



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Inadequate
Response to a Missing
Patient and Safety Concerns
at the Bay Pines VA
Healthcare System

Florida



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations of an inadequate response to a Code Orange (event) and patient safety concerns for a missing patient at the Bay Pines VA Healthcare System (facility), Florida.¹

The OIG received an anonymous complaint that a patient was missing from the facility's acute medicine unit for several days before being located at a community hospital. The OIG requested that facility leaders review the allegation and provide documentation to support their response. Based on the facility's response, the OIG identified potential deficiencies related to staff knowledge of Code Orange policy and processes, quality management reviews, and annual Code Orange training requirements.

The OIG concurred with the facility's findings and substantiated that the patient went missing from the facility in spring 2018. The VA police brought the patient to the emergency department after finding the patient asleep on VA property. An emergency department psychiatrist evaluated and determined that the patient lacked capacity to make discharge planning decisions.² The patient underwent neurocognitive testing which revealed "persistent and significant deficits across cognitive domains" and recommended placement for "continued monitoring and 24/7 supervision." Later that afternoon, the patient expressed frustration about the need for placement, and fiduciary and guardianship services during a discussion with the unit social worker.³ Later that day, the patient's nurse could not locate the patient on the unit. The patient remained missing and was located at a community hospital five days later.

The OIG concluded that staff contacted the covering physician to determine the patient's risk status before activating a Code Orange. The physician reviewed the patient's electronic health

¹ Code Orange is an emergency code designation for at-risk missing and wandering patients used by the facility; Bay Pines VAHCS Memorandum 516-13-00-024, *Management of At-Risk Wandering and Missing Patient*, August 2013, was in effect at the time of the event, Bay Pines VAHCS Memorandum 516-18-00-024, *Management of At-Risk Wandering and Missing Patient*, July 2018, contains the same or similar language regarding Code Orange.

² Decision-making capacity is a clinical determination that a patient has the requisite abilities to make a medical decision.

³ According to Veterans Benefits Administration, a fiduciary is a person or legal entity authorized by VA to serve as payee of VA benefits for beneficiaries unable to manage their financial affairs. VA will only determine an individual to be unable to manage his or her financial affairs after receipt of medical documentation or if a court of competent jurisdiction has already made the determination. A court appoints a guardian to legally manage the affairs of a person who lacks decision-making capacity.

record and determined that the patient was high risk [at risk]; however, the OIG learned that the physician documented this assessment only after receiving calls from a facility leader.⁴

Unit staff did not comply with the facility policy for patient identification. The intent of the patient identification policy is to ensure the correct identification of the individual receiving services or treatment. Proper identification decreases the potential for errors.⁵ Staff activated a Code Orange as soon as they discovered the patient was missing; however, they misidentified the patient which delayed the search for the missing patient by two hours. The facility does not have a policy addressing look-alike or soundalike names and the expected practice of adding alerts was not followed. Once staff identified the correct patient, the facility conducted a campus-wide search but did not locate the patient.

The OIG confirmed that at the time of this event the facility did not have a policy addressing look-alike or soundalike names. Although the charge nurse had assigned different nurses to care for the two patients with similar names and placed the patients in rooms on opposite ends of the unit, the unit clerk had not added name alerts to the patient room assignment bed board and the paper charts, as was common practice.

The administrative officer of the day (AOD) did not comply with policy, which requires AODs to contact outside hospitals and shelters to attempt to locate a missing patient.⁶ The AOD reported being unaware of the responsibility to contact outside hospitals. However, unit staff and social workers made multiple attempts and the patient was located at a community hospital five days after being missing and returned to the VA for admission.

The OIG reviewed the facility's quality management processes and determined the issue brief and the Code Orange debrief complied with Veterans Health Administration and facility policies and procedures.⁷ However, the OIG concluded that the incident report did not address the misidentified patient, and the fact finding did not review all personnel involved in the event. The OIG concurred with the facility's patient safety manager that they assigned the correct Safety Assessment Code (SAC) score, which did not require the facility to conduct a Root Cause

⁴ VHA considers a missing or wandering patient to be "at risk" if they are a harm to themselves or others if not found and returned to a safe environment. The lack of cognitive ability, the ability to make relevant decisions, contributes to the determination if a patient is considered "at risk."; VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.

⁵ Facility Memorandum 516-15-11-073, *Patient Identification*, March 2015. This memorandum expired on March 31, 2018 and was replaced by Facility Memorandum 516-18-11-073, *Patient Identification Process*, February 2019. The facility changed their identification wristband to help with patient identification, but verification of identity still needs to occur.

⁶ The AOD acts on behalf of the Director and is the central point of contact, during other than normal duty hours of all administrative functions of the medical center. VHA Directive 1096, *Administrative Officer of the Day (AOD)*, December 5, 2014; Facility Memorandum 516-13-00-024, Facility Memorandum 516-18-00-024.

⁷ Issue briefs are notification to VHA that provide specific information through the appropriate chain of command regarding events or issues that may impact VA. Issue briefs are to provide clear and concise information about unusual or significant events.

Analysis (RCA).⁸ Despite the SAC score, the facility missed an opportunity for improvement by not initiating an RCA at the time of the event. The facility informed the OIG that an RCA charter and team were being prepared to review the spring 2018 missing patient event. The RCA was completed and signed by the Facility Director approximately a month later.

The OIG concluded that staff received training on managing missing and wandering patients. VA police conducted initial training at new employee orientation and staff completed annual computer-based training. The OIG confirmed that of the 40 staff training records reviewed, 93 percent of staff in calendar year 2017 and 95 percent of staff in calendar year 2018 completed the Code Orange training.

The facility developed and distributed a visual aid for staff to refer to during Code Orange events. The OIG toured nine units throughout the facility and spoke with 27 staff; generally, staff were aware of the new Code Orange card on the unit. The OIG looked for and found Code Orange cards on all nine units.

In response to the event, VA police began conducting annual drills in seven clinical areas, starting with the unit where the event took place.

Following the event, nurse managers held a staff meeting and daily huddles to reinforce the importance of following the Code Orange cards, as well as introducing time-out huddles prior to calling a Code Orange to ensure the correct identity of the missing person is announced.⁹

The OIG made three recommendations related to patient identification, documentation, and understanding duties and responsibilities.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See Appendix A and B, pages 17–20 for the Directors' comments). The OIG will follow up on the planned actions until they are completed.



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⁸ A SAC score is a method used to evaluate the severity of the actual and potential adverse events that occur; VHA Handbook 1050.01.

⁹ A huddle is a brief team meeting to communicate information about patient care for a specified period; VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017; A time-out huddle is when staff pause to confirm the missing patient's identity before calling a Code Orange.

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Abbreviations

| | |
|------|-------------------------------------|
| AOD | administrative officer of the day |
| EHR | electronic health record |
| NCPS | National Center for Patient Safety |
| OIG | Office of Inspector General |
| RCA | root cause analysis |
| SAC | Safety Assessment Code |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |



Introduction

In April 2018, the VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous complaint alleging an inadequate response to a Code Orange (event) and patient safety concerns for a missing patient at the Bay Pines VA Healthcare System (facility), Florida.¹⁰

Background

The facility, part of the Veteran Integrated Service Network (VISN) 8, located in Bay Pines, Florida, operates eight community based outpatient clinics located in Bradenton, Cape Coral, Naples, Palm Harbor, Port Charlotte, Sarasota, St. Petersburg, and Sebring, Florida. In fiscal year 2018, the facility served 109,473 patients and had a total of 397 hospital operating beds, including 186 inpatient beds, 99 domiciliary beds, and 112 community living center beds. The facility is located on 337 acres, bordered by a busy thoroughfare, Boca Ciega Bay, a lagoon, and a memorial park. The facility provides a full range of medical, psychiatric, and extended care services in outpatient, inpatient, residential, nursing home, and home care settings.

Wandering, Missing or Absent Patients

Veterans Health Administration (VHA) acknowledges that VA facilities are responsible for all patients receiving care but notes that patients with physical, mental, or cognitive impairments may require additional monitoring and protection. VHA facilities must ensure staff know the whereabouts of patients and determine their potential risk to wander or become missing. If a patient wanders or becomes missing, responsible staff must initiate prompt search procedures.¹¹

VHA and the facility consider a patient to be at risk if there is the potential for harm to themselves or others if not returned to a safe environment. An at-risk wandering patient is one who strays beyond the view or control of staff, and an at-risk missing patient is one who

¹⁰ Code Orange is an emergency code designation for at-risk missing and wandering patients used by the Facility; Bay Pines VAHCS Memorandum 516-13-00-024, *Management of At-Risk Wandering and Missing Patient*, August 2013, was in effect at the time of the event, Bay Pines VAHCS Memorandum 516-18-00-024, *Management of At-Risk Wandering and Missing Patient*, July 2018, contains the same or similar language regarding Code Orange; A missing or wandering patient is considered “at-risk” if they lack cognitive ability to make relevant decisions; VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010. This directive expired on December 31, 2015, and has not been rescinded or replaced.

¹¹ VHA Directive 2010-052.

disappears from patient care areas located on VA property. An absent patient is one who leaves the treatment areas without staff’s knowledge and staff do not consider the patient to be at risk.¹²

Code Orange Protocol

Facility staff activate the Code Orange protocol when they identify that an at-risk patient is wandering or becomes missing.¹³ The protocol includes the steps found in table 1.¹⁴

Table 1. Code Orange Protocol

| Protocol Steps | Description |
|--|---|
| Preliminary Search | Unit staff conduct a preliminary search of the local area where the patient went missing, common areas, and adjacent areas. The search should last no longer than 15 minutes. |
| Code Orange Protocol Activation and Full Search | If a provider determines a missing patient is at risk, that provider enters a Missing Patient Warning Note in the electronic health record (EHR). Staff activate the Code Orange protocol. VA police conduct a full search of the VA campus. |
| Notification | The VA Police Service Communication Center initiates overhead Code Orange announcements and all facility staff receive an email alerting them to a missing patient. The email includes a picture or description of the patient, requests that staff check their immediate areas, and directs staff to contact the VA police if they locate the patient. |
| Missing Patient Record Flag | The administrative officer of the day (AOD) places a missing patient record flag on the patient's EHR. The flag identifies the patient as missing and instructs staff to notify the VA police if the patient is located. The AOD removes the flag once the patient is located. ¹⁵ |
| Notification to Law Enforcement | If the patient is not located, the VA police contact local law enforcement to request a health and welfare check and enter the patient’s information into the national database of missing persons. ¹⁶ |

Source: Facility Memorandum 516-13-00-024

Allegations and Related Concerns

In April 2018, the OIG received an anonymous complaint that a patient was missing from the facility’s acute medicine unit for several days before being located at a community hospital. The OIG requested that the facility review the allegation and provide documentation to support the

¹² VHA Directive 2010-052, Facility Memorandum 516-13-00-024, Facility Memorandum 516-18-00-024.

¹³ Facility Memorandum 516-13-00-024; Facility Memorandum 516-18-00-024.

¹⁴ Facility Memorandum 516-13-00-024; Facility Memorandum 516-18-00-024.

¹⁵ The AOD acts on behalf of the Facility Director, conducts all administrative functions and is the central point of contact during off-hours. VHA Directive 1096, *Administrative Officer of the Day (AOD)*, December 5, 2014.

¹⁶ A health and welfare check consists of local law enforcement or other first responders visiting a patient’s home (or last known residence) to ensure the patient is safe.

response. In June 2018, the facility provided a response substantiating the allegation that the patient went missing. In September and October, the OIG requested additional information from the facility. By mid-October, the facility and the VISN had provided the OIG with the additional requested information.

Based on the facility's response, the OIG identified potential deficiencies related to staff knowledge:

- Code Orange policy and processes
- Quality management reviews and implementation of changes
- Code Orange training requirements

Scope and Methodology

The OIG initiated the inspection on November 20, 2018, and conducted a site visit the week of January 14, 2019.

The OIG team reviewed relevant VHA and facility policies and procedures related to wandering and missing patients, The Joint Commission standards, and Agency for Healthcare Research and Quality literature. In addition, the team reviewed the patient's EHR, an issue brief, a fact finding, an incident report, relevant committee meeting minutes, police logs, Code Orange debriefing and supplemental reports, patient safety reports for fiscal year 2018 through quarter 1, fiscal year 2019, and staff training records for missing and wandering patients for calendar years 2017 and 2018.

The OIG interviewed a total of 52 staff.¹⁷ The interviews included facility leaders, the Chief of Medicine, an AOD, quality management staff, VA police staff, clinical staff involved in the patient's care, and other staff with relevant knowledge of the event. During the site visit, the OIG toured multiple inpatient units and the community living center.

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

¹⁷ The OIG interviewed 52 staff, 25 staff had direct involvement or knowledge of the missing patient event, and a selected sample of 27 staff from various units to determine their understanding of the Code Orange protocol. The sample of staff were from the; Community Living Center (East, Central, and West), General Medicine (5B and 5D), Medical and Surgical Intensive Care Units, Palliative Care Unit, and Telemetry and Cardiac Progressive Care Unit (4A).

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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

Patient Case Summary

In early spring 2018, an ambulance brought a patient in their 70s with multiple chronic medical conditions and a diagnosis of dementia to the facility's emergency department.¹⁸ The patient presented with an elevated blood alcohol level, complaining of left shoulder pain and having "signed out" of a skilled nursing facility.¹⁹ The emergency department physician placed a consult for psychiatry to assess the patient. The physician and the evaluating psychiatrist cleared the patient for discharge from the hospital. However, after four hours of observation and intravenous hydration, the patient still appeared intoxicated, demonstrated poor judgment, and was unsteady when standing. For the patient's safety, a second emergency department physician admitted the patient under the Marchman Act.²⁰

Three days later, the unit physician discontinued the Marchman order as the patient had exhibited no signs of alcohol withdrawal and discharged the patient from the hospital the next day. The patient refused assistance with housing placement.

Approximately eight hours after discharge, VA police found the patient asleep on VA property and brought the patient to the emergency department. The patient reported to the triage nurse having difficulty obtaining lodging. The emergency department physician on duty assessed the patient as medically stable and cleared for discharge from the emergency department. Prior to discharge, the patient met with an emergency department social worker requesting assistance with housing placement; however, the patient ultimately decided against placement and stated he/she could secure their own lodging. The social worker provided the patient with numerous housing resources and encouraged the patient to contact the social worker for further assistance.

Later that afternoon, a staff member found the patient "wandering around the hospital" and brought the patient to the emergency department. The emergency department psychiatrist assessed the patient for a second time and determined that the patient lacked decision-making capacity regarding discharge planning.²¹

¹⁸ The OIG uses the singular form of they (their/them) to protect the patient's privacy.

¹⁹ Dementia, caused by ongoing damage to brain and nerve cells, is not a specific disease but rather a term for a group of symptoms, including memory loss, reduced ability to organize or plan, and communicate. Blood alcohol levels are determined by a laboratory test in which the concentration of alcohol, specifically ethanol, is measured in a discreet volume of blood. In this instance, the VA laboratory measured the weight of ethanol in grams per deciliter of blood. In Florida, the legal blood alcohol level to drive a vehicle is 0.08 g/dl.

²⁰ The Marchman Act is a Florida Statute, Substance Abuse Impairment Act of 2003, that provides for voluntary and involuntary assessment, stabilization, and treatment of adults who are impaired due to substance abuse. One pathway to involuntary treatment, as is this case, is a hospital admission through the emergency department, after an emergency department physician formally certifies that the patient meets specified criterion.

²¹ Decision-making capacity is a clinical determination that a patient has the requisite abilities to make a medical decision.

Two days after being discharged from the medicine unit, the patient was readmitted with a diagnosis of dementia and a plan to conduct neuropsychology testing to assess cognitive abilities and to assist with safe housing placement. Following facility policy, admission orders included restricting the patient to the unit, and entering a consult for neuropsychology for evaluation and testing of cognitive abilities.²² The patient did not have orders entered for close observation.

On day 6 of the hospital readmission, neuropsychology evaluated the patient and found “persistent and significant deficits across cognitive domains” and recommended placement for “continued monitoring and 24/7 supervision.” The unit social worker began working on housing placement, fiduciary, and guardianship services.²³ The emergency contact (a friend) listed in the patient’s EHR declined to be responsible for the patient and did not know how to contact the patient’s family.

Two days later, the unit social worker met with the patient and updated the patient on progress for placement, assignment of a fiduciary, and guardianship services. Per social work documentation, the patient disagreed with placement and the assignment of a fiduciary and guardian. The social worker met with the patient again on days 9 and 10 of the hospital readmission, and the patient continued to question the need for placement, fiduciary, and guardianship services. The social worker documented on the afternoon of day 10 that the patient was becoming frustrated with the process, and repeatedly insisted they could make their own decisions.

Following day 10’s evening medications and dinner, the patient’s nurse could not locate the patient on the unit. The flow coordinator contacted the night physician, who determined the patient was at risk.²⁴ Nursing staff activated a Code Orange.

The next day, the patient remained missing. Two days after the patient went missing, the police reported to the AOD that the patient had not yet been located. On days 4 and 5 of the patient being missing, multiple social workers made a series of telephone calls attempting to locate the patient within the surrounding community and at local hospitals and shelters.

²² In April 2014, the facility implemented a policy that does not allow patients on the acute care units to leave the assigned units without a physician’s order. The purpose of this policy is to enhance safety, prevent infection, and expedite patient flow. Facility Memorandum 516-14-111-003, *Acute Care Inpatient Off-Ward Policy*, April 2014. This memorandum was due for recertification on April 30, 2017, and has not been rescinded or recertified.

²³ According to Veterans Benefits Administration, a fiduciary is a person or legal entity authorized by VA to serve as payee of VA benefits for a beneficiary unable to manage his or her financial affairs. VA will only determine an individual to be unable to manage his or her financial affairs after receipt of medical documentation or if a court of competent jurisdiction has already made the determination. According to the Military Officers Association of America, a court appoints a guardian to legally manage the affairs of a person who lacks decision-making capacity.

²⁴ A flow coordinator is a staff member with a clinical background that coordinates inpatient admissions and bed assignments; VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, and amended March 7, 2017.

On day 6 of the patient being missing, the outreach social worker for homeless veterans located the patient receiving inpatient care for intoxication at a nearby community hospital. The community hospital transferred the patient back to the VA, and the patient was readmitted for alcohol withdrawal, placement, and fiduciary and guardianship services.

In late spring 2018, the facility discharged the patient to a local assisted living facility.²⁵ Approximately two weeks following discharge, the patient received a court-appointed guardian.

Inspection Results

1: Missing Patient

The OIG concurred with the facility's findings and substantiated that the patient went missing from the facility in spring 2018. Upon review of the facility's response, the OIG identified potential deficiencies related to staff knowledge of Code Orange policy and processes, quality management reviews, and Code Orange training requirements.

2: Code Orange Policy and Processes

The OIG reviewed the facility's Code Orange policy and processes and determined unit staff failed to properly identify the missing patient, which caused a delay of two hours in searching for the missing patient. The facility does not have a policy addressing look-alike or soundalike names and the expected practice of adding alerts was not followed. The covering physician did not plan to document the assessment of the patient as high risk [at risk] until requested by a facility leader. The facility conducted a preliminary and full search; however, those searches were conducted on the misidentified patient; and the AOD failed to contact outside hospitals and shelters to attempt to locate the missing patient.

Inaccurate Communication of Patient Information

The OIG determined that unit staff failed to properly identify the missing patient.²⁶ The misidentification of the patient delayed the search for the missing patient by two hours during this Code Orange event.

²⁵ An assisted living facility is supportive housing which provides health care supervision to patients who have medical or psychiatric limitations, are not able to live independently, and need supervision and supportive care; VHA Handbook 1140.01, *Community Residential Care Program*, February 10, 2014. This handbook expired February 28, 2019, and has not been rescinded or recertified.

²⁶ Facility Memorandum 516-15-11-073, *Patient Identification*, March 2015. This memorandum expired on March 31, 2018, and was replaced by Facility Memorandum 516-18-11-073, *Patient Identification Process*, February 2019. The facility changed their identification wristband to help with patient identification, but verification of the patient's identity still needs to occur.

The facility requires the use of two identifiers when confirming a patient's identity. The intent of two identifiers is to ensure the correct identification of the individual receiving services or treatment. Proper identification decreases the potential for errors.²⁷

The missing patient's nurse notified the unit charge nurse, who in turn notified the flow coordinator that the patient was missing. The flow coordinator informed the OIG that a unit clerk provided the flow coordinator with the wrong patient's information and because of this the flow coordinator activated the Code Orange protocol by contacting the VA police with the wrong patient's information. Approximately two hours after the patient became missing, the misidentified patient presented to the unit nursing station after hearing their name called on the overhead paging system. It was at this time that unit staff realized they activated the Code Orange on the wrong patient.

Because staff did not follow the identification policy by confirming the missing patient with two identifiers, staff and the VA police searched for the wrong patient for two hours. The OIG could not determine if the patient would have been located sooner had unit staff complied with the patient identification policy.

Although not a direct response to the misidentified patient, the facility was in the process of instituting a new patient identification wristband with picture identification and color-coded alerts for risks, such as Code Orange. According to the Chief of Quality Systems, the new patient identification wristbands will improve the overall patient identification process.

Patient Misidentification

The OIG confirmed that at the time of this event, the facility did not have a policy addressing look-alike or soundalike names. However, during interviews, staff reported the expected practice of the unit clerk was to add name alerts to the patient room assignment bed board and the paper charts of look-alike or soundalike patients.

At the time of the event, the unit had two patients with look-alike or soundalike names and similar demographics. In response to the look-alike or soundalike names, the unit clerk informed the OIG that the patients would be assigned to different nurses and physically separated on the unit. The unit clerk stated that the missing patient and the misidentified patient did not have name alerts.

Because of the misidentification, a delay of two hours occurred in the VA police's search for the missing patient. Had the initial search been for the missing patient, the patient may have been located prior to leaving the VA campus.

²⁷ Acceptable identifiers for patient identification include: Full name (first and last), full date of birth, full social security number, or government issued picture identification; Facility Memorandum 516-15-11-073; Facility Memorandum 516-18-11-073.

Assessment of Risk

Although the covering physician documented the missing patient as high risk [at risk] the OIG determined that the covering physician did not immediately document a missing patient assessment in the EHR; instead, the physician documented the assessment only after receiving a call from a facility leader.

Facility policy directs clinical staff to contact the physician, who determines risk status, if a patient wanders or becomes missing. The physician's assessment determines if staff should activate a Code Orange. The policy requires the physician, or clinical staff, who determine the patient's risk status to enter a "Missing Patient Warning Note" in the patient's EHR.²⁸

After conducting a preliminary search of the area, the flow coordinator contacted the covering physician to determine the patient's risk status. The covering physician reviewed the correct patient's EHR and determined that the patient was "high risk" [at risk] due to a dementia diagnosis. Because of this determination, the flow coordinator activated the Code Orange protocol.

The covering physician informed the OIG that the physician's usual practice is to not document the missing patient assessment in the patient's EHR. The physician stated a telephone call was received from the Chief of Staff requesting documentation of the assessment and risk determination. The covering physician documented the assessment and risk determination as an addendum to the nurse manager's "Missing Patient Warning Note."

Preliminary and Campus-wide Search

While the facility conducted a preliminary search of the area when the patient could not be located and a full search after activating the Code Orange protocol, those searches were conducted on the misidentified patient.

Facility policy requires that staff initiate a preliminary search, conduct a risk assessment, and if the patient is determined to be at risk, the VA police initiate a campus-wide search for the missing patient. Facility policy states that the VA Police Service Communication Center emails the patient's name, photograph or description, and clothing description to all facility staff, and initiate overhead Code Orange announcements. If the patient remains missing at the end of the campus-wide search, the VA Police Service Communication Center notifies local law enforcement agencies.²⁹

Once the nurse identified the patient as missing, unit staff conducted a preliminary search of the unit and surrounding areas. After 15 minutes and the patient not being located, the physician

²⁸ Facility Memorandum 516-13-00-024; Facility Memorandum 516-18-00-024.

²⁹ Facility Memorandum 516-13-00-024; Facility Memorandum 516-18-00-024.

determined the patient to be at risk and the flow coordinator activated a Code Orange. The nurse manager entered a Missing Patient Warning Note in the patient's EHR.

VA police responded to the Code Orange by conducting a campus-wide search of the facility property. The operator sent a facility-wide Code Orange email requesting staff to search their immediate areas for the patient and initiated overhead announcements.

The AOD was notified, as well as the Facility Director and other facility leaders. In addition, the VA police attempted to conduct a health and welfare check, but were unable to do so, since the patient's last address on file was a rehabilitation center that the patient had left three months prior. The VA police also alerted local law enforcement by placing a message with the Florida Crime Information Center, asking agencies to contact the VA police if the patient was found. The day after the patient became missing, VA police conducted a daylight search covering the shoreline and national park but did not locate the patient.

Attempts to Locate the Patient Following the Search

The OIG determined that the AOD failed to contact outside hospitals and shelters to attempt to locate the missing patient.³⁰ However, unit staff and social workers made multiple attempts and the patient was located at a community hospital on day 6 of being missing and returned to the VA for admission.

Facility policy states that while a patient is missing, the AOD is responsible for communicating with nearby treatment facilities.³¹

Based on a review of the AOD reports from day 1 of the patient being missing through day 4, the OIG determined that the AOD did not contact outside facilities in an attempt to locate the missing patient. The AOD was unaware of the responsibility of contacting outside hospitals.

Unit staff attempted to call the patient and the emergency contact multiple times over the weekend but were unable to make contact. On day 4 of the patient being missing, several social workers began calling outside facilities, shelters, and community agencies to locate the patient. The social workers continued their efforts until day 6 when an outreach social worker for homeless veterans located the patient at a community hospital.

3: Quality Management Reviews

The OIG reviewed the facility's quality management processes and determined the issue brief and the Code Orange debrief complied with VHA and facility policies and procedures. However,

³⁰ The AOD acts on behalf of the Director and is the central point of contact, during other than normal duty hours of all administrative functions of the medical center. VHA Directive 1096, *Administrative Officer of the Day (AOD)*, December 5, 2014; Facility Memorandum 516-13-00-024, Facility Memorandum 516-18-00-024.

³¹ Facility Memorandum 516-13-00-024; Facility Memorandum 516-18-00-024.

the OIG concluded that the incident report did not address the misidentified patient, the fact finding did not review all personnel involved in the event, and the facility missed an opportunity for improvement in the Code Orange process by not conducting a Root Cause Analysis (RCA) at the time of the event.

Issue Brief

The OIG confirmed that the facility leaders submitted an issue brief in accordance with VHA guidance.

Issue briefs are notifications to VHA that provide specific information through the appropriate chain of command regarding events or issues that may impact VA. Issue briefs are to provide clear and concise information about unusual or significant events.³² VHA tracks events through updates to the issue briefs.³³

Although Code Oranges do not typically require an issue brief, the facility submitted an issue brief due to having misidentified the patient. Facility leaders told the OIG they received email notification of the Code Orange event on the evening of the event. Facility leaders discussed the event three days later and submitted the issue brief to the VISN the following day. The facility provided an update once the patient was located.

Code Orange Debrief

The OIG concluded that the VA police conducted a Code Orange debriefing in accordance with facility policy.

Facility policy states that the VA Police Service must hold Code Orange debriefings with healthcare management.³⁴

In spring 2018, following the event, the VA police conducted a Code Orange debriefing with staff from quality management, education, and nursing leadership, where they reviewed and answered the required 31-question checklist. The checklist ensures a complete review of all steps taken during a Code Orange and identifies opportunities for process improvement.³⁵ Although the VA police did not conduct a separate debriefing for the misidentified patient, the OIG noted that the misidentified patient was included in the missing patient's debriefing.

³² Issue brief guidance is through VHA Deputy Secretary for Health for Operations and Management (10N), *Guide to VHA Issue Briefs*, updated March 29, 2018.

³³ VHA Directive 2010-052.

³⁴ Facility Memorandum 516-13-00-024, Facility Memorandum 516-18-00-024.

³⁵ Facility Memorandum 516-13-00-024, Facility Memorandum 516-18-00-024.

Incident Report

Staff failed to initiate an incident report on the misidentified patient.

Facility policy requires that staff initiate an incident report anytime misidentification of a patient results in an actual or potential adverse event.³⁶

The OIG determined that the patient safety manager entered an incident report six days after the activation of the Code Orange, and it did not refer to the misidentified patient or delay in identifying the correct patient that was missing. Also, no staff directly involved in the missing patient event entered an incident report.

Fact Finding

The OIG determined that the nursing service completed a fact finding on the misidentified patient; however, nursing service limited their interviews to only the nursing staff.

VHA utilizes fact findings to objectively review a collection of facts surrounding an adverse event or alleged adverse event. The fact-finding report form charges a manager or service chief with obtaining credible information to determine appropriate actions in response to the event.³⁷

Although nursing service staff conducted a fact finding on the misidentified patient and missing patient, nursing service did not interview or include the role of the unit clerk, or the covering physician involved in the Code Orange. Because of this, the OIG concluded that the fact finding was not a comprehensive review of the event.

Safety Assessment Code and Root Cause Analysis

The OIG concurred with the facility patient safety manager's assigned Safety Assessment Code (SAC) score, and that the SAC score did not require the facility to conduct an RCA. However, the facility missed an opportunity for improvement by not initiating an RCA despite the SAC score.

SAC

The VA National Center for Patient Safety (NCPS) defines the SAC as a scoring system to evaluate actual and potential adverse events. The scoring system ranks severity for actual adverse

³⁶ VHA Handbook 1050.01. Adverse events are "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook expired in March 2016 and has not been rescinded or recertified; Quality Systems evaluates incident reports; Facility Memorandum 516-15-11-073; Facility Memorandum 516-18-11-073.

³⁷ Statement taken from the Fact Finding Report Form.

events (level of injury, length of stay, or time to return to previous level of function) and the probability (frequency) of an actual event or close call recurrence.³⁸

Table 2. SAC Matrix

| Probability | Severity | | | |
|-------------|--------------|-------|----------|-------|
| | Catastrophic | Major | Moderate | Minor |
| Frequent | 3 | 3 | 2 | 1 |
| Occasional | 3 | 2 | 1 | 1 |
| Uncommon | 3 | 2 | 1 | 1 |
| Remote | 3 | 2 | 1 | 1 |

Source: NCPS SAC matrix

The patient safety manager reviews the incident and determines the SAC score. A SAC score of 3, for potential or actual, requires an RCA. However, the SAC score is not the only determining factor for initiating an RCA, as facility leaders and quality management can request an RCA.

The patient safety manager assigned a potential SAC score of 2 (moderate and frequent) and an actual SAC score of 1 (minor and frequent) denoting that there was no injury or increased length of stay. Based on the SAC matrix and what the patient safety manager explained, the OIG concurred with the facility and their reasoning on assignment of the SAC score.

RCA

The NCPS states that an RCA is a type of focused review used for adverse events and close calls that require analysis. NCPS requires a facility to complete an RCA when a SAC score is a 3; however, it does not prevent a facility from doing an RCA with a lower SAC score.³⁹

During interviews with the Chief of Staff, Associate Director for Patient Care Services, and the patient safety manager, all three stated that the facility supports RCAs, the facility does not limit the number of RCAs conducted in a year, and that the facility could still conduct an RCA on this event. The Chief of Staff and the Associate Director for Patient Care both told the OIG that they were unsure why an RCA was not done and that they were considering requesting an RCA.

³⁸ VA established NCPS to develop and nurture a culture of safety throughout VHA. VHA defines a close call as, “an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention; VHA Handbook 1050.01.

³⁹ VA established NCPS to develop and nurture a culture of safety throughout VHA. VHA defines a close call as, “an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention; VHA Handbook 1050.01.

The facility informed the OIG that an RCA charter and team were being prepared to review the missing patient event of spring 2018. The RCA was completed and signed by the Facility Director approximately a month later.⁴⁰

4: Code Orange Training

The OIG concluded that staff received training on managing missing and wandering patients. Training included: new employee orientation; distribution of Code Orange cards as a visual aid; Code Orange drills; computer-based annual training; and team meetings and huddles.

New Employee Orientation

VHA and facility policy require the facility to train new employees on policies and procedures to identify, assess, and find missing patients.⁴¹ The OIG confirmed that the VA police conduct initial trainings on Code Orange during new employee orientation where they discuss the Code Orange process and hand out Code Orange cards.

Code Orange Cards

In fiscal year 2018, the Missing and Wandering Patient Subcommittee developed and distributed a visual aid for staff to refer to during Code Orange events. The visual aid is an orange card with printed instructions detailing each step of the process and is intended to be kept near the telephone as a reference. During the OIG site visit, the OIG toured nine units throughout the facility and spoke with 27 staff. The OIG looked for and found Code Orange cards on all nine units, and staff were generally aware of the location of the Code Orange cards on their unit.

Code Orange Drills

VHA requires facilities to conduct missing patient drills annually, or more often, if necessary.⁴² The facility's Missing and Wandering Patient Subcommittee identified seven clinical areas that required drills once per shift annually.⁴³

Although the facility was preparing to implement drills, they had not begun at the time of the event. VA police began conducting drills in spring 2018, in response to the event, starting with a

⁴⁰ The content of the RCA is protected by 38 U.S.C. § 5705, as implemented by 38 C.F.R. Sections 17.500-17.511, and not discussed in this report.

⁴¹ VHA Directive 2010-052; Facility Memorandum 516-13-00-024; Facility Memorandum 516-18-00-024.

⁴² VHA Directive 2010-052.

⁴³ The facility identified the clinical areas in fiscal year 2017 but did not update the Memorandum until July 2018. Facility Memorandum 516-18-00-024; The identified clinical areas were Acute Care, Community Living Center, Domiciliary, Intensive Care, Mental Health Unit (locked), Outpatient Areas, and Peri-Operative Care Unit; an actual search may substitute for a drill.

morning and afternoon training on the unit where the event took place. They distributed Code Orange cards to staff, reviewed the Code Orange process, and assessed if areas needed improvement or action. The OIG reviewed Code Orange drill documentation for fiscal year 2018 through quarter 1, fiscal year 2019, and confirmed that the facility complied with VHA requirements.

Annual Training

Facility policy requires that service chiefs ensure staff complete annual computer-based Code Orange training.⁴⁴ The OIG reviewed calendar year 2017 and 2018 training records for the 13 staff involved in the Code Orange event and the 27 staff interviewed while the OIG toured the facility. The OIG confirmed that of the 40 staff training records reviewed, 93 percent of staff in calendar year 2017 and 95 percent of staff in calendar year 2018 completed the Code Orange training.

Nursing Huddles

Following the event, nurse managers discussed Code Orange procedures with unit staff. They held a staff meeting and daily huddles to reinforce the importance of following the Code Orange cards, as well as introducing time-out huddles to ensure the correct identity of the missing person.⁴⁵

Conclusion

The OIG concurred with the facility's findings and substantiated that the patient went missing from the facility in spring 2018.

The OIG determined unit staff failed to properly identify the missing patient, which caused a delay of two hours in searching for the missing patient. The facility does not have a policy addressing look-alike or soundalike names and the expected practice of adding alerts was not followed. The covering physician did not plan to document the assessment of the patient as high risk [at risk] until requested by a facility leader. The facility conducted a preliminary and full search; however, those searches were conducted on the misidentified patient. Once staff identified the correct patient, the facility conducted a campus-wide search but did not locate the patient. The AOD failed to contact outside hospitals and shelters to locate the missing patient.

The OIG reviewed the facility's quality management processes and determined the issue brief and the Code Orange debrief complied with VHA and facility policies and procedures. However,

⁴⁴ Facility Memorandum 516-13-00-024; Facility Memorandum 516-18-00-024.

⁴⁵ A huddle is a brief team meeting to communicate information about patient care for a specified period; VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017; A time-out huddle is when staff pause to confirm the missing patient's identity before calling a Code Orange.

the incident report did not address the misidentified patient and the fact finding did not review all personnel involved in the event. The OIG concurred with the facility's patient safety manager that they assigned the correct SAC score and the SAC score did not require an RCA. The facility missed an opportunity for improvement by not initiating an RCA at the time of the event despite the SAC score. The facility informed the OIG that an RCA charter and team were being prepared to review the missing patient event of spring 2018. The RCA was completed and signed by the Facility Director about a month later. The OIG concluded that staff received training on managing missing and wandering patients through a variety of means including: new employee orientation; distribution of Code Orange cards as a visual aid; Code Orange drills; computer-based annual training; and team meetings and huddles.

Recommendations 1–3

1. The Bay Pines VA Healthcare System Director develops a policy to address patients with look-alike or soundalike names, educates staff on the use of the policy, and monitors compliance.
2. The Bay Pines VA Healthcare System Director implements missing patient documentation training for staff, and monitors compliance.
3. The Bay Pines VA Healthcare System Director ensures that staff responsible for contacting outside facilities for missing patients receive training on their duties and responsibilities, and monitors compliance.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 18, 2019

From: Director, VA Sunshine Healthcare Network (VISN 08)

Subj: Healthcare Inspection—Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Florida

To: Director, Healthcare Inspections, (54HL08)
Director, GAO/OIG Accountability Liaison (GOAL) office (VHA 10EG GOAL Action)

1. I have reviewed and concur with the recommendations made during the Office of Inspector General's (OIG) Healthcare Inspection – Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Bay Pines, FL.
2. Additionally, I have reviewed and concur with the healthcare system director's actions and timeframe for closing all recommendations. VISN 8 leadership will work with the healthcare system to ensure timely compliance.
3. We value the OIG's partnership in ensuring we continue to improve the healthcare delivery processes in service to America's Veterans.

(Original signed by:)

Miguel H. LaPuz, M.D. MBA
Network Director. VISN 8

Appendix B: System Director Comments

Department of Veterans Affairs Memorandum

Date: June 11, 2019

From: Director, Bay Pines VA Healthcare System (516/00)

Subj: Healthcare Inspection—Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Florida

To: Director, VA Sunshine Healthcare Network (10N08)

I have reviewed and concur with the recommendations made during the Office of Inspector General's (OIG) Healthcare Inspection – Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Bay Pines, FL. Resolution actions are in progress for all recommendations. VAHCS Memorandum 516-18-11-073 "Patient Identification Process" will be revised to address patients with look-alike or sound-alike names. VAHCS Memorandum Policy 516-18-00-024 "Management of At-Risk Wandering and Missing Patient" is being revised to more clearly define procedures, duties and responsibilities of staff during a Code Orange. A plan of action will be developed to educate, implement, and monitor the following:

- The process for addressing patients with look-alike or soundalike names located in the same patient care area

- Missing patient documentation training for providers and relevant staff

- Staff duties and responsibilities for contacting outside facilities for missing patients

Thank you to the OIG team for providing a thorough report which provided an opportunity for the healthcare system to strengthen processes and further improve the care we provide to Veterans.

(Original signed by:)

Paul M. Russo, MHSA, FACHE, RD
Healthcare System Director/CEO

Comments to OIG's Report

Recommendation 1

The Bay Pines VA Healthcare System Director develops a policy to address patients with look-alike or soundalike names, educates staff on the use of the policy, and monitors compliance.

Concur.

Target date for completion: September 30, 2019

Director Comments

Chief Nurse, Nursing Operations and Acting Chief, Health Administration Services (HAS) are revising VAHCS Memorandum 516-18-11-073 "Patient Identification Process" to include the process for addressing patients, with look-alike or soundalike names, who are located in the same patient care area. VAHCS Memorandum 516-19-136-013 "Bed Management System (BMS)" has been revised to include the process for patients with the same or similar name alert.

Inpatient and Emergency Department staff including physicians, nursing, HAS clerks and social workers will be educated on the requirements of VAHCS Memorandum 516-18-11-073 "Patient Identification Process." The revised policy will be reviewed by staff using the Talent Management System (TMS). Relevant new employees will receive education on the new Patient Identification Process policy during their orientation period. Compliance will be monitored using the TMS Administrator's Completion Report with the goal of 95% compliance by September 30, 2019. The compliance rate will be reported to the Patient Safety Committee.

Recommendation 2

The Bay Pines VA Healthcare System Director implements missing patient documentation training for staff, and monitors compliance.

Concur.

Target date for completion: September 30, 2019

Director Comments

The Chief of Staff, Chief Nurse of Nursing Operations and the Acting Chief of HAS have been assigned to educate, implement and monitor facility provider missing patient documentation policy per VAHCS Memorandum 516-18-00-024 "Management of At-Risk Wandering and Missing Patient." A Wandering Patient Warning Note will be documented when the patient is assessed as such. The Missing Patient Warning Note will be documented at the time of an actual

event. An electronic patient safety event report will be generated for missing patients or near-miss events through the Joint Patient Safety Reporting system.

A Patient Safety Barcode Identification (PSBI) wristband has been implemented for all inpatients, 23-hour observation patients, ambulatory surgery patients, invasive procedure patients (requiring informed consent), and emergency department patients prior to escorting the patient to the floor or care delivery areas. An orange color-coded “Wander” indicator that alerts that a patient/resident has been identified as a wander risk is an option to add to the PSBI. Selection of this alert is based on clinical information gathered during the initial triage/admission assessment and/or reassessment process, medical provider orders, and patient assessment screens. Specific details of the alert indicators are documented in the electronic health record.

HAS leadership, and inpatient staff including physicians, nursing, administration officers of the day (AOD), HAS clerks and social workers will be educated on the requirements of VAHCS Memorandum 516-18-00-024 “Management of At-Risk Wandering and Missing Patient.” The updated policy will be reviewed by staff using TMS. Relevant new employees will receive education on the new “Management of At-Risk Wandering and Missing Patient” policy during their orientation period. Compliance will be monitored using the TMS Administrator’s Completion Report with the goal of 95% compliance by September 30, 2019. The compliance rate will be reported to the Patient Safety Committee.

Recommendation 3

The Bay Pines VA Healthcare System Director ensures that staff responsible for contacting outside facilities for missing patients receive training on their duties and responsibilities, and monitors compliance.

Concur.

Target date for completion: September 30, 2019

Director Comments

The Chief of Police is revising VAHCS Memorandum 516-18-00-024 “Management of At-Risk Wandering and Missing Patient” to clearly define procedures, duties and responsibilities of staff for contacting outside facilities during a Code Orange. Staff responsible for contacting outside facilities will be educated on the requirements of VAHCS Memorandum Policy 516-18-00-024 “Management of At-Risk Wandering and Missing Patient” using the TMS. Relevant new employees will receive education regarding responsibilities for contacting outside facilities during their orientation period. Compliance will be monitored using the TMS Administrator’s Completion Report with the goal of 95% compliance by September 30, 2019. The compliance rate will be reported to the Patient Safety Committee.

OIG Contact and Staff Acknowledgments

| | |
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| Contact | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
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