



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Community
Living Center Processes and
Training at the West Texas
VA Health Care System in
Big Spring



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation that community living center (CLC) nursing staff did not respond when a patient experienced a medical emergency at the West Texas VA Health Care System (facility) in Big Spring. Additionally, the OIG found concerns related to a lack of defined CLC staff responsibilities when responding to medical emergencies, failure to conduct mock code trainings, and incomplete electronic health record (EHR) documentation.

Patient Case Summary

In early 2022, the patient, who was in their seventies and had a history of [diabetes](#), [hypertension](#), chronic pain, and end-stage [chronic obstructive pulmonary disease](#) (COPD), was admitted into the CLC Small House for [hospice care](#).¹ Upon admission to the CLC, the patient requested [full code](#) status, which included the initiation of [cardiopulmonary resuscitation](#) (CPR) in the event of a medical emergency.

In mid-2022, the patient experienced a medical emergency and became unresponsive. The CLC registered nurse taking care of the patient documented the patient's [vital signs](#), which indicated severely low blood pressure and oxygen saturation, notified the CLC physician of the patient's condition via telephone, and was instructed by the CLC physician to transfer the patient to a higher level of care. The CLC registered nurse activated the emergency medical services (EMS) response for the patient by contacting the administrative officer of the day (AOD), and monitored the patient until EMS arrived. EMS transferred the patient to a community hospital where the patient died a short time after arrival.

Inspection Results

The OIG did not substantiate that facility CLC nursing staff failed to respond to the patient's medical emergency.² Although CLC nursing staff responded, the OIG found that the CLC registered nurse was unaware of the facility's medical emergency policy and, as a result, failed to follow policy by not obtaining the [automated external defibrillator](#) (AED) and calling 911 immediately to activate the EMS response. Facility policy states that staff responding to a medical emergency outside the main building will activate EMS by calling 911 and follow [basic](#)

¹ The OIG uses the singular form of they (their) in this instance for privacy purposes. The Small House is considered part of the CLC; however, the CLC Small House is located in a separate building. The Small House provides a home-like environment for up to 10 patients. The residents received care 24-hours a day by nursing staff. At the time of the patient's medical emergency, the CLC Small House had five residents and care was provided by a registered nurse and two certified nursing assistants. Underlined terms are hyperlinked to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

² CLC nursing staff refers to registered nurses, licensed practical nurses, and certified nursing assistants.

[life support](#) (BLS) guidelines, which include retrieving the AED, assessing for breathing and a pulse, and monitoring the patient until EMS personnel arrive.³ The facility policy also states that CLC medical staff will manage medical emergencies that occur within the CLC.

In an interview, the CLC registered nurse stated not being aware of the CLC medical emergencies policy. The CLC registered nurse stated that the appropriate emergency response for a full code patient would be to begin BLS and retrieve the AED. The CLC registered nurse further explained that although the patient became unresponsive during the medical emergency, the patient had a pulse and was breathing. The registered nurse believed that the appropriate medical emergency response was to contact a CLC provider for further direction.

The CLC physician told the registered nurse to transfer the patient to a community hospital for a higher level of care. The registered nurse notified the AOD to activate the EMS response and monitored the patient until EMS arrived. The OIG could not determine if following policy by obtaining the AED and calling 911 immediately would have affected the patient's outcome.

The OIG determined that CLC and facility leaders failed to define CLC staff responsibilities in responding to medical emergencies in the CLC, and had not provided mock code training to CLC staff since October 2019 due to [COVID-19](#). This failure may have led to CLC nursing staff being unclear on specific roles, responsibilities, and necessary actions to be taken when medical emergencies occur on the CLC.

Although the facility policy outlines actions staff should take in responding to a medical emergency, the facility policy does not assign specific roles and responsibilities to each staff member responding to the medical emergency. The OIG found that when the patient experienced the medical emergency, the CLC registered nurse was working on the CLC with two nursing assistants, all of whom were required to be BLS certified. During the patient's medical emergency, the CLC registered nurse, who was the only licensed clinician, was not able to remain at the patient's bedside. The CLC registered nurse was in and out of the patient's room completing tasks that included contacting the CLC physician, following the CLC physician's orders to transfer the patient to a higher level of care, contacting the AOD to activate the EMS response, monitoring the patient's medical status, and printing the necessary EHR documents for the patient's transfer.⁴

The OIG found discrepancies in the statements made by CLC and facility leaders and CLC nursing staff in understanding the responsibilities and expectations during a medical emergency. The CLC nurse manager and facility leaders informed the OIG in interviews that CLC nursing

³ Facility Policy HCSM 111AC-16, *Medical Emergencies*, June 1, 2020. American Heart Association, "Part 3: Adult Basic and Advanced Life Support," accessed August 18, 2022, <https://www.ahajournals.org/doi/epdf/10.1161/CIR.0000000000000916>.

⁴ Due to conflicting information obtained from interviews with the nursing assistants and a VA police officer, the OIG could not determine if the nursing assistants remained with the patient throughout the medical emergency until EMS personnel arrived at the Small House.

staff have the ability to activate the EMS response, monitor the patient's vital signs, and print EHR documents for transfer. Collectively, the CLC nursing staff informed the OIG that it was their understanding that the CLC registered nurse was responsible for activating the EMS response, monitoring the patient, and printing the transfer documents. Although the OIG could not determine if discrepancies in understanding roles, responsibilities, and expectations during the medical emergency affected the outcome for this patient, the OIG determined they influenced the CLC registered nurse's ability to remain with the patient throughout the medical emergency to continuously monitor the patient's condition.

The OIG determined that CLC leaders failed to ensure that CLC nursing staff completed mock code training. The Veterans Health Administration (VHA) requires facilities to implement a mock code program necessary for staff to practice the hands-on critical skills used during a patient's medical emergency.⁵ According to facility policy, mock codes should occur with CLC nursing staff quarterly, but through document reviews, the OIG found that the last mock code occurred in the CLC in October 2019. The OIG was told that mock codes were put on hold in 2020 due to COVID-19.

The OIG was told in an interview that at the time of the patient's medical emergency, the Small House had an AED but did not have a bag-mask device used to assist patients with breathing. At the time of the OIG site visit in September 2022, however, the OIG learned through an interview that the bag-mask device was available for use at the Small House. The OIG also learned that CLC nursing staff needed to be trained on how to use an AED. As of November 2022, the OIG confirmed that the AED training had occurred for CLC nursing staff. The OIG could not determine if the lack of mock code and AED training and the lack of a bag-mask device affected the outcome for this patient. The OIG determined, however, that the nursing staff's lack of training in how to respond and work cohesively during a medical emergency and missing emergency equipment may negatively affect other patients during a medical emergency.

The OIG determined the CLC registered nurse failed to document relevant patient care information during and after the patient's medical emergency. VHA and facility policy states documentation in a patient's EHR must be relevant and complete.⁶

The CLC registered nurse told the OIG of continuing to monitor the patient's vital signs throughout the medical emergency, but the OIG found no EHR documentation of subsequent patient vital sign readings. The OIG reviewed a VA police report and found that EMS personnel, upon arrival, assessed and determined that the patient did not have a pulse and was not breathing, initiated CPR, and transferred the patient to a higher level of care. The OIG found that the CLC registered nurse did not document actions taken by EMS personnel in the patient's EHR. The

⁵ VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021.

⁶ VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. Facility Policy HCSM 136-31, *Medical Records*, November 1, 2020.

CLC registered nurse told the OIG that in a retrospective review of the case, documentation should have included the EMS response to the patient. Additionally, the OIG was told by the facility risk manager that when CLC patients are transferred to a community hospital, facility staff are expected to document all relevant patient transfer information in a higher level of care transfer note (transfer note). The OIG found that the CLC registered nurse documented using the transfer note; however, not all required elements of the note had been completed. The OIG determined that the documentation failure did not affect the outcome for this patient, but complete and timely documentation is vital to the integrity of VHA's health information management, so that if requested, patients or their designee(s) can have access to accurate health record information.

The OIG made three recommendations to the Facility Director related to ensuring CLC nursing staff are trained on roles and responsibilities when responding to medical emergencies, completing mock codes within the CLC to include all CLC nursing staff, and all CLC clinical staff meeting EHR documentation requirements.

VA Comments and OIG Response

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



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Abbreviations

AED	automated external defibrillator
AOD	administrative officer of the day
BLS	basic life support
CLC	community living center
EHR	electronic health record
EMS	emergency medical services
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 at the West Texas VA Health Care System (facility) in Big Spring to review the care of a patient who died while a resident in the community living center (CLC).

Background

The facility is within Veterans Integrated Service Network (VISN) 17 and operates a level 3 medical center and five community-based outpatient clinics located in the West Texas and Southeastern New Mexico area.¹ From October 1, 2020, through September 30, 2021, the facility provided care to 18,537 patients. The facility offers primary care and specialty care services through outpatient clinics, rural health care, and telehealth service. Although the facility stopped providing inpatient services in October 2013, the facility maintains 40 CLC beds and 40 domiciliary beds.²

Community Living Center

According to the Veterans Health Administration (VHA), a CLC is a component of long-term care that provides skilled nursing and specialty programs to patients needing short-term and long-term services and is typically located on a VA medical facility campus.³ Patients are admitted into CLCs based on an assessment of medical and rehabilitation needs and level of physical and cognitive functioning. The CLC staff typically consist of an interdisciplinary team that provides individualized and outcome-oriented care.

[Hospice care](#) is often provided within a facility's CLC. According to a facility leader, the facility's CLC has a separate building called the Small House where hospice patients reside.⁴

¹ VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Model Fact Sheet." The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex. "The George H. O'Brien, Jr. VA Medical Center is located in Big Spring, Texas, with VA Clinics located in: Abilene, Texas; San Angelo, Texas; Midland/Odessa, Texas; Fort Stockton, Texas; and Hobbs, New Mexico."

² A VHA domiciliary offers a residential therapeutic setting for veterans with mental health and addictive disorders who require additional structure and support due to psychosocial challenges including homelessness and unemployment. VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

³ VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. This handbook is the most recent and was in place during the time of the events discussed in this report.

⁴ Underlined terms are hyperlinked to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

The Small House is a home-like environment with 10 beds for patients who are cared for 24-hours a day by nursing staff.⁵

Allegations and Related Concerns

On July 14, 2022, the OIG received an allegation that CLC nursing staff did not respond when a patient experienced a medical emergency. The OIG reviewed the care the patient received at the time of the medical emergency and identified additional concerns related to lack of defined CLC staff responsibilities to respond to medical emergencies and failure to conduct mock code trainings, and incomplete electronic health record (EHR) documentation.

Scope and Methodology

The OIG initiated a healthcare inspection on August 15, 2022; conducted a site visit from September 12–14, 2022; and interviewed facility leaders, relevant providers, and staff.⁶

In addition, the OIG reviewed VHA and facility policies and procedures related to medical emergencies, patient transfers, documentation requirements, and [life-sustaining treatments](#). The OIG also reviewed the patient’s EHR, nurse training records, [peer reviews](#), relevant emails, committee meeting minutes, and other related documents.

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, as amended, 5 U.S.C. §§ 401–24. 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

⁵ CLC nursing staff refers to registered nurses, licensed practical nurses, and certified nursing assistants.

⁶ Facility staff interviewed included Acting Facility Director, Chief of Staff, Associate Director of Patient Care Services, Associate Chief of Staff and CPR Committee Facilitator, Associate Chief Nurse Extended Care Nursing Service, Associate Chief of Staff Geriatrics and Extended Care, CLC nursing manager, chief of quality management, risk manager, CLC providers and nursing staff, a pharmacist, a VA police officer, and health administration services staff (AODs).

to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

The patient was in their seventies with a history of [diabetes](#), [hypertension](#), end-stage [chronic obstructive pulmonary disease](#) (COPD), and chronic pain, and was admitted to the facility's CLC Small House on a day in 2022 (day 1) for hospice care. At the time of admission into the CLC, the patient was on home oxygen and [opiates](#) for chronic pain and shortness of breath. The CLC physician prescribed opiate pain medication to address the patient's chronic pain and shortness of breath, including immediate-release morphine every four hours as needed.⁷ The CLC physician documented that the patient's desire for [full code](#) status, including having [cardiopulmonary resuscitation](#) (CPR) administered if necessary, may not align with hospice care.

On day 85, the CLC physician added sustained-release morphine (an opiate pain medication) to better control the patient's chronic pain and shortness of breath. The CLC physician noted that the patient should be monitored for oversedation.⁸ The patient increasingly missed activities and was spending more time sleeping. The patient's chronic pain and shortness of breath remained difficult to manage, despite medication adjustments.

On day 91, a CLC nurse practitioner met with the patient to discuss life-sustaining treatments and the patient's progressive COPD. Although the patient verbalized understanding that death was approaching, the patient continued to want CPR to be initiated if the situation arose. The patient's EHR reflected the above discussion, and no changes were made to the patient's life-sustaining treatment plan at that time.

On day 95, the patient tested positive for [COVID-19](#). A CLC nurse practitioner advised the patient to remain in isolation for 14 days and plan for emergency department evaluation if symptoms worsened.

On day 96, the CLC physician documented that the patient's mental status was "mildly slowed" at times. The CLC physician discussed mental status changes and the possible need to transfer to

⁷ E.L. Ross, K. Hahn, 2008, "Kadian (morphine sulfate extended-release) Capsules for treatment of chronic, moderate-to-severe, nonmalignant pain," *International Journal of Clinical Practice* Volume 62, Issue 3 (February 1, 2008): 471-479, accessed March 6, 2023, <https://onlinelibrary.wiley.com/doi/10.1111/j.1742-1241.2007.01688.x>. Opioid therapy is typically used to treat moderate-to-severe pain. Immediate-release or short-acting formulations require administration every 3–4 hours and are appropriate for immediate pain relief. Long-acting or extended-release is recommended for around-the-clock control.

⁸ *Department of Justice/Drug Enforcement Administration*, "Drug Fact Sheet, Morphine," accessed January 11, 2023, https://www.getsmartaboutdrugs.gov/sites/default/files/2022-11/Morphine%202022%20Drug%20Fact%20Sheet_1.pdf. The signs of overdose include sleepiness, lowered blood pressure, slowed breathing, and slow pulse.

a higher level of care with the patient. The next day, the CLC interdisciplinary team discussed the mental status changes that the patient recently experienced and the possibility of transferring the patient to a higher level of care if the patient's health further declined.⁹ During an interdisciplinary team meeting, staff documented that the patient agreed to be transferred if health declined, but not for short lapses of mental capacity.

The CLC physician met with the patient later that same day to discuss the patient's prognosis and full code status. The patient expressed concern that staff would not provide care if the patient was not a full code. The CLC physician explained to the patient that changing from a full code to [do-not-resuscitate](#) status did not mean the CLC staff will not provide treatment to the patient, and that a code status could be reversed at any time. The patient then agreed to change from a full code status to do not resuscitate.

On day 99, the patient had a witnessed fall resulting in a baseball sized [hematoma](#) on the patient's back. Due to the patient's chronic pain, shortness of breath, and the pain from the new injury, the CLC physician increased the patient's immediate-release dose of morphine.

On day 103, the CLC physician noted that the patient's [decision-making capacity](#) was "good" when the patient decided to rescind the do-not-resuscitate order and revert back to full code status. In a second note on that same day, the CLC physician documented that the patient was having hallucinations but had insight and was oriented during the encounter with the CLC physician. The CLC physician considered multiple causes for the hallucinations and planned to continue to monitor the patient.

The next day, the CLC interdisciplinary team met and acknowledged the change in the patient's code status from do not resuscitate back to full code. The CLC physician cited both nursing and patient reports that the patient had been sleeping more and continued to hallucinate.

The following day, the patient complained of increased pain in both feet. The patient's left foot was cool to the touch and the pain was more severe than the right foot. The CLC physician discussed with the patient that the hospice treatment options would be centered around comfort care but offered to transfer the patient to a community hospital for further evaluation, which the patient declined.

On day 110, the CLC physician and nursing staff noted the patient's pain was uncontrolled. During the CLC interdisciplinary rounds, the team discussed the patient's complaint of pain, and a nurse practitioner documented in an action plan the pharmacist's recommendation to increase the dose and frequency of the long-acting (sustained release) morphine. The CLC physician initiated the new morphine order for the patient, and a nurse practitioner documented the plan to

⁹ The CLC interdisciplinary team consisted of providers; nursing staff; a pharmacist; a nutritionist; and recreation, physical, and occupational therapists.

monitor the patient for changes in mental status and to transfer care to a community hospital for persistent symptoms.

On day 111, at 7:30 p.m., in EHR notes, the CLC registered nurse assumed care of the patient and documented that the patient was asleep in bed and difficult to wake.¹⁰ At approximately 9:35 p.m., the patient reported experiencing pain and the registered nurse gave the patient medications, including the scheduled long-acting morphine. At 10:25 p.m., the CLC registered nurse responded to the patient's request for breathing treatment, and noted the patient was tremulous and sitting at bedside. The CLC registered nurse provided the breathing treatment to the patient and assisted the patient back to bed.

On day 112, at 2:19 a.m., the patient was again sitting up at bedside and asked for an inhaler as well as opiate pain medications. The CLC registered nurse provided the inhaler and inquired about pain level, but the patient did not respond. The CLC registered nurse documented asking the patient if opiate pain medication was needed because the patient was having a difficult time staying awake and noted that the patient was dropping everything the patient tried to pick up. The CLC registered nurse did not administer the patient's pain medication. The CLC nursing staff assisted the patient back into bed.

At approximately 2:35 a.m., a CLC nursing assistant was cleaning the patient's room and the CLC registered nurse returned to find that the patient was attempting to get up. The CLC registered nurse documented the patient had two jerking movements, fell back onto the bed pillow, and became unresponsive. The CLC registered nurse documented that the patient's [vital signs](#) were blood pressure 55/41, heart rate 66, oxygen level 77, and respirations 12, which indicated severely low blood pressure and oxygen saturation.¹¹

At 2:37 a.m., the CLC registered nurse called and notified the CLC physician about the patient's change in condition. The CLC physician directed the CLC registered nurse to transfer the patient to a higher level of care. The CLC registered nurse called the administrative officer of the day (AOD) and requested the AOD to contact emergency medical services (EMS).

¹⁰ In an interview, the CLC Small House registered nurse reported that at the time of the patient's medical emergency, the CLC Small House had five residents and care was provided by a registered nurse and two certified nursing assistants.

¹¹ Johns Hopkins Medicine, "Vital Signs (Body Temperature, Pulse Rate, Respiration Rate, Blood Pressure)," accessed October 11, 2022, <https://www.hopkinsmedicine.org/health/conditions-and-diseases/vital-signs-body-temperature-pulse-rate-respiration-rate-blood-pressure>. For healthy adults: A normal pulse ranges from 60 to 100 beats per minute. Normal respiration rate at rest is 12 to 16 breaths per minute. A normal blood pressure is 120/80. Cleveland Clinic, "Blood Oxygen Level," accessed October 11, 2022, <https://my.clevelandclinic.org/health/diagnostics/22447-blood-oxygen-level?view=print>. Normal oxygen saturation reading is 95 percent to 100 percent.

At 2:48 a.m., the CLC registered nurse documented checking the patient, obtaining a pulse, and placing an oxygen monitor. The CLC registered nurse subsequently noted that EMS personnel arrived at 2:49 a.m. and exited at 2:51 a.m. with the patient.

At 6:18 a.m., the CLC registered nurse documented receiving a call from an officer from the Big Spring Police Department stating that the patient was deceased.

Inspection Results

CLC Nursing Staff's Response to the Patient's Medical Emergency

The OIG did not substantiate that facility CLC nursing staff failed to respond to the patient's medical emergency. Although CLC nursing staff responded, the OIG found that the CLC registered nurse was unaware of the facility's medical emergency policy and as a result, failed to follow policy by not obtaining the [automated external defibrillator](#) (AED) and calling 911 immediately to activate the EMS response.

Facility policy states that staff responding to a medical emergency outside the main building will activate EMS by calling 911 and following [basic life support](#) (BLS) guidelines, which include retrieving the AED, assessing for breathing and a pulse, and monitoring until EMS personnel arrive.¹² The facility policy also states that CLC medical staff will manage medical emergencies that occur within the CLC.

The OIG found that several hours after administering the patient's bedtime medication, the CLC registered nurse and a nursing assistant witnessed the patient becoming unresponsive. The CLC registered nurse called the CLC physician, who ordered that the patient be transferred to a community hospital for a higher level of care. The CLC registered nurse then contacted the AOD to activate EMS response. Prior to EMS personnel arriving, the CLC registered nurse documented feeling a pulse and placing a [pulse oximeter](#) on the patient.

In an interview, the CLC registered nurse admitted being unaware of the CLC medical emergencies policy. The CLC registered nurse stated that the current practice was to notify a CLC provider when an emergency occurs and follow the directions of that provider. The CLC registered nurse stated that the appropriate emergency response for a full code patient would be to begin BLS and retrieve the AED. The CLC registered nurse further explained that in this patient's case, the patient became unresponsive but had a pulse. The registered nurse believed that the appropriate medical response was to contact a CLC provider for further direction. The CLC registered nurse reported not retrieving the AED because the patient had a pulse and was

¹² Facility Policy HCSM 111AC-16, *Medical Emergencies*, June 1, 2020. American Heart Association, "Part 3: Adult Basic and Advanced Life Support," accessed August 18, 2022, <https://www.ahajournals.org/doi/epdf/10.1161/CIR.0000000000000916>.

breathing. However, the CLC registered nurse failed to follow policy by not obtaining the AED and not calling 911 immediately to activate the EMS response.

The OIG concluded that CLC nursing staff responded to the acute change in the patient's condition by following the guidance provided by the CLC physician. The OIG could not determine if following policy by obtaining the AED and calling 911 immediately would have affected the patient's outcome.

Deficiencies in CLC Emergency Processes and Mock Code Training

The OIG found that the facility lacked defined CLC staff responsibilities to respond to medical emergencies in the CLC and had not provided mock code training to CLC staff in three years. After reviewing the patient's care, the OIG identified that the CLC registered nurse failed to provide complete documentation of the patient's medical emergency.

Lack of Defined Staff Responsibilities During a Medical Emergency

The OIG determined that CLC and facility leaders failed to define CLC staff responsibilities to respond to medical emergencies and this failure may have led to CLC nursing staff being unclear on specific roles, responsibilities, and the necessary actions to be taken when medical emergencies occur in the CLC.

As previously stated, the facility policy outlines actions staff should take when responding to a medical emergency, including initiating BLS, and calling 911. However, the facility policy does not assign specific roles and responsibilities to each staff member responding to a medical emergency.¹³

In an interview, the CLC nurse manager stated that CLC staff follow the facility's medical emergency policy and noted that the facility policy is to call 911. In addition, the CLC nurse manager stated that all CLC nursing staff are required to be BLS certified. Collectively, the CLC nurse manager and facility leaders noted that CLC nursing staff have the ability to activate the EMS response, monitor the patient's vital signs, and print EHR documents for transfer.

The registered nurse and the two nursing assistants caring for the patient at the time of the patient's medical emergency informed the OIG that it was their understanding that the CLC registered nurse had the responsibility to activate the EMS response, monitor the patient, and print the transfer documents. The CLC registered nurse further stated that when responding to an emergency on the CLC, it was the CLC registered nurse's practice to notify a provider and follow instructions.

¹³ Facility Policy HCSM 111AC-16, *Medical Emergencies*, June 1, 2020; American Heart Association, "Part 3: Adult Basic and Advanced Life Support," accessed August 18, 2022, <https://www.ahajournals.org/doi/epdf/10.1161/CIR.0000000000000916>.

During interviews with CLC staff, the OIG found that during the patient's medical emergency, the CLC registered nurse, who was the only licensed clinician, was not able to remain at the patient's bedside. The CLC registered nurse was in and out of the patient's room completing tasks that included contacting the CLC physician, following the CLC physician's orders to transfer the patient to a higher level of care, contacting the AOD to activate the EMS response, monitoring the patient's medical status, and printing the patient's EHR documents necessary for transfer.¹⁴

The OIG found discrepancies between CLC and facility leaders and CLC nursing staff in understanding responsibilities and expectations during a medical emergency. Although CLC and facility leaders believed all CLC nursing staff (including nursing assistants) had the ability to assess and provide care during a medical emergency, CLC nursing staff believed it was the registered nurse's responsibility to contact the CLC provider, follow the provider's orders, monitor the patient's medical status, activate the EMS response, and print transfer documents.

Although the OIG could not determine if discrepancies in understanding roles, responsibilities, and expectations during the medical emergency affected the outcome for this patient, they influenced the CLC registered nurse's ability to remain at bedside with the patient throughout the medical emergency to continuously monitor the patient's condition. This discrepancy in understanding may have been due to the lack of mock code trainings in the CLC.

Failure to Conduct Mock Code Trainings

The OIG determined that the failure to conduct mock code trainings with CLC nursing staff may have led to role confusion during the patient's medical emergency.

VHA requires facilities to implement a mock code program.¹⁵ The purpose of a mock code is to provide hands-on practice of critical skills needed during a medical emergency. The facility's mock code training included reviewing the process for activating EMS response, initiating the steps in BLS, retrieving any necessary equipment, using the AED, and monitoring the patient.¹⁶

Facility policy requires that mock codes should occur quarterly. According to the CPR committee chairperson and the CLC nurse manager, mock codes were put on hold in 2020 due to COVID-19. The OIG confirmed through document reviews that the CLC's last mock code occurred in October 2019. CLC nursing staff involved in the patient's care that night could not recall participating in mock code trainings. A facility leader reported, and the OIG confirmed, that mock code trainings restarted in the CLC in November 2022.

¹⁴ Due to conflicting information obtained from interviews with the nursing assistants and a VA police officer, the OIG could not determine if the nursing assistants remained with the patient throughout the medical emergency until EMS personnel arrived at the Small House.

¹⁵ VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021.

¹⁶ Necessary equipment may include an AED and a bag-mask device to assist with breathing.

The OIG learned through an interview with the CLC registered nurse that, at the time of the patient's medical emergency on day 112, the Small House had an AED but did not have a bag-mask device to assist with breathing during BLS. During the OIG site visit in September 2022, however, the OIG learned through an interview with Associate Director of Patient Care Services that the bag-mask device was available at the Small House.¹⁷ The OIG also learned that CLC nursing staff needed to be trained on how to use an AED. As of November 2022, the OIG confirmed that AED training occurred for nursing staff.

The OIG could not determine if the lack of mock code and AED training and the lack of a bag-mask device affected the outcome for this patient. The OIG determined, however, that the nursing staff's lack of training in how to respond and work cohesively during a medical emergency and missing emergency equipment may negatively affect other patients during a medical emergency.

Incomplete EHR Documentation

After review of the patient's care, the OIG determined the CLC registered nurse failed to document relevant patient care information in the EHR during and after the patient's medical emergency.

VHA and facility policy states documentation in a patient's EHR must be timely, relevant, and complete.¹⁸ Facility policy further states that clinical personnel, such as providers and nurses, should document sufficient information that will be utilized to plan patient care, outline the patient's condition, and document the treatment provided.¹⁹

The CLC registered nurse told the OIG of continuing to monitor the patient, including the vital signs, until EMS personnel arrived but did not document the updated vital signs in the patient's EHR. The OIG confirmed that the CLC registered nurse did not document the patient's updated vital sign readings in the patient's EHR.

According to the VA police report, EMS personnel assessed the patient upon arrival and determined that the patient did not have a pulse and was not breathing. EMS personnel confirmed that the patient did not have a do-not-resuscitate order, initiated CPR, and transferred the patient to a community hospital for a higher level of care. In reviewing the EHR, the OIG found no evidence that the CLC registered nurse documented the actions taken by EMS

¹⁷ American Heart Association, "Part 3: Adult Basic and Advanced Life Support," accessed August 18, 2022, <https://www.ahajournals.org/doi/epdf/10.1161/CIR.0000000000000916>. When performing CPR, "once chest compressions have been started, a single trained rescuer delivers rescue breaths by mouth to mask or by bag-mask device to provide oxygenation and ventilation."

¹⁸ VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. Facility Policy HCSM 136-31, *Medical Records*, November 1, 2020.

¹⁹ Facility Policy HCSM 136-31, *Medical Records*, November 1, 2020.

personnel. The CLC registered nurse told the OIG that in a retrospective review of the case, the CLC registered nurse's documentation should have included the EMS response to the patient.

According to the facility risk manager, after a patient is transferred out of the CLC and to a community hospital, facility staff are expected to document the episode of care by utilizing the higher level of care transfer note (transfer note). The transfer note was developed to assist in capturing all relevant information about the patient and the patient's transfer.

The OIG found that the CLC registered nurse's transfer note was incomplete and did not contain responses to all the elements. In interviews, facility leaders and the CLC nurse manager reported reviewing the CLC registered nurse's documentation of the patient's episode of care and stated the documentation should have included the subsequent vital sign readings and an assessment of the patient's status and condition at the time of transfer.

The OIG concluded that the CLC registered nurse's documentation at the time of the patient's medical emergency and transfer was incomplete and did not contain all relevant information. The OIG determined that the documentation failure did not affect the outcome for this patient, but complete and timely documentation is vital to the integrity of VHA's health information management, so that if requested, patients or their designee(s) can have access to accurate health record information.

Conclusion

The OIG did not substantiate that facility CLC nursing staff failed to respond to the patient's medical emergency. At the time of the medical emergency, the CLC registered nurse notified the CLC physician about the patient's acute change in condition and followed the CLC physician's orders to transfer the patient to a higher level of care. The CLC registered nurse also contacted the AOD to activate EMS response, and monitored the patient until EMS personnel arrived. The OIG found the CLC registered nurse did not obtain the AED or call 911 immediately as directed by the facility policy because the patient had a pulse and was breathing.

CLC and facility leaders failed to define staff responsibilities to respond to medical emergencies. This failure may have led CLC nursing staff to be unclear on specific roles, responsibilities, and necessary actions to be taken when medical emergencies occur in the CLC. Although the CLC registered nurse monitored the patient, the CLC registered nurse did not remain with the patient throughout the medical emergency due to completing tasks that included contacting the CLC physician, following the CLC physician's orders to transfer the patient to a higher level of care, contacting the AOD to activate the EMS response, monitoring the patient's medical status, and printing the patient's EHR documents necessary for transfer.

The failure to conduct mock code trainings with CLC nursing staff may have led to role confusion during the patient's medical emergency. Within a mock code, nursing staff practice and review the process for activating EMS response and initiating BLS. The last opportunity that

CLC staff had to participate in a mock code was in October 2019. In addition, at the time of the patient's medical emergency, the Small House had an AED but did not have a bag-mask device used to assist patients with breathing. At the time of the OIG site visit in September 2022, the OIG learned that the bag-mask device was available for use at the Small House. The OIG also learned that CLC nursing staff needed to be trained on how to use an AED. As of November 2022, the OIG confirmed that the AED training occurred for CLC nursing staff.

The CLC registered nurse failed to document relevant patient care information in the EHR during and after the patient's medical emergency. The CLC registered nurse monitored the patient's vital signs; however, the CLC registered nurse did not document the patient's updated vital sign readings in the patient's EHR. In addition, the OIG found no documentation of the EMS response to the patient.

Recommendations 1–3

1. The West Texas VA Health Care System Director ensures that community living center nursing staff are trained on their roles, responsibilities, and necessary actions when responding to a medical emergency.
2. The West Texas VA Health Care System Director certifies that mock codes are completed within the community living center at regular intervals and include all community living center nursing staff.
3. The West Texas VA Health Care System Director ensures that documentation requirements are met by community living center clinical staff and monitors compliance.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 24, 2023

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Healthcare Inspection—Inadequate Community Living Center Processes and Training at the
West Texas VA Health Care System in Big Spring

To: Director, Office of Healthcare Inspections (54HL08)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We sympathize with this Veteran's family and loved ones in this time of loss. I have reviewed and concur with the findings, recommendations and submitted action plans of the West Texas VA Health Care System.
2. As a High Reliability Organization, we are committed to ongoing improvement and a review of processes, to ensure we deliver the highest quality of care in the safest manner to our Veterans. These recommendations give us an opportunity to do that.

(Original signed by:)

Wendell E. Jones
VISN 17 Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 24, 2023

From: Director, West Texas VA Health Care System (519)

Subj: Healthcare Inspection—Inadequate Community Living Center Processes and Training at the West Texas VA Health Care System in Big Spring

To: Director, VA Heart of Texas Health Care Network (10N17)

1. We are saddened by the loss of this, and every Veteran. I would like to thank the Office of Inspector General for their thorough review of this case and recommendations on process improvements, including our hospice care. West Texas VA Health Care System appreciates the opportunity to partner with the OIG on our high reliability journey. We remain steadfast in our commitment to zero harm.
2. I appreciate the opportunity to review the Office of the Inspector General (OIG) draft report, Inadequate CLC Processes and Training at the West Texas VA Health Care System in Big Spring, Texas. I have reviewed and concur with the OIG's report, Inadequate CLC Processes and Training at the West Texas VA Health Care System in Big Spring, Texas.

(Original signed by:)

Robert A. Hoff
Acting Director
West Texas VA Health Care System

Facility Director Response

Recommendation 1

The West Texas VA Health Care System Director ensures that community living center nursing staff are trained on their roles, responsibilities, and necessary actions when responding to a medical emergency.

Concur.

Target date for completion: May 5, 2023

Director Comments

West Texas VA Health Care System (WTVAHCS) proactively began re-educating staff through intensive training focusing on how to appropriately respond to medical emergencies October 12, 2022. The education department held four different training sessions with all Community Living Center (CLC) staff. The curriculum included American Heart Association Basic Life Support (BLS), the appropriate use of the Automated External Defibrillator (AED), and staff roles and responsibilities as identified in local Health Care System Memorandum (HCSM) 111AC-16 “Medical Emergencies” and Nursing Service Policy (NSP) NSP-554 “Higher Level of Care”; to include required actions to take when responding to a medical emergency. The successful BLS refresher training took place during the week of May 1, 2023 through May 5, 2023 with the BLS Coordinator hosting, 39 of the 43 staff members completed the training, which is a 90% completion rate. Additionally, the WTVAHCS began identifying each resident in the CLC that has the code status “Do Not Resuscitate” during the Watchlist Huddle to ensure clinicians are aware of each resident’s status.

Requesting the closure of this recommendation prior to publication based on the information provided.

OIG Comments

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

Recommendation 2

The West Texas VA Health Care System Director certifies that mock codes are completed within the community living center at regular intervals and include all community living center nursing staff.

Concur.

Target date for completion: May 5, 2023

Director Comments

The Education and Training department conducted six unannounced mock codes in the CLC with a focus on how to appropriately respond to medical emergencies from November 9, 2022, through November 17, 2022. Following each mock code, the BLS Coordinator provided a debriefing session with all participants to discuss how to improve their knowledge and skills. Additional Mock codes will be scheduled on a quarterly basis to include all CLC staff. These unannounced mock codes will be conducted on all shifts. A mock code was completed during the week of May 1, 2023 through May 5, 2023 for newly hired employees and staff that were unable to participate in November 2022.

Requesting the closure of this recommendation prior to publication based on the information provided.

OIG Comments

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

Recommendation 3

The West Texas VA Health Care System Director ensures that documentation requirements are met by community living center's clinical staff and monitors compliance.

Concur.

Target date for completion: October 2023

Director Comments

West Texas VA Health Care System CLC staff utilize templates in the Computerized Patient Record System (CPRS) to document; 1) when a patient requires a higher level of care (NSP-554) and/or 2) the patient experiences a medical emergency (HCSM 111AC-16). Both templates were reviewed in depth with all nursing staff on November 16, 2022. Chart reviews will be completed for CLC residents that required a higher level of care and/or experienced a medical emergency. In every instance that a CLC resident requires a higher level of care, the appropriate CPRS template(s) is used to meet documentation requirements by nursing staff.

Risk Management has been and will continue to monitor each transfer for documentation to a higher level of care and/or medical emergency to ensure the proper documentation has been completed. Audits will continue until 90% compliance has been reached for six consecutive months. Audits will continue as required by the VISN 17 Director of Learning and will be reported through the CPR Quality Quarterly Suspense. Outcomes will be reported to Medical Executive Board through WTVAHCS CPR Committee on a quarterly basis. The numerator is the

number of higher level of care notes with complete documentation/the denominator is the total higher level of care notes.

Glossary

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

automated external defibrillator. “Portable, life-saving devices designed to treat people experiencing sudden cardiac arrest, a medical condition in which the heart stops beating suddenly and unexpectedly.”¹

basic life support. “Refers to the type of care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress or an obstructed airway. It requires knowledge and skills in cardiopulmonary resuscitation (CPR), using automated external defibrillators (AED) and relieving airway obstructions in patients of every age.”²

blood glucose. “Blood sugar.”³

cardiopulmonary arrest. “The loss of airway, breathing, or circulation necessary to maintain life that would result in death if not treated, often referred to as a code.”⁴

cardiopulmonary resuscitation. “An organized, sequential response to cardiac arrest, including recognition of absent breathing and circulation, basic life support with chest compressions and rescue breathing, advanced cardiac life support (ACLS) with definitive airway and rhythm control, and post-resuscitative care.”⁵

chronic obstructive pulmonary disease. “A chronic inflammatory lung disease that causes obstructed airflow from the lungs.”⁶

COVID-19. “A disease caused by a virus named SARS-CoV-2...[which] often causes respiratory symptoms that can feel much like a cold, a flu, or pneumonia.”⁷

decision-making capacity. “A clinical judgment about a patient’s ability to make a particular type of health care decision at a particular time.”⁸

¹ U.S. Food and Drug Administration, “Automated External Defibrillators (AEDs),” accessed November 22, 2022, <https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds>.

² American Red Cross Training Services, “What is (BLS)?” accessed February 23, 2023, <https://www.redcross.org/take-a-class/performing-bls/what-is-bls>.

³ Mayo Clinic, “Blood sugar testing: Why, When and How,” accessed September 23, 2019, <https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/blood-sugar/art-20046628>.

⁴ VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

⁵ Merck Manual, “Cardiopulmonary Resuscitation (CPR) in Adults,” accessed February 23, 2023, <https://www.merckmanuals.com/professional/critical-care-medicine/cardiac-arrest-and-cpr/cardiopulmonary-resuscitation-cpr-in-adults?query=cpr#>.

⁶ Mayo Clinic, “COPD,” accessed June 10, 2020, <https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679>.

⁷ Centers for Disease Control and Prevention, “Basics of COVID-19,” accessed October 25, 2022, <https://www.cdc.gov/coronavirus/2019-ncov/your-health/about-covid-19/basics-covid-19.html>.

⁸ VHA Handbook 1004.03(2), *Life Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals, and Preferences*, January 11, 2017, amended May 10, 2021.

diabetes. “A chronic disease that occurs when the pancreas is no longer able to make insulin, or when the body cannot make good use of the insulin it produces...Not being able to produce insulin or use it effectively leads to raised glucose levels in the blood.”⁹

do-not-resuscitate order. “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.”¹⁰

full code. “The summoning of professionals trained in CPR to revive a person in cardiac, respiratory, or cardiopulmonary arrest.”¹¹

hematoma. “A mass of usually clotted blood that forms in a tissue, organ, or body space as a result of a broken blood vessel.”¹²

hospice care. “Helps people who have advanced, life-limiting illnesses to spend their final days comfortably, with dignity, control and good quality of life.”¹³

hypertension. “A common condition that affects the body’s arteries... [in which] the force of the blood pushing against the artery wall is consistently too high.”¹⁴

life-sustaining treatment. “a medical treatment that is intended to prolong the life of a patient who would be expected to die soon without the treatment.”¹⁵

opiates. “The natural or synthetic drugs that have a morphine-like pharmacological action. Medically, opiates are used primarily for relief of pain. Opiates include morphine and drugs structurally similar to morphine (e.g., codeine, hydrocodone, hydromorphone, oxycodone).”¹⁶

peer review. A review of a specific episode of care performed by a peer with the goal of identifying opportunities for practice improvement.¹⁷

⁹ International Diabetes Federation, “What is diabetes,” accessed February 23, 2023, <https://www.idf.org/aboutdiabetes/what-is-diabetes.html>.

¹⁰ U.S. National Library of Medicine, MedlinePlus, “Do-not-resuscitate order,” accessed March 26, 2019, <https://medlineplus.gov/ency/patientinstructions/000473.htm>.

¹¹ Merck Manuals, “Do not resuscitate DNR orders,” accessed April 16, 2019, <https://www.merckmanuals.com/home/fundamentals/legal-and-ethical-issues/do-not-resuscitate-dnr-orders>.

¹² Merriam-Webster.com Dictionary, “hematoma,” accessed October 25, 2022, <https://www.merriam-webster.com/dictionary/hematoma>.

¹³ Cleveland Clinic, “Hospice,” accessed October 25, 2022, <https://my.clevelandclinic.org/health/treatments/21673-hospice>.

¹⁴ Mayo Clinic, “High blood pressure (hypertension),” accessed February 23, 2023, <https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410>.

¹⁵ VHA Handbook 1004.03(2), *Life Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals, and Preferences*, January 11, 2017, amended May 10, 2021.

¹⁶ Mayo Clinic Laboratories, “Opiates,” accessed November 7, 2022, <https://test.mayocliniclabs.com/test-info/drug-book/opiates.html>.

¹⁷ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

pulse oximeter. A medical device used to measure a patient’s oxygen saturation level.¹⁸

vital signs. “[A measure of] essential body functions including your heartbeat, breathing rate, temperature, and blood pressure.”¹⁹

¹⁸ Merriam-Webster.com Dictionary, “pulse oximeter,” accessed December 5, 2022, <https://www.merriam-webster.com/dictionary/pulse%20oximeter>.

¹⁹ U.S. National Library of Medicine, MedlinePlus, "Vital signs," accessed May 15, 2020, <https://medlineplus.gov/ency/article/002341.htm>.

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