Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00191-406

Healthcare Inspection

Alleged Lapse in Timeliness of Care
West Palm Beach VA Medical Center
West Palm Beach, Florida

July 2, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations about the lack of timeliness of care and management action at the West Palm Beach VA Medical Center (facility), West Palm Beach, Florida.

We substantiated the allegation that the patient was not on the schedule for any interventional radiology (IR) procedures; however, the patient was brought to the IR area for insertion of a peripherally inserted central catheter line, which is not an IR procedure.

We substantiated that the patient was transported from the Emergency Department (ED) to the IR area without being appropriately monitored and was not placed on a monitor immediately on arrival to the IR area. In addition, we found that required communication between nursing staff in the ED and the IR nurse did not take place prior to the patient being transported from the ED to the IR area. We also found that the facility policy for handoff communication does not describe how handoff communication is to be documented.

We did not substantiate that cardiopulmonary resuscitation (CPR) was not begun promptly when a "code" was called. Our review of the patient's electronic health record found that when the patient was recognized to be in distress, resuscitation efforts took place quickly.

We did not substantiate the allegation that management was notified of CPR timeliness concerns but failed to take proper action.

We recommended that the Facility Director ensure that unstable patients be appropriately monitored during transport from one location to another. We also recommended that the Facility Director ensure that ED and IR nursing staff receive education in handoff communication requirements and that the facility policy for handoff communication be reviewed for inclusion of documentation requirements.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 7–10, for the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations about the lack of timeliness of care and management action at the West Palm Beach VA Medical Center (facility), West Palm Beach, Florida.

Background

The facility is a tertiary care facility with 181 acute care beds and provides a broad range of medical, surgical, and psychiatric inpatient care, as well as primary and specialty care outpatient services. The facility is part of Veterans Integrated Service Network (VISN) 8 and serves a veteran population of 56,677 unique patients.

Interventional Radiology (IR) Services, a part of the facility's Radiology Services, is an area where procedures are done that use minimally invasive image-guided techniques to diagnose and treat diseases. According to the American College of Radiology,[1] typical staffing for IR procedures would include the physician who is performing the procedure, a registered nurse (RN) to monitor the patient and administer medications, and an IR technician (IRT) to assist with image obtainment and positioning the patient. In addition, there is usually another nurse or IRT in a control room who is also watching the procedure and recording activities as needed.

In October 2014, the Office of Healthcare Inspections received allegations that:

1. A patient was brought to the IR area who was not scheduled for an IR procedure.
2. The patient was transported from the Emergency Department (ED) to the IR area without being on a heart monitor and was not placed on a heart monitor immediately on arrival in the IR area.
3. IR staff did not promptly begin cardiopulmonary resuscitation (CPR) when the patient "coded."[2]
4. Facility management was notified of the CPR timeliness concerns but failed to take proper action.

[1] Practice Guideline for Interventional Clinical Practice Collaborative statement from the American College of Radiology, the American Society of Interventional and Therapeutic Neuroradiology, and the Society of Interventional Radiology, J Vasc Interv Radiol 2005; 16:149–155

[2] The term "coded" refers to a medical emergency where the patient has cessation of breathing and/or heartbeat.

Scope and Methodology

We conducted a site visit January 26–30, 2015. We interviewed the complainant, an IR nurse, IRTs, members of the code team, and a pulmonologist. We reviewed the patient's electronic health record (EHR) and relevant policies, documents, and data.

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

Case Summary

The patient was a male in his early seventies with multiple comorbidities, including prostate cancer with widespread metastasis to the bones, diabetes, heart disease with a history of coronary artery bypass surgery, an implanted cardiac defibrillator, and a history of deep vein thrombosis and strokes. He was admitted to an inpatient unit at the facility in fall 2013 for treatment of pneumonia. He required intensive care and was on a ventilator[3] and hemodialysis[4] for part of the stay. When stabilized, the patient was transferred to the facility's community living center[5] (CLC) in mid-fall 2013. The patient was evaluated for hospice care;[6] however, he was not in agreement with this plan. He was never placed in hospice care and did not have a "do not resuscitate"[7] order in effect at the time of his death.

In winter 2014, just before midnight, the patient complained of abdominal discomfort and dizziness. He was noted to be mildly hypotensive and tachycardic and then became unresponsive and was possibly having a seizure. A "rapid response"[8] was initiated, and the patient was stabilized and transferred from the CLC to the ED approximately 1 hour after his initial complaints because the Medical Intensive Care Unit (MICU) did not have any available beds. The patient was placed on a heart monitor and supplemental oxygen in the ED. About 3 hours later, the patient again experienced dizziness and nausea and became briefly unresponsive. No seizure activity was noted. During the day, the patient had intermittent episodes of restlessness, hypotension, confusion, and decreased levels of responsiveness. The patient's intravenous catheter (IV) and fluids also had to be restarted with great difficulty several times, so the patient's provider decided to have a peripherally inserted central catheter (PICC) inserted in IR. Mid-afternoon, the patient was transported to the IR suite by the IR technician for insertion of a PICC for management of IV fluids and medications.

The IR nurse noted that the patient was "pale and lethargic" on arrival to the IR area. Supplemental oxygen was placed on the patient, and the patient was oriented to date, place, and self at this time. The IR nurse confirmed with the patient's physician that the patient was capable of giving consent for a PICC. Shortly after consent was obtained, the patient became restless, and the IR nurse called the MICU in an attempt to reach the patient's physician. While on the phone with a clerk in the MICU, the patient "passed out." The nurse yelled for anyone in the vicinity to "call a code," hung up the

[3] A ventilator is a machine designed to mechanically move air into and out of the lungs for a patient who is physically unable to breathe or breathing insufficiently.
[4] Hemodialysis is a method used to remove waste products from the blood when the kidneys are in a state of renal failure.
[5] Formerly known as a nursing home.
[6] Hospice care provides medical services, emotional support, and spiritual resources for people who are in the last stages of a serious illness, such as cancer or heart failure.
[7] A written order to withhold CPR or advanced cardiac life support in case a patient's heart were to stop or the patient was to stop breathing.
[8] Calling a "Rapid Response" triggers assistance from a team of health care providers who respond to hospitalized patients with early signs of clinical deterioration on non-intensive care units to prevent respiratory or cardiac arrest

phone, and immediately placed the patient on a heart monitor. The patient's heart rate was around 40 beats per minute, but the nurse was not able to feel a pulse, and the patient's breathing was agonal. CPR was started.

Due to IR's close proximity to the MICU, the code team responded to IR within seconds. A member of the code team documented in the EHR that the nurse and code cart were noted to be at the patient's bedside and CPR was started. The patient did not respond to resuscitation efforts, and efforts were ceased after 31 minutes, at which time the patient was pronounced dead.

Inspection Results

Allegation 1. Unscheduled IR Procedure

We substantiated the allegation that the patient was not on the schedule for any IR interventions; however, the patient was brought to the area for insertion of a PICC, not an IR procedure. The IR nurse on duty was cross-trained to insert PICCs.

A PICC can be inserted anywhere in the facility, but depending on the workload of the IR nurse, it is sometimes more convenient for a patient to come to the IR area for the procedure. We were told that the IRTs do not like to have PICCs inserted in the IR area because they have to set up the room and the procedure is often not scheduled in advance.

Allegation 2. Lack of Monitoring of Patient During and After Transport

We substantiated that the patient was transported from the ED to the IR area without being on a heart monitor and was not placed on a monitor immediately on arrival to the IR area. In addition, we found that required communication between nursing staff in the ED and the IR nurse did not take place prior to the patient being transported to the IR.

Local policy[9] states that the referring clinic or service (in this case the ED) is responsible for transportation of unstable patients by qualified personnel to and from Imaging Service. Unstable patients include those who are on cardiac monitoring equipment and/or require continuous observation.

The patient was on a heart monitor in the ED. It is documented in one note in the EHR that the patient was transported "to angio by RN." However, another note in the EHR states that the patient was accompanied by "IR tech and escort staff." We confirmed during interviews that the patient was transported from the ED to the IR area without a heart monitor or nurse in attendance.

The Joint Commission requires all health care providers to "implement a standardized approach to handoff communications including an opportunity to ask and respond to

[9] Imaging Service Policy Number A-5, *MANAGEMENT OF UNSTABLE PATIENTS*, February 2013.

questions."[10] The facility policy for handoff communications states that during each transfer of care, handoff communications will occur: (1) Nurse to nurse when relinquishing and assuming patient care responsibility, and (2) Temporary transfers of care for testing purposes, such as to Radiology Services from another area of the facility. However, local policy does not require that completion of phone or in-person handoff communication be documented in the EHR.[11]

We confirmed during interviews that no efforts were made either by phone, in person, or documentation in the EHR of handoff communication between the ED nursing staff and the IR nursing staff.

Allegation 3. CPR Not Prompt

We did not substantiate that CPR was not begun when "the code was called." EHR documentation reflected that when the patient was recognized to be in distress, resuscitation efforts took place quickly. According to the EHR, the patient was placed on supplemental oxygen upon arrival to the IR area. The exact time of arrival was not documented. An informed consent for insertion of a PICC line was signed by the patient, and approximately 8 minutes later, while the IR nurse was on the phone to MICU attempting to locate a physician, the patient's condition deteriorated. The IR nurse loudly requested to anyone in the vicinity that a code be called, placed the patient on a heart monitor, checked if the patient had a pulse or was breathing, and started CPR. According to times documented in the EHR, the code team arrived immediately and took over resuscitation measures.

Allegation 4. Management Response

We did not substantiate the allegation that management was notified about CPR not being started timely but failed to take proper action. An internal review was completed. Additionally, the area manager recommended that because of the infrequency of this type of event, and the potential for a knowledge gap, a formal debriefing should be conducted and documented following each resuscitation event in the IR area.

Conclusions

We substantiated the allegation that the patient was not on the schedule for any IR interventions; however, the patient was brought to the area for insertion of a PICC line, not an IR procedure.

We substantiated that the patient was transported from the ED to the IR area without being on a heart monitor and was not placed on a monitor immediately on arrival to the IR area. In addition, we found that required communication between nursing staff in the ED and the IR nurse did not take place prior to the patient being transported to the ED.

[10] See Agency for Healthcare Research and Policy, http://psnet.ahrq.gov/primer.aspx?primerID=9, Accessed January 23, 2015, citing Joint Commission requirement.
[11] Medical Center Memorandum 548-99-217, *Hand-Off Communications Process,* December, 30, 2012.

We also found that the memorandum for handoff communication does not describe how handoff communication is to be documented.

We did not substantiate that CPR was not begun when "the code was called." The patient's EHR reflected that when the patient was recognized to be in distress, resuscitation efforts took place quickly.

We did not substantiate the allegation that management was notified about CPR not being started timely but failed to take proper action.

Recommendations

1. We recommended that the Facility Director implement procedures to ensure that unstable patients being transported from one area to another in the facility be monitored safely and accompanied by appropriate personnel.

2. We recommended that the Facility Director ensure that Emergency Department and Interventional Radiology nursing staff receive education on handoff communication requirements.

3. We recommended that the Facility Director ensure that the facility policy for the handoff communication process be reviewed for inclusion of documentation of handoff communication.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: May 11, 2015

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Healthcare Inspection—Alleged Lapse in Timeliness of Care, West Palm Beach VA Medical Center, West Palm Beach, Florida

To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the status update response submitted by West Palm Beach VA Medical Center regarding their OIG review.

2. The facility has taken appropriate actions as detailed in the response. Thank you!

(original signed by:)
David Whitmer for Paul D. Bockelman, MBA, FACHE
Acting Network Director, VISN 8

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 17, 2015

From: Director, West Palm Beach VA Medical Center (548/00)

Subj: Healthcare Inspection—Alleged Lapse in Timeliness of Care, West Palm Beach VA Medical Center, West Palm Beach, Florida

To: Director, VA Sunshine Healthcare Network (10N8)

1. West Palm Beach VA Medical Center (WPB VA MC) would like to thank the Office of Inspector General (OIG) Team for the recommendations based on their review. We concur with the findings and are implementing the corrective actions identified to improve processes.

2. Our goal is to deliver the best care to our Veterans each and every day focusing on Quality, Safety, and Value and we appreciate the OIG Team's consultative and collaborative approach in helping us to meet our goal.

Charleen R, Szabo, FACHE
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director implement procedures to ensure that unstable patients being transported from one area to another in the facility be monitored safely and accompanied by appropriate personnel.

Concur

Target date for completion: 07/01/2015

Facility response:

The MCM 548-11-199 Admission, Transfer and Discharge policy has been reviewed and revised to provide clarification to ensure patient's needs are consistently met by staff whose competencies meet monitoring requirements and equipment needs prior to transporting patients throughout the continuum of care. The MCM is currently going through a second collaboration process and when it is posted, staff will be made aware in the Daily Bulletin. All clinical services will be required to introduce the revised MCM with discussion of expectations to confirm all staff in their unit was made aware by 07/01/2015. The Patient Safety Manager will collect all supporting documentation to verify clinical staff was made aware of the newly revised MCM.

Recommendation 2. We recommended that the Facility Director ensure that Emergency Department and Interventional Radiology nursing staff receive education on handoff communication requirements.

Concur

Target date for completion: 07/01/2015

Facility response:

The MCM 548-99-217 Hand Off Communication policy will be reviewed and revised to provide clarification by specifically identifying the steps to be consistently followed during the hand off communication process to include supporting documentation requirements. When the MCM completes the collaboration process and it is posted, staff will be made aware in the Daily Bulletin. Emergency Department and Interventional Radiology nursing staff will receive education on the revised MCM with supporting documentation to confirm all staff in their unit was made aware by 07/01/2015. The Patient Safety Manager (PSM) will collect all supporting documentation to verify clinical staff was made aware of the newly revised MCM. The PSM will review all reported Hand-Off Communication events to measure effectiveness.

Recommendation 3. We recommended that the Facility Director ensure that the facility policy for the handoff communication process be reviewed for inclusion of documentation of handoff communication.

Concur

Target date for completion: 07/01/2015

Facility response:

The MCM 548-99-217 Hand Off Communication policy will be reviewed and revised to provide clarification by specifically identifying the steps to be consistently followed during the hand off communication process to include supporting documentation requirements. When the MCM completes the collaboration process and it is posted, staff will be made aware in the Daily Bulletin.

Appendix C

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Martha Kearns, MSN, FNP, Team Leader Carol Torczon, MSN, ACNP Thomas Wong, DO

Appendix D

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