



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in COVID-19
Screening and Facility
Response for a Patient Who
Died at the Michael E.
DeBakey VA Medical Center
in Houston, Texas



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to the screening for [COVID-19](#) and subsequent treatment of a patient with serious mental illness who presented for same-day care at the Michael E. DeBakey VA Medical Center (facility) in Houston, Texas.¹ During the course of the inspection, the OIG identified additional concerns related to the facility's deficiencies in educating Mental Health Intensive Case Management (MHICM) patients and families on COVID-19 screening processes, noncompliance with the facility's missing patient policy, and facility leaders' failures related to [adverse events](#) reporting and [institutional disclosure](#). Aside from serious quality of care issues, this inspection also involves a vulnerable patient disappearing for four days after being put in the care of the facility. The patient's family contacted the facility and informed them that the patient was missing, but the facility was not able to locate the patient. The patient was ultimately found off-site four days later in the midst of a medical emergency, taken to the facility for care, and passed away the following day.

Synopsis of Events²

The patient, who was in their late 60s, had a medical history of [congestive heart failure](#), chronic schizophrenia, and recent diagnosis of [prostate cancer](#).³ During interviews, and in the patient's electronic health record (EHR), physicians and a nurse described the patient as having cognitive and communication impairments.

On a morning in mid-summer 2020 (day 1), the patient presented with a family member to the facility for a complaint of low back pain. The patient reported to the Emergency Department triage area and was directed to the main entrance screening area to undergo COVID-19 screening. The family member wanted to accompany the patient given the patient's chronic schizophrenia, but told the OIG that they were not allowed to because of COVID-19 restrictions.

A triage nurse at the main entrance screening area met with the patient, performed the screening (except for the temperature screen), and arranged a primary care walk-in clinic appointment. The

¹ World Health Organization, *WHO Director-General's Opening Remarks at the Media Briefing on COVID-19, 11 March 2020*, accessed November 4, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. VHA Public Health, *Novel Coronavirus Disease (COVID-19)*, accessed on August 5, 2020, <https://www.publichealth.va.gov/n-coronavirus/index.asp>. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

² The synopsis of events was compiled from the OIG's analysis and review of the patient's EHR, facility security video, the facility VA Police reports, and interviews with staff and the patient's family.

³ The OIG uses the singular form of they (their) in this instance for patient privacy.

triage nurse and a triage physician documented in the EHR that the patient's COVID-19 screening was negative. The patient then walked unescorted to the primary care clinic.

A primary care nurse took the patient's vital signs, which showed a fever with a temperature of 102.8 degrees Fahrenheit, fast breathing, low [oxygenation](#), and a pain level of 7 out of 10. The covering primary care physician acknowledged not evaluating the patient, and primary care staff contacted the triage physician regarding further evaluation of the patient.

The triage physician escorted the patient back to the main entrance screening area and documented that the patient's temperature was not checked in the main entrance screening area due to a miscommunication. The triage physician ordered a COVID-19 test for the patient, a transport staff member took the patient by wheelchair to the outpatient drive-through testing area, and the patient underwent COVID-19 testing. During early July, a [rapid COVID-19 test](#) was only available in the Emergency Department for patients presenting with COVID-19 symptoms. Outpatient tests (including tests from the drive-through area), if positive, were sent to the Palo Alto VA Medical Center in California, for verification and had a turnaround time of several days.⁴

A facility staff member then escorted the patient to the parking lot by the Emergency Department. The patient did not return into the facility and was alone on the facility's main drive at the bus stop for approximately an hour until a city bus pulled in and blocked the view of the security video. When the bus pulled away, the patient was no longer visible on security video.

On day 2, and again on day 4, the patient's family member came to the facility to search for the patient, stating that the patient had not returned home and was missing. Facility staff made overhead pages for the patient and searched for the patient, but the patient was not located within the main building or on the facility grounds.

On day 5, the patient suffered a witnessed [cardiac arrest](#) at a city bus stop, approximately two miles from the facility, and was brought to the facility's Emergency Department for further care. The result of a second COVID-19 laboratory test, administered in the Emergency Department, was positive. The patient was admitted to the medical intensive care unit for continued care of cardiac arrest, kidney failure, and COVID-19, but the patient died on day 6.

OIG Findings

The OIG found the facility had a visitor's policy that allowed visitors to accompany patients who had mental illness and impaired communication skills. Although the patient's family member

⁴ Facility's Department of Pathology and Laboratory Services, and Microbiology, Molecular, and Immunology Department, Standard Operating Procedure, *ID NOW COVID-19 Procedure*, April 30, 2020. Facility Standard Operating Procedure, *Xpert Xpress SARS-Cov-2 Test*, March 30, 2020. The ordering triage physician did not receive the positive results of the patient's day 1 COVID-19 test until day 6.

told the OIG that the facility's Emergency Department staff said visitors were not allowed, the OIG was unable to confirm this because the identity of the screening staff member was unknown. The family member further indicated thinking that "they [facility staff] have [the patient's] record" and did not need to inform staff that the patient had communication needs.

The OIG substantiated that facility staff did not completely screen the patient for COVID-19 initially. Screening staff did not ensure the patient's temperature was taken before allowing the patient to enter the facility. In June 2020, the facility's COVID-19 Operational Plan and triage screening process required that a patient complete several steps, including temperature screening, as part of COVID-19 screening within the main entrance screening area, before entering the facility.⁵

After primary care clinic staff notified triage staff that a patient had arrived at the clinic with a temperature of 102.8 degrees Fahrenheit, a triage physician documented that the patient's temperature was not taken at the temperature check point due to a miscommunication between the triage nurse and the triage physician.

The OIG substantiated that facility staff failed to medically manage the patient who exhibited COVID-19 symptoms. Specifically, a covering primary care physician did not ensure the patient, who had COVID-19 symptoms, was isolated in an exam room while waiting for further medical examination and disposition. The triage physician sent the patient to the drive-through COVID-19 testing area without further medical evaluation, did not complete a plan of care for post-screening/testing follow-up, and did not follow facility policy for intrafacility transport of patients suspected to have COVID-19.⁶ Additionally, the OIG found that the primary care nurse failed to document the patient's [episode of care](#) and determine if the patient required transfer to a higher level of care.⁷

VISN 16 guidelines require staff to isolate a patient with COVID-19 symptoms in an exam room, to consult with Infection Prevention and Control, and to determine the patient's disposition, including a transfer to the Emergency Department, admission to the hospital, or discharge home.⁸ The Operational Plan noted that "clinically unstable patients needing Emergency or Acute Care...should be referred to the Emergency Department." The Operational Plan also required

⁵ Facility Standard Operating Procedure, *COVID-19 Operational Plan*, June 15, 2020. A similar screening process is applied to visitors, staff, and contractors entering the facility. The OIG review examined only the screening of patients requiring entry into the facility for care.

⁶ The patient's assigned primary care physician was not on duty on day 1, and a *covering* physician decided to send the patient back to the triage area. VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*, March 6, 2020. For the purposes of this report, a patient suspected to have COVID-19 is a patient who exhibits symptoms of COVID-19 or answered yes to any of the COVID-19 screening questions.

⁷ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. Facility Standard Operating Procedure, *COVID-19 Operational Plan*. VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*.

⁸ VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*.

that a primary care nurse who encounters a patient suspected to have COVID-19 to “efficiently triage the patient by taking vital signs to determine if the patient can be escorted to Prime Care [Primary Care] or require a higher level of care and be escorted to the Emergency Department.”⁹

During interviews with the OIG, staff physicians, including the Acting Chief of Staff, the patient’s primary care physician, and infection control clinicians, asserted that given the patient’s vital signs and medical history, each would have transferred the patient to the Emergency Department for further evaluation. During an OIG interview, the covering primary care physician stated, “we are not supposed to be seeing patients who have a positive COVID-19 screen or fever in the [primary care] clinic.” The triage physician stated in an interview that actions taken were in response to the [pandemic](#), a high sense of urgency to rule out a COVID-19 diagnosis, and a concern that the patient was in the building. The triage physician also stated that patients suspected to have COVID-19 were not intended to enter the facility. Conversely, clinical leaders told the OIG that if a patient is [febrile](#) and has symptoms consistent with COVID-19, a provider should conduct further assessment and evaluation.

The OIG concluded that the failure to fully screen, isolate, and evaluate the patient resulted in potential COVID-19 exposure to facility staff, patients, and the general public when the patient moved unescorted through the facility grounds.

The OIG did not substantiate facility staff withheld patient information from a family member who held a [durable power of attorney](#). The OIG found that the triage nurse did not provide patient information to the family member because the name provided did not match EHR documentation of [next-of-kin](#).¹⁰ The OIG also found the patient did not designate the family member as a durable power of attorney for health care. In addition, there were several contradictory entries in the EHR related to the designation of the family member as the patient’s [surrogate](#), and the OIG determined that the MHICM team failed to address these discrepancies.

VHA requires that EHR entries are accurate and facilitate communication and continuity of patient care.¹¹ VHA also requires MHICM staff to serve as the “fixed point of clinical responsibility” for each patient in the program, coordinating all VHA care for MHICM-enrolled patients.¹² The OIG learned that MHICM staff and the patient’s psychiatrist erroneously believed, due to name discrepancies, that the patient had two involved family members rather than the one individual who was involved in the patient’s healthcare decisions.

⁹ Facility Standard Operating Procedure, *COVID-19 Operational Plan*.

¹⁰ For the purposes of this report, the referenced family member was one individual. The OIG learned that the patient’s family member, who sought information about the care the patient received on day 1, commonly used a middle name instead of the first name, which most likely led to facility staff’s confusion regarding if there were one or two family members involved with the patient’s healthcare decisions.

¹¹ VHA Handbook 1907.01.

¹² VHA Handbook 1163.06, *Intensive Community Mental Health Recovery Services*, January 7, 2016.

The patient's EHR also indicated that during three episodes of care, prior to the events discussed in this report, the patient may have needed assistance in making healthcare decisions. MHICM staff failed to coordinate the patient's medical care by not addressing inaccurate information in the patient's EHR regarding the family member's identity and role, and the patient's ability to make independent healthcare decisions.¹³

The OIG determined that MHICM staff failed to provide necessary care coordination that could have assisted the family when seeking medical care for the patient on day 1, when the patient or the family member did not receive education on the facility's COVID-19 screening policy and procedures.¹⁴ Additionally, when interviewed by the OIG, MHICM case managers could not verbalize the facility's COVID-19 screening and visitor policies.

The OIG determined that facility staff failed to identify the patient as an at-risk missing patient and failed to follow VHA and facility missing patient policies. The OIG further determined that facility staff did not report that a patient was missing to the patient safety manager as required per VHA and facility policies on the reporting of adverse events.¹⁵

The OIG determined that on days 2 and 4, facility clinical staff failed to assess the severity of the patient's medical condition and identify the patient as at-risk and missing when the family member came to the facility to search for the patient. The OIG determined that the Deputy Associate Director for Patient Care Services failed to act when notified of the missing patient on day 4.

VA Police did not follow the facility's policy for conducting a missing patient search. Specifically, VA Police failed to appoint a search coordinator responsible for notifying the patient's provider that the patient was missing.¹⁶ The VA Police officers stated that the clinical side of the facility was responsible for notifying the patient's primary care provider or the Chief of Staff of the missing patient. Additionally, the OIG determined that the failure by staff to report that the patient was missing as an adverse event or to alert a patient safety manager precluded a timely and comprehensive review of the event.

The OIG determined that facility leaders were aware of the patient's encounters with staff on day 1 and subsequent missing status on days 5 and 6; however, leaders failed to ensure a timely quality review of the patient's episode of care. The OIG further identified that facility leaders did not timely or accurately disclose to the patient's family the failures in the COVID-19 screening

¹³ VHA Handbook 1163.06.

¹⁴ VHA Handbook 1163.06.

¹⁵ Facility Policy, No. 00Q-018, *Management Plan for Wandering and At Risk Missing Patients*, January 12, 2018. Facility Policy, No. 00Q-004, *Patient Safety Improvement (PSI) Plan*, January 1, 2019. VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.

¹⁶ Facility Policy, No. 00Q-018.

process and subsequent medical mismanagement that led to the patient's adverse clinical outcome.

On July 6, the Acting Chief of Staff initiated an [issue brief](#) in response to the missing patient who had been found, admitted to the facility through the Emergency Department, and subsequently died.¹⁷ However, the issue brief, dated day 6, did not include critical details of the patient's episode of care on day 1, specifically the patient's clinical symptoms, COVID-19 screening details, and at-risk factors. Further, the OIG found that, despite facility leaders' awareness of the missing patient on day 6, facility employees had not notified the Patient Safety Manager until early the next month when the facility's Director of Quality discussed the issue brief and emailed the document to the Patient Safety Manager.

Although quality and administrative reviews of the missing patient's adverse event eventually took place, the OIG found that several facility leaders, including the Director of Quality, the Acting Chief of Staff, and the Facility Director, had the information from the day 6 issue brief and the ability to initiate reviews earlier. The OIG concluded that the Facility Director and Director of Quality failed to ensure completion of a [root cause analysis](#) within 45 calendar days of the facility leaders' first knowledge of the patient's adverse event.

VHA requires that clinicians disclose adverse events resulting in serious harm or death to the patient or patient's representative. An institutional disclosure is required when an adverse event results in death and "must be initiated as soon as reasonably possible and generally within 72 hours" after an adverse event.¹⁸ The OIG determined that the October 2 institutional disclosure, provided by the Deputy Chief of Staff to the patient's family, inaccurately noted that it appeared the patient was never tested for COVID-19 and "left the area on [the patient's] own without receiving a formal assessment for the fever." The OIG concluded that the family received a delayed institutional disclosure that omitted facts regarding the patient's care that may have influenced the family's perception of events.

The OIG made nine recommendations to the Facility Director related to COVID-19 screening, the visitor standard operating procedure for patients who require mental or behavioral health support during COVID-19 screening, identification of patients' surrogates, MHICM care coordination, missing and at-risk patients, adverse event reporting, issue briefs, root cause analyses, and institutional disclosures.

Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes C and D). The OIG will

¹⁷ The issue brief noted that a member of the patient's family tagged the facility in a day 5 social media post.

¹⁸ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

A handwritten signature in black ink that reads "John D. Daigh, Jr., M.D." The signature is written in a cursive style.

JOHN D. DAIGH, JR., M.D.
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Abbreviations

COVID-19	Coronavirus Disease 2019
EHR	electronic health record
MHICM	Mental Health Intensive Case Management
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations related to the screening for [COVID-19](#) and subsequent treatment of a patient with serious mental illness who presented for same-day care at the Michael E. DeBakey VA Medical Center (facility) in Houston, Texas.

Background

The facility, part of Veterans Integrated Service Network (VISN) 16, consists of a medical center in Houston, Texas, and 10 community-based outpatient clinics. The facility is classified by the Veterans Health Administration (VHA) as level 1a.¹ From October 1, 2018, through September 30, 2019, the facility served 117,051 unique patients and had a total of 538 operating beds, including 397 inpatient beds and 141 community living center beds.

VHA COVID-19 Response

On March 27, 2020, in response to the World Health Organization's declaration of a COVID-19 [pandemic](#), VHA announced the release of the COVID-19 Response Plan.² The Response Plan outlined screening procedures at VHA facilities, consistent with the Centers for Disease Control and Prevention guidelines, such as screening patients for COVID-19 related signs and symptoms, including a fever, before entering a treatment area.³

On April 8, 2020, the VHA Office of the Under Secretary for Health issued an operational memo requiring VHA facility directors to establish local procedures to ensure "the continuity of essential health care functions and services during an emergency."⁴

On June 15, 2020, the facility issued a COVID-19 Operational Plan (Operational Plan). The Operational Plan outlined the screening procedures for all patients, visitors, facility staff, and

¹ U.S. Department of Veterans Affairs, About the Michael E. DeBakey VA Medical Center - Houston, Texas, accessed November 25, 2020, <https://www.houston.va.gov/about/index.asp>, updated June 25, 2020. The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and complexity. Level 1a facilities are considered the most complex.

² World Health Organization, *WHO Director-General's Opening Remarks at the Media Briefing on COVID-19, 11 March 2020*, accessed November 4, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. VHA Public Health, *Novel Coronavirus Disease (COVID-19)*, accessed on August 5, 2020, <https://www.publichealth.va.gov/n-coronavirus/index.asp>.

³ VHA Office of Emergency Management, *COVID-19 Response Plan – Version 1.6, March 23, 2020*, accessed on August 5, 2020, <https://www.publichealth.va.gov/n-coronavirus/index.asp>. Centers for Disease Control and Prevention (CDC), *Screening and Triage at Intake*, accessed August 5, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis/screening.html>, updated April 14, 2020.

⁴ VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020. Executive in Charge, VHA Office of the Under Secretary for Health Memorandum, *Crisis Standards of Care in VHA during the COVID-19 Pandemic*, April 8, 2020.

contractors entering the facility. The Operational Plan required staff to ask COVID-19 screening questions of all patients, visitors, and staff entering the facility. The questions addressed symptoms of illness, such as fever, new or worsening cough, sore throat, shortness of breath, and flu-like symptoms; information related to recent travel in the past 14 days to domestic and international locations; and if the individual had, in the last 14 days, been in close contact with anyone with laboratory-confirmed COVID-19 while not wearing personal protective equipment.⁵

Further required screening included a temperature screening, and the use of hand sanitizer for all who entered the facility. If a person screened positive for symptoms of COVID-19, the Operational Plan outlined how to clinically manage the individual for further assessment. Additionally, the facility's procedures required that visitors were limited to situations where patients had physical or emotional needs and required assistance to receive care.⁶

In late June 2020, the city of Houston experienced an increase in the number of COVID-19 cases.⁷ The facility's Deputy Associate Director for Patient Care Services reported that facility staff screened approximately 600 patients per day in the first week of July 2020.

Serious Mental Illness

The National Institute of Mental Health defines serious mental illness as “a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.”⁸ Schizophrenia is a type of serious mental illness disorder with symptoms including hallucinations, such as hearing and seeing things that do not exist, and distorted beliefs about reality.⁹

Some individuals with schizophrenia have difficulty processing information such as following conversations and using newly learned information. Cognitive symptoms can also include memory impairments and difficulty making decisions.¹⁰ Patients with schizophrenia manage best in consistent environments with little changes to routines and learned processes.

⁵ Facility Standard Operating Procedure, *COVID-19 Operational Plan*, June 15, 2020. The Operational Plan was first developed on March 6, 2020, and updated as the response to the COVID-19 pandemic evolved.

⁶ Facility Standard Operating Procedure, *Standard Operating Procedure for Patient Visitors During COVID-19 Pandemic*, June 19, 2020.

⁷ National Public Radio, *Houston's COVID-19 Cases Level Off After Sudden Surge In Late June*, accessed December 15, 2020, <https://www.npr.org/2020/07/21/893880851/houstons-covid-19-cases-level-off-after-sudden-surge-in-late-june>, July 21, 2020.

⁸ National Institute of Mental Health, *Mental Illness*, accessed October 9, 2020, www.nimh.nih.gov/health/statistics/mental-illness.shtml, updated February 2019.

⁹ Mayo Clinic, *Schizophrenia, Symptoms and Causes*, accessed November 4, 2020, <https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443>, updated January 7, 2020. American Psychiatric Association, *What Is Schizophrenia?*, accessed November 4, 2020, <https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia>.

¹⁰ National Institute of Mental Health, *Schizophrenia*, accessed November 27, 2020, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>, updated May 2020.

The American Psychiatric Association asserts it is essential for families of patients with schizophrenia to be “informed and supported.”¹¹ Research has recognized the role of family in the lives of veterans with schizophrenia and found the majority of veterans want family to be involved in their treatment despite barriers (such as transportation and time constraints) and concerns about privacy and family burden.¹² Further research shows that family support influences how well the patient socially adapts, particularly for patients who have hallucinations, and that family support is a critical element in preventing relapse and adhering to treatment regimens.¹³

Mental Health Intensive Case Management

Mental Health Intensive Case Management (MHICM) is a part of VHA’s Intensive Community Mental Health Recovery Services. The goal is to provide community-based clinical case management services, and coordinate care between VHA and existing community services for veterans with serious mental illness, severe functional impairment, and who are high-utilizers of inpatient mental health care.¹⁴ VHA distinguishes case management for the MHICM program from traditional case management by the following characteristics:

- (1) A high staff-to-veteran ratio, with multiple visits per week as needed
- (2) Clinical case management provided by an interdisciplinary team where all members of the team are available to provide for the Veteran
- (3) Interventions occurring primarily in the community rather than in office settings
- (4) Availability maintained, around the clock when feasible, for [Intensive Community Mental Health Recovery Services] over a prolonged period as clinically indicated¹⁵

Allegations and Related Concerns

The OIG received three allegations between July 8 and July 10, 2020, regarding the facility screening procedures for COVID-19 and treatment of a patient who had a serious mental illness

¹¹ American Psychiatric Association, *What Is Schizophrenia?*

¹² Amy N. Cohen, Eric R. Pedersen, Shirley M. Glynn, Alison B. Hamilton, Kirk P. McNagny, Christopher Reist, Eran Chemerinski, and Alexander S. Young. “Preferences for Family Involvement among Veterans in Treatment for Schizophrenia,” accessed December 1, 2020. *Psychiatric Rehabilitation Journal*, 42, no. 3 (March 2019): 210–19. <https://doi.apa.org/doiLanding?doi=10.1037%2Fprj0000352>.

¹³ Wiwik Widiyawati, Ah Yusuf, Shrimarti Rukmini Devy and Dini Mei Widayanti. “Family Support and Adaptation Mechanisms of Adults Outpatients with Schizophrenia,” accessed December 1, 2020. *Journal of Public Health Research 2020*, vol. 9, 1848 (July 3, 2020). <https://doi.org/10.4081/jphr.2020.1848>.

¹⁴ VHA Handbook 1163.06, *Intensive Community Mental Health Recovery Services*, January 7, 2016.

¹⁵ VHA Handbook 1163.06.

and presented to the facility seeking care for lower back pain. The OIG reviewed the complaints, and on July 15, 2020, initiated a healthcare inspection.

The purpose of the inspection was to evaluate the following allegations:

1. Facility leaders did not have measures in place during COVID-19 screening to support patients with mental illness and impaired communication, including the subject patient (patient).¹⁶
2. Facility staff failed to properly screen the patient for COVID-19.
3. Facility staff failed to medically manage the patient with COVID-19 symptoms, mental illness, and impaired communication skills.
4. Facility staff did not provide the patient's information to a family member who had a [durable power of attorney](#) (DPOA).

The OIG identified and reviewed additional concerns:

5. Deficiencies in educating MHICM patients and family on COVID-19 screening processes
6. Noncompliance with the facility missing patient policy
7. Failure of leaders related to [adverse event](#) reporting and [institutional disclosure](#).

Scope and Methodology

The OIG initiated the inspection on July 15, 2020, and conducted a virtual site visit from September 9 through October 8, 2020. The OIG conducted the inspection virtually given the concerns with travel and the potential spread of COVID-19.¹⁷

The OIG team interviewed 37 individuals including complainants, members of the patient's family, facility leaders, and facility staff from quality management, patient safety, mental health, primary care, infection prevention, nursing, VA Police, and medical support administration. The team also participated in a virtual video tour of the facility's COVID-19 screening process.

The OIG team reviewed relevant VHA directives and handbooks, facility policies and procedures, including COVID-19 guidelines, external standards and guidelines, professional literature, the patient's electronic health record (EHR), administrative investigations and

¹⁶ For the purposes of this report, the OIG considered facility leaders to include senior level executives, service chiefs, and chief medical officers.

¹⁷ Centers for Disease Control and Prevention, *Travel During COVID-19*, accessed November 5, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>, updated October 21, 2020.

responses, staff emails, quality reviews, patient safety reports, VA Police reports, facility security video, and staffing lists.¹⁸

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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.

¹⁸ The OIG reviewed external standards and guidelines including the American Psychiatric Association, the Centers for Disease Control and Prevention, and the World Health Organization.

Summary of Events

The summary of events was compiled from the OIG's analysis and review of the patient's EHR, facility security video, the facility VA Police report, and interviews with staff and the patient's family. The patient, who was in their late 60s, had a medical history of [congestive heart failure](#), chronic schizophrenia, and recent diagnosis of [prostate cancer](#).¹⁹ During interviews with the OIG, two physicians described the patient as having cognitive impairments and communication problems. Further, EHR entries by physicians and an MHICM nurse noted intermittent auditory hallucinations, and impaired cognition and communication.

Mid-Summer 2020

In mid-summer 2020 (day 1), between 8:00 a.m. and 9:46 a.m., the patient presented with a family member to the facility for a complaint of low back pain. In interviews, a facility manager and the family member stated the patient reported to the facility's Emergency Department triage area and was directed to the main entrance screening area to undergo COVID-19 screening before visiting the primary care clinic.

9:46 a.m. A triage nurse at the main entrance screening area met with the patient and coordinated with the patient's primary care nurse to arrange a primary care walk-in clinic appointment.²⁰ The patient's regular primary care physician was not in clinic that day, but the patient was to be seen by a covering primary care physician.

10:08 a.m. The triage nurse communicated with the primary care nurse about a walk-in appointment for the patient.²¹

10:13 a.m. The triage nurse documented the patient answered "no" to the COVID-19 screening questions.

10:14–10:16 a.m. The triage nurse confirmed with the primary care nurse that the patient could be sent to the primary care walk-in appointment and requested a note be entered into the EHR stating such fact. The triage physician documented in the EHR the patient's negative COVID-19 screening.

10:18 a.m. Security video captured the patient entering the main entrance and crossing the lobby unaccompanied.

¹⁹ The OIG uses the singular form of they (their) in this instance for patient privacy.

²⁰ For the purposes of this report, *triage nurse* is used to describe the registered nurse and *triage physician* is used to describe the provider in the COVID-19 main screening area.

²¹ On day 2, the triage nurse entered documentation into the EHR that the patient answered no to the COVID-19 screening questions. This documentation was a screen shot of the Skype™ conversation between the triage nurse and primary care nurse that occurred on day 1.

10:19 a.m. The security video captured the patient in the hallway behind a lobby seating area, and a VA Police report stated the patient entered a clinic.

10:37 a.m. The primary care clinic clerk scheduled a primary care walk-in clinic appointment for the patient at this time, but the patient was not checked into the appointment.

10:47 a.m. The primary care nurse took the patient's vital signs, which showed a fever with a temperature of 102.8 degrees Fahrenheit, fast breathing, low [oxygenation](#), and a pain level of 7 out of 10.²²

Facility staff told the OIG team during interviews that the primary care nurse notified the triage nurse and the covering primary care physician about the patient's fever. In an interview, the covering primary care physician acknowledged not evaluating the patient but had spoken with the triage physician regarding further evaluation of the patient. The primary care nurse reported having spoken with the triage physician.

11:04 a.m. The triage physician entered an EHR note regarding a discussion with the patient who came to the facility with a complaint of low back pain. The triage physician documented there was a "miscommunication" [*sic*] and the patient entered the facility without having temperature checked in the main entrance screening area because the COVID-19 screening questions were all negative and a walk-in primary care clinic appointment had been scheduled for the patient. The triage physician documented the intent to order a COVID-19 drive-through test for the patient.

11:05 a.m. The triage physician ordered a COVID-19 [nasopharyngeal swab test \(nasal test\)](#) for the patient.

11:10–11:11 a.m. The triage physician entered the primary care clinic and escorted the patient back to the main entrance screening area for further evaluation per staff interviews and security video.

11:34–11:45 a.m. Facility transport staff transferred the patient by wheelchair to the outpatient COVID-19 testing area also known as the drive-through testing area. A facility clerk entered the patient's COVID-19 testing appointment at 11:45 a.m.

11:49 a.m. The patient checked in for the COVID-19 drive-through testing appointment at 11:49 a.m. and underwent COVID-19 testing.

12:20 p.m. The VA Police report detailed that an unidentified facility staff member escorted the patient via wheelchair back toward the front of the hospital.²³

²² The pulse oximeter read 93 percent oxygen on room air. Pallipedia, *Numeric rating scale (NRS)* (n.d.), accessed February 10, 2021, <https://pallipedia.org/numeric-rating-scale-nrs/>. A pain scale ranges from 0–10; zero reflects no pain, and 10 is the highest intensity of pain.

²³ The OIG was unable to identify this employee.

12:22 p.m. The VA Police report indicated that the unidentified facility staff member wheeled the patient to the Emergency Room Drive. Security video showed that the patient walked to the Main Drive and the VA Police report documented “It is believed [the patient] sits in a bench area in between the Emergency Room Drive and Main Drive.”

12:55 p.m. A clerk in the COVID-19 outpatient testing area completed an administrative check out of the patient following the drive-through testing appointment.

1:04 p.m. Per the VA Police report, the patient walked from a seat at the Main Drive and sat on a concrete planter facing the Emergency Department.

1:24 p.m. Security video showed that the patient left the Emergency Department area and sat directly in front of the hospital at the main bus stop. The patient sat at the bus stop until 2:14 p.m.

2:14 p.m. A city bus pulled into the bus stop, blocking the view of the security video. The bus left the bus stop at 2:16 p.m. The VA Police report documented the patient was no longer visible on security video after the bus pulled away from the bus stop. The VA Police were unable to find evidence of the patient on any other security video footage in the area of the bus stop for the next 30 minutes.

Day 2–Day 6

The VA Police report and interviews with the family member and facility staff indicated that on day 2, the patient’s family member returned to the facility to search for the patient, stating that the patient had not returned home and was missing. Facility staff made overhead pages for the patient and did not get a response. The VA Police suggested that the family member check the surrounding area hospitals and file a report with the local city police department.

Day 4

9:13 a.m. Information from the VA Police report and OIG team interviews indicated the patient’s family member returned to the facility, noting the patient had not returned home and was missing. The VA Police searched the main hospital building for the patient and reported to the family member that the patient was not located within the building or on the facility grounds.

Day 5

4:52 p.m. Local emergency medical service staff reported the patient suffered a witnessed [cardiac arrest](#) at a city bus stop according to the patient’s EHR.²⁴

²⁴ A report for the emergency transport of the patient indicated the location of the medical emergency was approximately two miles from the facility.

5:25 p.m. Emergency medical service staff brought the patient to the facility's Emergency Department for further care. Upon arrival in the Emergency Department, the patient sustained another cardiac arrest necessitating resuscitative efforts. [Cardiopulmonary resuscitation](#) was successful. The result of a second COVID-19 laboratory test, administered in the Emergency Department, was positive at 7:24 p.m. The patient was admitted to the medical intensive care unit for continued care of cardiac arrest, kidney failure, and COVID-19.

Day 6

7:08 a.m. The patient's medical status continued to deteriorate, and the family chose to prioritize the patient's comfort, requesting that the patient's status be changed to [do not resuscitate](#).

9:15 a.m. The patient died. No autopsy was performed.

3:29 p.m. The ordering triage physician received the patient's original outpatient laboratory test, from day 1, for COVID-19 that resulted as positive.²⁵ The triage physician forwarded the result to the patient's primary care physician at 4:43 p.m.

²⁵ Positive outpatient drive-through tests were sent to the Palo Alto VA Medical Center in California, for verification. Facility Standard Operating Procedure, *Xpert Xpress SARS-Cov-2 Test*, March 30, 2020. The ordering triage physician did not receive the positive results of the patient's day 1 COVID-19 test until day 6.

Inspection Results

1. Alleged Lack of Support During COVID-19 Screening for Patients with Mental Health and Impaired Communication Issues

The OIG did not substantiate that facility leaders failed to have a visitor policy in place during COVID-19 screening to support patients with mental health and impaired communication issues. However, the OIG was unable to determine if facility staff denied a family member the opportunity to accompany the patient who had mental illness and impaired communication skills when the patient presented to the facility for treatment and COVID-19 screening. The OIG found the facility had a visitor's policy, which allowed for visitors in limited circumstances, but the OIG could not identify the identity or credentials of the staff member, nor further learn of the reasons the family member may have been denied entry on day 1.

VHA COVID-19 policy permits visitors to enter a facility and accompany a patient if their assistance is required in the patient's care.²⁶ Additionally, facility policy allows one visitor per patient when the presence of the visitor gives the patient "physical or cognitive/emotional assistance" to attend outpatient appointments.²⁷ In June 2020, facility leaders modified the patient flow at entrances and the Emergency Department area due to COVID-19 precautions and screening.²⁸

The patient arrived at the Emergency Department on day 1 escorted by a family member for an evaluation of reported back pain. The patient's family member told the OIG that facility Emergency Department staff said the patient would be evaluated in primary care, not the Emergency Department, and visitors were not allowed. The family member told the OIG of not informing staff that the patient had communication needs because of an assumption "they [facility staff] have [the patient's] record." The family member told the OIG of remaining in the Emergency Department entrance area until the patient was taken by wheelchair to the main entrance screening area, and then the family member left the facility grounds.

The OIG team interviewed a complainant, family members, and an Emergency Department nurse manager, and reviewed the patient's EHR but could not determine who encountered the patient and the family member upon their arrival to the Emergency Department on day 1, or who instructed the family member regarding the visitor policy.²⁹ The OIG team also interviewed facility leaders and staff about the COVID-19 visitor policy and learned of different

²⁶ VHA Office of Emergency Management, *COVID-19 Response Plan Version 1.6*, March 23, 2020.

²⁷ Facility Standard Operating Procedure, *Standard Operating Procedure for Patient Visitors During COVID-19 Pandemic*.

²⁸ Facility Standard Operating Procedure, *COVID-19 Operational Plan*.

²⁹ Emergency Department security video footage was not available to assist in the analysis of events and participants.

understandings of who could approve a visitor to enter the facility and accompany a patient in need of support. Despite differing understandings of the visitor policy approval process, all those interviewed agreed that a visitor aiding a patient with a cognitive/emotional need should not be denied access to the facility.

The OIG concluded that a facility visitor policy was in place to support COVID-19 screening for patients requiring assistance. However, the OIG was unable to determine the identity of, or interview the facility employee who reportedly denied a family member the opportunity to accompany the patient on the medical visit. The OIG could not conclude that a facility employee had knowledge that the patient had mental illness and impaired communication skills and denied a family member the opportunity to accompany the patient.

2. Failure to Completely Screen the Patient for COVID-19

The OIG substantiated that facility staff did not completely screen the patient for COVID-19; specifically, screening staff did not ensure the patient's temperature was taken before allowing the patient to enter the facility.

In June 2020, the facility's Operational Plan and triage screening process required that a patient complete several steps as part of COVID-19 screening within the main entrance screening area before entering the facility:³⁰

1. A nurse verified a patient's appointment and asked COVID-19 screening questions.
2. If a patient answered yes to any of the questions, indicating possible exposure to or symptoms of COVID-19, a nurse directed the patient to a provider for further medical evaluation in the main entrance screening area.
3. If a patient answered no to all the screening questions, a nurse directed the patient to a screener located at the facility main entrance screening area to have their temperature taken:
 - a. A patient with a temperature under 99.5 degrees Fahrenheit could proceed into the facility.
 - b. A patient with a temperature over 99.5 degrees Fahrenheit is directed by staff to a medical provider in the main entrance screening area for further medical evaluation.³¹

On day 1, the patient presented at the COVID-19 main entrance screening area, answered no to the COVID-19 screening questions, and met with the triage physician who arranged a primary

³⁰ Facility Standard Operating Procedure, *COVID-19 Operational Plan*. A similar screening process applied to visitors, staff, and contractors entering the facility. The OIG examined only the screening of patients requiring entry into the facility for care.

³¹ Facility Standard Operating Procedure, *COVID-19 Operational Plan*.

care clinic appointment. The patient then walked unaccompanied to the primary care clinic. Upon arrival at the clinic, the primary care nurse documented that the patient's temperature was 102.8 degrees Fahrenheit.

After primary care clinic staff notified triage staff that a patient had arrived at the clinic with a temperature of 102.8 degrees Fahrenheit, the triage physician documented that the patient's temperature was not taken at the temperature check point due to a "miscommunication [*sic*]." The patient entered the facility without having the temperature checked in the main entrance screening area.

The OIG concluded that facility staff failed to take the patient's temperature as part of a COVID-19 screening due to miscommunication between the triage nurse and the triage physician.

3. Failure to Medically Manage a Patient with COVID-19 Symptoms

The OIG substantiated that facility staff failed to medically manage the patient who exhibited COVID-19 symptoms. Specifically, a covering primary care physician did not ensure the patient was isolated in an exam room while waiting for further medical examination and disposition.³² The triage physician sent the patient to the drive-through COVID-19 testing area without further medical evaluation, did not complete a plan of care for post-screening/testing follow-up, and did not follow facility policy for intrafacility transport of patients suspected to have COVID-19.³³ Additionally, the OIG found that the primary care nurse failed to document the patient's [episode of care](#) and determine if the patient required transfer to a higher level of care.³⁴

VISN 16 guidelines outline the triage and management of patients suspected to have COVID-19. The guidelines require staff to isolate a patient with COVID-19 symptoms in an exam room, to consult with Infection Prevention and Control, and to determine the patient's disposition, including a transfer to the Emergency Department, admission to the hospital, or discharge home.³⁵ The Operational Plan noted that "clinically unstable patients needing Emergency or Acute Care...should be referred to the Emergency Department."³⁶ Notably, during mid-summer 2020, a [rapid COVID-19 test](#) was only available in the Emergency Department for patients

³² VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*, March 6, 2020.

³³ The patient's assigned primary care physician was not on duty on day 1, and a covering physician decided to send the patient back to the triage area. For the purposes of this report, a patient suspected to have COVID-19 is a patient who exhibits symptoms of COVID-19 or answered yes to any of the COVID-19 screening questions. Facility Standard Operating Procedure, *Transport for COVID-19 Confirmed or PUI [Person Under Investigation] Patient*, April 8, 2020.

³⁴ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. Facility Standard Operating Procedure; COVID-19 Operational Plan; VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*.

³⁵ VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*.

³⁶ Facility Standard Operating Procedure, *COVID-19 Operational Plan*.

presenting with COVID-19 symptoms.³⁷ The Operational Plan also requires that a primary care nurse who encounters a patient suspected to have COVID-19 to “efficiently triage the patient by taking vital signs to determine if the patient can be escorted to Prime Care [Primary Care] or require a higher level of care and be escorted to the Emergency Department.”³⁸

Facility policy states that each time patient care is transferred to another provider, critical patient information must be communicated.³⁹ Documentation must occur at every episode of care to indicate the reason for the visit and include an assessment, clinical impression, or a plan of care.⁴⁰

Facility policy outlines protections for patients and staff during intrafacility transport of a patient confirmed to have or suspected of having COVID-19, including transport over the shortest distance to minimize contamination and exposure.⁴¹ The transport and receiving facility staff are required to conduct a face-to-face [hand-off communication](#) to include the patient’s diagnosis and current condition, recent changes, and anticipated changes in care.⁴² Policy also requires that transport and receiving staff document the hand-off communication in the EHR.⁴³

On day 1, the primary care nurse noted the patient was [febrile](#), and informed the covering primary care physician. Primary care staff called the triage physician to escort the patient back to the main entrance screening area. During interviews with the OIG, staff physicians, including the Acting Chief of Staff, the patient’s primary care physician, and infection control clinicians, asserted that given the patient’s vital signs and medical history, each would have transferred the patient to the Emergency Department for further evaluation. The OIG found that the covering primary care physician failed to properly medically manage the patient who had abnormal vital signs and physical complaints (body aches) indicating possible COVID-19 infection. Specifically, the covering primary care physician failed to⁴⁴

- medically evaluate the patient and address the abnormal vital signs documented by the primary care nurse, particularly the patient’s elevated temperature and low oxygenation,
- isolate the patient suspected to have COVID-19 in an exam room,

³⁷ Facility’s Department of Pathology and Laboratory Services, and Microbiology, *Molecular, and Immunology Department, Standard Operating Procedure, ID NOW COVID-19 Procedure*, April 30, 2020.

³⁸ Facility Standard Operating Procedure, *COVID-19 Operational Plan*.

³⁹ Facility Policy, No. 11-001, *Plan for the Provision and Continuity of Patient Care Services*, September 1, 2017.

⁴⁰ VHA Handbook 1907.01.

⁴¹ Facility Standard Operating Procedure, *Transport for COVID-19 Confirmed or PUI [Person Under Investigation] Patient*.

⁴² Facility Standard Operating Procedure, *Transport for COVID-19 Confirmed or PUI [Person Under Investigation] Patient*. Facility Policy, No. 11-001.

⁴³ VHA Handbook 1907.01; Facility Policy, No. 11-001.

⁴⁴ VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*.

- consult with an infection control clinician,
- transfer the patient, who presented with COVID-19 symptoms, to the Emergency Department with a transport team member, and⁴⁵
- document the episode of care and hand-off communication in the EHR.⁴⁶

The triage physician failed to

- follow facility policy on intrafacility transport of a patient suspected of having COVID-19,⁴⁷
- medically evaluate the patient and address the abnormal vital signs taken by the primary care nurse, particularly the patient's elevated temperature and low oxygenation,
- document a face-to-face hand-off communication with the receiving drive-through clinical staff regarding critical patient information,⁴⁸
- document the patient's care plan after completion of the COVID-19 drive-through testing, and⁴⁹
- provide the patient with follow-up instructions or directions including precautions for COVID-19.⁵⁰

The primary care nurse failed to

- document the patient's episode of care, and⁵¹
- determine if the patient required transfer to a higher level of care.⁵²

During an OIG interview, the covering primary care physician stated, "we are not supposed to be seeing patients who have a positive COVID-19 screen or fever in the [primary care] clinic." The triage physician stated in an interview that actions taken were in response to the pandemic, a high sense of urgency to rule out a COVID-19 diagnosis, and a concern that the patient was in the building. The triage physician also stated that patients suspected to have COVID-19 were not intended to enter the facility "which is why...[we] have that layer of protection...which would

⁴⁵ VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*; Facility Standard Operating Procedure, *Transport for COVID-19 Confirmed or PUI [Person Under Investigation] Patient*.

⁴⁶ VHA Handbook 1907.01. Facility Policy, No. 11-001.

⁴⁷ Facility Standard Operating Procedure, *Transport for COVID-19 Confirmed or PUI Patient*.

⁴⁸ Facility Standard Operating Procedure, *Transport for COVID-19 Confirmed or PUI Patient*. Facility Policy, No. 11-001.

⁴⁹ VHA Handbook 1907.01.

⁵⁰ VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*.

⁵¹ VHA Handbook 1907.01.

⁵² Facility Standard Operating Procedure, *COVID-19 Operational Plan*; VISN 16 Guidelines, *Triage and Management of Suspect COVID-19 Patients*.

be the triage tent [outside the main entrance screening area].” Conversely, clinical leaders told the OIG that if a patient is febrile and has symptoms consistent with COVID-19, a provider should conduct further assessment and evaluation. The OIG team learned from a facility infection prevention physician that because the patient was sent to the drive-through testing area, the patient was considered an outpatient, and thus, the potential exposures were reported to a community health department for [contact tracing](#).⁵³

The OIG concluded that the covering primary care physician and the triage physician should have isolated and referred the patient, with a transport team, to the Emergency Department for further assessment for COVID-19 upon discovery of the patient’s fever. The OIG further concluded that staff’s failure to fully screen, isolate, and evaluate the patient resulted in potential COVID-19 exposure to facility staff, patients, and the general public when the patient moved unescorted through the facility grounds.

4. Alleged Withholding of Patient Information

The OIG did not substantiate facility staff withheld patient information from a family member who held a DPOA. The OIG found the patient did not designate the family member as a DPOA. The OIG also found that the triage nurse could not provide patient information to the family member who provided a name that did not match documentation of [next-of-kin](#) in the patient information section of the EHR.⁵⁴ In addition, there were several contradictory entries in the EHR related to the designation of the family member as the patient’s [surrogate](#), and the OIG found the MHICM team failed to address these discrepancies.

VHA requires that EHR entries are accurate and facilitate communication and continuity of patient care.⁵⁵ Should a patient lack [decision-making capacity](#) to make a healthcare decision, and is determined unlikely to regain this capacity, VHA requires a provider to identify a surrogate and document this in the patient’s EHR.⁵⁶ A patient can also select a surrogate, or a [health care agent](#), designated in a durable power of attorney for health care, to make decisions in the event of an impairment.⁵⁷ VHA prioritizes the surrogate as a person who has a durable power of attorney for health care first, a [legal guardian](#) second, and then a patient’s next-of-kin.⁵⁸

⁵³ The OIG determined further review of the contact tracing process was out of scope of this inspection.

⁵⁴ For the purposes of this report, the referenced family member is one individual. The OIG learned that the patient’s family member, who sought information about the care the patient received on July 2, 2020, commonly used a middle name instead of a first name, which most likely led to facility staff’s confusion regarding if there were one or two family members involved with the patient’s healthcare decisions.

⁵⁵ VHA Handbook 1907.01.

⁵⁶ VHA Handbook 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended June 25, 2020.

⁵⁷ VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.

⁵⁸ VHA Handbook 1004.01(3).

VHA also requires MHICM staff to serve as the “fixed point of clinical responsibility” for each patient in the program, coordinating all VHA care for MHICM-enrolled patients.⁵⁹ MHICM staff are to include, with a patient’s consent, family members in treatment planning, and this may include contacts with the family members.⁶⁰ Facility policy requires MHICM staff to collaborate with staff regarding patient autonomy in healthcare settings.⁶¹

Contradictory Entries Related to the Patient’s Surrogacy Status

The OIG reviewed the patient’s EHR and found several contradictory entries related to the patient’s surrogacy status. In multiple EHR entries, facility staff inconsistently documented the patient’s family member’s status as a *guardian*, a *durable power of attorney for health care*, or as a *durable power of attorney* (see [appendix A](#)). The OIG reviewed the EHR and could not find documentation that the patient selected the family member to be a durable power of attorney for any reason, including healthcare decision making, or that a legal guardianship had been explored or adjudicated.⁶²

Lack of Clarity Regarding Identity of Next-of-Kin

During the inspection, the OIG found documentation in the patient’s EHR that the family member was identified as the next-of-kin.⁶³ However, the OIG found several inaccurate EHR entries regarding the family member’s name and role in the patient’s medical care. The patient had only one family member who provided the majority of caregiving to the patient since 2001. The OIG learned that MHICM staff and the patient’s psychiatrist erroneously believed, due to name discrepancies, that the patient had two involved family members rather than the one individual who was involved in the patient’s healthcare decisions.⁶⁴ The OIG would expect MHICM staff, responsible for patient care coordination, to know who is participating in the patient’s care, such as a family member.⁶⁵ The triage nurse told the OIG of not providing information about the patient to the family member, because the name offered by the family member did not match the next-of-kin’s name documented in the patient’s EHR.

⁵⁹ VHA Handbook 1163.06.

⁶⁰ VHA Handbook 1163.06.

⁶¹ Facility Policy, Guideline No. ICMHRS-001, *Psychosocial Rehabilitation and Recovery Services (PRRS): Intensive Community Mental Health Recovery Services (ICMHRS)*, September 18, 2019.

⁶² VHA policy requires facilities to use distinct note titles for discussions about advance care planning or the appointment of a health care agent or surrogate to ensure ease of finding the information in the EHR. VHA Handbook 1004.02.

⁶³ The next-of-kin was reported by first name, middle initial, and last name.

⁶⁴ The OIG learned that the patient’s family member interchangeably used a middle name or the first name, leading to facility staff confusion.

⁶⁵ VHA Handbook 1163.06.

MHICM Failure to Address Concerns Regarding Decision Making

The accurate identification of the patient's family member's role in the patient's care became necessary for care coordination as the patient's ability to make healthcare decisions declined. The patient's EHR indicated on the following dates that the patient may have needed assistance in making healthcare decisions:

- In early 2020, an inpatient mental health nurse documented, regarding the [advance directive](#) process, that “the patient was incapable of understanding and there was no representative present.”
- Approximately two weeks later, an inpatient mental health social worker documented, regarding the discharge process, that the “[patient] is unable to engage... due to cognitive deficits.”
- In early summer 2020, the radiation oncology provider documented that “[the patient] was not able to repeat back treatment details or risks [and] benefits.”

Despite documentation of concerns regarding the patient's decision-making capacity issues, the OIG found that the facility's MHICM staff did not correct the inconsistent and inaccurate surrogate documentation, or perform or obtain a clinical assessment of decision-making capacity as required by VHA and facility policies.⁶⁶

The contradictory and inconsistent entries in the patient's EHR fostered confusion as to the family member's name or role in the patient's healthcare decisions and access to patient information. MHICM staff failed to coordinate the patient's medical care by not addressing inaccurate information in the patient's EHR regarding the family member's identity and role, and the patient's ability to make independent healthcare decisions.⁶⁷

5. MHICM Deficiencies in Care Coordination and Education of Patient and Family on COVID-19 Screening Processes

The OIG determined that MHICM staff failed to provide necessary care coordination that could have assisted the family when seeking medical care for the patient on day 1 when MHICM staff did not provide education to the patient or the family member on facility COVID-19 screening policy and procedures.⁶⁸

VHA policy requires MHICM staff to coordinate care for MHICM-enrolled patients across the VHA system, including medical and mental health care, for both routine and non-routine needs.⁶⁹

⁶⁶ VHA Handbook 1004.01(3); Facility Policy, No. 11-018, *Informed Consent*, July 27, 2018.

⁶⁷ VHA Handbook 1163.06.

⁶⁸ VHA Handbook 1163.06.

⁶⁹ VHA Handbook 1163.06.

MHICM staff caseloads are low, with a high staff-to-patient ratio, to allow for frequent and intense contacts, such as when a patient's clinical care needs change, requiring increased coordination of care, and collaboration with physicians outside of the MHICM program.⁷⁰ The MHICM program also supports "all advocacy, all the time" for patients who have mental health illness and recognizes family members as participants in patients' treatment.⁷¹

On March 27, 2020, VHA announced a comprehensive COVID-19 response plan that included recommendations on communications to staff, patients, volunteers, visitors, and the general public about facility readiness during the pandemic. Examples of communications provided in the plan included messages about operational procedures, such as screening or cancellations of services due to COVID-19.⁷²

The OIG determined that MHICM staff documented in the EHR that education was provided to the patient on reducing infection spread and changes in MHICM services due to COVID-19 precautions.⁷³ Changes included a move to case management over the telephone, but maintained that medication management would continue during face-to-face appointments with the patient. The OIG could not find evidence of education to the patient or the family on how to access care at the facility under COVID-19 procedures, such as explanation of changes to facility entry points and visitor policies. Additionally, when interviewed by the OIG, MHICM case managers could not verbalize the facility's COVID-19 screening and visitor policies.

During an OIG interview, the patient's family member expressed confusion regarding the COVID-19 screening process, why the patient was not seen in the Emergency Department, and why a description of the patient's communication problems to clinical staff was needed.

The OIG concluded that MHICM staff failed to coordinate medical care for the patient on day 1. As the fixed point of care coordination, MHICM staff did not educate the patient or the family member on the facility COVID-19 policies and procedures, which could be challenging to navigate for a patient with cognitive deficits and a serious mental illness, such as schizophrenia.

6. Noncompliance with VHA and Facility Missing Patient Policies

The OIG determined that facility staff failed to identify the patient as an at-risk missing patient and failed to follow VHA and facility missing patient policies. The OIG further determined that

⁷⁰ MHICM patient caseloads are low as compared to other VHA case management programs. VHA Handbook 1163.06.

⁷¹ VHA Handbook 1163.06.

⁷² VHA Public Health, *Novel Coronavirus Disease (COVID-19)*. VHA Office of Emergency Management, *COVID-19 Response Plan Version 1.6, March 23, 2020*.

⁷³ MHICM staff's documentation regarding the patient began approximately the same time as the release of the VHA comprehensive COVID-19 response plan. VHA Office of Emergency Management, *COVID-19 Response Plan Version 1.6, March 23, 2020*.

facility staff did not report the missing patient as an adverse event to a patient safety manager, per VHA and facility requirements.⁷⁴

VHA policy defines an at-risk patient as one who “lack[s] cognitive ability (either permanently or temporarily) to make relevant decisions.”⁷⁵ At-risk patients are defined as “missing” if they have “disappear[ed] from the patient care areas (on VA property)” and their whereabouts are unknown.⁷⁶

Facility policy outlines steps to occur when a patient is reported missing:

- A supervisor initiates a preliminary search and notifies the VA Police.
- The VA Police identify a search coordinator who requests three separate overhead pages for the patient.
- If the patient has not been located within 15 minutes, the search coordinator contacts the missing patient’s provider who notifies the Chief of Staff.
- The Chief of Staff notifies the Facility Director who can authorize an expansive search known as a Code Purple.
- The patient’s provider enters the missing person event into the patient safety reporting system and the patient safety staff enters a missing [patient record flag](#) in the EHR.⁷⁷

Facility policy defines a missing and at-risk patient as an adverse event and requires that staff report the event to the patient safety manager.⁷⁸ VHA requires that all staff report adverse events, including missing patients, to the patient safety manager.⁷⁹

The OIG determined that the patient met the at-risk and missing patient criteria.⁸⁰ The patient was in their 60s with a medical history of chronic schizophrenia. When seen at the primary care clinic on day 1, the patient was febrile, had low oxygenation levels, complained of low back pain, and had a history of cognitive and communication impairments. The patient’s psychiatrist told the OIG that prolonged interactions with the patient were difficult. The patient would function for short periods of time, but “the longer conversations were with [the patient], the more

⁷⁴ Facility Policy, No. 00Q-018, *Management Plan for Wandering and At Risk Missing Patients*, January 12, 2018. Facility Policy, No. 00Q-004, *Patient Safety Improvement (PSI) Plan*, January 1, 2019. VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.

⁷⁵ VHA Directive 2010-052.

⁷⁶ Facility Policy, No. 00Q-018.

⁷⁷ Facility Policy, No. 00Q-018. Code Purple is the “[facility’s] designation that the Medical Center Director has authorized a [f]ull [s]earch to be conducted of all areas of the [facility] (i.e., all buildings, ground areas, and adjacent areas to the [facility], as appropriate, including neighborhood attractions).”

⁷⁸ Facility Policy, No. 00Q-004, *Patient Safety Improvement (PSI) Plan*, January 1, 2019. Facility Policy, No. 00Q-018.

⁷⁹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

⁸⁰ Facility Policy, No. 00Q-018.

disorganized that [the patient] would become.” The psychiatrist described the patient as “low functioning” and that family has “always done most things for [the patient].” Additionally, the psychiatrist stated that given the patient’s age and risk for infection—indicated by the elevated temperature—the patient was at-risk for [delirium](#) on day 1. The Acting Chief of Staff also stated, when interviewed, that the patient was at-risk for delirium. The acute symptoms, patient’s older age, suspected COVID-19 status, and chronic schizophrenia increased the patient’s risk factors and potentially decreased the patient’s ability to make appropriate decisions regarding care. Additionally, the new facility infrastructure, due to the COVID-19 screening and testing areas and limited access to return to the facility, were likely difficult to manage for the patient.

The OIG reviewed the EHR and found no evidence that facility providers made arrangements for the patient to re-enter the facility for the primary care clinic appointment. Having met the at-risk criteria, the patient also met the missing patient criteria because the patient was last seen on VA property, disappeared from a patient care area, and the family member did not know the patient’s whereabouts.⁸¹

The OIG determined that on days 2 and 4, facility clinical staff failed to assess the severity of the patient’s medical condition and identify the patient as at-risk and missing when the family member came to the facility. The triage nurse and two nursing supervisors, known as Administrative Nursing Officers of the Day, had opportunities and expertise to review the patient’s EHR and identify the patient’s medical issues and risk factors; however, no further action was taken to elevate concerns to the patient’s primary care provider.

On day 4, the VA Police did not follow the facility policy for conducting a missing patient search. Specifically, VA Police failed to appoint a search coordinator responsible for notifying the patient’s provider that the patient was missing.⁸² VA Police officers told the OIG that the clinical side of the facility was responsible for notifying the patient’s primary care provider or the Chief of Staff of the missing patient, and the notification was not the responsibility of the VA Police.

The OIG determined that the Deputy Associate Director for Patient Care Services failed to act when notified of the missing patient. After being informed by a nurse supervisor, on day 4, that the patient’s family member “was very persistent” and stated it was not like the family member’s sibling “to ... not contact [the family member] for that many days,” the Deputy Associate Director for Patient Care Services took no further action to locate the patient.

The OIG concluded that facility clinical staff—the triage nurse, two nursing supervisors, and the Deputy Associate Director for Patient Care Services—failed to use their clinical expertise to identify the patient as being at risk and missing. The preliminary search for the patient concluded without finding the patient and without the VA Police appointing a search coordinator,

⁸¹ Facility Policy, No. 00Q-018.

⁸² Facility Policy, No. 00Q-018.

contacting the patient's primary care provider, and elevating the concerns to VA Police leaders. Additionally, the failure by staff to report that the patient was missing as an adverse event or to alert a patient safety manager precluded a timely and comprehensive review of the event.

7. Facility Leaders' Awareness and Actions

Adverse Event Reporting

The OIG determined that facility leaders were aware of the patient's encounters with staff on day 1 and subsequent missing status on days 5 and 6; however, leaders failed to ensure a timely quality review of the patient's episode of care (see appendix B). The OIG further identified that facility leaders did not timely or accurately disclose to the patient's family the failures in the COVID-19 screening process and subsequent medical mismanagement that led to the patient's adverse clinical outcome.⁸³

Facility policy requires the patient safety manager and Director of Quality, Safety and Value (Quality) to review incidents involving missing and at-risk missing patients.⁸⁴ VHA requires that upon notification of an adverse event, the patient safety manager determines if the event requires a [root cause analysis](#), or inclusion in an [aggregate review](#).⁸⁵ If a root cause analysis is required, facility policy requires completion of the root cause analysis within 45 calendar days of the Quality staff's first awareness of the adverse event.⁸⁶

[Issue briefs](#), directed to facility and VISN leaders, are documents that clearly, concisely, and factually outline incidents that may affect patient care or generate media attention.⁸⁷ Issue briefs are important in determining whether or not the care provided was high quality and should include information on immediate corrective actions and plans for additional review. VHA guidance requires updates to an issue brief until the incident is resolved.⁸⁸

The OIG found that on day 5, the Acting Chief of Staff initiated an issue brief in response to the missing patient who had been found, admitted to the facility through the Emergency Department, and subsequently died.⁸⁹ The OIG reviewed the issue brief, dated day 6, and found it did not include critical details of the patient's episode of care on day 1, specifically the clinical

⁸³ An adverse event may lead to an adverse clinical outcome. This report focuses on patient harm in terms of adverse clinical outcomes. Within the context of this report and for this patient, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

⁸⁴ Facility Policy, No. 00Q-018; The facility patient safety manager reports to the Director of Quality.

⁸⁵ VHA Handbook 1050.01.

⁸⁶ Facility Policy, No. 00Q-004, *Patient Safety Improvement (PSI) Plan*, January 1, 2019.

⁸⁷ Deputy Under Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, revised June 2017.

⁸⁸ Deputy Under Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*.

⁸⁹ The issue brief noted a member of the patient's family tagged the facility in a day 5 social media post.

symptoms, COVID-19 screening details, and at-risk factors. The document indicated that no additional details would be provided, that no incident report was filed, and “N/A” for severity and risk assessment. Additionally, the OIG determined that the issue brief, not updated until fall 2020, documented that the lack of clarity on the patient’s surrogacy status made it “harder to determine” if the patient had been missing. The issue brief noted the lack of documentation in the EHR regarding the patient’s care.

In an interview with the OIG, the Acting Chief of Staff reported, on or about day 5, of receiving a report from the facility’s Administrative Nursing Officer on Duty who was concerned and stating, “did we lose an incapacitated patient.” The Acting Chief of Staff requested a management review, which was completed by the Chief of Primary Care on day 9, who documented the course of the patient’s care on day 1 but did not include conclusions or an analysis of the care provided.⁹⁰

In an interview with the OIG, the facility’s Director of Quality reported that the first notification of the missing patient event was received after the OIG announced initiation of the healthcare inspection. When the OIG asked the Director of Quality about receiving facility issue briefs, the Director of Quality reported reviewing the issue brief involving the patient when the issue brief was released on day 6. The Director of Quality stated the patient’s case did not get the needed attention due to Quality staff’s confusion with another patient who was also missing around the same time in mid-summer 2020. Additionally, the patient’s issue brief did not indicate the patient was missing from the facility.⁹¹

The OIG found that, despite facility leaders’ awareness of the missing patient on day 6, facility employees had not notified the Patient Safety Manager until early the next month when the Director of Quality discussed the issue brief with, and emailed the document to, the Patient Safety Manager. The OIG learned that the Director of Quality asked the Emergency Department Medical Director to enter a patient safety report, and the report was filed on August 24, 2020.⁹²

The OIG learned that Quality staff reviewed the at-risk and missing patient adverse event on the same day and chartered a root cause analysis. However, the Acting Chief of Staff did not request a fact-finding review until August 26, 2020. On September 24, the Facility Director signed the completed root cause analysis, 79 calendar days following the Facility Director’s first knowledge of the missing patient (adverse event) on day 6. On October 29, the fact-finding reviewers concluded that the care provided on day 1 did not meet the standard of care for primary care,

⁹⁰ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A management review is a review of events conducted for non-quality assurance purposes, and can be used to collect facts and evidence regarding an event.

⁹¹ The OIG found the issue brief did indicate that the patient was missing from the facility; the issue brief noted the “[patient] never returned from the drive-thru testing area to see [the primary care provider].”

⁹² On August 20, 2020, the OIG team contacted the facility, alerting the Facility Director to a pending healthcare inspection. The Patient Safety Manager reports to the Director of Quality.

because the patient did not receive clinical assessment (for fever), follow-up, education, or instruction.

Although quality and administrative reviews of the missing patient's adverse event eventually took place, the OIG found that several facility leaders, including the Director of Quality, the Acting Chief of Staff, and the Facility Director, had the information from the day 6 issue brief and the ability to initiate reviews earlier. The OIG concluded that the Facility Director and Director of Quality failed to ensure completion of a root cause analysis within 45 calendar days of the facility leaders' first knowledge of the patient's adverse event.⁹³

Delayed and Inaccurate Institutional Disclosure

VHA requires that clinicians disclose adverse events resulting in serious harm or death to the patient or patient's representative. An institutional disclosure is required when an adverse event results in death and "must be initiated as soon as reasonably possible and generally within 72 hours" after an adverse event.⁹⁴

The OIG found that the Deputy Chief of Staff discussed the option of a disclosure with the patient's primary care provider on day 8, and concluded that, as the patient's family was seeking information, the triage physician could conduct a [clinical disclosure](#).⁹⁵ An institutional disclosure was conducted on October 2, 2020.

The OIG determined that the October 2 institutional disclosure, provided by the Deputy Chief of Staff to the patient's family, contradicted the EHR documentation of care. The Deputy Chief of Staff told the patient's family that it appeared the patient was never tested for COVID-19 and "left the area on his own without receiving a formal assessment for the fever." However, the EHR documented that the patient was tested for COVID-19 at 11:48 a.m. on day 1, and there was no documented treatment plan for further assessment of the patient's fever, or instruction for the patient to follow-up after COVID-19 testing.⁹⁶ The OIG concluded that the family received a delayed institutional disclosure that omitted facts regarding the patient's care that may have influenced the family's perception of events.

⁹³ Facility Policy, No. 00Q-004, *Patient Safety Improvement (PSI) Plan*.

⁹⁴ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

⁹⁵ VHA Directive 1004.08.

⁹⁶ The day 1 COVID-19 positive result was not returned until day 6.

Conclusion

The OIG did not substantiate that facility leaders failed to have a visitor policy in place during COVID-19 screening to support patients with mental health and impaired communication issues. However, the OIG was unable to determine if facility staff denied a family member the opportunity to accompany the patient who had mental illness and impaired communication skills when the patient presented to the facility for treatment and COVID-19 screening. The OIG found the facility had a visitor's policy that allowed for visitors in limited circumstances, but the OIG could not determine the identity or credentials of the staff member, nor further learn of the reasons for denying the family member entry on day 1.

The OIG substantiated that facility staff did not completely screen the patient for COVID-19. Specifically, screening staff did not ensure the patient's temperature was taken before allowing the patient to enter the facility. The OIG concluded that facility staff failed to take the patient's temperature as part of a COVID-19 screening due to miscommunication between the triage nurse and triage physician.

The OIG substantiated that facility staff failed to medically manage the patient who exhibited COVID-19 symptoms. Specifically, a covering primary care physician did not ensure the patient, who had COVID-19 symptoms, was isolated in an exam room while waiting for further medical examination and disposition. The triage physician sent the patient to the drive-through COVID-19 testing area without further medical evaluation and did not complete a plan of care for post-screening/testing follow-up. The triage physician also did not follow facility policy for intrafacility transport of patients suspected to have COVID-19. The primary care nurse failed to document the patient encounter and determine if the patient required transfer to a higher level of care.

The OIG concluded that the covering primary care physician and the triage physician should have isolated and referred the patient, with an escort, to the Emergency Department for further assessment for COVID-19 upon discovery of the patient's fever. The OIG further concluded that the failure to fully screen, isolate, and evaluate the patient resulted in potential COVID-19 exposure to facility staff, patients, and the general public when the patient moved unescorted through the facility grounds.

The OIG did not substantiate facility staff withheld patient information from a family member who held a DPOA. The OIG found the patient did not designate the family member as the DPOA for any reason, including health care decision making.

The OIG also found that the triage nurse could not provide patient information to the family member, because the name offered by the family member did not match the next-of-kin's name documented in the patient's EHR. In addition, there were several contradictory entries in the EHR related to the designation of the family member as the patient's surrogate, and the OIG found the MHICM team failed to address these discrepancies. The contradictory and inconsistent

entries in the patient's EHR fostered confusion as to the family member's name or role in the patient's healthcare decisions and subsequent access to patient information. MHICM staff failed to coordinate the patient's medical care by not addressing inaccurate information in the patient's EHR regarding the family member's identity and role, and the patient's ability to make independent healthcare decisions.

The OIG identified that, as the fixed point of care coordination, MHICM staff did not educate the patient or the family member on the facility COVID-19 policies and procedures that could be challenging to navigate for a patient with cognitive deficits and a serious mental illness, such as schizophrenia.

The OIG determined that facility staff failed to identify the patient as an at-risk missing patient and failed to follow VHA and facility missing patient policies. The OIG further determined that facility staff did not report the missing patient as an adverse event to a patient safety manager, per VHA and facility requirements. The OIG concluded that the facility's clinical staff—the triage nurse, two nursing supervisors, and the Deputy Associate Director for Patient Care Services—failed to use their clinical expertise to identify the patient as being at-risk and missing. The failure by staff to report that the patient was missing as an adverse event or to alert a patient safety manager precluded a timely and comprehensive review of the adverse event.

The OIG determined that facility leaders were aware of the patient's encounters with facility staff on day 1 but failed to ensure timely quality reviews of the patient's episode of care. The OIG further identified that facility leaders did not timely or accurately disclose to the patient's family the failures in the COVID-19 screening process and subsequent medical mismanagement which led to the patient's adverse clinical outcome.

The OIG determined that the October 2, 2020, institutional disclosure, provided by the Deputy Chief of Staff to the patient's family, contradicted the EHR documentation of care. The OIG concluded that the family received a delayed institutional disclosure that omitted facts regarding the patient's care that may have influenced the family's perception of events.

Recommendations 1–9

1. The Michael E. DeBakey VA Medical Center Director evaluates the visitor standard operating procedures for patients who require mental or behavioral health support during COVID-19 screening, and takes action as needed.
2. The Michael E. DeBakey VA Medical Center Director ensures that clinical staff screen and manage suspected COVID-19 patients according to Veterans Health Administration and Veterans Integrated Service Network 16 guidelines and Michael E. DeBakey VA Medical Center policies.
3. The Michael E. DeBakey VA Medical Center Director monitors compliance with the Veterans Health Administration requirement for Mental Health Intensive Case Management staff to identify and accurately document patients' surrogates.
4. The Michael E. DeBakey VA Medical Center Director strengthens processes to ensure Mental Health Intensive Case Management staff inform patients, families, and other support persons on the procedures for accessing medical and mental health care while navigating the COVID-19 screening and testing process, including visitor policies.
5. The Michael E. DeBakey VA Medical Center Director ensures clinical and non-clinical staff comply with Veterans Health Administration and Michael E. DeBakey VA Medical Center policies on missing and at-risk patients.
6. The Michael E. DeBakey VA Medical Center Director monitors compliance with Veterans Health Administration policies related to timeliness and reporting of adverse events to the patient safety manager.
7. The Michael E. DeBakey VA Medical Center Director ensures that issue briefs are initiated timely and are comprehensive, accurate, and updated as appropriate.
8. The Michael E. DeBakey VA Medical Center Director ensures leaders complete root cause analyses within 45 days of leaders' awareness of applicable adverse events.
9. The Michael E. DeBakey VA Medical Center Director consults with the VA Office of General Counsel regarding the accuracy and content of the institutional disclosure to the subject patient's family, and takes action as appropriate.

Appendix A: Inconsistent EHR Documentation of the Patient's Family Member's Surrogate Role

Table A.1. Documentation of the Family Member's Surrogate Role in the Patient's EHR by Clinician and Date

Clinician Entry	Guardian	DPOA for Health Care (Health Care Agent)	DPOA
Clinic Social Worker	X		
Urology Physician's Assistant	X		
Urology Physician's Assistant	X		
Urology Physician's Assistant	X		
Radiation Oncology Provider		X	
Radiation Oncology Nurse			X
MHICM Case Manager	X		

Source: *OIG analysis of EHR entries.*

Appendix B: Facility Leaders' Awareness of the Missing Patient

Table B.1. Date of Facility Leaders' Awareness of the Missing Patient

Staff Role	Date	Information Source
Deputy Director	Day 5	The Communications Director notified the Deputy Director of a silver alert noted on social media.
Acting Chief of Staff	Day 5	The administrative nursing officer on duty reported the event to the Acting Chief of Staff, who initiated an issue brief.
Facility Director Deputy Director Acting Chief of Staff Associate Director for Patient Care Services Deputy Associate Director for Patient Care Services Director of Quality	Day 6	The Facility Director approved an issue brief regarding the patient and the issue brief was sent to leaders, who are indicated in the first column. The issue brief stated that the patient's family had returned to the facility after day 1, to locate the patient, and that there was local media interest in the event.
Director of Quality	Day 6	The Director of Quality reviewed the issue brief, and erroneously determined that the patient was not missing from the facility, but from the community.
Deputy Chief of Staff	Day 8	The patient's primary care physician asked the Deputy Chief of Staff if an institutional disclosure should take place. The Deputy Chief of Staff determined a clinical disclosure could occur.
Acting Chief of Staff	Day 9	The Acting Chief of Staff received the Chief of Primary Care's review of the patient's episode of care as requested.
Acting Chief of Staff	Day 14	The OIG contacted the Acting Chief of Staff to express concerns with the COVID-19 screening and care the patient received.

Source: OIG analysis of interviews, executive staff emails, and facility reports in mid-summer 2020.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 4, 2021

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas

To: Director, Office of Healthcare Inspections, (54HL07)
Director, GAO/OIG Accountability Liaison Office (VHA 10B GOAL Action)

1. The South Central VA Health Care Network ((10N16) assures Veterans, their families, and caregivers that we are fully committed to improving our processes and systems moving forward to prevent a situation like this from happening again.
2. The South Central VA Health Care Network (10N16) has reviewed and concurs with the nine recommendations contained in the draft report to the Healthcare Inspection – Deficiencies in COVID-19 Screening and Facility Response for a Patient who Died at the Michael E. DeBakey VA Medical Center, Houston, Texas.
3. If you have questions regarding the information submitted, please contact 601-206-6900.

(Original signed by:)

Skye McDougall, PhD
Network Director

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 4, 2021

From: Director, Michael E. DeBakey VA Medical Center (580/00)

Subj: Healthcare Inspection—Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and respond to the draft OIG report, *Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas*. Our staff are saddened by the loss of the Veteran and have thoroughly reviewed the report looking for opportunities for improvement.
2. I have reviewed and concur with the nine (9) recommendations contained in the draft report. Corrective actions have been developed or implemented and are identified in the Directors Comments. The MEDVAMC is committed to ensuring each and every Veteran presenting to our VA receives only the highest quality of care.
3. If you have additional questions, please contact the Director of Quality, Safety and Value.

(Original signed by:)

Lindsey Crain, MHA, FACHE
Deputy Director, Michael E. DeBakey VA Medical Center

On behalf of:

Francisco Vazquez, MBA
Director, Michael E. DeBakey VA Medical Center

Facility Director Response

Recommendation 1

The Michael E. DeBakey VA Medical Center Director evaluates the visitor standard operating procedures for patients who require mental or behavioral health support during COVID-19 screening, and takes action as needed.

Concur.

Target date for completion: Completed September 30, 2020; Recommend Closure

Director Comments

The Michael E. DeBakey VA Medical Center (MEDVAMC) has developed a visitors standard operating procedure (SOP) which allows a caregiver to accompany any Veteran to our facility and Community Based Outpatient Clinic (CBOC) who may require assistance due to a physical and/or mental disability. The policy was amended on August 30, 2020 to allow one caregiver to accompany the Veteran for outpatient procedures and/or care within the facility. All screening staff were educated and trained regarding the amended SOP by September 30, 2020.

Early on during the pandemic, MEDVAMC recognized the need to set up a special process to assist Veterans presenting to the medical center with mental health issues. We operationalized an outside Mobile Mental Health (MH) Station from July 2020 through December of 2020 for Veterans with a MH appointment, requiring MH medication, presenting with behavioral health concerns, or presenting for an unscheduled MH visit. The station, which was staffed by mental health professionals, was set up outside at the main entrance with signage. The MH mobile station facilitates ongoing and immediate evaluation.

The station was relocated in January 2021 to the main lobby when the primary screening was moved indoors. All screening staff at the main campus and at the CBOCs were trained regarding the requirements and are able to manage and direct the Veteran to the appropriate MH area for assistance.

OIG Comment

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

Recommendation 2

The Michael E. DeBakey VA Medical Center Director ensures that clinical staff screen and manage suspected COVID-19 patients according to Veterans Health Administration and

Veterans Integrated Service Network 16 guidelines and Michael E. DeBakey VA Medical Center policies.

Concur.

Target date for completion: Completed May 31, 2021; Recommend closure.

Director Comments

MEDVAMC recognizes that effective screening and management of potential COVID-19 patients is essential to keeping our Veterans and staff safe during the pandemic. In keeping with VHA and VISN guidelines, we have initiated standard operating procedures and competencies for staff assigned as screeners. The SOPs are updated in accordance with VHA guidance staff retrained, and competencies validated. The staff have validated competencies as evidenced by demonstration of skills and knowledge required to further evaluate Veterans who present with positive signs and symptoms of COVID-19. The screening forms have been updated to include documentation of the signs and symptoms identified, vital signs (temperature, pulse and oxygen level) in the computerized patient record system (CPRS) and provide a handoff at appropriate times and/or regarding the disposition of patients.

MEDVAMC performed 90-day audits to ensure compliance and sustainability and achieved 100% compliance for the new process from October-December 2020. Quality audits from January 2021 to May 2021 remain at 99% compliance. Competencies on 100% of screening staff were completed. New screening staff will be oriented and trained with the appropriate competencies established. The screening staff's competencies will be assessed, and ongoing audits will continue to ensure compliance is sustained.

OIG Comment

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

Recommendation 3

The Michael E. DeBakey VA Medical Center Director monitors compliance with the Veterans Health Administration requirement for Mental Health Intensive Case Management staff to identify and accurately document patients' surrogates.

Concur.

Target date for completion: July 30, 2021

Director Comments

Determining whether every Veteran in our Mental Health Intensive Case Management (MHICM) program has a surrogate decision maker and ensuring that our documentation regarding the identity and nature of the surrogacy is up to date is an essential part of maintaining their continuity and quality of care. In order to ensure compliance with the VHA requirement for MHICM staff to identify and accurately document patients' surrogates, during the initial intake to MHICM, team members will determine whether or not the Veteran has a surrogate decision maker, who the decision maker is and the scope of their surrogate decision making authority. Team members will also continue to collect information about any advanced directives the veteran may have and will facilitate creation of advanced directives or identification of surrogate decision makers if the Veteran needs assistance making these arrangements. The Veteran's preference will be documented in the medical record. Upon intake, prior to discharge from inpatient MH stay, and any time there is a concern for cognitive or capacity change, the MHICM provider will be alerted and will actively assess decision-making capacity. Once the concern is identified, a formal assessment will be performed, and pertinent information will be documented accordingly. Documentation of surrogate designation and advance directive will be added to the monthly MHICM audit as a standard to ensure sustainability. MHICM leadership is drafting the changes and will implement them no later than July 30, 2021.

Audits will be performed by MHICM staff on a random review of 15 MHICM patients monthly. Compliance monitored by the Mental Health Care Line leadership team and reported quarterly to the Clinical Executive Board, chaired by the Chief of Staff.

OIG Comment

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

Recommendation 4

The Michael E. DeBakey VA Medical Center Director strengthens processes to ensure Mental Health Intensive Case Management staff inform patients, families, and other support persons on the procedures for accessing medical and mental health care while navigating the COVID-19 screening and testing process, including visitor policies.

Concur.

Target date for completion: July 30, 2021

Director Comments

Keeping our Veterans and their family members informed about COVID-19 screening, testing and visitor policies is a vital part of the MEDVAMC mission. During the pandemic, these

policies were adjusted and changed as necessary to accommodate evolving needs and guidance. Fortunately, the MHICM team sees their patients at least weekly and more if needed. Case managers are able to provide MHICM Veterans and their families with the facility visitor policy at enrollment and update Veterans and families on changes as they occur. Any changes and updates to our visitor policy, COVID-19 screening policy, COVID-19 testing policy, and Personal Protective Equipment (PPE) policy will be communicated to Veterans, caregivers, families, surrogates, and/or any other support persons during the weekly visit. Visitor, COVID-19 screens, testing, and PPE policies will also be included as part of the program handbook and orientation materials. Communication of this information will be documented in the medical record. If mid-cycle changes occur outside of the orientation period, MHICM staff will note in the medical record that a revised policy was provided to the Veterans and caregivers. If a caregiver or a surrogate decision maker is not present when MHICM staff meets with the Veteran to receive a physical copy of the policy during the visit, MHICM staff will mail a copy of the policy to the Veteran's caregiver, designated surrogate decision maker, or other community care team members with Veteran's consent. MHICM conducts routine medical record review as part of the Commission on Accreditation of Rehabilitation Facilities accreditation process. This routine medical record review specifically addresses provision of the handbook and orientation materials. MHICM leadership is drafting the changes to SOP and plans to implement all changes no later than July 30, 2021.

OIG Comment

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

Recommendation 5

The Michael E. DeBakey VA Medical Center Director ensures clinical and non-clinical staff comply with Veterans Health Administration and Michael E. DeBakey VA Medical Center policies on missing and at-risk patients.

Concur.

Target date for completion: July 31, 2021

Director Comments

MEDVAMC recognizes the importance of managing Veterans at risk for wandering. The Management Plan for Wandering and At-Risk Missing Patients policy (MCP 00Q-018) is required for annual training for current staff, to include new employees during orientation and as needed for policy updates. MEDVAMC conducted a facility wide training on the policy MCP 00Q-018 in October 2020. As of June 1, 2021, MEDVAMC staff compliance rate is 99.3 %. Additionally, The Deputy Associate Director/Patient Care Services (DADPCS) and the Nursing

Officer of the Day (NOD) were retrained and are able to identify notification of required staff for missing and wandering patients, to include patient safety, chief of staff and medical center director. An evaluation of the training was completed by patient safety to ensure understanding of the training. Additionally, the policy will validate that the missing patient drills comply with VHA Directives and local policy, compliance will be monitored through the Patient Safety committee.

OIG Comment

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

Recommendation 6

The Michael E. DeBakey VA Medical Center Director monitors compliance with Veterans Health Administration policies related to timeliness and reporting of adverse events to the patient safety manager.

Concur.

Target date for completion: Completed April 30, 2021; Recommend closure

Director Comments

The Michael E. DeBakey VA Medical Center Director recognizes the importance of monitoring compliance with VHA policies related to the timely reporting of patient safety incidents. The Joint Patient Safety Reporting system (JPSRs) training has been reinforced among staff and is presented in New Employee Orientation (NEO). This training consists of how to access the JPSR site, how to enter an incident report and the importance of timely reporting. To demonstrate compliance, Patient Safety incidents are captured and reviewed daily, recapped during the morning report and a more in-depth weekly report delineating the number of JPSRs, delinquent JPSR and timeliness of JPSR closures are provided to the Pentad and Service Line Leaders. Further, these reports are shared and disseminated with front line employees through their leadership. The Patient Safety Manager and Director Quality, Safety and Value review the JPSR reports for trends and actively work with the appropriate service line(s) to help create action plans and process improvement initiatives.

OIG Comment

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

Recommendation 7

The Michael E. DeBakey VA Medical Center Director ensures that issue briefs are initiated timely and are comprehensive, accurate, and updated as appropriate.

Concur.

Target date for completion: June 4, 2021; Recommend closure

Director Comments

Issue Brief (IB) and Heads Up Message (HUM) timeliness comply with the 10N Guide to VHA Issue Briefs and have been communicated to Clinical and Administrative Leadership within the Medical Center to ensure that the IBs are not only timely, but also accurately reflect the issue and are updated as new information is revealed.

To further guarantee IBs and HUMs are initiated as per the guidance, any IBs and HUMs sent after business hours are to have a warm handoff with a member of the senior leadership team. Complex clinical and administrative issues are reviewed and approved by a member of the senior leadership team prior to receiving the Medical Center Director's final approval and submission to the VISN through the Issue Brief Tracker. The status of Issue Briefs and Issue Brief Updates will be reviewed during morning report with the senior leadership team to ensure that timely, accurate updates are provided. The Supervisory Health System Specialist to the Medical Center Director will serve as the primary IB coordinator for the facility to ensure IBs are updated appropriately. Any Health System Specialists assigned to the senior leadership team will serve as alternates in the absence of the Supervisory Health System Specialist to the Medical Center Director to ensure there are no gaps in this process. These changes have been implemented and compliance is maintained through daily reports to senior leadership to validate timeliness.

OIG Comment

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

Recommendation 8

The Michael E. DeBakey VA Medical Center Director ensures leaders complete root cause analyses within 45 days of leaders' awareness of applicable adverse events.

Concur.

Target date for completion: Completed March 15, 2021; Recommend closure

Director Comments

The MEDVAMC recognizes the importance of timely reporting of adverse events and identifying and acting upon opportunities for improvement. We are committed to ensuring the completion of Root Cause analysis (RCA) within the designated 45-day time frame. To validate compliance, a report has been created and generated by Patient Safety to display the trajectory of RCAs, and includes initiation, progress, and timely conclusion of the RCA. It also includes the action and outcome measures (AOMs). This report is presented every Wednesday during the Pentad morning report. Issues or impediments to completion are addressed and escalated as appropriate to the Pentad for mitigation. Since the process improvement RCA plan was developed in March, 100% have been completed within the 45-day threshold. The sustainability of this process is ongoing, and we continue to meet the standard. The Medical Center will continue to monitor RCA compliance weekly through weekly briefings to the senior leadership team to ensure a sustained compliance rate of 100%.

OIG Comment

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

Recommendation 9

The Michael E. DeBakey VA Medical Center Director consults with the VA Office of General Counsel regarding the accuracy and content of the institutional disclosure to the subject patient's family, and takes action as appropriate.

Concur.

Target date for completion: Completed June 21, 2021; Recommend closure

Director Comments

MEDVAMC is committed to honest and forthright communication with Veteran family members. In June 2021, the MEDVAMC Chief of Staff consulted with the VA Office of General Counsel (OGC) regarding the accuracy and content of the initial institutional disclosure to the patient's family. Upon review of the situation, the MEDVAMC Director has decided to schedule a private meeting with the Veteran's family member to provide a revised and more thorough institutional disclosure. During this meeting, the MEDVAMC Medical Center Director and Chief of Staff will re-review details and pertinent documents related to this situation in order to provide the Veteran's family member with the accurate and complete information that a family member deserves. We will empathetically discuss the adverse event and inform the family member of their rights, including the right to file a tort claim. The established date for disclosure was June 21, 2021 at 1500.

OIG Comment

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

Glossary

To go back, press “alt” and “left arrow” keys.

advance directive. “[A] written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that individual becomes unable to make those decisions.” A type of advance directive includes a durable power of attorney for health care or health care agent.⁹⁷

adverse event. “[A]re untoward incidents, therapeutic misadventures, ... or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility.”⁹⁸

aggregate review. Used to determine common causes of similar adverse events, this is a process of analyzing a group of data, rather than data from one patient event.⁹⁹

cardiac arrest. “[T]he abrupt loss of heart function, breathing, and consciousness.”¹⁰⁰

cardiopulmonary resuscitation. Also known as CPR, a life-saving technique useful in emergencies when breathing has stopped, or when the heart has stopped beating.¹⁰¹

clinical disclosure. “[A] process by which the patient’s clinician informs the patient or the patient’s personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient’s care.”¹⁰²

congestive heart failure. “[O]ccurs when your heart muscle doesn’t pump blood as well as it should. Certain conditions... leave your heart too weak or stiff to fill and pump efficiently.”¹⁰³

contact tracing. A process to identify and notify individuals possibly exposed to COVID-19 and to provide instructions on how to monitor health and “slow the spread” of the virus.¹⁰⁴

⁹⁷ VHA Handbook 1004.02.

⁹⁸ VHA Handbook 1050.01.

⁹⁹ VHA Handbook 1050.01.

¹⁰⁰ Mayo Clinic, *Patient Care & Health Information, Diseases & Conditions – Sudden Cardiac Arrest*, accessed November 6, 2020, <https://www.mayoclinic.org/diseases-conditions/sudden-cardiac-arrest/symptoms-causes/syc-20350634>, updated December 18, 2018.

¹⁰¹ Mayo Clinic, *Patient Care & Health Info – Cardiopulmonary Resuscitation (CPR): First Aid*, accessed November 6, 2020, <https://www.mayoclinic.org/first-aid/first-aid-cpr/basics/art-20056600>, updated February 16, 2018.

¹⁰² VHA Directive 1004.08.

¹⁰³ Mayo Clinic, *Patient Care & Health Information, Diseases & Conditions – Heart Failure*, accessed November 6, 2020, <https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142>, updated May 29, 2020.

¹⁰⁴ Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19), Contact Tracing*, accessed December 4, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html>, updated December 3, 2020.

COVID-19. An infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).¹⁰⁵

decision-making capacity. “[C]linical judgment about a patient’s ability to make a particular type of health care decision at a particular time.” Although generally presumed, when a patient’s decision-making capacity is questioned, “the responsible practitioner must make an explicit determination based on an assessment of the patient’s ability to do the following:

- (1) Understand the relevant information,
- (2) Appreciate the situation and its consequences,
- (3) Reason about treatment options, and
- (4) Communicate a choice.”¹⁰⁶

delirium. “[A] serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment.” With a rapid onset, it can be caused by factors such as infection and symptoms, including not knowing who or where you are.¹⁰⁷

do not resuscitate. “A do-not-resuscitate order, or DNR order, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient’s breathing stops or if the patient’s heart stops beating.”¹⁰⁸

durable power of attorney. A legal instrument authorizing an appointed person to act for another (the principal), effective upon the principal becoming unable to make independent decisions.¹⁰⁹

episode of care. “All services provided to a patient with a clinical problem within a specific period of time across a continuum of care in an integrated system.”¹¹⁰

febrile. “[M]arked or caused by fever.”¹¹¹

¹⁰⁵ World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed November 4, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it).

¹⁰⁶ VHA Handbook 1004.01(3).

¹⁰⁷ Mayo Clinic, *Patient Care & Health Information, Diseases & Conditions – Delirium*, accessed December 16, 2020, <https://www.mayoclinic.org/diseases-conditions/delirium/symptoms-causes/syc-20371386>, updated September 1, 2020.

¹⁰⁸ MedlinePlus Medical Encyclopedia, *Do-Not-Resuscitate Order*, accessed November 6, 2020, <https://medlineplus.gov/ency/patientinstructions/000473.htm>, updated October 8, 2020.

¹⁰⁹ Merriam-Webster, *Durable Power of Attorney*, accessed November 17, 2020, <https://www.merriam-webster.com/dictionary/power%20of%20attorney>.

¹¹⁰ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

¹¹¹ Merriam-Webster, *Febrile*, accessed January 13, 2021, <https://www.merriam-webster.com/dictionary/febrile>, updated December 16, 2020.

hand-off communication. Communications regarding critical patient care information between facility staff at the point of transfer in patient care from one care provider to another. Hand-off communications “include an opportunity to ask and respond to questions, including read back or repeat back, as appropriate.”¹¹²

health care agent. An individual designated by a patient to make health care decisions on the patient’s behalf. A durable power of attorney for health care “is a type of advance directive in which an individual designates another person... to make health care decisions on the individual’s behalf.”¹¹³

institutional disclosure. “[A] formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”¹¹⁴

issue brief. Intended for internal use, issue briefs provide facility, Veterans Integrated Service Network, and VHA leaders clear, concise, and accurate information about a situation or an event.¹¹⁵

legal guardian. “[A] person appointed by a court of appropriate jurisdiction to make decisions, including medical decisions, for an individual who has been judicially declared to be incompetent.” Of note: guardianships can be limited and may not include authority for health care decisions.¹¹⁶

nasopharyngeal swab test. Refers to the portion of a nasopharyngeal culture (or “a sample of secretions from the uppermost part of the throat”) process when “[a] sterile cotton-tipped swab is gently passed through a nostril and into the nasopharynx” (the part that covers the roof of the mouth).¹¹⁷

next-of-kin. “[A] relative (18 years of age or older) of the patient who may act as surrogate.” The order of priority is “spouse, child, parent, sibling, grandparent, grandchild.”¹¹⁸

oxygenation. To combine with oxygen, in this case, blood with oxygen.¹¹⁹

¹¹² Facility Policy, No. 11-001.

¹¹³ VHA Handbook 1004.02.

¹¹⁴ VHA Directive 1004.08.

¹¹⁵ Deputy Under Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*.

¹¹⁶ VHA Handbook 1004.01(3).

¹¹⁷ MedlinePlus Medical Encyclopedia, *Nasopharyngeal Culture*, accessed November 6, 2020, <https://medlineplus.gov/ency/article/003747.htm>, updated October 8, 2020.

¹¹⁸ VHA Handbook 1004.01(3).

¹¹⁹ Merriam-Webster, *Oxygenate*, accessed November 6, 2020, <https://www.merriam-webster.com/dictionary/oxygenate>, updated October 5, 2020.

pandemic. A disease outbreak, which occurs over a wide geographic area and it can affect a large portion of the population.¹²⁰

patient record flag. An indicator in the electronic health record to alert staff of a patient “whose behavior, medical status, or characteristics may pose an immediate threat either to that patient’s safety, the safety of other patients or employees, or may otherwise compromise the delivery of safe health care in the initial moments of the patient encounter.”¹²¹

prostate cancer. “Prostate cancer is cancer that occurs in the prostate—a small walnut-shaped gland in men that produces... seminal fluid... and transports sperm.”¹²²

rapid COVID-19 test. The Abbott ID NOW COVID-19© test, which can detect the active COVID-19 virus in 13 minutes or less.¹²³

root cause analysis. “[A] process for identifying the basic or contributing causal factors [of] variations in performance associated with adverse events or close calls.”¹²⁴

silver alert. An alert program “designed to notify the public of missing older adults with a documented mental condition.” Of note, silver alerts require physician documentation of the missing person’s mental impairment.¹²⁵

surrogate. “[R]efers to an individual authorized under VHA policy to make health care decisions on behalf of a patient who lacks decision-making capacity.”¹²⁶

¹²⁰ Merriam-Webster, *Pandemic*, accessed November 5, 2020, <https://www.merriam-webster.com/dictionary/pandemic>, updated October 28, 2020.

¹²¹ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, corrected February 3, 2011.

¹²² Mayo Clinic, *Patient Care & Health Information, Diseases & Conditions – Prostate Cancer*, accessed November 6, 2020, <https://www.mayoclinic.org/diseases-conditions/prostate-cancer/symptoms-causes/syc-20353087>, updated April 17, 2019.

¹²³ Abbott, *ID NOW: The Forefront of COVID-19 Testing*, accessed November 16, 2020, <https://www.abbott.com/IDNOW.html>.

¹²⁴ VHA Handbook 1050.01.

¹²⁵ Texas Department of Public Safety, *Silver Alert*, accessed November 3, 2020, <https://www.dps.texas.gov/section/intelligence-counterterrorism/silver-alert>.

¹²⁶ VHA Handbook 1004.01(3).

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