DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center

New York

HEALTHCARE INSPECTION | REPORT #17-03347-290 | SEPTEMBER 18, 2018

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding quality of care issues in two[1] of the four Community Living Centers (CLC) at the Northport VA Medical Center (Facility), New York.[2] An anonymous complainant(s) made specific allegations:

- Patient A died at the Facility after choking on food in the CLC 3 dining hall due to lack of nursing staff available to supervise patients.
  - Staff called the wrong code,[3] resulting in a delayed response and the wrong staff responding to the code.
  - Managers misrepresented the cause of death as cardiac arrest, rather than choking.
- Patients on CLC 3[4] are regularly left unsupervised while eating.
- The locked CLC 3[5] lacks security due to malfunctioning door locks, staff not conducting hourly rounds, and lack of staff vigilance.[6]
- Patient B's wrists were bound together by a CLC 2 staff member due to lack of available nursing staff to supervise Patient B.
- Nurse Managers on the CLCs[7] are often unavailable and fail to provide adequate response to unit issues.

[1] The OIG limited the scope of its inspection to CLC 2 and CLC 3 as the allegations involved patients living in these units.

[2] In addition to the allegations listed in this report, the OIG received complaints of mold on the inpatient mental health unit (Unit 22). While onsite, the OIG team visited Unit 22 and confirmed the presence of mold. Upon request, the Facility provided the OIG with actions planned to address the concern.

[3] "Calling a code" is a term used to summon a team of providers trained to perform a higher level of care than first responders or to transport the patient to a site where a higher level of care may be initiated.

[4] For this report, the OIG limited the review of patients unsupervised while eating to CLC 3. This decision was made based on the allegation being coupled with others specific to CLC 3 and the OIG's inability to clarify the scope due to the complainant being anonymous.

[5] CLC 3 is a specialized locked unit for patients who wander, exhibit aggressive behaviors, present elopement risks, show significant cognitive impairment, or exhibit other high-risk behaviors.

[6] Vigilance occurs when staff are alert and observing for potentially dangerous situations.

[7] Although the original allegation mentioned a Nurse Manager on CLC 3, the OIG team interviewed staff from both CLC 2 and CLC 3 during the inspection and asked them about nurse managers. The decision to query staff regarding nurse managers on both units was made based on the location of the events in the allegations received and the OIG's inability to clarify the scope due to the complainant being anonymous.

A number of the allegations addressed in this report attribute specific actions to a lack of sufficient nurse staffing. In this report, the OIG limited the review to nurse staffing during meal times.

After interviews with staff and a review of nurse staffing data, OIG inspectors identified an ongoing challenge to maintain baseline CLC nurse staffing levels. Facility leaders addressed the nurse staffing shortages through the use of float assignments and staff overtime. Due to the potential risk to the quality of patient care and safety of patients associated with staffing shortages, the OIG determined that a healthcare inspection unique to CLC nurse staffing at the Facility was warranted. Results of that inspection will be issued in a separate report.

The OIG reviewed the circumstances surrounding the death of Patient A in the CLC 3 dining hall. Patient A's Death Certificate, supported by an autopsy performed by the Deputy Chief Medical Examiner, Suffolk County, New York, described the cause of death as "Complications of Aspiration[8] of Food Bolus." OIG inspectors found nothing to contradict this. Thus, the OIG team substantiated the first part of the allegation that "Patient A died at the Facility after choking on food," but found insufficient evidence to attribute the cause of Patient A's choking to the lack of nurse staffing.

The OIG team substantiated that CLC staff notified the operator of Patient A's emergency without specifically requesting the type of code to be initiated. In response, the operator called the wrong code, leading to multiple teams responding and a delay in transporting Patient A to the Emergency Department (ED). While it is impossible for the OIG to determine if calling the correct code or a more timely transfer to the ED would have altered the outcome of this case, it may have improved the patient's chances of surviving the incident. The OIG team did not substantiate that managers misrepresented the cause of death as cardiac arrest, rather than choking.

The OIG team found the Facility policies and practices related to emergency medical response were inconsistent with the Veterans Health Administration (VHA) Emergency Medicine Directive.[9] The OIG team also found that post-code debriefings were not completed as required for Patient A. The Safety/Engineering Service is responsible for Emergency Response Team supervision. OIG inspectors found that the Emergency Response Team lacked medical oversight in that neither the ED nor the Cardiopulmonary Resuscitation Committee were reviewing all Emergency Response Team event responses.

The OIG team was unable to substantiate or not substantiate that patients on CLC 3 were regularly left unsupervised while eating, as the evidence was insufficient to make such a determination. The Facility lacked a policy or process that outlined the expectations of a

[8] Aspiration is the breathing in of a foreign object (in this case a mass of food) into the airway.

[9] VHA Directive 1101.05(2), Emergency Medicine, September 2, 2016. This directive was amended March 7, 2017.

designated staff member responsible for monitoring staffing levels, both nurse and interdisciplinary team, throughout the meal to ensure that they remain congruent with patient needs.

The OIG team did not substantiate that CLC 3 lacked security due to malfunctioning door locks. A review of prior work orders revealed a history of malfunctioning door locks that, at the time of the OIG's first site visit in June 2017, had been addressed. OIG inspectors found CLC 3 secure at all points of entrance and exit.

The OIG team substantiated a lack of consistent documentation of hourly rounds. Documentation of hourly rounds was not occurring as required; however, the OIG team was unable to ascertain if the lack of documentation reflected an absence of completed hourly rounds and decreased unit security. The OIG team was unable to substantiate or not substantiate a lack of staff vigilance, as the evidence was insufficient to make a determination. OIG inspectors learned of staffing shortages that could create an environment where the increased workload assigned to each staff member was such that it became more difficult to remain vigilant.

The OIG team substantiated that Patient B's wrists were bound together by the strap of the palm protector; however, inspectors did not find evidence to suggest it was an intentional act done by a staff member due to a lack of available nursing staff to supervise Patient B. Reviews by the Facility, OIG Office of Investigations, and the OIG inspection team were inconclusive in determining how both of Patient B's wrists became bound by the strap of the palm protector.

The OIG team did not substantiate that nurse managers on the CLCs reviewed were often unavailable and failed to provide adequate response to unit issues. CLC staff interviewed consistently stated that while nurse managers were not always physically present on the unit because of other administrative responsibilities, they could be reached by telephone, even when off duty.

The OIG team reviewed the actions taken by the Facility staff and leaders in response to the events involving Patient A and Patient B. The Facility response involving Patient B was thorough and well documented. Following Patient A's event, the Facility took action to train staff in regard to calling the correct code team. However, OIG inspectors determined that the circumstances surrounding Patient A's care and eventual death warranted additional Facility response including consideration of an institutional disclosure and peer reviews.

The OIG made nine recommendations.

The Facility Director:

- Makes certain that staff conduct post–Code Blue debriefings as required and that compliance is monitored.

- Ensures the collection, review, and analysis of data following each Emergency Response Team event response and that those involving resuscitative care are reviewed by the Facility Cardiopulmonary Resuscitation Committee, and that compliance is monitored.
- Confirms that a review of the CLC meal staffing process is performed to evaluate the need for the designation of a staff person responsible for assigning (both nurse and interdisciplinary team) and monitoring staffing levels in the dining hall throughout meal times and takes appropriate action.
- Completes a review of the meal delivery process in the CLCs to confirm and document menu selection and diet type at the time that meal trays are served to the patient and makes policy updates, if warranted.
- Verifies that CLC safety rounds are conducted and documented, as required, and that compliance is monitored.
- Confers with Office of General Counsel to determine if an institutional disclosure of Patient A's care is warranted.
- Obtains peer reviews of the care provided by practitioners (including supervisors in the case of the resident physicians) during the emergency management of Patient A while in the CLC and ED.
- Reviews and updates, as warranted, Facility policies and practices related to emergency medical response (such as obtaining emergent intravenous access) and adequate medical oversight and all staff (including resident physicians) complete training and compliance is monitored.

The Veterans Integrated Service Network 2 Director oversees and provides assistance to the Northport VA Medical Center Director in the review and update of Facility policies and practices on emergency medical response and adequate medical oversight.

Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 37–43, for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

ACLS	Advanced Cardiovascular Life Support
ADL	activities of daily living
AED	automated external defibrillator
AHA	American Heart Association
BLS	Basic Life Support
CLC	Community Living Center
CPR	cardiopulmonary resuscitation
ED	Emergency Department
EHR	electronic health record
ERT	Emergency Response Team
FD	Fire Department
ICU	Intensive Care Unit
IO	intraosseous
IV	intravenous
LPN	licensed practical nurse
LTC	long-term care
MS	multiple sclerosis
NA	nursing assistants
NOD	Nurse Officer of the Day
OIG	Office of Inspector General
PD	Police Department
RRT	Rapid Response Team
RT	respiratory therapist
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations made regarding quality of care issues in two of the four Community Living Centers (CLC) at the Northport VA Medical Center (Facility), New York.

Background

The Facility is part of Veterans Integrated Service Network (VISN) 2 and provides medical, surgical, psychiatric, rehabilitative, and long-term care. The campus has 70 buildings on 269 acres. (See Figure 1 for main campus map.) In fiscal year 2016, the Facility served more than 31,000 patients and had a total of 381 operating beds, including 173 inpatient beds, 38 domiciliary beds, and 170 CLC beds.

CLCs

The Facility CLCs provide short- and long-term care to patients with a variety of medical conditions who need assistance with activities of daily living (ADL)[10] as well as skilled nursing or medical care. The CLCs provide rehabilitation services and other specialty programs for patients. CLC staff strive to provide patient-centered care tailored to each patient's[11] needs and preferences. The Facility has four CLCs, as described below. Patients are assigned to a CLC based on their medical condition and individual care needs.

[10] ADLs include tasks such as bathing, toileting, personal hygiene, eating, and personal mobility such as walking or wheelchair propulsion and bed mobility.

[11] All veterans who reside in a CLC are typically referred to as residents. However, since this report will be discussing patient care provided by medicine and surgery resident doctors, to avoid confusion, the term "patient" will be used to describe CLC patients and the term "resident" will be used to describe resident doctors.

Building 92:

- CLC 1 has a maximum capacity of 41 patients and provides long-term,[12] palliative,[13] and dementia care.
- CLC 2 has a maximum capacity of 41 patients and provides long-term and palliative care.

Building 8:

- CLC 3 is a locked unit with a maximum capacity of 30 patients and provides care to patients that are high risk for elopement or injury.[14]
- CLC 4 has a maximum capacity of 22 patients and provides palliative and respite care[15] as well as sub-acute rehabilitation.

[12] "Long term care refers to a continuum of medical and social services designed to support the needs of people living with chronic health problems that affect their ability to perform everyday activities. It includes traditional medical and social services as well as housing." McCall, N. "Who Will Pay for Long Term Care?" Health Administration Press, January 1, 2001, p.3.

[13] "Palliative care is specialized medical care for people with serious illness focusing on providing relief from the symptoms and stress and improve quality of life." https://getpalliativecare.og/whatis/. (The website was accessed on July 12, 2017.)

[14] CLC 3 is a specialized locked unit for patients who wander, exhibit aggressive behaviors, present elopement risks, show significant cognitive impairment, or exhibit other high-risk behaviors.

[15] VHA Handbook 1140.02 defines respite care as "a distinct VA program with the unique purpose of providing temporary relief for unpaid caregivers from routine care giving tasks, thus supporting caregivers in maintaining the chronically ill veteran in the home." VHA Handbook 1140.02, *Respite Care*, November 10, 2008. This handbook was scheduled for recertification on October 31, 2013, and has not been recertified.

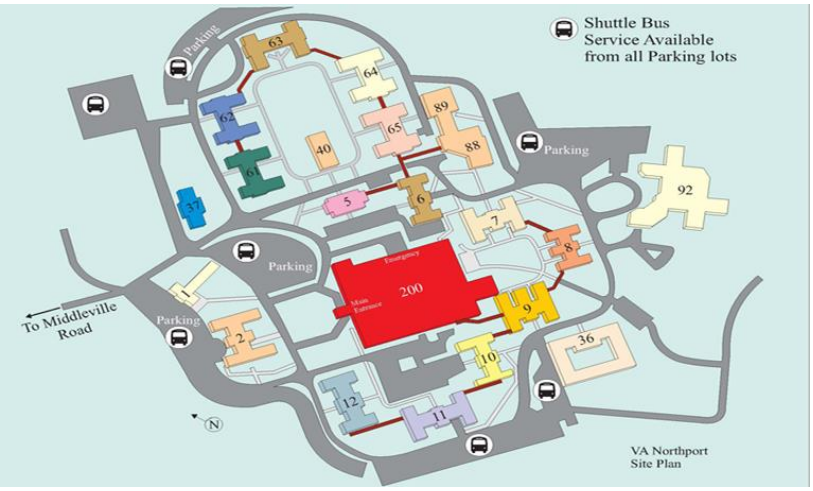

Figure 1. Facility Campus Map
Source: https://www.northport.va.gov/images/facility_map.jpg. (The website was accessed on July 12, 2017.)

Facility Emergency Responses

The Facility has three types of emergency response teams: Code Blue Team, Emergency Response Team (ERT), and Rapid Response Team (RRT).[16] The type of response initiated during an emergency is determined by the nature of the event and whether it takes place inside or outside Building 200, the main medical center.

Code Blue Team

The Facility uses the term Code Blue for medical emergencies such as a patient in cardiopulmonary arrest.[17] The Code Blue Team is comprised of representatives from Medicine, Surgery, Respiratory Therapy, Nursing, and Anesthesia Services. While on duty, team members carry digital pagers that operators activate to notify the team of a patient with a suspected cardiopulmonary arrest.[18]

The Code Blue Team is responsible for responding to cardiopulmonary arrests that occur within Building 200. Initial treatment of a patient in cardiopulmonary arrest is the responsibility of the first cardiopulmonary resuscitation (CPR) trained employee present at the medical emergency. When a cardiopulmonary arrest is suspected, Facility employees are trained to call the operator to activate the Code Blue Team and immediately begin CPR, if qualified.

[16] Only the Code Blue Team and the ERT will be discussed in this report.

[17] Cardiopulmonary arrest is the loss of airway, breathing, or circulation necessary to maintain life.

[18] Center Memorandum 11-151, *Cardiopulmonary Resuscitation in Building 200, The Primary/Specialty Care Pavilion, the Community Living Center, and on Hospital Grounds*, December 6, 2012.

To call a Code Blue, the first responder or another staff member calls the operator on the Facility's designated emergency telephone extension, states there is a Code Blue, and gives the location. The operator then activates the Code Blue Team pagers, makes an overhead page twice saying "Code Blue," and gives the location of the event, for example "Code Blue, Unit 34."

ERT

The ERT is responsible for responding to medical emergencies throughout the Facility campus but excludes certain inpatient units in Building 200.[19] [20] The ERT consists of Fire Department (FD) and Police Department (PD) personnel. All ERT personnel are trained in American Heart Association (AHA)[21] basic first aid and certified in Basic Life Support (BLS).[22] FD personnel are to assess, stabilize, and transport patients to the Facility Emergency Department (ED) while PD personnel are to assist with traffic control if needed (either vehicular or human). The ERT is requested by calling the operator on the Facility's designated emergency telephone extension and specifying the need for an ERT. The operator who receives the call requests the caller's name and contact number, location of the event, and type of emergency. The operator then notifies the ERT by calling them on the telephone or two-way radio.

In the event of a cardiopulmonary arrest in any of the CLCs, the Facility's policy is for staff to call the ERT and have staff qualified to do so initiate CPR immediately.[23] An automated external defibrillator (AED)[24][25] is available in the CLCs in the event a patient is found unresponsive and needs defibrillation. The ERT arrives at the CLC with an ambulance for patient transport as well as a fire truck, and provides care within the team's scope of practice and competencies. If deemed appropriate and safe, FD staff will assess, stabilize, and transport the patient/visitor/staff member to the ED for further medical evaluation and treatment.

---

[19] The ERT does not respond to patient emergencies but does respond to visitor and staff medical emergencies on inpatient units 21, 22, 33, and 34 in Building 200.

[20] Center Memorandum 138-039, *Emergency Response Team (ERT)*, dated June 23, 2015.

[21] The AHA is a non-profit organization in the United States that fosters appropriate cardiac care in an effort to reduce disability and deaths caused by cardiovascular disease and stroke.

[22] BLS is a course that teaches the first responder basic steps for treatment of a patient who is without a pulse or is not breathing. It typically includes basic skills such as CPR with the goal of providing short term care while waiting for transfer of the patient to a higher level of care.

[23] Center Memorandum 11-151.

[24] An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart (termed defibrillation) to try to restore a normal rhythm. AEDs are used to treat sudden cardiac arrest (SCA). Sudden cardiac arrest is a condition in which the heart suddenly and unexpectedly stops beating. When available, AEDs should be used as rapidly as possible in conjunction with CPR. AEDs are user-friendly devices which only require the user to turn on the power and follow the voice and onscreen prompts.

[25] What is an Automated External Defibrillator, National Heart, Lung and Blood Institute, December 2, 2011. https://www.nhlbi.nih.gov/health/health-topics/topics/aed. (The website was accessed on August 22, 2017.)

CPR

CPR is a procedure to support and maintain breathing and circulation for an individual who has stopped breathing (respiratory arrest), whose heart has stopped (cardiac arrest), or both (cardiopulmonary arrest). The AHA's 2015 CPR guidelines recommend responders immediately start chest compressions for adults in sudden cardiopulmonary arrest. The AHA further recommends that when multiple responders are available, chest compressions, airway, and breathing be performed concurrently.[26]

Basic and Advanced Cardiovascular Life Support

Veterans Health Administration (VHA) requires BLS certification[27] for all individuals that provide direct clinical care to patients.[28] BLS curriculum includes CPR, the use of AEDs, and rescue breathing. The course teaches that the first responder is to initiate BLS and continue BLS until a higher[29] level of care, such as Advanced Cardiovascular Life Support (ACLS)[30] is obtained.[31] ACLS is a set of knowledge and skills that the provider uses to care for a patient in cardiac arrest. ACLS providers administer medications in a sequential manner, usually by intravenous (IV) access. Successful BLS and ACLS depend, in part, on high-quality, early CPR and rapid defibrillation, which can significantly increase the patient's chance for survival.[32]

Crash Carts

Crash carts are portable carts that contain medications and equipment needed for the implementation of ACLS. The determination where crash carts are located is based on the patient population, the environment of care, and the emergency response policy in place. In 2015, the Facility's CPR Committee determined that the CLCs would not have crash carts because CLC

---

[26] Highlights of 2015 and 2017 American Heart Association Focused Updates. (The website was accessed on June 19, 2017.)

[27] The terms BLS and CPR are used interchangeably in this report.

[28] VHA Directive 1177, *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training For Staff*, November 6, 2014. This policy was in place at the time of the event and was rescinded and replaced in April 2017.

[29] Higher level of care is when someone arrives to the scene who can provide more lifesaving interventions than BLS. For example, when an ambulance arrives on scene and the paramedics take over care of the patient.

[30] The AHA uses the term "Advanced Cardiovascular Life Support" in the guidelines, and this term is equivalent to the term "Advanced Cardiac Life Support" that is used in VHA policy. American Heart Association Guidelines for CPR and Emergency Cardiovascular Care, Part 5. (The website was accessed on August 22, 2017.)

[31] American Heart Association Guidelines for CPR and Emergency Cardiovascular Care, Part 5. (The website was accessed on August 22, 2017.)

[32] American Heart Association Guidelines for CPR and Emergency Cardiovascular Care, Part 7. (The website was accessed on August 22, 2017.)

and ERT personnel are not ACLS certified and would not utilize the contents in the crash cart. The committee also determined it was most efficient to use effective BLS delivery with the combination of a quick transport of the patient to the ED when a code occurs.

Emergency Foreign Body Airway Obstruction Response

Emergency foreign body airway obstruction (choking) occurs when a foreign body becomes lodged in the airway (windpipe), blocking the flow of air.[33] A piece of food is the most common foreign body responsible for choking in adults. A foreign body may cause a partial or complete obstruction of the airway. Signs of a severe airway obstruction include poor air exchange and increased breathing difficulty, such as a silent cough, cyanosis,[34] or the inability to speak or breathe. Choking victims may clutch their neck in a demonstration of the universal choking sign. When a foreign body produces signs of severe airway obstruction, responders must act quickly to relieve the obstruction.[35]

According to the 2015 AHA Emergency Cardiovascular Care guidelines, if the adult victim with a foreign body obstruction becomes unresponsive, the responder should carefully lower the patient to the ground, immediately activate emergency services, and begin effective CPR (without a pulse check).

Dietary Management

In the VA, clinical dietitians are responsible for completing nutrition assessments that take into account a variety of elements, including a patient's current medical conditions, appetite, weight history, activity level, and eating or feeding problems.[36] Based on the results of the patient's assessment, a medical nutrition therapy plan is created which may include interventions such as restricted calorie intake levels, meal schedules, and texture modified diets. Patients who have a difficult time chewing due to dental problems are often prescribed diets that include soft and/or pre-cut food. The Facility refers to this type of diet as a "geri diet" and identifies it by placing the food on a tray with a purple food tray mat.

---

[33] Choking First Aid- Mayo Clinic. https://www.mayoclinic.org/first-aid/first-aid-choking/basics/art-20056637. (The website was accessed on June 29, 2017.)

[34] Cyanosis is a bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood.

[35] Emergency Cardiovascular Care Guidelines-Part 5-Adult Basic Life Support and Cardiopulmonary Resuscitation Quality. (The website was accessed on August 22, 2017.)

[36] VHA Handbook 1109.02, *Clinical Nutrition Management,* February 14, 2012. This handbook was scheduled for recertification on the last working day of February 2017 and has not been recertified.

Restraint Free Environments

VHA's *Rights and Responsibilities of VA Patients and Residents of CLC* states, "In the Community Living Center, you have the right to be free from chemical and physical restraints. In the inpatient acute care setting, and only in rare cases, the use of chemical and physical restraints may be used if all other efforts to keep you or others free from harm have not worked."[37] A restraint-free environment epitomizes the concept of patient-centered care by allowing the patient the physical freedom to move as able.[38] The Facility's policy[39] addressing use of restraints states that restraint use is to be limited to circumstances where there is an imminent risk of a patient hurting himself/herself or others, to maintain medical treatment, and to ensure healing.

Three types of restraints are described; physical, chemical, and seclusion. Physical restraints are defined as any mechanical or physical material, device, or equipment that is attached to or adjacent to a patient's body. This item restricts the patient's freedom of movement and normal access to their own body. The patient cannot easily remove the physical restraint.[40] Chemical restraints are defined as the use of any type of drug to restrict a patient's movement or freedom. Chemical restraint may be used solely for the purpose of sedating a patient.[41] Seclusion is the involuntary confinement of a patient alone in a room where he or she is physically prevented from leaving.[42]

Allegations

OIG staff received multiple allegations from an anonymous complainant(s):

- Patient A died at the Facility after choking on food in the CLC dining hall due to lack of nursing staff available to supervise patients.
    - Staff called the wrong code, resulting in a delayed response and the wrong staff responding to the code.
    - Managers misrepresented the cause of death as cardiac arrest, rather than choking.

---

[37] *Rights and Responsibilities of VA Patients and Residents of Community Living Centers (CLC).*

[38] American Nurse Today, Moving toward a Restraint Free Environment. https://www.americannursetoday.com/moving-toward-a-restraint-free-environment/. (The website was accessed on June 16, 2017.)

[39] Center Memorandum 118-18, *Restraint and Seclusion: Use of*, February 8, 2016.

[40] Physical Restraints on the Elderly, http://nursinghomeabuseguide.com/abuse-injuries/elderly-restraints/physical/. (The website was accessed on June 16, 2017.)

[41] Chemical Restraints on the Elderly, http://nursinghomeabuseguide.com/abuse-injuries/elderly-restraints/chemical/. (The website was accessed on June 16, 2017.)

[42] Center Memorandum 118-18.

- Patients on CLC 3 are regularly left unsupervised while eating.
- The locked CLC 3 lacks security due to malfunctioning door locks, staff not conducting hourly rounds, and lack of staff vigilance.
- Patient B's wrists were bound together by a CLC 2 staff member due to lack of available nursing staff to supervise Patient B.
- Nurse Managers on the CLCs[43] are often unavailable and fail to provide adequate response to unit issues.

A number of the allegations addressed in this report attribute specific actions to a lack of nurse staffing. In this report, the OIG limited the review to nurse staffing during meal times.

After interviews with staff and a review of nurse staffing data, OIG inspectors identified an ongoing challenge to maintaining baseline CLC nursing staff levels. Facility leaders addressed the nurse staffing shortages through the use of float assignments and staff overtime. Due to the potential risk to the quality of patient care and safety of patients associated with staffing shortages, the OIG determined that a healthcare inspection unique to CLC nurse staffing at the Facility was warranted. Results of that inspection will be issued in a separate report.

[43] Although the original allegation mentioned a Nurse Manager on CLC 3, the OIG team interviewed staff from both CLC 2 and CLC 3 during the inspection and asked them about nurse managers. The decision to query staff regarding nurse managers on both units was made based on the location of the events stated in the allegations received and OIG's inability to clarify the scope due to the complainant(s) being anonymous.

Scope and Methodology

The OIG staff initiated the review on May 15, 2017, and conducted two site visits at the Facility June 5–8, and August 1–2, 2017. Upon arriving onsite in June, OIG inspectors conducted an unannounced inspection of CLC 2 to observe the environment of care and use of restraints, if any. The OIG team also made two announced visits to CLC 3 on June 6 and 7 to observe how staff performed dinner service and overall unit operations. During the August visit, after notifying the Facility Director, the OIG team called a mock code[44] to CLC 3 to assess staff response.

OIG staff reviewed the electronic health record (EHR) of Patient A from February 2015 to March 2017 and the EHR of Patient B from February 2009 to August 2017 to determine the validity of the allegations.

The OIG team reviewed Joint Commission standards, relevant VHA and Facility policies and procedures,[45] Long Term Care Institute policies, internal Facility fact-finding documents, Facility meeting minutes, CLC staff training records, CLC nursing schedules, operator logs, police reports, work orders, an audio file of an operator calling a Code Blue, and other relevant documents including Patient A's death certificate and autopsy findings.

The OIG team interviewed the Chief of Staff, Associate Director of Patient Care Services, physicians and nurses who responded to Patient A's code, Acting Chief of Surgery, Chief of Pulmonary Medicine, Nutrition and Food Service Manager, a nurse practitioner, nurse managers, CLC nurses and nursing assistants/aides, a respiratory therapist (RT), Chief of Engineering, Chief of VA Police, telephone operators, and Assistant Fire Chief.[46] The team also interviewed one patient's family members.

The complainant(s) were anonymous. As such, some aspects of the review were limited by an inability to clarify allegation intent or request additional information regarding the specifics of an allegation.

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).

[44] Mock codes are training scenarios for medical staff participating in Code Blues.

[45] The Facility was in the process of revising and/or replacing some of the policies applied to the events leading to this report. In preparing this report, the OIG team looked at both the old policies that were in place at the time of the events as well as the new or revised policies.

[46] The OIG team interviewed a total of 38 Facility staff individually, some on multiple occasions. The OIG team also conducted 4 group interviews with a total of 17 nursing staff. Additional staff members who were not available during the onsite visits were interviewed by phone after each site visit.

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 substantiate or not substantiate an allegation when the available evidence is insufficient to determine whether an alleged event or action took place.

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

Inspection Results

Allegation 1: Management and Death of Patient A

The OIG reviewed the circumstances surrounding the death of Patient A in the CLC 3 dining room. Patient A's Death Certificate, supported by an autopsy, by the Deputy Chief Medical Examiner, Suffolk County, New York, described the cause of death as "Complications of Aspiration of Food Bolus."[47] The OIG inspectors found nothing to contradict this. Thus, the OIG team substantiated the first part of the allegation that "Patient A died at the Facility after choking on food," but found insufficient evidence to attribute the cause of Patient A's choking to the lack of nurse staffing.

The OIG team substantiated that CLC staff notified the operator of Patient A's emergency without specifically requesting the type of code to be initiated. In response, the operator called the wrong code, leading to multiple teams responding and a delay in transporting Patient A to the ED. While it is impossible for the OIG to determine if calling the correct code or a more timely transfer to the ED would have altered the outcome of this case, it may have improved the patient's chances of surviving the incident

The OIG team did not substantiate that managers misrepresented the cause of death as cardiac arrest, rather than choking.

Patient A—Summary of Events

Patient A was late 60s and resided in CLC 3 since 2008 with a history of psychiatric illnesses and medical issues. Patient A had no major medical issues while in CLC 3 but had a mental impairment that required use of psychiatric medication and supervision because of behavioral problems. Due to poor dentition,[48] Patient A was on a geri diet and had no history of choking episodes. Patient A was listed as full code on the care plan.[49]

On a day in 2017 (hospital day 1), Patient A ate 100 percent of breakfast and lunch without assistance. Dinner service started at 5:24 p.m. with five Nursing Assistants (NA) assigned to supervise approximately 20 patients in the dining hall and one Licensed Practical Nurse (LPN) assigned as the medication nurse. Staff delivered Patient A's food tray and reported visually confirming that it was the assigned meal.

As patients finished their meals, staff permitted them to leave the dining hall to go back to their rooms or other common areas in the unit. Those patients who wished to have a cigarette started

[47] Aspiration is the breathing in of a foreign object (in this case a mass of food) into the airway.

[48] Dentition refers to the condition of the teeth.

[49] Patients who have requested full code status are those that desire full resuscitation (including CPR, intubation, and defibrillation) in case their breathing or heart stops.

lining up at the smoking patio entrance in anticipation of the scheduled 6:00 p.m. designated smoking break. The hallway to the smoking patio where patients lined up was not visible from the dining hall or nurses' station. (See Figure 2.)

Patient A Found Unresponsive

Around 5:45 p.m., the LPN left the dining hall to get apple sauce for a patient in order to administer medication. Two NAs (NA1 and NA2) were providing one to one[50] direct supervision. One NA (NA3) left the dining hall to assist a patient in the bathroom. While in the bathroom, NA3 reported hearing an altercation taking place in the hallway outside the bathroom. NA3 left the patient in the bathroom and went into the hallway to de-escalate the two quarreling patients. NA3 called the charge nurse, who was at the nurses' station, to assist with the situation. NA3 reported escorting one of the quarreling patients back to the dining hall while the charge nurse escorted the other patient to the smoking patio and began the designated smoke break early.

[50] One-to-one direct supervision requires that one staff member continuously monitor a patient to ensure safety of the patient or others.

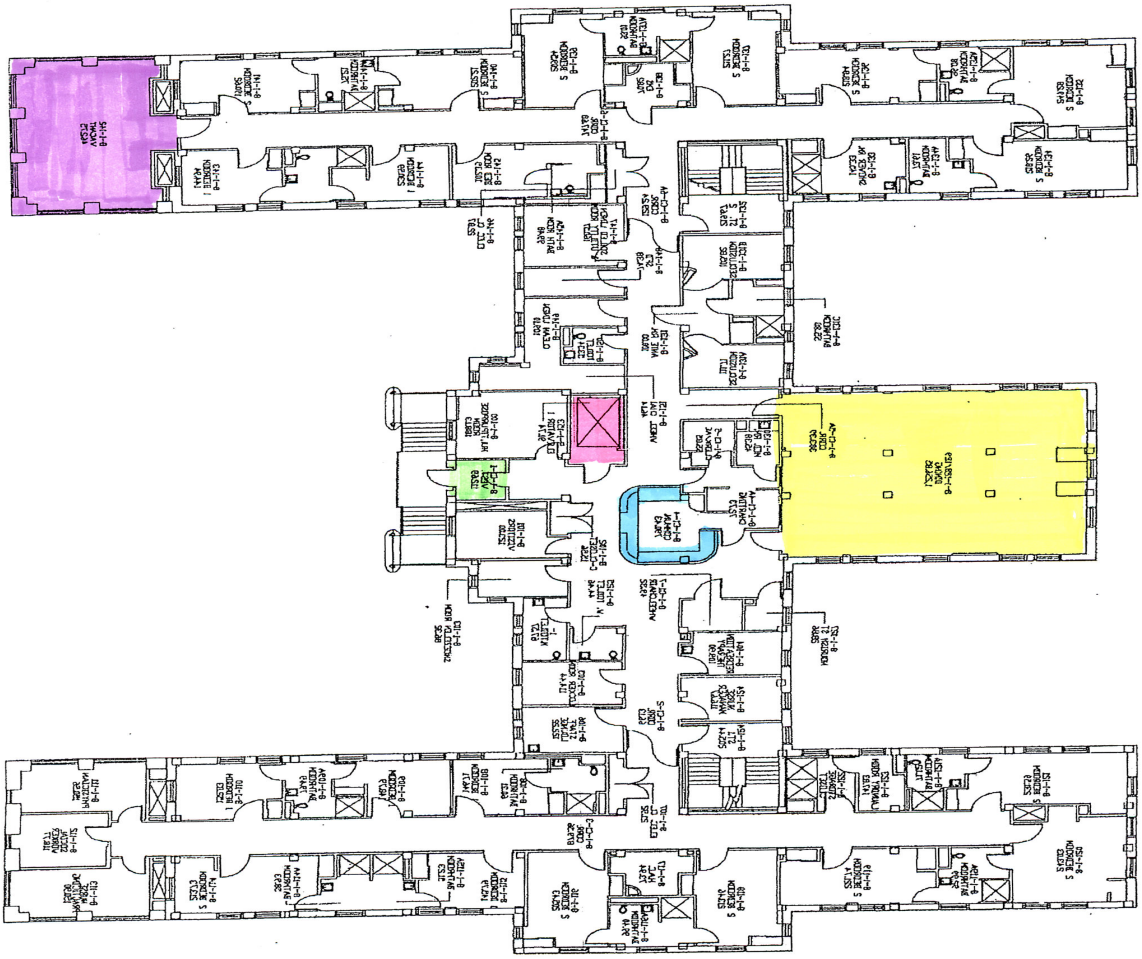

Figure 2. Facility CLC 3 Floor Plan[51]
Source: Obtained from Facility by VA OIG
Blue - Nurses' Station; Yellow – Dining Hall; Purple – Smoking Patio; Green – Main Entrance; Pink – Elevator

NA3 reported returning to the dining hall at approximately 5:50 p.m. and saw Patient A slumped over on the couch unresponsive (Event). NA3 reported calling for assistance and other CLC staff initiated CPR on Patient A while NA3 went to the nurses' station and placed a call to activate an emergency response.

OIG inspectors were unable to determine how much time had elapsed between the time that Patient A was last responsive and NA3 found Patient A slumped over on the couch. Staff delivered Patient A's food tray at approximately 5:30 p.m. One staff person reported last observing Patient A to be oriented around 5:40 p.m. to 5:45 p.m.

[51] Facility CLC 3 floor plan provided by Facility.

Calling of the Code

In a statement taken after the Event, NA3 reported calling the operator while at the nurses' station and stating, "We need help, we have a code in CLC 3, Building 8, send someone, hurry." At 5:50 p.m., the operator documented: "Code Blue reported by [phone extension in nurses' station] for CLC 3, Code Blue pager 2x, overhead pager 2x, Fire Department [FD call sign] and Police [PD call sign] notified."

ERT Code Response

According to the ERT records, the FD received operator notification via radio at 5:58 p.m.[52] and arrived at CLC 3 at 5:59 p.m. ERT documentation showed that CLC staff began CPR at approximately 5:55 p.m. Four ERT members arrived and took over BLS management from the CLC staff. Staff reported performing a blind finger sweep[53] to remove potential food particles in Patient A's mouth with no results. The Code Blue Team arrived as the ERT was getting ready to move Patient A onto the gurney for transport to the ED.

Code Blue Team Response

The senior surgery resident[54] heard the Code Blue page overhead and instructed the third-year surgery resident to respond to the code. The third-year surgery resident and a second-year surgery resident took a central line[55] kit[56] from the supplies in Building 200 before proceeding to CLC 3. The two surgery residents met three medicine residents on the way to CLC 3 and all five residents arrived together. One resident noted that upon arrival, the ERT was in the process of performing BLS on Patient A.

The surgery resident[57] told the OIG inspectors that the surgery resident's role in a code was to provide venous access; upon arrival to CLC 3, the surgery resident placed a central line in Patient A's groin in anticipation of giving ACLS medications. The surgery resident reported

[52] During the OIG team's onsite inspection of the operator's suite, inspectors noticed varying times on the numerous computer monitors, closed circuit television video display monitors, and telephones used by the operators. Inspectors noted that the times varied as much as 15 minutes.

[53] A blind finger sweep is performed by opening the mouth of an unconscious person, reaching inside and sweeping the mouth to remove any food particles or foreign objects.

[54] Residents refer to physicians who have graduated from their intern year (first year of residency) but are still in residency training. Senior residents are in their last year of training.

[55] A central line is a large gauge catheter that is inserted into a large vein in the groin, chest, or neck that can deliver medications or fluids to the central circulation rapidly.

[56] Central lines come prepackaged in sterile kits that often contain a sterile gown, mask, and antiseptic in addition to the tool required for catheter placement.

[57] The term surgery resident will be used in this report to denote the third-year surgery resident for the purposes of clarity.

performing the central line insertion with Patient A on the floor. The surgery resident documented asystole as the indication for the central line.[58]

The surgery resident reported being unaware that the CLC did not have a crash cart which had the equipment and medications for performing ACLS. CLC nursing staff informed the residents that they did not have a crash cart; however, by that time, the surgery resident was almost finished placing the central line. Statements taken after the Event documented a member of the ERT recommended multiple times "we got to get out of here" but was told "just a sec… let us get this line."

Nursing Response

The Nurse Officer of the Day[59] (NOD A) heard the Code Blue called overhead and sent another NOD (NOD B) to CLC 3. When interviewed by OIG inspectors, NOD A reported calling CLC 3 to ask if they called an ERT. NOD A reported that the CLC staff person was not sure but thought that NA3 had done so. NOD A reported calling the operator to initiate the ERT. OIG inspectors did not find evidence of this call on the operator log. NOD A drove over to the CLC and observed the resident putting in a central line. NOD A informed the resident that they needed to transport Patient A out of the CLC, but the resident was almost finished inserting the central line.

NOD B responded to the code as instructed and took statements from CLC 3 staff after the Event. In addition to the two NODs who responded, two Intensive Care Unit (ICU) nurses assigned to the Code Blue Team heard the overhead page and reported to CLC 3.

RT Code Response

When interviewed by OIG inspectors, the RT reported being the last person to arrive to CLC 3 during the code. The RT reported carrying the airway tool kit[60], which held the instruments required for intubation.[61] The RT reported placing a scope inside Patient A's mouth in an attempt to intubate Patient A but had no time for proper visualization because the patient was ready for transport. A member of the ERT reported that while the RT was attempting intubation, one of the residents said "we don't have time for that. Intubation does [not] take place until the 3rd round of meds." ERT prepared Patient A for transport to the ED and staff dispersed. The RT rode back to

[58] Asystole refers to the lack of heart beat, commonly known as "flatline."

[59] The Nurse Officer of the Day is responsible for the overall administration of Nursing and Patient Services in the absence of nurse leadership during non-administrative tour of duty.

[60] The airway kit included a set of McGill forceps used to remove foreign bodies from the airway and a video laryngoscope, which has a camera to allow visualization of the vocal cords.

[61] Intubation is a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth or nose. In most emergency situations, the tube is placed through the mouth. The tube can be connected to a bag-valve-mask or ventilator to give the patient assisted breaths.

the ED with the police and called another RT to come to the ED to ensure that intubation equipment was ready for Patient A's arrival.

ED and Hospital Course of Care

At 6:13 p.m., in preparation for Patient A's arrival, a staff member placed a call from an extension in the ED to the operator requesting activation of the Code Blue Team. Patient A arrived at the ED at 6:18 p.m. ERT documentation noted "Delayed [transport] due to central line initiation [onsite]." A responding ED staff member reported that when Patient A arrived at the ED, the ED staff did not know whether they or the Code Blue Team were in charge of the initiation of treatment. The Code Blue Team members were delayed in returning to the ED from CLC 3 so ED staff initiated treatment. The RT arrived and intubated Patient A and found that Patient A's

> airway [was] occluded with meat and vegetables. Had to use scope and forceps to remove large mass of meat palm size that lodged before the [vocal] cords. Other smaller pieces of meat were removed along with large pieces of vegetables.

Although documentation in the EHR categorized the intubation as "difficult," the RT succeeded after one attempt. Per ACLS protocol, Patient A received four rounds of 1 milligram (mg) doses of epinephrine[62] without effect. Given the lack of response, one of the residents suggested administering 5 mg of epinephrine. After receiving the additional 5 mg of epinephrine at 6:26 p.m., Patient A had return of spontaneous circulation.[63]

Around 6:45 p.m., staff transferred Patient A to the ICU. Shortly after arriving in the ICU Patient A became pulseless again. Code Blue Team staff, already in the ICU, started BLS and ACLS resulting in the return of spontaneous circulation.

Documentation in the EHR noted that Patient A was sedated and kept on a post cardiac arrest hypothermia protocol[64] while in the ICU. On hospital day 3, Patient A's endotracheal tube[65]

---

[62] Epinephrine is a resuscitation medication that increases heart rate and contractility resulting in improved circulation. The typical dose is 1 mg every three–five minutes.

[63] Return of spontaneous circulation typically signals the end of resuscitation when the patient is able to generate a pulse without CPR.

[64] Hypothermia protocol can significantly improve rates of long-term neurologically intact survival. Body temperature is between 32°Celsius (C) and 36°C for at least 24 hours.

[65] An endotracheal tube is a flexible plastic tube that is put in the mouth and then down into the trachea (airway). The purpose of using an endotracheal tube is to ventilate the lungs. https://www.merriam-webster.com/medical/endotracheal%20tube. (The website was accessed on May 30, 2018.)

dislodged during a computed tomography[66] exam. A Code Blue was called and return of spontaneous circulation was achieved after six minutes of CPR. The physicians started Patient A on another 24-hour post cardiac arrest hypothermia protocol and stopped sedation medications. By hospital day 5, Patient A showed no signs of brain activity.[67] Patient A remained on a ventilator[68] until a family meeting to define goals of care could take place the next day.

On hospital day 6, the Chief of Neurology examined Patient A and reviewed the head computed tomography scans which showed signs of brain injury from lack of oxygen and opined that Patient A's prognosis was "very poor." After a discussion with the medical team, Patient A's family elected to remove Patient A from the ventilator, and Patient A died shortly thereafter.

Choking

The Death Certificate, supported by an autopsy performed by the Deputy Chief Medical Examiner, Suffolk County, New York, described the cause of death as "Complications of Aspiration of Food Bolus." OIG inspectors found nothing to contradict this. Thus, the OIG team substantiated the first part of the allegation that "Patient A died at the Facility after choking on food" but found that the evidence was insufficient to attribute the cause of Patient A's choking to the lack of nurse staffing.

The Facility staff that the OIG team interviewed did not witness an actual choking episode, and Patient A was ultimately found by staff in a state of cardiopulmonary arrest. Therefore, despite the autopsy findings described above, the OIG team was unable to identify the precise sequence of events. Several clinical scenarios are possible, some more likely than others, and these are discussed in the conclusion section.

In recent years, the AHA focused their efforts on treating the cardiac causes of arrest in adults because respiratory causes of arrest are relatively rare. Therefore, the BLS-ACLS protocol has de-emphasized the need for ensuring an open airway[69] as it assumes that patients with cardiac arrest become pulseless with their lungs full of air.

The best chance of survival for a patient with an airway obstruction is to remove the foreign body as soon as possible. In interviews, staff who found Patient A unresponsive stated that they

---

[66] Computed Tomography, or CAT scans, are special x-ray tests that produce cross-sectional images of the body using x-rays and a computer. https://www.merriam-webster.com/dictionary/computed%20tomography. (The website was accessed on May 30, 2018.)

[67] Patient A had no pupil response to light and no gag or pain withdrawal reflexes.

[68] "A ventilator is a machine that supports breathing." https://www.nhlbi.nih.gov/health/health-topics/topics/vent. (The website was accessed on August 29, 2017.)

[69] The old ACLS protocol used airway-breathing-circulation as the sequential steps for resuscitation while the current protocol advocates circulation-airway-breathing.

did not suspect choking to be the cause of the unresponsiveness and immediately started CPR. Literature suggests that had abdominal thrusts (commonly referred to as the Heimlich maneuver) and/or chest thrusts been performed, they would have likely been no more effective in removing an obstruction from the airway than CPR. Studies have found that the chest pressure generated by CPR is greater than that generated from the abdominal thrusts or chest thrusts.[70]

The residents participating in the resuscitation attempt focused on ACLS protocol. In interviews, the surgery resident stated that, "In a code, airway doesn't come before circulation," inferring that Patient A needed the central line for IV access before having the airway secured.

The ERT Code Sheet documented "airway obstruction [possible]" as a presenting problem for Patient A. An ERT staff member told the RT and the other ERT member that Patient A had become difficult to ventilate, but the medicine resident leading the code did not recall hearing this. The RT present during the code had the equipment to remove the airway obstruction in CLC 3 but was instructed to wait to attempt intubation until Patient A was transported to the ED.

Meal Supervision

Because of insufficient evidence, the OIG team was unable to substantiate or not substantiate that the choking occurred due to a lack of nursing staff available to supervise patients during meals.

VHA Handbook 1142.01[71] states that appropriate numbers of staff need to be assigned to the dining hall to provide assistance and ensure patient safety during meals. The Handbook further states that all members of the interdisciplinary team, including nursing staff, participate in serving meals to ensure that every patient has the assistance needed. At the time of the Event, Facility CLC nurse leaders reported that the expectation was a minimum of two nursing staff be present in the dining hall to start handing out meal trays to patients and that all available unit staff were to help throughout the meal. Neither VHA nor Facility policies delineate appropriate staff-to-patient ratios at meal time. The Facility expectation was that the CLC charge nurse was responsible for knowing the staffing levels during meals; however, this expectation was not written as policy. At the time of the Event, the charge nurse was not in the dining hall and therefore could not definitively know the location of staff. However, during the interview, the charge nurse told the OIG team where staff members were believed to be throughout the meal.

The goal of VHA CLCs is to reflect a home-like environment with attention to privacy and comfort, including at meal times.[72] On CLC 3, at the time of the Event, once the patients were

[70] A. Langhelle, et al., "Airway Pressure with Chest Compressions versus Heimlich Maneuver in Recently Dead Adults with Complete Airway Obstruction," *Resuscitation*, 44 (2000): 105-108.

[71] VHA Handbook 1142.01, *Criteria and Standards for VA CLC*, August 13, 2008. This handbook expired on August 31, 2013 and has not been updated.

[72] VHA Handbook 1142.01.

finished with their meals, they were free to leave the dining hall, resulting in variability in the number and acuity of patients who remained in the dining hall at any given time.

Statements made by staff in interviews consistently noted that the charge nurse was at the nurses' station during the dinner service and that the charge nurse started the smoking break early and was at the smoking patio at the time staff found Patient A unresponsive. It is less clear which patients and which staff were in the dining hall at various points during and after the meal.

Code Response

The OIG team substantiated that CLC staff notified the operator of Patient A's emergency and in response the operator called the wrong code that lead to multiple teams responding and a delay in transporting Patient A to the ED.

Facility CPR policy[73] states

> The first person to find a patient in cardiopulmonary arrest will note the time and summon help immediately by either contacting someone in the vicinity to notify the telephone operator of the need for the "Code team" or "CODE BLUE"…They will return to the patient to wait for the arrival of the Code team.

Facility CPR policy[74] sets protocols for telephone operators to activate the Code Blue Team for emergencies in Building 200 and the ERT for emergencies elsewhere on campus.

> Emergencies occurring outside of building 200: Upon notification, the telephone operator will utilize the 2-way radio…to communicate with the Emergency Department. The operator will advise them, of the emergency, and state the exact location. The Emergency Response Team will respond to the location of the emergency.

The Facility ERT policy[75] states

> Calls requesting the [ERT] team should be made through the Hospital emergency number…The operator will notify the FD by calling the fire house at Ext…unless directed to do so differently…The operator receiving the call will query the caller

[73] Center Memorandum 11-151.
[74] Center Memorandum 11-151.
[75] Center Memorandum 138-039.

for the following information: Name of caller; Call back telephone number; Nature of emergency; Location of emergency.

OIG inspectors were told that CLC 3 staff were trained to call for an ERT for emergencies on the unit. OIG inspectors observed a mock code while onsite, and once notified, it took the ERT approximately three minutes to arrive at CLC 3.

Facility policy[76] states that the FD personnel are to assess, stabilize, and transport patients to the ED. Upon arrival to a call, the FD personnel assesses the individual and initiates or continues treatment, such as basic first aid or CPR. The FD personnel notifies the ED of the status of the individual and communicates when they are en route to the ED in order for ED staff to prepare for the patient's arrival.

Patient A experienced a delay in transport from CLC 3 to the ED. NA3 reported calling the operator and stating, "We need help, we have a code in CLC 3, Building 8, send someone, hurry." When interviewed, the charge nurse reported believing NA3 called an ERT. When the ERT had not arrived, the charge nurse called the operator again to convey that a patient was "coding." OIG inspectors found no documentation of the charge nurse's call. The operator initiated a Code Blue Team response by activating the Code Blue pagers and doing an overhead page of "Code Blue CLC 3" twice at 5:50 p.m.

At the time of the Event, the operator had been in the position for five months with three of the months for training. The operator reported being trained to call the ERT for emergencies in CLC 3, but because the person on the phone said, "Code Blue," the operator called a Code Blue. The operator did not feel it was appropriate to question the medical staff. The operator activated the Code Blue Team and the ERT.

OIG inspectors found an eight-minute discrepancy between the time the operator logged the call to the ERT and the FD received the call. The OIG inspection team was unable to determine the exact cause of the discrepancy but identified asynchrony of the clocks in the operator's suite that may have accounted for some of the time difference between the operator and the FD documentation.[77] Once the ERT received the call, they arrived to CLC 3 in one minute.

During interviews, Code Blue Team members stated that they heard the overhead page multiple times and responded to CLC 3. Some shared that they felt it was their duty to respond to the code called in CLC 3 to see if they could be of assistance, while others indicated they were unaware

[76] Center Memorandum 138-039.

[77] When OIG inspectors toured the operator suite, they found that the operators used the computer clocks to document the time in the log, but the clocks in the room were all different. The FD used the phone line clock, which was two minutes slower than the operator clocks.

that they were not supposed to report to CLC 3 for codes. The entire Code Blue Team responded to the CLC 3 code.

Although CLC staff knew that the ERT was supposed to respond to codes in the CLC to provide stabilization and quick transport of the patient to the ED, the Code Blue Team residents did not. The residents were also unaware that CLC 3 did not have a crash cart. The residents arrived at the scene prepared to provide ACLS. The ERT spent 18 minutes[78] in CLC 3 while the Code Blue Team attempted to perform ACLS protocol in a setting that lacked support for ACLS. The Code Team Registered Nurse, NOD A, and the ERT told the residents that Patient A should be transported out of the CLC, but the residents said to hold transport for the central line placement. The surgery resident stated that had the residents known that the crash cart was not available in the CLC, they would not have started the central line; the medicine resident stated that in retrospect, the residents would have moved the patient to the ED faster.

Approximately 28–30[79] minutes elapsed from the time Patient A was found unresponsive to the time Patient A arrived in the ED.

Misrepresentation of the Cause of Death

The OIG team did not substantiate that managers misrepresented the cause of death as cardiac arrest, rather than choking.

While the allegation seems to suggest that there may have been an intentional attempt to hide or alter information about how Patient A died, the OIG team did not find evidence of this. Rather, OIG inspectors heard from CLC 3 staff and managers that at the time they found Patient A unresponsive, they thought that Patient A's condition was cardiac related because there were no indications of choking. Documentation in the EHR in the days following the Event (but prior to Patient A's death) notes choking. At the time of OIG onsite interviews, one member of management speculated as to how, other than Patient A choking while eating the meal, the food may have become lodged in Patient A's airway. The member of management surmised that the food was on its way down and was pushed back up by the chest compressions. In an OIG team interview, the Chief of Staff, who had not seen the autopsy, believed that Patient A had an aspiration and a cardiac arrest, and noted the timing could not be determined. Lacking access to the definitive cause of death from the autopsy report, managers could not inform staff, and they could only speculate as to the cause of Patient A's death.

Additional Findings

While onsite the OIG identified additional findings discussed below.

[78] The OIG used the FD Code Log to determine this time.

[79] This takes into consideration the two-minute time difference between the operator's clock and the FD clock.

Meal Delivery and Confirmation

OIG inspectors met with the Nutrition and Food Service Supervisor and another Registered Dietitian to review the processes in place to ensure that patients received the meal that providers ordered for them. The OIG inspectors were told that kitchen staff verified that the menu selection and diet type (for example, geri) were correct for each patient's tray and placed a ticket with the patient's name, menu selections, and diet type on the food tray. Next, staff placed the food tray on the cart for transport to the unit. Once on the unit, a CLC Meal Service Start sheet must be signed by CLC staff to indicate that nursing staff was present and ready to serve the meal. CLC nursing staff performed another visual check as the trays were handed out to ensure that each patient received the correct tray.

Two nursing staff members reported that on the evening of March 22, 2017, they saw Patient A with pre-cut steak medallions. OIG staff reviewed records and confirmed Patient A ordered steak medallions for dinner on March 22, 2017, and that the geri diet remained active. Other than undocumented visual checks by staff, the Facility lacked a mechanism to retrospectively verify the menu selection and diet type that was actually served to a specific patient.

The RT who removed the food from Patient A's airway documented that the "Pt's airway occluded with meat and vegetables, had to use scope and forceps to remove large mass of meat palm size that lodged before the cords. Other smaller pieces of meat were removed along with large pieces of vegetables." OIG inspectors were unable to determine if Patient A received properly cut food.

Code Coordination

OIG inspectors found that, as a result of the incorrect code being called, a multiple number of people responded to the code, causing responder role confusion. At least 15 ERT and Code Blue Team staff,[80] 7 CLC staff, and police responded to CLC 3 at the time of the Event. Documented statements taken from staff after the Event noted poor communication and a lack of role delineation and decision-making among responders. Following interviews with the residents, the OIG identified an opportunity for Facility managers to clarify the types of emergency response teams on campus and their associated responsibilities.

Venous Access During ACLS

The AHA ACLS Provider Manual states that a peripheral IV is preferred for venous access and that a central line is not necessary during most resuscitation attempts because it may cause

[80] Six physicians (three medicine and three surgery residents), four ERT staff, two NODs, two ICU registered nurses, and one RT.

interruptions in CPR and complications during insertion (blood vessel laceration and bleeding). Placing central lines emergently can lead to higher infection risks[81] and increase the risk of needle stick injuries to staff.

In cases where IV access is not available, AHA recommends insertion of an intraosseous (IO) needle[82]for rapid and safe delivery of ACLS medications. Trained emergency responders and nursing staff can learn to perform the procedure, which often takes seconds to complete. The VHA Emergency Medicine Directive recommends stocking IO drills in the ED.[83]

However, delivery of fluids and medicines by the IO route was not a real-time option in Patient A's case either in the CLC or at the Facility in general. The Facility did not have IO equipment and, therefore, used central lines for IV access during a code. Additionally, OIG inspectors found that the Facility policy is to not perform ACLS in the CLC, thus, IO insertion, even if available at the Facility, would not have been attempted. The use of IO equipment likely would not have made a significant change in outcome for Patient A, but it may mitigate the risk associated with emergent central line insertion for other patients. The OIG inspection team brings this issue to the Facility for consideration since IO insertion is at the forefront of ACLS.

Code Debrief

Facility policy[84] states that, for the purpose of continuous quality improvement, the Code Blue Team and ERT will meet after each code to conduct a debriefing of the resuscitation event. The policy states that a code debriefing worksheet is to be completed by the critical care nurse manager or designee and that data will be collected for quarterly review by the CPR Committee.

Patient A had multiple codes on hospital day 1. Staff involved with these codes reported that no debriefing occurred with the team or with their supervisors. The OIG inspection team did not find, and Facility staff were unable to provide, evidence of completed code debriefings related to Patient A's care.

[81] The Centers for Disease Control estimates that central line infections cause thousands of deaths and billions in added cost to the health care system each year. https://www.cdc.gov/hai/bsi/clabsi-resources.html. (The website was accessed on August 17, 2017.)

[82] The IO drill inserts a needle into the bone marrow veins in the bone (generally the pelvis, leg, sternum, or arm). All ACLS medications can be administered through the IO needle. The needle can remain in the bone for 72 hours before it needs to be changed. Multiple IO needles may be placed for large volume resuscitation or a central line may be placed when the patient is more stable.

[83] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016. This directive was amended March 7, 2017.

[84] Center Memorandum 11-151.

ERT Oversight

The ERT lacked medical oversight. VHA policy[85] states

> …each facility have an established Cardiopulmonary Resuscitative Committee or equivalent that reviews each episode of resuscitative care under the facility's area of responsibility, and that such events and their outcomes are recorded, reported, and undergo routine evaluation for appropriateness, process, and outcomes in the context as part of the facility's continuous quality improvement program.

VHA's National Program for Emergency Medicine does not provide policy and procedure specific to ERTs. Facilities are expected to create their own ERT policy and are able to utilize the expertise of the VISN Emergency Management leaders when developing processes if needed. At the Facility, the Safety/Engineering Service was responsible for the ERT supervision. The ERT policy[86] requires FD staff to record their response to incidents in the FD daily log book and complete an ERT record sheet. The record sheets are to be reviewed and analyzed by the ED committee and staff in the Quality Management department. The ED nurse manager stated that ERT record sheets are completed and sent to Quality Management, and the Associate Chief of Quality Management confirmed that the ERT record sheets are reviewed by a registered nurse in performance improvement. The ED committee was not reviewing the record sheets. Facility quality management staff reported that at one point the ERT record sheets were reported to the CPR Committee, but that that was no longer the case as the Facility CPR Committee members did not feel the ERT incidents should be reported to them.

Allegation 2: Meal Supervision—CLC 3

The OIG team was unable to substantiate or not substantiate that patients on CLC 3[87] were regularly left unsupervised while eating; the evidence was insufficient to make such a determination.

As noted in Allegation 1, VHA Handbook 1142.01[88] requires that appropriate numbers of staff be assigned to the dining hall to provide assistance and ensure patient safety during meals. It further states that all members of the interdisciplinary team, including all available unit nursing staff, participate in serving meals to ensure that every patient has the assistance needed. Facility nurse leaders reported that they expected all available unit staff to help in the dining hall

[85] VHA Directive 2008-063, Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees, October 17, 2008. This directive is expired October 31, 2013, and has not been updated.

[86] Center Memorandum 138-039.

[87] For this report, the OIG limited the review to CLC 3. This decision was made based on the allegation being coupled with others specific to CLC 3 and OIG's inability to clarify the scope due to the complainant being anonymous.

[88] VHA Handbook 1142.01.

throughout the meal and that the charge nurse was responsible for knowing the staffing levels during meals. However, the Facility lacked a policy or process that outlines these expectations.

OIG inspectors observed a meal on CLC 3 and found nursing staff present and assisting patients with their meals as needed, but did not see, nor were they told of, non-nursing members of the interdisciplinary team present in the dining hall. During interviews, CLC 3 staff and nurse managers reported that patients were adequately supervised during meal times. Nurse managers reported that staffing was managed on a shift-by-shift basis. At the time of the OIG's second site visit, OIG inspectors learned that the Associate Director of Patient Care Services was required to report CLC nurse staffing levels to the VISN daily.

In an effort to determine if a lack of meal time staffing had been previously reported or resulted in patient harm, OIG inspectors reviewed Facility CLC-specific issue briefs from December 2016 through April 2017, Root Cause Analyses from October 2016 through April 2017,[89] patient advocate records from October 2016 through May 2017, and Resident Council meeting[90] minutes from October 2016 through August 2017. In the course of that review, the OIG found documentation in the Resident Council meeting minutes of June 2017 that patients complained about delayed meal start while awaiting the arrival of staff to distribute trays and supervise meal time. The meeting minutes showed the Facility tried to increase staffing to resolve the complaint. These documents revealed no additional allegations of insufficient staffing. In an effort to keep staffing at baseline levels, nurse managers addressed staffing shortages through the use of float assignments,[91] as well as mandated and voluntary staff overtime.

Staff and managers told the OIG that meal times had adequate staffing. Meal times require an increased level of patient supervision given the variability in the number and acuity of patients in the dining hall. This creates challenges for proper patient supervision. The Facility lacked a policy or process that outlined the expectations of a designated staff member responsible for monitoring staffing levels, both nurse and interdisciplinary team, throughout the meal to ensure that they remain congruent with patients need.

Allegation 3: Security—CLC 3

The OIG team did not substantiate that CLC 3 lacked security due to malfunctioning door locks. At the time of the first OIG site visit in June 2017, prior work orders revealed a history of malfunctioning doors on CLC 3 that Facility staff addressed. The OIG team substantiated a lack

[89] According to VHA Handbook 1050.01, a root cause analysis is a specific type of focused review that is used for all adverse events or close calls requiring analysis.

[90] Resident Council Meetings were monthly meetings held to discuss various issues specific to CLCs. Attendees included but were not limited to CLC patients and their families, CLC Leaders and Nurse Managers, representatives of Nutrition Food Service, Psychology, Social Work Service, Recreation Therapy, and Engineering Service.

[91] Float assignments occur when nursing staff are moved from one unit to another in an attempt to maintain adequate staffing levels.

of consistent documentation of hourly rounds on CLC 3. Staff were not documenting hourly rounds as required; however, the OIG team was unable to ascertain if the lack of documentation reflected an absence of completed hourly rounds and decreased unit security. The OIG team was unable to substantiate or not substantiate a lack of staff vigilance as the evidence was insufficient to make a determination.

Malfunctioning Door Locks

The OIG team did not substantiate that CLC 3 lacked security due to malfunctioning door locks.

OIG inspectors found CLC 3 secure at all points of entrance and exit. Both entrance doors were locked from the inside requiring a staff member to unlock the doors for persons to enter or leave the unit. The elevator to the floor opened to an enclosed glass area with a door to the unit. Staff must unlock this door to provide access to the elevator. OIG inspectors found other outside access doors secured and locked, requiring a staff member to unlock them for use. The OIG team observed a single window opened approximately 5 inches just outside the dining hall. The nurse manager informed the OIG team that the window was configured to only open approximately 5 inches.

In discussing unit security with Facility staff, staff confirmed that a single patient eloped two times in one shift. This took place at a time when staff reported the unit was having problems with the door locks and had to take alternative steps to try to prevent patient elopement. OIG inspectors found that from January through April 2017, staff submitted five work orders to request repair of malfunctioning doors or locks. OIG inspectors reviewed the Facility's work order tracking system and found the five work orders still in "pending" status. During the June 2017 site visit, OIG inspectors confirmed that staff completed the repairs but had not updated the status in the work order system.

Hourly Rounds

The OIG team substantiated a lack of consistent documentation of hourly rounds on CLC 3. Facility nursing policy[92] requires that CLC staff document in the EHR every eight hours by completing all fields in the "Nursing-LTC ADL"[93] note template. One element in this template requires staff to note whether or not safety rounds were completed every hour throughout the shift for that patient. Nurse managers told OIG inspectors that hourly safety rounds were an expectation on the CLCs. The OIG reviewed one CLC 3 patient's EHR for documentation of hourly rounds in the Nursing-LTC ADL note for 45 shifts. Inspectors found that documentation

[92] Nursing Service Memorandum C-1, September 17, 2014.

[93] Nursing-LTC ADLs are Long Term Care Activities of Daily living notes nursing staff use to document the daily activities of patients.

of hourly rounds was absent in 16 out of 45 shifts or more than one third of the shifts.[94] OIG inspectors determined that documentation of hourly rounds was not occurring as required; however, the OIG team was unable to ascertain if the lack of documentation reflected an absence of completed hourly rounds and decreased unit security.

Staff Vigilance

The OIG team was unable to substantiate or not substantiate a lack of staff vigilance on CLC 3 as the evidence was insufficient to make a determination. Vigilance occurs when staff are alert and observing for potentially dangerous situations. The OIG team reviewed Facility CLC-specific issue briefs, root cause analyses, patient advocate records, and Resident Council meeting minutes to determine if lack of staff vigilance was reported as a concern or attributed as a cause in a patient incident and found none related to CLC 3. While onsite, OIG inspectors held two open forums with nursing staff designed to provide staff with an opportunity to share their concerns related to the CLCs. Many shared a concern about the staffing levels being too low. The OIG team was unable to substantiate or not substantiate a lack of staff vigilance; however, OIG inspectors learned of staffing shortages that could create an environment where the increased workload assigned to each staff member could make it more difficult to remain vigilant. As noted above, the OIG conducted an inspection specific to CLC staffing concerns; results of that inspection will be issued in a separate report.

Allegation 4: Concerns Regarding Use of Physical Restraints—CLC 2

Patient B—Summary of Events

Patient B is late 60s with a history of multiple medical problems including multiple sclerosis (MS)[95] who resided in CLC 2 for care of progressive debilitation due to MS. Patient B was not able to walk and required assistance with all ADLs. Patient B had residual functional movement in the right upper extremity that allowed operation of a nurse call light and television remote control. Because of the advanced nature of Patient B's MS, Patient B had very limited use of the

[94] The required Nursing LTC ADL notes were missing for eight shifts reviewed, and the documentation of hourly rounds was absent in the Nursing LTC ADL notes for eight shifts.

[95] According to the National Institutes of Health's National Center for Complementary and Integrative Health, "MS is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. Symptoms of MS include muscle weakness (often in the hands and legs), tingling and burning sensations, numbness, chronic pain, coordination and balance problems, fatigue, vision problems, and difficulty with bladder control." https://nccih.nih.gov/health/multiple-sclerosis. (The website was accessed on September 6, 2017.)

left upper extremity with related contractures[96] of the left elbow joint and hand. Patient B wore a left-hand palm protector to prevent the nails from cutting into the palm.[97]

At 1:33 p.m. on a day in 2017, an NA saw Patient B and documented in the EHR that "…safety rounds performed every hour this shift…." At some time between 3:00 p.m. and 4:00 p.m., a nurse practitioner saw Patient B operating the television with the right hand. At 4:49 p.m., using the right hand, Patient B took the medication given by an LPN. The LPN left Patient B's room and confirmed during interviews that at the time, Patient B had full use of the right hand and was not restrained. At 5:12 p.m., when conducting hourly rounds, an NA found Patient B's hands bound by the Velcro® strap of the palm protector. The NA reported immediately alerting the nurse manager and bringing the nurse manager to Patient B's room at 5:15 p.m. to observe the situation. Documentation in the EHR stated that Patient B was found with "…wrists crossed and bound in front of [him/her] by [his/her] L [left] hand palm protector…." Staff freed Patient B's hands, performed a wellness check, and notified nurse leaders and the VA Police.

Following an interview with VA Police, staff took Patient B to the ED. Patient B was examined by a physician and found to be free from pain with no obvious trauma and released back to CLC 2.

Use of Restraints

The OIG team substantiated that Patient B's wrists were bound together by the strap of the palm protector (Incident); however, the OIG inspectors did not find evidence to suggest it was an intentional act done by a staff member due to a lack of available nursing staff. A review of the limited available evidence was inconclusive in determining how Patient B's hands became bound.

The palm protector worn by Patient B consisted of a soft pad that was positioned into the palm of the left hand and held in place by a long strap that wrapped around the back of the hand and was secured with Velcro®. At the time of the Incident, it was the Facility's practice to leave the strap unaltered in length after donning the palm protector. The Nurse Manager told the OIG that since this Incident, safety checks and rounds include staff closely examining patient's hands and ensuring that the palm protector was positioned properly to maintain optimal skin protection.

[96] Contractures of joints in MS occur when involuntary spasms of the muscles around a particular joint. Muscles are held in a constant state of contraction, causing increased stiffness and tone that can lead to decreased range of motion of major joints. This constant state of contracting muscles can eventually shorten the connective tissue around the joints causing contractures. When this occurs in the hand, the fingers clench into a fist and can press the fingertips and nails into the palm causing cuts or pressure sores.

[97] A palm protector is a device which holds the fingers out to prevent digging into the palm of the hand. It is fabricated from closed-cell foam and lined with a pile fabric and has an attached Velcro® strap to simplify application. Palm protectors are considered positioning devices for skin protection, not restraints.

During the course of the OIG inspection, inspectors conducted both unannounced and announced visits to CLC 2 and adjacent areas and found no evidence of patient restraint use. When asked about the use of restraints on the CLCs, CLC 2 staff and nurse managers consistently reported that the CLC was restraint free. As part of the investigation of this Incident, VA Police reviewed video footage of the hallway outside of Patient B's room. The footage showed nursing staff coming and going from Patient B's room in accordance with the provision of care/distribution of medications. No video evidence was found to confirm or dispute whether a staff member bound Patient B's wrists.

Facility leaders notified OIG Office of Investigations. After the OIG Office of Investigations determined the Incident was not a criminal case, Facility leaders continued the fact-finding review. The Facility's fact-finding review was inconclusive and stated it was possible that Patient B could have restrained one's self with the strap of the palm protector. The OIG team procured a similar palm protector and attempted to replicate that action. Inspectors found that if the strap was loose, it was possible to slip one's hand under the strap thereby having both hands simultaneously bound by the strap. In response to this Incident, the Facility initiated a practice to cut off the excess length of straps on the palm protectors to prevent the possibility of patients accidently restraining themselves.

Allegation 5: CLC Nurse Management Concerns

The OIG team did not substantiate that nurse managers on the CLCs[98] reviewed were often unavailable and failed to provide adequate response to unit issues.

While onsite, OIG inspectors interviewed nursing staff from CLC 2 and CLC 3. When asked if their nurse managers were available if needed, staff consistently told inspectors that there was good communication with nurse managers. Staff noted that nurse managers were not always on the unit because of other administrative responsibilities, but a nurse manager reported the ability to be reached by telephone, even when off duty.

When OIG inspectors asked staff for specific examples of when nurse managers failed to provide adequate responses to unit issues, staff reported an environment of care concern they believed had not been addressed. OIG inspectors discussed the status of this concern with the CLC 3 Nurse Manager. The CLC 3 Nurse Manager showed evidence that management was working to resolve the concern, but reported that those efforts may not have been communicated to all staff.

Throughout interviews onsite, nurse managers and staff shared concerns regarding CLC nurse staffing levels. Staff reported that overtime was often used, and sometimes mandated, as a mechanism to ensure adequate staffing levels from shift to shift. Staff shared frustrations with

[98] Although the original allegation mentioned a Nurse Manager on CLC 3, the OIG team interviewed staff from both CLC 2 and CLC 3 during the inspection. This decision was made based on the location of the events in the allegations received and OIG's inability to clarify the scope due to the complainant(s) being anonymous.

nursing vacancies that were not being filled, and delayed recruitment and on-boarding processes. Staff voiced that nurse managers were aware of the staffing challenges and were doing what they could to address the problem. The OIG conducted a healthcare inspection related to nurse staffing; results of that inspection will be issued in a separate report.

OIG Review of Facility Responses

OIG inspectors reviewed the actions taken by Facility staff and leaders in response to Patient A's Event and Patient B's Incident. The Facility response to the Incident involving Patient B was thorough and well-documented. Following Patient A's Event, the Facility took action to train staff in regards to calling the Code Blue Team. However, OIG inspectors determined that the circumstances surrounding the care provided during Patient A's Event and eventual death warranted additional actions, such as an institutional disclosure and peer reviews.

Institutional Disclosure

VHA[99] and The Joint Commission[100] require that patients, and when appropriate, their families, be informed of unanticipated outcomes related to an adverse event that occurred during care.[101] An institutional disclosure is a formal process by which Facility leaders, together with clinicians and other appropriate individuals, inform patients and their families that an adverse event has occurred during the patient's care.

VHA Handbook[102] states:

> Institutional disclosure must be initiated as soon as reasonably possible and generally within 72 hours… Under such circumstances, if the adverse event has resulted in or is reasonably expected to result in death or serious injury, institutional disclosure is required, but disclosure may be delayed to allow for a thorough investigation of the facts provided.

The Handbook[103] also says, "Documentation of institutional disclosures must be done using the CPRS[104] Institutional Disclosure of Adverse Event Note Template."

---

[99] VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012. This Handbook expired October 31, 2017, and has not been recertified.

[100] http://vaww.oqsv.med.va.gov/functions/integrity/accred/jointcommission.aspx. (The website was accessed on July 12, 2017.)

[101] Adverse events include events that resulted in death or serious injury; prolonged hospitalization; or life-sustaining intervention or intervention to prevent impairment or damage.

[102] VHA Handbook 1004.08.

[103] VHA Handbook 1004.08.

[104] Computerized Patient Record System, or EHR throughout this report.

As of August 2017, Facility leaders had not completed an institutional disclosure for Patient A. In interviews with leaders present during the time period following the Event, OIG inspectors learned that initial plans for a meeting with the family were delayed while awaiting additional information related to the case. As time passed, a decision was made that a formal institutional disclosure was not needed but a meeting with the family would occur. On May 19, 2017, the Chief of Staff, Chief of Geriatrics and Extended Care, two Patient Advocates, the Nurse Executive, and a CLC Nurse Manager met with Patient A's family. The Chief of Staff said in a statement to OIG:

> I was prepared to do [an institutional disclosure] at the meeting but the family meeting was almost exclusively focused on family members conveying their opinions/findings...They did not question the medical care stating they felt it was excellent. Therefore, I said little beyond expressing condolences and clarifying facts regarding medical issues as they were raised in their statements… They demonstrated a full awareness of events that transpired on the unit and of their right to pursue further action.… At that juncture I felt they were fully informed in areas of possible liability pertaining to the actions of our staff and the course of action available to them should they desire.

The OIG inspection team determined that circumstances surrounding Patient A's death warranted a timely, formal, and documented institutional disclosure.

Peer Review

Peer Review is an organized process carried out by an individual health care professional or select committee of professionals to evaluate the performance of other professionals.

VHA Directive 2010-025[105] states that all deaths occurring in the medical center and those occurring in the community setting that are brought to the attention of the medical center staff and identified concerns must be screened against death review criteria. The Directive lists 16 different criteria[106] that, if present, require a peer review for quality management, two of which applied to Patient A.

The Facility did not conduct peer reviews following the Event. The OIG team determined that peer reviews were warranted for all involved practitioners (or resident supervisors) during the emergency management of Patient A while in the CLC and ED.

[105] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This directive expired June 30, 2015 and has not been updated.

[106] VHA Directive 2010-025.

Code Blue Policy Training

Education records showed that following the Event, the Chief of Police provided education to the operators on the Facility policy for calling the Code Blue Team. However, the training did not cover when to activate the ERT or how operators were to respond when they encounter a caller requesting an action that was not consistent with policy. Since the Event, in an effort to simplify information, the Facility Risk Manager included a visual tool in the operator's code training that depicted which team to call by emergency type and location.

In correspondence with the OIG, the Chief of Police wrote that if a code needs to be canceled, the operator makes two overhead announcements and the code pagers are activated twice broadcasting the cancellation. This cancellation protocol was not in the written code policy but was provided to operators during training. The Chief of Police shared the plan to update the current policy to include the expected cancellation process. CLC staff also completed competency training specific to medical emergencies and equipment.

The Facility was in the process of updating the CPR policy to establish a procedural guide to be followed by staff in the event of cardiopulmonary arrest.

The dissemination of unit specific emergency response information that is readily available and actionable presents a challenge to temporary staff, such as float/intermittent nurses and medicine and surgery residents that rotate through the Facility for varying lengths of time. Medicine and surgery residents rotating on and off the Code Blue Team work at both the University hospital and the VA throughout the course of their residencies. The Associate Residency Program Director told OIG inspectors that staff trained the residents and they knew the locations covered by each of the code responses. Residents may have difficulty remembering the specific emergency processes shared at that orientation to the Facility because that orientation may occur well in advance of their arrival to the Facility.

While each of the actions taken by the Facility staff since the Event is a step in the right direction, without a comprehensive and systematic review of current policies related to emergencies, to include a robust and coordinated staff education effort and the implementation of environmental cues, the OIG remains concerned that the human errors seen in Patient A's case may recur.

Conclusion

The Medical Examiner concluded in the autopsy that Patient A died of complications of aspiration of food bolus, a finding consistent with documentation in the EHR reporting the removal of large pieces of food from Patient A's airway.

The Medical Examiner's findings were consistent with "Café Coronary" syndrome, a term coined for patients who have an airway obstruction (usually during or immediately after a meal) but are mistakenly thought to be having a heart attack. Patients with a Café Coronary may not demonstrate signs of choking or coughing prior to a cardiac arrest, so emergency responders must have a high level of suspicion for an airway obstruction when patients are found unresponsive in a dining area.[107] The mechanism of death caused by Café Coronary syndrome has been debated because of the rapidity of the fatality, often without the classic preceding symptoms of choking. One study author thought that death may be due to a combination of airway obstruction and reflex vagus nerve inhibition.[108] Patient A had many of the risk factors for Café Coronary syndrome including psychiatric illness, mental impairment, poor dentition, and use of psychiatric medication.[109]

A review of records confirmed that Patient A ordered, and nursing staff reported that Patient A received, the correct menu selection and diet type on the day of the Event. The RT documented removing a large mass of meat from Patient A's airway. Given this discrepancy, OIG inspectors were unable to determine if Patient A received properly cut food.

Staff and patients left the dining hall at varied times as the meal ended. OIG inspectors were unable to determine the number of staff present in the dining hall just prior to and at the time the Event occurred. Therefore, the OIG team was unable to substantiate or not substantiate that the choking occurred due to a lack of nursing staff available to supervise patients during meals.

OIG inspectors reviewed the response by staff to the Event and substantiated that CLC staff notified the operator of the emergency, without specifically requesting the type of code to be initiated. This led to multiple teams responding to the Event, the initiation of ACLS in a setting unable to support it, and a delay in transporting the patient to the ED. As a result of the wrong code being called, multiple people responded to the code, causing role confusion. The residents, unaware of the absence of a crash cart, initiated ACLS in a setting that lacked the medications necessary for ACLS. While it is impossible for the OIG to determine if calling the correct code

[107] R.K Haugen, MD, "The Café Coronary Sudden Deaths in Restaurants," *Journal of American Medical Association*, 186 no 2 (1963): 142-143.

[108] The vagus nerve inhibition may result from stimulation of the superior laryngeal nerve by the food bolus.

[109] Regula Wick, John D. Gilbert, and Roger W. Byard, "Café Coronary syndrome-fatal choking on food: An Autopsy Approach," *Journal of Clinical Forensic Medicine*, 13, (2006): 135-137.

or a more timely transfer to the ED would have altered the outcome of this case, it may have improved the patient's chances of surviving the incident.

The Facility is not equipped to use IO needles for IV access during a code, and the insertion of a central line was one of the reasons for the transport delay. While the use of an IO needle likely would not have altered the outcome for Patient A, it may mitigate risks associated with central line access for other Code Blue patients., If IO needles are used, central line placement would not be needed during a code. Since surgery residents respond to the codes mainly for vascular access, the use of IO needles may decrease the number of residents responding to the code, resulting in less role confusion.

Facility policy states that, for the purpose of continuous quality improvement, the Code Blue Team and ERT will meet after each code to conduct a debriefing of the event. The Facility was unable to provide evidence of completed code debriefings related to Patient A's care.

The Safety/Engineering Service is responsible for ERT supervision. However, the ERT lacked medical oversight, as required by VHA policy. OIG inspectors found that the ERT lacked medical oversight in that neither the ED nor the CPR Committee were reviewing all ERT event responses.

The OIG team did not substantiate that managers misrepresented the cause of death as cardiac arrest, rather than choking. While the allegation seems to suggest that there may have been an intentional attempt to hide or alter information about how Patient A died, the OIG team did not find evidence of this. OIG inspectors heard from frontline staff and managers that they initially thought that Patient A's condition was cardiac related because Patient A had no indications of choking when found unresponsive. Documentation in the EHR noted airway obstruction and clearly records the removal of food from Patient A's airway. Members of management shared with the OIG team their opinions of how Patient A may have died. However, managers lacked access to the autopsy report and could only speculate as to the cause of Patient A's death.

The OIG team was unable to substantiate or not substantiate that patients on CLC 3 were regularly left unsupervised while eating; the evidence was insufficient to make such a determination. VHA Handbook 1142.01 and nurse leaders expect nursing staff to be present throughout the course of meal times for patients. During the OIG team's onsite review, inspectors observed meal time on CLC 3 and found nursing staff present and assisting patients with their meals as needed. A review of prior incidents and Resident Council meeting minutes identified patient frustration with delayed meal starts while awaiting the arrival of staff to distribute trays and supervise meal time. These documents revealed no additional allegations of insufficient staffing. The Facility lacked a policy or process outlining the expectations of a designated staff member responsible for monitoring staffing levels throughout the meal to ensure that they remain congruent with the patients' needs. VHA policy requires that all members of the interdisciplinary team, including unit nursing staff, be present at meal time. OIG inspectors did

not see, nor were they told of, non-nursing members of the interdisciplinary team in the dining hall.

The OIG team did not substantiate that CLC 3 lacked security due to malfunctioning door locks. A review of prior work orders revealed a history of malfunctioning door locks that, at the time of the OIG review, had been addressed. OIG inspectors found CLC 3 secure at all points of entrance and exit.

The OIG team substantiated a lack of consistent documentation of hourly rounds. However, OIG inspectors were unable to ascertain if the lack of documentation reflected an absence of completed hourly rounds and decreased unit security.

The OIG team was unable to substantiate or not substantiate a lack of staff vigilance as the evidence was insufficient to make a determination. However, conditions such as staffing shortages could create an environment where the increased workload assigned to each staff member was such that it became more difficult to remain vigilant.

The OIG team substantiated that Patient B's wrists were bound together by the strap of the palm protector; however, OIG inspectors did not find evidence to suggest it was an intentional act done by a staff member due to a lack of available nursing staff to supervise Patient B. Facility reviews, OIG Office of Investigations, and the OIG inspection team review of the case were inconclusive in determining how both of Patient B's wrists became bound by the strap of the palm protector.

The OIG team did not substantiate that nurse managers on the CLCs reviewed were often unavailable and failed to provide adequate response to unit issues. CLC staff interviewed consistently stated that while nurse managers were not always physically present on the units because of other administrative responsibilities, they could be reached by telephone, even when off duty.

The OIG team reviewed the actions taken by the Facility in response to Patient A's Event and Patient B's Incident. The Facility response to the Incident involving Patient B was thorough and well documented. The OIG team identified vulnerabilities and the need for further review of the Event involving Patient A. The OIG team determined that the circumstances surrounding Patient A's care and eventual death warranted an institutional disclosure and peer reviews. While each of the actions taken by the Facility since the Event is a step in the right direction, without a comprehensive and systematic review of current policies related to emergencies, to include a robust and coordinated staff education effort and the implementation of environmental cues, the OIG remains concerned that the human errors seen in Patient A's case may recur.

A number of the allegations addressed in this report attribute specific actions to a lack of nurse staffing. Insufficient evidence one way or the other prevented the OIG team from substantiating those allegations. Through interviews with staff and a review of staffing data, the OIG team identified an ongoing challenge to maintain baseline CLC nursing staff levels that was addressed

through the use of float assignments and heavy reliance on overtime. Due to the potential risk to the quality of patient care and safety of patients associated with staffing shortages, the OIG determined that a healthcare inspection unique to CLC nurse staffing at the Facility was warranted. Results of that inspection will be issued in a separate report.

The OIG made nine recommendations.

Recommendations 1–9

1. The Northport VA Medical Center Director makes certain that staff conduct post-Code Blue debriefings as required and that compliance is monitored.

2. The Northport VA Medical Center Director ensures the collection, review, and analysis of data following each Emergency Response Team event response and that those involving resuscitative care are reviewed by the Facility Cardiopulmonary Resuscitation Committee, and that compliance is monitored.

3. The Northport VA Medical Center Director confirms that a review of the Community Living Centers' meal staffing process is performed to evaluate the need for designation of a staff person responsible for assigning (both nurse and interdisciplinary team) and monitoring staffing levels in the dining hall throughout meal times and takes appropriate action.

4. The Northport VA Medical Center Director completes a review of the meal delivery process in the CLCs to confirm and document menu selection and diet type at the time that meal trays are served to the patient and makes policy updates, if warranted.

5. The Northport VA Medical Center Director verifies that Community Living Centers' safety rounds are conducted and documented, as required, and that compliance is monitored.

6. The Northport VA Medical Center Director confers with Office of General Counsel to determine if an institutional disclosure of Patient A's care is warranted.

7. The Northport VA Medical Center Director obtains peer reviews of the care provided by practitioners (including supervisors in the case of the resident physicians) during the emergency management of Patient A while in the Community Living Center and Emergency Department.

8. The Northport VA Medical Center Director reviews and updates, as warranted, Facility policies and practices related to emergency medical response (such as obtaining emergent intravenous access) and adequate medical oversight, and all staff (including resident physicians) complete training and compliance is monitored.

9. The Veterans Integrated Service Network 2 Director oversees and provides assistance to the Northport VA Medical Center Director in the review and update of Facility policies and practices on emergency medical response and adequate medical oversight.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 24, 2018.

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: Healthcare Inspection—Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center, New York

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with the Office of Inspector General's findings and recommendations and the responses and actions initiated by Northport VAMC. Thank you for the opportunity to review our processes to ensure that we continue to provide exceptional care for our Veterans.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA, FACEP
Network Director

Comments to OIG's Report

Recommendation 9

The Veterans Integrated Service Network 2 Director oversees and provides assistance to the Northport VA Medical Center Director in the review and update of Facility policies and practices on emergency medical response and adequate medical oversight.

Concur.

Target date for completion: December 1, 2018

Director Comments

A comprehensive review of the facility's emergency management policies, practices and medical oversight is being conducted by Veterans Integrated Service Network Quality Management and Patient Safety Leadership to insure full compliance with the VA Emergency Medicine Handbook. The review will also include an evaluation of the Facility after action debriefing process, analysis and reporting practices. Review activities include leadership and staff interviews, document review of policies, procedures, committee minutes, post-code reports, and closed medical record reviews. Review results will be reported to the Veterans Integrated Service Network Quality, Safety and Value Committee with any identified needed improvements followed until closure.

.

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 19, 2018

From: Interim Director, VHA VISN 2 Northport New York #632

Subj: Alleged Quality of Care Issues in the CLCs, Northport, New York

To: Director, Seattle Regional Office (54SE)
VHA Management Review Services (VHA 10E1D MRS Action)

I have reviewed and concur with the Office of Inspector General's findings and recommendations and the responses and actions initiated by Northport VAMC. Thank you for the opportunity to review our processes to ensure that we continue to provide exceptional care for our Veterans.

(Original signed by:)

Cathy Cruise, MD
Interim Medical Center Director
VAMC Northport NY VISN 2

Comments to OIG's Report

Recommendation 1

The Northport VA Medical Center Director makes certain that staff conduct post–Code Blue debriefings as required and that compliance is monitored.

Concur.

Target date for completion: December 1, 2018

Director Comments

The CPR Committee reviews and monitors 100% of post code blue events for documentation of debriefing compliance and develops actions when appropriate. The Nurse Manager/Designee of the ICU and the NOD during WHEN tours will confirm the debriefing documentation is present post code and compliance will be recorded in the CPR Committee minutes. Post-code documentation will be monitored for 4 sequential months to ensure 90% compliance is achieved and maintained.

Recommendation 2

The Northport VA Medical Center Director ensures the collection, review, and analysis of data following each Emergency Response Team event response, and that those involving resuscitative care are reviewed by the Facility Cardiopulmonary Resuscitation Committee, and that compliance is monitored.

Concur.

Target date for completion: January 1, 2019

Director Comments

The Emergency Room Section Chief will develop a process to analyze, reconcile and trend all emergency response team (ERT) events. All ERT events involving resuscitative care will be reviewed at the CPR Committee including the identification of opportunities for improvement. The results of these reviews will be reflected in the CPR Committee minutes. Compliance will be monitored for 4 consecutive months ensuring 90% is maintained.

Recommendation 3

The Northport VA Medical Center Director confirms that a review of the Community Living Centers' meal staffing process is performed to evaluate the need for designation of a staff person responsible for assigning (both nurse and interdisciplinary team) and monitoring staffing levels in the dining hall throughout meal times and takes appropriate action.

Concur.

Target date for completion: December 1, 2018

Director Comments

The ACNS for Extended Care will develop and implement a Standard Operating Procedure (SOP) for the Community Living Center (CLC) Meal Staffing and Meal Delivery Process. The SOP will define the staffing levels and required disciplines during mealtime. The monitoring will include an attestation that staffing was maintained as per the SOP for all mealtimes. Conformance to the SOP will be monitored for 4 consecutive months until 90% compliance is achieved.

Recommendation 4

The Northport VA Medical Center Director completes a review of the meal delivery process in the CLCs to confirm and document menu selection and diet type at the time that meal trays are served to the patient and makes policy updates, if warranted.

Concur.

Target date for completion: December 1, 2018

Director Comments

The current Tray Accuracy monitor conducted by Nutrition and Food Service will be modified to include Patient Safety specific elements including correct diet order and correct texture. All trays identified as specialty diets indicated by a blue mat will be delivered to the Resident by the nursing staff. The Community Living Center (CLC) Meal Staffing and Meal Delivery Process SOP will be revised to reflect these changes. Compliance with the staffing requirements and meal delivery process will be monitored for 4 sequential months to ensure sustained compliance at $\geq$ 90%.

Recommendation 5

The Northport VA Medical Center Director verifies that Community Living Centers' safety rounds are conducted and documented, as required, and that compliance is monitored.

Concur.

Target date for completion: December 1, 2018

Director Comments

The charge nurse for each shift in the CLCs will monitor that safety rounds are conducted and record this on the 24-hour nursing report including signature. Nursing will actively monitor

compliance through nurse manager/designee observation of rounds being conducted by staff and through documentation review for 4 consecutive months to ensure 90% compliance is achieved and maintained.

Recommendation 6

The Northport VA Medical Center Director confers with Office of General Counsel to determine if an institutional disclosure of Patient A's care is warranted.

Concur.

Target Date for Completion: September 1, 2018

Director Comments

Northport has consulted with and is awaiting General Counsel's response for guidance to determine if an Institutional Disclosure is warranted.

Recommendation 7

The Northport VA Medical Center Director obtains peer reviews of the care provided by practitioners (including supervisors in the case of the resident physicians) during the emergency management of Patient A while in the Community Living Center and Emergency Department.

Concur.

Target date for compliance: December 1, 2018

Director Comments

Peer Reviews will be completed for practitioners involved in the care of this Veteran during the emergency.

Recommendation 8

The Northport VA Medical Center Director reviews and updates, as warranted, Facility policies and practices related to emergency medical response (such as obtaining emergent intravenous access) and adequate medical oversight, and all staff (including resident physicians) complete training and compliance is monitored.

Concur.

Target Date for Completion: November 1, 2018

Director Comments

The Cardiopulmonary Resuscitation (CPR) Policy was revised in April of 2018. The Designated Education Office (DEO) and the Director of Learning Officer (DLO) will develop and implement education specific to Emergency Medical Response (ERTs). This education will occur on a continual basis to ensure that 100% of all resident physicians are educated about emergency responses when rotating at the VA and 100% of CLC staff complete the training. Compliance with emergency medical response procedures will be monitored for 4 consecutive months until 90% compliance is achieved and maintained. Monitoring outcomes will be reported to the Executive Quality Council (EQC) committee and Clinical Executive Board (CEB).

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Kelley Brendler-Hall, RN Craig Byer, MS, RRA Bruce Nielson, JD Robyn Stober, JD Susan Tostenrude, MS Amy Zheng, MD
Other Contributors	Jennifer Christensen, DPM Alicia Castillo-Flores, MBA, MPH

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, New York/New Jersey VA Health Care Network (10N2)
Director, Northport VA Medical Center (632/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kirsten E. Gillibrand, Charles E. Schumer
U.S. House of Representatives: Yvette D. Clarke, Hakeem Jeffries, Peter T. King, Gregory W. Meeks, Grace Meng, Jerrold Nadler, Kathleen M. Rice, Thomas R. Suozzi, Nydia M. Velázquez, Lee M. Zeldin

The OIG has federal oversight authority to review the programs and operations of VA medical facilities. OIG inspectors review 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 leadership on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

OIG reports are available at www.va.gov/oig.