care and a critical care unit bed is unavailable.

6. The Charlie Norwood VA Medical Center Director ensures development and wide dissemination of a written policy regarding patient-owned medical devices and equipment that clearly outlines restrictions and acceptable uses when the patient is hospitalized.

7. The Charlie Norwood VA Medical Center Director ensures development and wide dissemination of a standardized method for documenting and ensuring compliance with the internal hand-off communication policy.

8. The Charlie Norwood VA Medical Center Director ensures that neurosurgery privileges are amended to include only procedures which facility infrastructure can support.

9. The Charlie Norwood VA Medical Center Director ensures that the nurse's failure related to the computed tomography (CT) event outlined in this report is evaluated and administrative action is taken, as indicated.

10. The Charlie Norwood VA Medical Center Director enhances processes to document Strategic Analytics for Improvement and Learning related improvement actions.

11. The Charlie Norwood VA Medical Center Director continues efforts to improve patient and employee satisfaction.

12. The Charlie Norwood VA Medical Center Director ensures prompt evaluation of sentinel events, to include root cause analyses, in accordance with Veterans Health Administration requirements.

13. The Charlie Norwood VA Medical Center Director evaluates the documentation failures related to Patient Y, and takes appropriate action, as indicated.

14. The Charlie Norwood VA Medical Center Director ensures the development of policy addressing the appropriate method for confirming and documenting nasogastric tube placement prior to administration of medications or tube feeding, including actions that should be taken when a nasogastric tube is partially dislodged.

15. The Charlie Norwood VA Medical Center Director requires the Associate Director for Patient and Nursing Services to ensure that all registered nurses assigned to work in critical care units promptly complete assessments for the missing unit-specific competencies.

16. The Charlie Norwood VA Medical Center Director requires the Associate Director for Patient and Nursing Services to enhance processes to ensure that nursing competency skills assessments are specific to individual duty assignments and completed in accordance with Veterans Health Administration and facility policy.

17. The Charlie Norwood VA Medical Center Director ensures that critical care unit staffing decisions include contingencies for staff absences.

18: The Charlie Norwood VA Medical Center Director continues efforts to recruit and hire for critical care unit and emergency department nurse vacancies, and ensures that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

19. The Charlie Norwood VA Medical Center Director ensures that unexcused nursing absences are managed in accordance with relevant Human Resource guidelines.

20. The Charlie Norwood VA Medical Center Director ensures that the emergency department security system is upgraded to meet current security requirements and to provide a safe environment for patients and staff.

21. The Charlie Norwood VA Medical Center Director continues efforts to recruit and hire for critical laboratory staff vacancies, and ensure that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

22. The Charlie Norwood VA Medical Center Director ensures that before policy changes are made that impact the delivery of quality patient care, broad discussion with all key stakeholders takes place and written guidance is widely disseminated.

23. The Charlie Norwood VA Medical Center Director ensures that policies and procedures regarding the appropriate transfer of critically ill patients are developed in conjunction with key stakeholders and that the process is widely disseminated to relevant staff.

24. The Charlie Norwood VA Medical Center Director ensures the Contracting Officer's Representative responsible for the technical administration of the transportation contract conducts surveillance of the contractor's performance and provides oversight of the contractual agreements.

25. The Charlie Norwood VA Medical Center Director ensures contingency plans are in place to rapidly mobilize staff when emergency department patients' care demands exceed the current staffing resources.

26. The Charlie Norwood VA Medical Center Director ensures there is a signed boarder policy which is widely disseminated.

27. The Veterans Integrated Service Network Director completes an assessment of the facility's ability to assure consistent availability of services and staffing to support providers' professional practice and the safe and timely delivery of care, and takes action as necessary.

# Appendix A: Case Summary—Patient Y

The patient was in their 80s with a medical history of advanced dementia, Parkinson's Disease, and hypertension. The patient was admitted to the facility's community living center for respite care (Day 1). Seven days after admission (Day 8) the patient was diagnosed with congestive heart failure. An echocardiogram completed the following day confirmed significant heart failure. Over the next several days, the patient's clinical condition remained stable including oxygenation levels with the use of supplemental oxygen.

On Day 14, the patient was transferred to the facility emergency department for treatment of low blood potassium. A chest x-ray obtained in the emergency department showed congestive heart failure and a possible left lobe pneumonia. The patient was admitted to a medical ward and started on antibiotics. A speech therapist evaluated the patient's swallowing function and recommended no liquids or solid foods by mouth and for oral medications to be crushed prior to administration. Four days later, a repeat chest x-ray indicated worsening congestive heart failure and increased fluid in the lungs. Despite the worsening chest x-ray, the patient's oxygen level remained within normal limits on supplemental nasal oxygen. A pulmonologist evaluated the patient on Day 28 and documented that in addition to congestive heart failure, the patient had aspiration pneumonia. The pulmonologist recommended suctioning to address the aspiration risk, and the patient was also started on antibiotic therapy.

The patient's condition remained unchanged for approximately 11 days when oxygen saturation levels decreased to 75 percent.[68] After multiple oral suctioning attempts by a nurse, the patient's oxygen saturation increased to 93 percent but lowered again to approximately 80 percent. Facility staff transferred the patient to the CCU for further monitoring. In the CCU, an NG was placed [*OIG inspectors could not identify from the EHR who placed the NG tube*] and a note signed at the early morning documented the need for the use of soft restraints to prevent the patient from removing the NG tube. An x-ray was completed and the radiologist recommended advancement of the NG tube by 15 centimeters. That afternoon, a repeat x-ray confirmed that the NG tube had been advanced.

The following day, a nurse verified orders to administer 20 milliliters of oral liquid potassium. Sometime after 9:30 a.m., the patient was given potassium and water via the NG tube. The patient experienced acute respiratory distress. Approximately one hour later, the Anesthesiology Service was summoned to the CCU to intubate the patient. The responding nurse anesthetist discovered that the NG tube was not in the correct position and removed it. The endotracheal

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[68] Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low. https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930. (The website was accessed on February 20, 2019.)

tube was inserted without difficulty. The patient was then connected to a ventilator. Abdominal and chest x-rays confirmed the presence of the endotracheal tube and a new NG tube.

The following day, a hospice care physician evaluated the patient and had a discussion with a family member, who requested that life support be withdrawn, and comfort care be initiated. The patient died 10 days later. In early 2019, the facility conducted an institutional disclosure to the patient's family.[69]

The facility subsequently provided OIG with additional information that was not documented in the EHR; specifically, that after the patient dislodged the original NG tube, a nurse partially reinserted the NG tube and did not confirm placement with an x-ray and did not document that the NG tube was repositioned.[70]

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[69] An institutional disclosure is a formal process by which facility leaders and clinicians inform the patient or the patient's family that an adverse event occurred during the patient's care that resulted in death or serious injury.

[70] During an interview with the OIG, the nurse stated that the NG was dislodged, and admitted to repositioning it. The nurse also told the OIG team that because the NG tube did not come completely out, correct placement of the NG tube was verified by pushing air through the tube and listening with a stethoscope for the sound of air entering the stomach. Because the NG tube had not come completely out, the nurse did not think it necessary to request an x-ray to verify correct placement.

# Appendix B: Glossary

**Aortic enteric fistula** is an abnormal, tube-like connection between two structures inside the body. When the connection is between the aorta and a loop of bowel that is near the aorta, it is known as an aortic enteric fistula (AEF).

https://www.cedars-sinai.edu/Patients/Health-Conditions/Aortoenteric-Fistula-AEF.aspx. (The website was accessed on March 5, 2019.)

**Aspiration** is to draw in or out using a suction. Aspiration can occur from breathing in a foreign object (or substance), or can be a medical procedure to remove something from an area of the body. These substances can be air, body fluids, or bone fragments. Aspiration as a medical procedure may also be used to remove tissue samples for a biopsy.

https://medlineplus.gov/ency/article/002216.htm. (The website was accessed on March 1, 2019.)

**Bi-PAP** (bilevel positive airway pressure) is a type of ventilator. It is a device that helps with breathing.

https://www.hopkinsmedicine.org/healthlibrary/test_procedures/neurological/bipap_135,314. (The website was accessed on January 30, 2019.)

**Bradycardia** is a slower than normal heart rate. The hearts of adults at rest usually beat between 60 and 100 times in a minute.

https://www.mayoclinic.org/diseases-conditions/bradycardia/symptoms-causes/syc-20355474. (The website was accessed on February 1, 2019.)

**Cardiac arrest** is the abrupt loss of heart function, breathing, and consciousness. The condition usually results from an electrical disturbance in the heart that disrupts its pumping action, stopping blood flow to the body.

https://www.mayoclinic.org/diseases-conditions/sudden-cardiac-arrest/symptoms-causes/syc-20350634. (The website was accessed on February 1, 2019.)

**Cardiac stents** support the walls of the artery to help prevent it from re-narrowing after an angioplasty. The stent looks like a tiny coil of wire mesh.

https://www.mayoclinic.org/tests-procedures/coronary-angioplasty/about/pac-20384761 (The website was accessed on June 18, 2018.)

**Chronic obstructive pulmonary disease** is a chronic inflammatory lung disease that causes obstructed airflow from the lungs.

https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679. (The website was accessed on February 1, 2019.)

**Cirrhosis** is a late stage of scarring of the liver caused by many forms of liver diseases and conditions**.**

https://www.mayoclinic.org/diseases-conditions/cirrhosis/symptoms-causes/syc-20351487. (The website was accessed on February 1, 2019.)

**Computed tomography (CT) scan** combines a series of x-ray images taken from different angles and uses computer processing to create cross-sectional images of the bones, blood vessels, and soft tissues inside the body.

https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675. (The website was accessed on June 18, 2018.)

**Congestive heart failure** occurs when the heart muscle does not pump blood as well as it should.

https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142. (The website was accessed on May 1, 2019.)

**Continuous renal replacement therapy (CRRT)** is any renal replacement therapy that is intended to be applied 24-hours-per-day in an intensive care unit.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1661614/. (The website was accessed on February 4, 2019.)

**Coronary artery disease** develops when the major blood vessels that supply the heart with blood, oxygen, and nutrients become damaged or diseased.

https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes/syc-20350613. (The website was accessed on February 4, 2019.)

**Craniotomy** is the surgical removal of part of the bone from the skull to expose the brain. The bone flap is temporarily removed, then replaced after the brain surgery has been done.

https://www.hopkinsmedicine.org/healthlibrary/test_procedures/neurological/craniotomy_92,P08767. (The website was accessed on February 4, 2019.)

**Duodenitis** is an inflammation in the first part of the small intestine.

https://www.mayoclinic.org/symptoms/vomiting-blood/basics/causes/sym-20050732. (The website was accessed on February 20, 2019.)

**Echocardiogram** uses sound waves to produce images of the heart, which allows the physician to see the heart beating and pumping blood.

https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856. (The website was accessed on February 19, 2019.)

**Electrocardiogram** (EKG) records the electrical signals in the heart. It is a common test to detect heart problems and monitor the heart's status in many situations.

https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983. (The website was accessed on June 18, 2018.)

**Endoscopy** is a procedure that involves inserting a long flexible tube down the throat and into the esophagus. A tiny camera on the end of the endoscope allows a physician to examine the esophagus, stomach, and beginning of the small intestine.

https://www.mayoclinic.org/tests-procedures/endoscopy/multimedia/endoscopy/img-20007299. (The website was accessed on February 4, 2019.)

**End-stage renal disease** occurs when the gradual loss of kidney function reaches an advanced state. Dialysis or a kidney transplant is needed to stay alive.

https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/symptoms-causes/syc-20354532. (The website was accessed on February 4, 2019.)

**Esophagectomy** is removal of part of the esophagus.

https://www.merriam-webster.com/medical/esophagectomy. (The website was accessed on February 4, 2019.)

**Esophageal perforation** is a hole in the esophagus.

https://medlineplus.gov/ency/article/000231.htm. (The website was accessed on February 25, 2019.)

**Fistula** is an abnormal passage that leads from an abscess or hollow organ or part to the body surface, or from one hollow organ or part to another, and that may be surgically created to permit passage of fluids of secretions.

https://www.merriam-webster.com/dictionary/fistula. (The website was accessed on February 4, 2019.)

**Full -time employee equivalent (FTE)** employees are those employees who worked, on average, 30 hours or more a week for than 120 days in a year, or the number of employees expected to work those hours.

https://www.healthcare.gov/shop-calculators-fte/. (The website was accessed on February 4, 2019.)

**Gastroenterology** is a branch of medicine that is concerned with the structure, functions, diseases, and pathology of the stomach and intestines.

https://www.merriam-webster.com/dictionary/gastroenterology. (The website was accessed on February 4, 2019.)

**Hemoglobin** is a protein that carries oxygen to the body's organs and tissues and transports carbon dioxide from the organs and tissues back to the lungs.

https://www.mayoclinic.org/tests-procedures/hemoglobin-test/about/pac-20385075. (The website was accessed on February 4, 2019.)

**Hemorrhage** is a copious or heavy discharge of blood from the blood vessels.

https://www.merriam-webster.com/dictionary/hemorrhage. (The website was accessed on February 20, 2019.)

**Hypotension** (low blood pressure) is a blood pressure reading lower than 90 millimeters of mercury for the top number (systolic) or 60 millimeters of mercury for the bottom number.

https://www.mayoclinic.org/diseases-conditions/low-blood-pressure/symptoms-causes/syc-20355465. (The website was accessed on February 4, 2019.)

**Implantable cardioverter-defibrillator** is a device placed in the chest to reduce the risk of dying if the lower chambers of the heart go into a dangerous rhythm and stop beating effectively (cardiac arrest).

https://www.mayoclinic.org/tests-procedures/implantable-cardioverter-defibrillators/about/pac-20384692. (The website was accessed on February 4, 2019.)

**Intracranial hemorrhage** is caused by bleeding from a ruptured blood vessel within the cranium. It occurs in the space between the brain and skull where the accumulation of blood may cause pressure on the brain.

https://www.merriam-webster.com/medical/intracranial%20hemorrhage. (The website was accessed on February 4, 2019.)

**Intubation** is the introduction of a tube into a hollow organ (such as the trachea).

https://www.merriam-webster.com/dictionary/intubation. (The website was accessed on February 20, 2019.)

**Mid-line shift** is an indicator of increased intracranial pressure due to mass effect (swelling).

https://radiopaedia.org/articles/midline-shift. (The website was accessed on March 13, 2019.)

**Myasthenia gravis** is characterized by weakness and rapid fatigue of any of the muscles under voluntary control. There is no cure, but treatment can help relieve signs and symptoms such as weakness of arm or leg muscles, double vision, difficulties with speech, chewing swallowing and breathing.

https://www.mayoclinic.org/diseases-conditions/myasthenia-gravis/symptoms-causes/syc-20352036. (The website was accessed on March 15, 2019.)

**Nasogastric tube** is the intubation of the stomach through the nasal passages. It is a way of delivering nutrition or medications directly to the stomach.

https://www.merriam-webster.com/dictionary/nasogastric. (The website was accessed on February 4, 2019.)
https://www.mayoclinic.org/tests-procedures/home-enteral-nutrition/about/pac-20384955. (The website was accessed on February 4, 2019.)

**Neurologic check** is an evaluation of a person's nervous system. Aspects of the exam include an assessment of motor and sensory skills, balance and coordination, mental status, reflexes, and functioning of the nerves.

https://www.hopkinsmedicine.org/healthlibrary/conditions/adult/nervous_system_disorders/neurological_exam_85,P00780. (The website was accessed on February 4, 2019.)

**Oxygen saturation** is a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry. Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low.

http://www.pulseox.info/pulseox/what2.htm.( The website was accessed on February 20, 2019.)

https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930. (The website was accessed on April 26, 2019.)

**Peripheral neuropathy** is a result of damage to the peripheral nerves, often causing weakness, numbness, and pain, usually in the hands and feet.

https://www.mayoclinic.org/diseases-conditions/peripheral-neuropathy/symptoms-causes/syc-20352061. (The website was accessed on February 4, 2019.)

**Peripheral vascular disease** is a circulatory problem in which narrowed arteries reduce blood flow to the limbs.

https://www.mayoclinic.org/diseases-conditions/peripheral-artery-disease/symptoms-causes/syc-20350557. (The website was accessed on February 4, 2019.)

**Pneumonia** is an infection that inflames the air sacs in one or both lungs. The air sacs may fill with fluid or pus (purulent material), causing cough with phlegm or pus, fever, chills, and difficulty breathing.

https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204. (The website was accessed on April 26, 2019.)

**Pseudoaneurysm** is a vascular abnormality (as an elongation or buckling of the aorta) that resembles an aneurysm in radiography.

https://www.merriam-webster.com/medical/pseudoaneurysm. (The website was accessed on February 14, 2019.)

**Pulseless electrical activity** occurs when there is a cardiac rhythm on the monitor that would normally be associated with a pulse. However, the patient is pulseless.

https://www.acls.net/acls-pulseless-arrest-algorithm-pea.htm. (The website was accessed on February 4, 2019.)

**Rapid Response Team** is a group of expert clinicians who provide additional care for patients who experience sudden changes in their condition. The goal of the team is to prevent avoidable patient progression to cardiopulmonary arrest.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4445360/. (The website was accessed on January 1, 2019.)

**Subarachnoid hemorrhage** is bleeding in the space between the brain and the surrounding membrane (subarachnoid space). The primary symptom is a sudden, severe headache.

https://www.mayoclinic.org/diseases-conditions/subarachnoid-hemorrhage/symptoms-causes/syc-20361009. (The website was accessed on February 4, 2019.)

**Subdural hematoma** is a collection of blood between the covering of the brain (dura) and the surface of the brain.

https://medlineplus.gov/ency/article/000713.htm. (The website was accessed on February 4, 2019.)

**Tachycardia** is a common type of heart rhythm disorder in which the heart beats faster than normal while at rest.

https://www.mayoclinic.org/diseases-conditions/tachycardia/symptoms-causes/syc-20355127. (The website was accessed on February 4, 2019.)

**Tagged red blood cell scan** is a nuclear scan using small amounts of radioactive material to mark (tag) red blood cells. The body is then scanned to see the cells and track how they move through the body.

https://www.ucsfhealth.org/tests/003835.html. (The website was accessed on February 4, 2019.)

**Thrombolytics** are drugs used to break up or dissolve blood clots, which are the main cause of both heart attacks and stroke.

https://medlineplus.gov/ency/article/007089.htm. (The website was accessed on March 13, 2019.)

**Thrombocytopenia** is a condition in which a person has a low blood platelet count. Platelets are colorless blood cells that help blood clot.

https://www.mayoclinic.org/diseases-conditions/thrombocytopenia/symptoms-causes/syc-20378293. (The website was accessed on February 4, 2019.)

**Vascular Surgery** encompasses the diagnosis and comprehensive disorders of the arteries, veins, and lymphatic systems.

https://vascular.org/about-svs/definition-vascular-surgery. (The website was accessed on January 1, 2019.)

# Appendix C: VISN Director Comments

**Department of Veterans Affairs Memorandum**

Date:  Date May 31, 2019

From:  Director, VA Southeast Network (10N7)

Subj:  Draft Report: Healthcare Inspection—Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia

To:    Director, Office of Healthcare Inspections Rapid Response Team (54RR)
       Director, GAO/OIG Accountability Liaison (GOAL) office (VHA 10EG GOAL Action)

1.  I have had the opportunity to review the Healthcare Inspection – Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta GA. The subjective writing of the Executive Summary is inconsistent with the document narrative and recommendations.

2.  VISN 7 submits concurrence to Network recommendations 1, 2 and 27 and the attached Charlie Norwood VA Medical Center submission.

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

4.  If you have any questions or require further information, please contact the VISN 7 Quality Management Officer at (678) 924-5700.

*(Original Signed by:)*

Leslie Wiggins
Director, VA Southeastern Network (VISN 7)

# Comments to OIG's Report

## Recommendation 1

The Veterans Integrated Service Network Director evaluates the quality and professionalism of Executive Leadership Team communications and takes action when indicated.

Concur.

Target date for completion: August 6, 2018

### Director Comments

Office of Inspector General (OIG) recognition of actions taken by the VISN7 Network Director are appreciated. Per request of the Network and Medical Center Director the National Center for Organizational Development (NCOD) completed an initial review on July 7 thru August 2, 2018. Evidence of a follow-up visit between February 25–March 15, 2019 by the NCOD in March 2019 indicated positive feedback and a strong leadership commitment to improving practices.

In addition, the Office of Accountability and Whistleblower Protection (OAWP) and OIG previously completed evaluations of the same claims and did not substantiate allegations. OAWP cautioned both the facility and VISN leadership that behavior would likely continue due to an employee historical concerns. It is important to note these allegations began prior to the current Director's arrival at the facility. OAWP Leadership personally provided this report and feedback to the Facility Director and Network Director due to the large and potential negative impact of the investigation.

### OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Veterans Integrated Service Network during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 2

The Veterans Integrated Service Network Director requires the development of, and follow-through on, corrective action plans responding to relevant findings from National Center for Organizational Development's 2018 site visits and reports.

Concur.

Target date for completion: March 18, 2019

## Director Comments

Office of Inspector General (OIG) recognition of actions taken and completed from the National Center for Organization Developments August 2018 review are appreciated. The CNVAMC Leadership Team had a written plan in partnership with NCOD. The March 18, 2019 NCOD comparison report demonstrates active improvement, actions taken and completed by the CNVAMC Leadership team to address relevant findings. One hundred percent of recommendations from the NCOD were completed and closed with ongoing support for employee engagement.

In addition, during the follow-up meeting in March 2019, NCOD representatives reported this is the first time the CNVAMC completed all agreed actions. The Comparison Report reflected significant improvement in all areas with the largest improvements seen in setting an organizational Vision, Goals, and Objectives communication plan.

### OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Veterans Integrated Service Network during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 27

The Veterans Integrated Service Network Director completes an assessment of the facility's ability to assure consistent availability of services and staffing to support providers' professional practice and the safe and timely delivery of care, and takes action as necessary.

Concur.

Target date for completion: February 14, 2019

## Director Comments

The Veterans Integrated Service Network Director completes a variety of ongoing assessments and follow-up modalities to ensure consistent operational services and staffing for the safe and timely delivery of care at CNVAMC. The Network Director personally completes, requests and appreciates assessments from National and Regional program subject matter experts.

On February 11-14, 2019 the Network Director completed an on-site visit to evaluate facility and program operations. In addition, Management Meetings are held between the ND, VISN Leadership, Medical Center Director and Facility Leadership no less than quarterly as an ongoing assessment of Vacancies, All Employee Survey, Budget, Construction Projects/ Activations, Enrollment, Logistics, Care in Community, Efficiency, Scheduling, Access, Health Equity, SAIL and Human Resource activity.

## OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Veterans Integrated Service Network during follow-up until evidence reflects that corrective actions were completed and effective.

# Appendix D: Facility Director Comments

**Department of Veterans Affairs Memorandum**

Date:  May 30, 2019

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

Subj:  Healthcare Inspection—Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia

To:    Director, VA Southeast Network (VISN 10N7)

1. In response to the VA Office of Inspector General (OIG) Healthcare Inspection of Leadership, Clinical and Administrative concerns, we concur with the recommendations.

2. If you have any questions or require further information, please contact Mary Harper, Chief, Quality Management at (706) 733-0188.

*(Original Signed by:)*

Robin Jackson, PhD
Interim Medical Center Director

# Comments to OIG's Report

## Recommendation 3

The Charlie Norwood VA Medical Center Director develops a process to ensure that Light Electronic Action Framework hiring requests are tracked and processed timely.

Concur.

Target date for completion: March 2018

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. In March of 2017, the Medical Center Director (MCD) chartered a system redesign of human resources recruitment processes lead by a certified black-belt employee.

As a result of the system redesign process, in October of 2017, the ELT implemented the Light Electronic Action Framework, (LEAF) that provided consistency and transparency of the hiring approval process. Training was provided for all Service Chiefs, Administrative Officers, and Section Chiefs who engage in hiring practices (April 4, 2018, April 10, 2018, April 17, 2018, April 19, 2018, April 24, 2018, May 2, 2018, and May 9, 2018). LEAF subject matter experts (SMEs) in Human Resources and Executive Assistants (EA) were identified and made available for any staff member who encountered challenges and requested assistance. Each member utilizing LEAF has the ability to run a report through the menu option in LEAF system to see the status of their recruitment action. In response to this recommendation additional training will be provided to all users of LEAF and each Pentad member's EA will be responsible for providing oversight and weekly review of all recruitment actions to identify delays and/or errors.

### OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Charlie Norwood VA Medical Center Director during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 4

The Charlie Norwood VA Medical Center Director reviews the facility's hiring processes to identify opportunities to improve the efficiency and timeliness of hiring actions, and take corrective action, as needed.

Concur.

Target date for completion: August 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. As of early 2018, Medical Support Assistants (MSA), Food and Nutrition and Environmental Management Services frontline workers were exempted from the MCRC process. As of February 2019, the Facility Director streamlined the resource hiring process to eliminate the need for Director approval for vice and expansion positions. Each Pentad member provided training and education to their respective Service Chiefs on their streamlined process to expedite hiring and the to improve the efficiency and timeliness of hiring actions. This was also widely communicated to all service chiefs during the morning Enterprise Huddle, and monthly Recognition Ceremony in February 2019. The Medical Center also established an Operational (March 1, 2019) and Organizational (May 1, 2019) Oversight Committee and Board to review hiring timeliness and overall effectiveness.  In response to this recommendation the facility will request an external review of the Human Resource process to identify and/or eliminate any redundant processes.

## Recommendation 5

The Charlie Norwood VA Medical Center Director ensures development and broad dissemination of a written critical care unit bed management policy that clearly states the process to be followed when an inpatient requires intensive care and a critical care unit bed is unavailable.

Concur.

Target date for completion: September 30, 2019.

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director has designated the ADPNS and COS to review and complete a critical care unit bed management policy clearly stating the process to follow when a bed is unavailable.

## Recommendation 6

The Charlie Norwood VA Medical Center Director ensures development and broad dissemination of a written policy regarding patient-owned medical devices and equipment that clearly outlines restrictions and acceptable uses when the patient is hospitalized.

Concur.

Target date for completion: September 30, 2019

## Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director will ensure the Chief of Staff and ADPNS develop a written policy on the use of patient-owned medical devises and equipment. The CNVAMC education department will conduct widespread training on the management of patient-owned medical devices and equipment that clearly outlines restrictions and acceptable uses when the patient is hospitalized.

## Recommendation 7

The Charlie Norwood VA Medical Center Director ensures development and broad dissemination of a standardized method for documenting and ensuring compliance with the internal hand-off communication policy.

Concur.

Target date for completion: September 30, 2019

## Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The facility has in place a policy and standardized method for the communication and handoff of patient i.e., Hand-Off Communication (SBAR), dated January 20, 2017. The Facility Director will ensure the CNVAMC education department conducts widespread training and broad dissemination of the policy and implement an appropriate approach to ensure compliance with our hand-off communication policy, Hand-off Communication (SBAR), dated January 20, 2017.

## Recommendation 8

The Charlie Norwood VA Medical Center Director ensures that neurosurgery privileges are amended to include only procedures which facility infrastructure can support.

Concur.

Target date for completion: June 30, 2019

## Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director directed the COS to review all neurosurgery privileges within the facility to ensure compliance with infrastructure capabilities and support. The Acting Chief of Staff revised the neurosurgery privileges template to reflect only the procedures the facility can support; approved by the credentialing and

privileging committee January 2019. The Chief of Staff and Medical Staff Office are actively amending the neurosurgeons' privileges and they will be presented to the credentialing and privileging committee meeting June 11, 2019 for approval.

## Recommendation 9

The Charlie Norwood VA Medical Center Director ensures that the subject nurse's failure related to the computed tomography (CT) event outlined is evaluated and administrative action is taken, as indicated.

Concur.

Target date for completion: July 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The above referenced incident occurred in January 2018. The OIG concluded no negative impact to the patient and the allegation was not substantiated. The facility will do a review of the incident and actions surrounding this event to evaluate if administrative actions are appropriate.

## Recommendation 10

The Charlie Norwood VA Medical Center Director enhances processes to document Strategic Analytics for Improvement and Learning related improvement actions.

Concur.

Target date for completion: July 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Medical Center Director stood up a facility SAIL team on July 2017 consisting of two Black-belt System Redesign Specialist, a Clinical Nurse Specialist and Senior Supervisory Health Systems Specialist. As of September 2017, SAIL processes, activities, action plans and progress reports are completed monthly, stored on the Morning Report Share-point. A monthly calendar is produced scheduling each topic for presentation by the identified SAIL Workgroup. Since Augusta 2016 SAIL updates are reported to the Quality Safety Value Committee of the Governance Structure on a quarterly basis. In January of 2019 the Executive Leadership Team in conjunction with the Strategic Operations Committee held a one-week stand-down providing training and education to all interested Service Chiefs and staff on SAIL processes, approaches to interrupting data and how their individual Services/Departments feed into the SAIL Metrics. The Medical Center published the

Augusta Forward Concept of Operations plan and provided training for all leaders to include Service Chiefs with the requirement for cascading down to their staff. This document established the facilities approach to SAIL, individual Service connection to SAIL metrics and the pathway for progress. In response to this recommendation the SAIL metrics have been incorporated into the governance structure as reporting body for enhanced continuity.

## Recommendation 11

The Charlie Norwood VA Medical Center Director continues efforts to improve patient and employee satisfaction.

Concur.

Target date for completion: January 7, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Medical Center Director established the position of the Veterans and Employee Engagement Officer in May 2018. This position worked in conjunction with leadership in 2018 to implement numerous Veteran and Employee Engagement activities to include, picnics, educations sessions, Employee of the Month, Inspire Veterans Recognition Program, focus groups, quarterly town halls, Daily Management System (DMS). In January 2019 the Executive Leadership Team launched the Augusta Forward initiative that provides for a facility wide stand-down each month that focuses on employee engagement activities, questions for the Director sessions, review of that quarter's performance and strategic planning for the upcoming quarter. The facility implemented the Augusta Forward process that includes enhanced actions for engagement with patients and employees targeting improvements in Veteran and employee satisfaction. The Medical Center Director engaged with NCOD in July of 2018 to partner with the Leadership team on employee engagement strategies and team-building with the newly established ELT. The Medical Center has an ongoing relationship with NCOD to continue working on Employee Engagement and Veteran Satisfaction.

### OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Charlie Norwood VA Medical Center Director during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 12

The Charlie Norwood VA Medical Center Director ensures prompt evaluation of sentinel events, to include root cause analyses, in accordance with Veterans Health Administration requirements.

Concur.

Target date for completion: June 30, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director has charged the Chief of Quality Management and COS with the development and implementation of an enhanced sentinel event process that allows for the immediate review and determination of actions with appropriate monitoring and follow-up to completion. The facility reviews all Joint Patient Safety Reports, as mentioned in the report, and provides trended reports of events in the Quality, Safety, Value and Innovation Council as well as Pentad briefings on a monthly basis. The quality management staff, to include patient safety, risk management and VASQIP nurse, immediately contacts leadership of any serious or sentinel events and conducts root cause analyses (RCA) within the required timelines. The facility takes any immediate actions needed to prevent further harm or injury. Monthly briefs are provided on status of RCA actions. For events scored less than a SAC 3 but deemed to need a more thorough review, an in-depth focus review is conducted. Quality management is near completion of an enhanced process to rapidly review events from a multiple of sources with a multidisciplinary team approach to review events within 24 hours of the next duty day.

## Recommendation 13

The Charlie Norwood VA Medical Center Director evaluates the documentation failures related to Patient Y, and takes appropriate action, as indicated.

Concur.

Target date for completion: December 31, 2018

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. In October 2018, the Nurse Manager of the ICU abruptly resigned. An Acting Nurse Manager was identified and immediately recognized an absence of documentation of current competency in the ICU. In November 2018, the Acting Nurse Manager administered an ICU knowledge assessment to all RNs to identify trends in knowledge and skill deficits. In December 2018 she was actively working with medical education to identify online resources for education of the staff and determine hands-on skills

assessment to be completed. The total number of trainings were divided into a five-month schedule to provide the staff with sufficient time to complete all training. Concurrent hands-on skills assessment was provided to each nurse as they completed their education portion.

The Associate Chief Nurse of Medicine Services and Acting Nurse Manager immediately conducted a management review of the care provided and determined the RNs involved did not the standard of practice nor document care provided appropriately. The RN who did not follow the standard of practice received a counseling from the nurse manager and remedial education on the correct practice for care of a patient with a nasogastric tube. The second RN involved resigned prior to completion of the management action.

### OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Charlie Norwood VA Medical Center Director during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 14

The Charlie Norwood VA Medical Center Director ensures the development of policy addressing the appropriate method for confirming and documenting nasogastric tube placement prior to administration of medications or tube feedings, including actions that should be taken when a nasogastric tube is partially dislodged.

Concur.

Target date for completion: July 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director will enlist a multidisciplinary team to complete a guideline for the care of patients with a nasogastric tube and have staff complete a competency. The Acting NM in the ICU has identified and provided standardized training with competency skill check-offs to the ICU RNs.

## Recommendation 15

The Charlie Norwood VA Medical Center Director requires the Associate Director for Patient and Nursing Services to ensure that all registered nurses assigned to work in critical care units promptly complete assessments for the missing unit-specific competencies.

Concur.

Target date for completion: June 30, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. In October 2018, the Nurse Manager of the ICU abruptly resigned. An Acting Nurse Manager was identified and immediately recognized an absence of documentation of current competency in the ICU. In November 2018, the Acting Nurse Manager administered an ICU knowledge assessment to all RNs to identify trends in knowledge and skill deficits. In December 2018 she was actively working with medical education to identify online resources for education of the staff and determine hands-on skills assessment to be completed. The total number of trainings were divided into a five-month schedule to provide the staff with sufficient time to complete all training. Concurrent hands-on skills assessment was provided to each nurse as they completed their education portion. As of May 31, 2019, training and skill competency was completed for all learning and competency needs identified in the nursing competency assessment. Two ICU RNs who did not complete the skills check-off are pending management action.

## Recommendation 16

The Charlie Norwood VA Medical Center Director requires the Associate Director for Patient and Nursing Services to enhance processes to ensure that nursing competency skills assessments are specific to individual duty assignments and completed in accordance with Veterans Health Administration and facility policy.

Concur.

Target date for completion: July 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. In October 2018 the ADPNS instructed the Acting Chief of Medical Center Education to conduct a competency review with all nurse managers to determine and standardize competencies required across Nursing Services. The comprehensive competency review was completed in December 2018. The competency review identified standardized competencies to be completed in new nurse orientation and unit specific competencies to be developed in collaboration with Medical Center Education. In January 2019 the ADPNS developed standardized training for all nurse managers and chief nurses; an education plan has been developed with Associate Chief Nurse input. Revision of our competency program is ongoing with an estimated completion date of July 31, 2019.

## Recommendation 17

The Charlie Norwood VA Medical Center Director ensures that critical care unit staffing decisions include contingencies for staff absences.

Concur.

Target date for completion: October 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director will require the ADPNS and Nursing Services to identify the appropriate number of intermittent ICU [intensive care unit] and ED [emergency department] RNs required to meet the average vacancy needs of the facility and initiate recruitment by July 15, 2019 with a target onboarding date of October 2019.

## Recommendation 18

The Charlie Norwood VA Medical Center Director continues efforts to recruit and hire for critical care unit and emergency department nurse vacancies, and ensure that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

Concur.

Target date for completion: August 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. While the CCU staff populate both the CCU and Step-Down beds, staffing requirements are different for the 11 CCU and 9 Step-down (SD) beds. All staff are trained to work either part of the unit. Currently there are 5 ICU RN vacancies and 3.5 Step-down RN vacancies, all of which have occurred since March 2019. Active recruitment is ongoing and the ADPNS has been directed to identify the appropriate number of intermittent ICU and ED RNs required. The average daily census has not exceeded 16 for the past 12 months. NHPPD across ICU and Step-down is currently 16. This exceeds Step-down targets by 5 hours providing 35 additional nursing hours per day and exceeds ICU targets by one hour per day providing seven additional hours per day allowing for a surge of three ICU patients.

In June 2018, the ED Nursing Service received a new organizational chart approving 12 additional staff to include four RNs. In September of 2018, the ED Nurse Manager selected seven ED Nurses, meeting all of the total RN vacancies. Authorized entry on duty (EOD) dates were established as February, March and April of 2019. In February of 2019, the ED Nurse Manager learned of a potential loss of four nurses in the months of April and May due to various

reasons (transfers with spouse, education, etc.) These vacancies did not occur, and new staff have arrived. The current vacancy of RNs is 2 FTE. Of the two, one is selected and will onboard 6/9/19. The second is a May 2019 vacancy that has been authorized to recruit.

In response to the above recommendation the facility will continue to recruit and the ADPNS has been directed to identify the intermittent staffing required to meet the average vacancy needs of the ICU and ED.

# Recommendation 19

The Charlie Norwood VA Medical Center Director ensures that unexcused nursing absences are managed in accordance with relevant Human Resource guidelines.

Concur.

Target date for completion: July 1, 2019

## Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director will require the ADPNS and Nursing Services to ensure appropriate administrative actions are taken to address unexcused absences in accordance with relevant Human Resources guidelines.

# Recommendation 20

The Charlie Norwood VA Medical Center Director ensures that the emergency department security system is upgraded to meet current security requirements and to provide a safe environment for patients and staff.

Concur.

Target date for completion: May 17, 2019

## Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director ensured an interim security system for the Emergency Department was installed to include the ability of the external doors to be locked remotely by ED staff (May 2019). The VA Police also make frequent rounds through the ED and the VA Police Offices are located proximate to the ED. The ED is monitored by the VA Police on the VA Security System cameras. The computers in the ED are equipped to activate the silent duress alarm. Additionally, the VA Police conduct drills with the staff in the ED. A comprehensive security system has been approved and under procurement that will provide a long-term permanent solution.

### *OIG Comments*

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Charlie Norwood VA Medical Center Director during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 21

The Charlie Norwood VA Medical Center Director continues efforts to recruit and hire for critical laboratory staff vacancies, and ensure that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

Concur.

Target date for completion: September 30, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. As of May 2017, the former Chief of Pathology met with the interim Facility Director to discuss staffing challenges. Three stand downs were held to include the ELT, Human Resources, and Laboratory and Pathology leadership to implement a recruitment strategy for hiring laboratory technicians. Recruitment actions for staffing were achieved but the facility had a rapid turnover soon erased the gains made. In January 2018 the Facility Director asked the Chief of Laboratory and Pathology to develop a plan of what was needed to ensure 24/7 operations. The ELT approved 100% authorization of staffing in line with the Chief's proposal. The Chief of Laboratory and Pathology reported continued frustration with HR and hiring. The Facility Director directed a bi-weekly sit-down with the Pentad, Laboratory and Pathology and HR to review hiring actions starting in August 2018. Gains and losses were experienced; however, consistent services were provided until December 2018 when the Chief of Laboratory and Pathology verbalized shortages in covering the night time shift on the weekends, due to the departure of night shift employees and unavailability of part-time staffing. The clinical leadership decided to extend point of care testing by the ED and ICU staff to enable the existing laboratory staff to focus on critical testing.

The Facility Director has directed the COS to develop and implement a plan to fully staff the laboratory department and ensure optimal staffing is attained and alternate methods are consistently available to meet patient care needs.

## Recommendation 22

The Charlie Norwood VA Medical Center Director ensures that before policy changes are made that impact the delivery of quality patient care, there is broad discussion with all key stakeholders and written guidance is widely disseminated.

Concur.

Target date for completion: May 28, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director will engage with stakeholder as appropriate in the determination of programmatic and policy changes that may impact their operations. It is recognized that immediate and emergent decisions will be made to ensure that safe and effective care is delivered within the CNVAMC.

### OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Charlie Norwood VA Medical Center Director during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 23

The Charlie Norwood VA Medical Center Director ensures that policies and procedures regarding the appropriate transfer of critically ill patients are developed in conjunction with key stakeholders and that the process is widely disseminated to relevant staff.

Concur.

Target date for completion: August 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director has directed the Chief of Staff, ADPNS and the Assistant Director to work in partnership with the academic affiliate to develop and implement a safe and effective process for the transfer of critically ill patients across the shared bridge as appropriate. The process will be established in a Memorandum of Understanding (MOU) between both medical facilities outlining the responsibilities of all stakeholders.

## Recommendation 24

The Charlie Norwood VA Medical Center Director ensures the Contracting Officer's Representative responsible for the technical administration of the transportation contract conducts surveillance of the contractor's performance and provides oversight of the contractual agreements.

Concur.

Target date for completion: June 1, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director will reassign COR oversight and responsibilities for the ambulance contract from primary care to the Chief of Hospital Administrative Services (HAS). The Chief of HAS is to implement processes to ensure transportation contractor's performance is in compliance with the contractual agreements.

### OIG Comments

Deficient conditions existed at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Charlie Norwood VA Medical Center Director during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 25

The Charlie Norwood VA Medical Center Director ensures contingency plans are in place to rapidly mobilize staff when emergency department patients' care demands exceed the current staffing resources.

Concur.

Target date for completion: August 31, 2019

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The Facility Director directed the Chief of Staff and ADPNS to review our current emergency department response plan to meet the surge demand to include the use of community partnerships, care in the community and other methods to provide safe, consistent care.

## Recommendation 26

The Charlie Norwood VA Medical Center Director ensures there is a signed boarder policy which is broadly disseminated.

Concur.

Target date for completion: November 30, 2015

### Director Comments

The Office of Inspector General (OIG) recognition of actions taken by the CNVAMC Director and executive leadership team are appreciated. The facility has an MCP, 03-15-28 Plan for Patients Placed in Temporary or Overflow Bed Locations, dated 11/30/2015 that is current and in effect. Policies are available on the facility internet and in a searchable PDF format. An updated policy is in development and will be signed upon completion. The Chief, Medical Center Education will be directed to ensure wide dissemination to appropriate staff and stakeholders.

### OIG Comments

The facility's 2015 boarder policy did not include the necessary elements as required by Veterans Health Administration 1101.05. The 2018 draft policy, that did include the necessary elements, was unsigned and staff were unaware of its content at the time of the OIG team's site visits in November and December 2018. The OIG considers this recommendation open and will review documentation submitted by the Charlie Norwood VA Medical Center Director during follow-up until evidence reflects that corrective actions were completed and effective.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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