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VETERANS HEALTH ADMINISTRATION

Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

Healthcare Inspection | **23-02958-203** | **July 24, 2024**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation that a patient experienced a delay in receiving basic life support during a medical emergency on the grounds of the Carl T. Hayden VA Medical Center (facility) in Phoenix, Arizona, and later died at a community hospital.[1] The OIG also evaluated aspects of the patient's clinical care prior to the medical emergency, and facility leaders' and staff's actions following the medical emergency.

Inspection Results

The OIG substantiated that the patient experienced a delay in receiving basic life support. The OIG also identified deficiencies in the initiation of the patient's emergency medical care, the quality of the patient's care prior to the medical emergency, and completion of comprehensive quality reviews. However, the OIG was unable to determine whether a change in care would have resulted in a different outcome for the patient.

The patient, who had a medical history of high blood pressure, high cholesterol, and congestive heart failure, attended an outpatient urology appointment in the facility's Ambulatory Care Clinic (ACC).[2] After the appointment, a family member met the patient to provide a ride home. While still on facility grounds, the patient became unresponsive and the family member drove the car back to the front entrance of the ACC, parked, exited the vehicle, and entered the ACC lobby to obtain help. A hospitality employee, located at the ACC information desk, attempted to activate a rapid response through the facility operator and reported that the operator gave directions to call VA police.[3] The hospitality employee did not call VA police and instead dialed

[1] Basic life support refers to care provided to someone experiencing cardiac arrest, respiratory distress, or an obstructed airway. "What is BLS?" American Red Cross, accessed November 29, 2023, https://www.redcross.org/take-a-class/performing-bls/what-is-bls.

[2] Congestive heart failure or heart failure is a chronic long-term condition when one's heart can't pump blood well enough to give a normal supply to the body. Blood and fluids can also collect in the lungs and legs causing edema or swelling. "Congestive Heart Failure," Cleveland Clinic, accessed January 16, 2023, https://my.clevelandclinic.org/health/diseases/17069-heart-failure-understanding-heart-failure.

[3] A rapid response system provides evaluation and treatment of unstable patients and leads to improved patient outcomes including decreased risks of cardiac arrest and death. Geoffrey K. Lighthall, Layla M. Parast, Lisa Rapoport, and Todd H. Wagner, "Introduction of a Rapid Response System at a United States Veterans Affairs Hospital Reduced Cardiac Arrests," *Anesthesia & Analgesia* 111, no. 3 (September, 2010): 679-86, https://journals.lww.com/anesthesia-analgesia/Fulltext/2010/09000/Introduction_of_a_Rapid_Response_System_at_a.15.aspx.

911 to obtain assistance.[4] Approximately 11 minutes after the hospitality employee placed the 911 call, the Phoenix Fire Department arrived at the entrance of the ACC and initiated basic life support to the patient. The paramedics transported the patient to a community hospital where the patient died two days later.

Delayed Response to a Medical Emergency

Facility policy states the rapid response team only responds to events inside buildings connected to the main hospital and that staff should call 911 and the VA police when medical assistance is needed outside of these areas, including the facility's parking garage and parking lots.[5] The hospitality employee recognized that although activating the facility's rapid response process for a medical emergency outside the ACC entrance was not facility policy, it would have provided faster access to basic life support.[6] The OIG was unable to determine why operators did not initiate a rapid response as the operators did not remember the event due to the amount of time that had elapsed between the medical emergency and the OIG inspection.

Clinical leaders told the OIG that a rapid response would have prevented the patient from experiencing a delay in receiving basic life support.[7] As the patient was outside the building, facility leaders told the OIG that facility policy supported calling 911 rather than a facility rapid response due to the size of the facility campus. However, facility leaders had a general unawareness of the exact location of the patient's medical emergency. During OIG interviews, the Deputy Associate Director of Patient Care Services, the Chief of Staff, and the Facility Director acknowledged that the patient experienced a delay in receiving basic life support. The OIG is concerned that facility policy regarding responses to medical emergencies does not align with Veterans Health Administration (VHA) policy to "optimize patient safety for those requiring resuscitation" and ensure "emergency response capability to manage cardiac arrests on VHA property."[8]

The OIG found five facility policies and procedures with conflicting and inconsistent instructions on how facility operators and ACC information desk staff should respond to medical emergencies. Facility leaders interviewed were unaware of the multiple conflicting policies and

[4] Facility policy states that staff should call 911 and the VA police when an individual needs medical assistance outside of buildings connected to the main hospital, including the facility's parking garage and parking lots. Facility Policy Memorandum 11-101, *Rapid Response Team (RRT)*, July 2, 2019; The OIG learned that following the patient event, the chief of nutrition, hospitality, and food service provided hospitality staff with training regarding the facility rapid response team policy. Specifically, how to contact VA police in addition to 911 when responding to a medical emergency that occurs outside the building.

[5] Facility Policy Memorandum 11-101.

[6] The patient was in a vehicle parked outside the ACC entrance and visible from the ACC information desk.

[7] Clinical leaders included the chief of medicine service and specialty care, the chief of the Emergency Department, and the chair of the cardiopulmonary resuscitation committee.

[8] VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021.

procedures. Facility policies that are inconsistent with VHA requirements, in addition to facility policies and procedures that conflict with one another, likely contribute to staff's uncertainty about how to obtain assistance during a medical emergency.

The Facility Director failed to ensure non-clinical hospitality staff were offered cardiopulmonary resuscitation (CPR) training. VHA directs staff to provide reasonable assistance within their scope and training when responding to a medical emergency.[9] VHA also requires medical center directors ensure layperson CPR training "ranging from awareness to actual training" is available to all non-clinical staff.[10] The OIG found that the hospitality employee who became aware of the patient's medical emergency did not receive layperson CPR training at the facility. The OIG is concerned that failure to ensure that layperson CPR training is offered to non-clinical staff may prevent staff participation in initial interventions during a medical emergency.

During an unannounced site visit, the OIG found no public access automated external defibrillators (AED) in the ACC lobby or first floor hallways. Per VHA policy, medical center directors must ensure public access AEDs are available in high-use areas.[11] The lack of public access AEDs limits the ability for laypersons to provide care when individuals are experiencing medical emergencies. The OIG discussed the need for placement of a public access AED in the ACC lobby with the Veterans Integrated Service Network Director and the Facility Deputy Director who ultimately ensured the installation of an AED in the ACC lobby in January 2024.

Quality of Care Concerns

The OIG reviewed the patient's cardiology care in the months leading up to the medical emergency and the care provided during a urology appointment prior to the medical emergency. The patient was receiving cardiology care for congestive heart failure and urology care for elevated prostate-specific antigen levels.[12]

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[9] Assistant Deputy Under Secretary for Health for Clinical Operations, "Responses to Emergency and Non-Emergency Conditions at or on the Grounds of Medical Centers, Health Care Centers (HCC), Community-Based Outpatient Clinics (CBOCs) and Other Outpatient Centers in VHA," memorandum to Network Directors, February 16, 2016.

[10] VHA Directive 1177. For the purposes of this report, the OIG recognizes layperson training as training needed to participate in the initial intervention of a cardiac or respiratory arrest.

[11] VHA Directive 1177.

[12] Congestive heart failure or heart failure is a chronic long-term condition when one's heart can't pump blood well enough to give a normal supply to the body. Blood and fluids can also collect in the lungs and legs causing edema or swelling. "Congestive Heart Failure," Cleveland Clinic, accessed January 16, 2023, https://my.clevelandclinic.org/health/diseases/17069-heart-failure-understanding-heart-failure; Prostate-specific antigen is a protein which is made by the prostate gland and is often elevated in prostate cancer. National Cancer Institute, "What is a PSA test?," accessed January 8, 2024, https://www.cancer.gov/types/prostate/psa-fact-sheet#what-is-the-psa-test.

The OIG found a cardiologist did not order a wearable cardioverter defibrillator vest (WCD) for the patient, despite recommending the treatment in the plan of care documentation.[13] Although the cardiologist and a cardiology physician assistant confirmed in OIG interviews that a WCD was no longer indicated during a follow-up appointment, the discrepancy between the documented plan for a WCD and the absence of a WCD order for the patient was not resolved in the electronic health record.

Additionally, the OIG found an assessment of the patient's vital signs was required per facility policy but not performed at the outpatient urology appointment prior to the patient's medical emergency.[14] This resulted in an incomplete assessment of the patient. The OIG is unable to determine whether the assessment of vital signs would have indicated the patient's impending clinical deterioration.[15] The chief of urology and Surgical Service nurse leaders told the OIG that vital signs were historically not consistently performed during urology appointments due to discrepancies in the check-in process. The surgical clinic nurse manager reported a formal process for capturing urology patients' vital signs was implemented in mid-October 2023. The OIG concluded that not assessing vital signs at the appointment may have contributed to a missed opportunity for early identification of the patient's clinical decline.

Deficiencies in Facility Leaders' and Staff's Response to a Medical Emergency

VHA encourages staff to use the Joint Patient Safety Reporting (JPSR) system, which alerts the patient safety manager and recognizes the use of an organized process such as a look-back to identify patients that have been exposed to "potential risk incurred through past clinical activities."[16] Facility leaders were informed of the patient's medical emergency on two occasions within 10 days of the event, but took no further actions. Facility leaders' lack of response upon

[13] A WCD is a vest that can "stop an abnormal heart rhythm without anyone's help." The vest is indicated for patients at risk for sudden cardiac arrest and is worn when waiting for a more permanent solution such as an implantable cardioverter defibrillator or a heart transplant. "LifeVest," Cleveland Clinic, accessed October 2, 2023, https://my.clevelandclinic.org/health/treatments/17173-lifevest.

[14] Facility Policy Memorandum HIMS [Health Information Management Service]-01, *Completion of Medical Records*, March 25, 2021.

[15] Vital signs measure essential body functions including blood pressure, respiration rate, pulse, and body temperature. US National Library of Medicine, Medline Plus, "Vital signs," accessed May 15, 2020, https://medlineplus.gov/ency/article/002341.htm.

[16] VHA Directive, 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.This directive was in place during the time of the events discussed in this report. It was amended by VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 5, 2024. Unless otherwise specified, the 2024 directive contains the same or similar language regarding patient safety as the 2023 directive; VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. Part of the intent of the look back process is "to notify identified patients and offer care and recourse, as appropriate."

awareness of the event was not in alignment with high reliability organization principles and I CARE values as the lack of action did not demonstrate a commitment to harm prevention.[17]

Inadequate Safety Review

When facilitating a patient safety report, patient safety managers must assign investigators who are subject matter experts, assess the level of harm associated with events, track events to ensure investigations are completed timely, and close patient safety reports within 14 days or reports will be marked overdue.[18]Approximately two months after the patient's medical emergency, when the patient safety manager became aware of the event, the patient safety manager requested a patient safety report be entered into the JPSR system but did not manage the patient safety report per VHA guidance.[19]

Despite having awareness of the delay in basic life support and the location of the patient's medical emergency, the patient safety manager did not incorporate that information into the patient safety report investigation or assign investigators with the expertise to examine clinical aspects of the patient's care; this resulted in an inaccurate harm assessment. The patient safety manager's deficient interpretation and analysis of the patient safety report represents a missed opportunity to identify a need to perform further quality management actions. The Facility Director and the patient safety manager failed to ensure the facilitation of a timely review of the patient safety report as the investigation and closure exceeded VHA's time frame.[20] Additionally, the patient safety manager attributed the delay to the lack of staff responsible for patient safety report management. Delays in investigation and closure of patient safety reports may result in recurrence of patient safety events that have been reported but not investigated.

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[17] "High reliability means evidence-based, high-quality care is consistently delivered for every patient, every time, at any facility across VHA." Leaders' commitment to HRO is critical as, "transformative change requires the support and participation of highly visible and vocal leaders to promote and demonstrate their sustained commitment.. . through their actions." VA, VHA, "VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only," April 2023; 38 C.F.R. § 0.601 (2023); VA's core values, known as I CARE, underscore VA employee obligations to "care for Veterans, their families, caregivers, and survivors."; "I CARE Core Values, Characteristics, and Customer Experience Principles," VA I CARE, accessed January 25, 2024, https://www.va.gov/icare/core-values.asp.

[18] VHA Directive 1050.01; VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022. This guidebook was in effect during the events discussed in this report. It was replaced by VHA, *National Center for Patient Safety JPSR Guidebook*, October 2023. Unless otherwise specified, the 2023 guidebook contains the same or similar language regarding patient safety as the 2022 guidebook. Investigators review the event assigned to them and are responsible for a "timely and accurate investigation."; Patient safety managers are responsible for briefing facility leaders when there is a delay in an investigations.

[19] "The Joint Patient Safety Reporting (JPSR) system is the Veterans Health Administration (VHA) patient safety event reporting system and database." "JPSR as a user-based reporting system is capturing real time incident reporting data." VHA, *National Center for Patient Safety JPSR Guidebook*.

[20] The OIG did not review the average time frame in which patient safety reports were investigated and closed at the facility, and only examined the patient safety report relevant to this inspection.

The OIG made 10 recommendations to the Facility Director related to congruence of facility policies and procedures and their alignment with VHA directives, offering layperson CPR training, placement of public access AEDs, outpatient clinic compliance with vital signs completion, complaint review processes, communication consistent with high reliability organization and I CARE values, training on patient safety reporting, and investigation and closure of patient safety reports.

VA Comments and OIG Response:

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

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Contents

Abbreviations

ACC	ambulatory care clinic
AED	automated external defibrillator
BLS	basic life support
CHF	congestive heart failure
CPR	cardiopulmonary resuscitation
EHR	electronic health record
HRO	high reliability organization
JPSR	Joint Patient Safety Reporting
OIG	Office of Inspector General
PCP	primary care physician
PSA	prostate-specific antigen
RCA	root cause analysis
SAC	safety assessment code
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WCD	wearable cardioverter defibrillator

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation that a patient experienced a delay in receiving basic life support (BLS) during a medical emergency on the grounds of the Carl T. Hayden VA Medical Center (facility) in Phoenix, Arizona, and later died at a community hospital.[1] The OIG also evaluated aspects of the patient's clinical care prior to the medical emergency, and facility leaders' and staff's actions following the medical emergency.

Background

The facility is within the Phoenix VA Health Care System and is part of Veterans Integrated Service Network (VISN) 22, which also includes outpatient clinics located throughout central Arizona.[2] The Veterans Health Administration (VHA) classifies the facility as a level 1a, highest complexity.[3] The facility provides healthcare services including primary and long-term care, and specialty and emergency medicine. From October 1, 2021, through September 30, 2022, the facility provided care to 116,361 patients.

Prior OIG Reports

In the past year, the OIG has published two reports concerning inadequate quality management processes and deficiencies conducting disclosures at the facility.[4] In a June 2023 report, the OIG found that leaders did not consistently complete institutional disclosures for sentinel events that

[1] BLS refers to care provided to someone experiencing cardiac arrest, respiratory distress, or an obstructed airway. "What is BLS?" American Red Cross, accessed November 29, 2023, https://www.redcross.org/take-a-class/performing-bls/what-is-bls.

[2] Outpatient clinics are located in the following Arizona cities: Gilbert, Globe, Phoenix, Scottsdale, Payson, Show Low, and Surprise.

[3] VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities as levels 1a, 1b, 1c, 2 or 3, with level 1a being the most complex and level 3 being the least complex. A level 1a facility has "high volume, high risk patients, most complex clinical programs, and large research and teaching programs."

[4] Disclosures can be clinical or institutional. Clinical disclosures involve a clinician informing a patient or patient's representative that a harmful adverse event occurred. Institutional disclosures require VA medical facility leaders and clinicians to inform a patient or patient's representative that an adverse event that resulted in, or is expected to result in death occurred, and "provide specific information about the patient's rights and recourse." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

may have contributed to patients' deaths.[5] The OIG made six recommendations, with one related to institutional disclosures that has been closed.[6]

In an October 2023 published report, the OIG substantiated that a patient did not receive a clinical disclosure but did receive a delayed institutional disclosure. Further, the OIG identified deficiencies in quality management processes, including failure to (1) enter patient safety events into the Joint Patient Safety Reporting (JPSR) system and review adverse events, and (2) initiate a required root cause analysis (RCA).[7] The OIG made five recommendations, with one related to institutional disclosures and one related to the review of adverse events. All four recommendations remain open.[8]

Allegations and Related Concerns

In late spring 2023, a confidential complainant submitted allegations to the OIG that the patient experienced a delay in receiving medical treatment following facility staff awareness of the medical emergency, and the patient died as a result.

Eight days later, the OIG reviewed the allegations and determined further information was necessary. The OIG contacted facility leaders with questions regarding the allegations, and received a response seven weeks later. The OIG reviewed the response and determined the response was inadequate. The OIG opened an inspection in late summer to examine the circumstances surrounding the patient's death including the delay in initiating BLS. The OIG also reviewed concerns related to (1) the quality of care provided to the patient prior to the medical emergency, and (2) facility leaders' and staff's response to the patient's medical emergency.

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[5] "A sentinel event is any patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that results in death, permanent harm or severe temporary harm." VHA Directive, 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.This directive was in place during the time of the events discussed in this report. It was amended by VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 5, 2024. Unless otherwise specified, the 2024 directive contains the same or similar language regarding patient safety as the 2023 directive.

[6] VA OIG, *Comprehensive Healthcare Inspection of the Phoenix VA Health Care System in Arizona*, Report No. 22-00051-136, June 29, 2023.

[7] "The Joint Patient Safety Reporting (JPSR) system is the Veterans Health Administration (VHA) patient safety event reporting system and database." "JPSR as a user-based reporting system is capturing real time incident reporting data." VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022. This guidebook was in effect during the events discussed in this report. It was replaced by VHA, *National Center for Patient Safety JPSR Guidebook*, October 2023. Unless otherwise specified, the 2023 guidebook contains the same or similar language regarding patient safety as the 2022 guidebook; An "RCA is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01.

[8] VA OIG, *Deficiencies in Quality Management Processes and Delays in the Communication of Test Results and Follow-Up Care at the Phoenix VA Health Care System in Arizona*, Report No. 22-03599-07, October 31, 2023.

Scope and Methodology

The OIG conducted a virtual site visit from October 23 through 26, 2023. The OIG also conducted an unannounced site visit from November 6 through 7, 2023, to assess the setting of the medical emergency and its proximity to key locations and resources.

The OIG interviewed the confidential complainant and selected facility leaders, providers, and staff. The OIG reviewed relevant VHA and facility policies and procedures, JPSR system data, Patient Advocate Tracking System data, organizational charts, training records, committee meeting minutes, email communications, quality reviews, and the patient's electronic health record (EHR).[9] The review also included video surveillance of the patient's medical emergency and the 911 call audio.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

[9] The Patient Advocate Tracking System is a computer platform that tracks patient complaints for all VA medical facilities. VHA Directive 1003.04; *VHA Patient Advocacy,* February 7, 2018. This directive was in effect during the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023. The 2023 directive has the same or similar language as the 2018 directive related to Patient Advocate Tracking System data.

Patient Case Summary

The patient, in their late 70s, had a medical history of high blood pressure, high cholesterol, and congestive heart failure (CHF).[10] The patient's 2016 workup for CHF did not demonstrate coronary artery disease.[11] The primary care provider (PCP) ordered an echocardiogram in 2019 to assess for CHF.[12] The echocardiogram demonstrated a reduced ejection fraction of 40 to 45 percent.[13] A cardiologist saw the patient in the summer of 2020 and diagnosed the patient with heart failure with a reduced ejection fraction.[14] The cardiologist continued the patient's same medications for heart failure and recommended a cardiology appointment follow-up in six months.

In late fall 2022, the patient's newly assigned PCP evaluated the patient, noting the patient complained of pain and swelling of the lower legs as well as shortness of breath but no chest pain. On physical exam, the patient's blood pressure, pulse, and respirations were normal. Because of the leg swelling and shortness of breath, the PCP ordered an echocardiogram to evaluate the ejection fraction. Laboratory tests were also ordered. The PCP noted the patient's blood test results indicated an elevated prostate-specific antigen (PSA) level, requested a urology consult, and notified the patient.[15]

A second echocardiogram was completed in early 2023 and demonstrated a reduced ejection fraction of 25 to 30 percent. The PCP ordered a cardiology consult for the CHF, shortness of breath, and worsening ejection fraction, and notified the patient.

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[10] CHF or heart failure is a chronic long-term condition when a person's heart cannot pump blood well enough to give a normal supply to the body. Blood and fluids can also collect in the lungs and legs causing edema or swelling. "Congestive Heart Failure," Cleveland Clinic, accessed January 16, 2023, https://my.clevelandclinic.org/health/diseases/17069-heart-failure-understanding-heart-failure.

[11] Coronary artery disease is a disease that develops when the blood vessels supplying the heart muscle with blood becomes damaged and narrowed. A complete blockage of blood flow may cause a heart attack. Mayo Clinic, "Coronary artery disease," accessed April 29, 2020, https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes/syc-20350613.

[12] An echocardiogram is a test that uses ultrasound waves to show the structure and movement of the heart muscle, how well the heart pumps, the thickness of the heart walls, and if the heart is enlarged. Veterans Health Library, Chest Echocardiography (Transthoracic)," accessed March 5, 2024, https://www.veteranshealthlibrary.va.gov/Search/3,82009.

[13] An ejection fraction is the measurement of how much blood is being pumped out of the heart chambers. A normal ejection fraction is between 50 and 70 percent. "Ejection fraction," Cleveland Clinic, accessed January 10, 2023, https://my.clevelandclinic.org/health/articles/16950-ejection-fraction.

[14] When patients have an ejection fraction less than 40 percent, they are diagnosed with heart failure with reduced ejection fraction (HFrEF). Lower ejection fractions may cause more severe heart failure symptoms such as shortness of breath, fatigue, or weakness, and a higher risk of complications like cardiac arrest. "Ejection fraction," Cleveland Clinic, accessed January 10, 2023, https://my.clevelandclinic.org/health/articles/16950-ejection-fraction.

[15] PSA is a protein which is made by the prostate gland and is often elevated in prostate cancer. National Cancer Institute, "What is a PSA test?," accessed January 8, 2024, https://www.cancer.gov/types/prostate/psa-fact-sheet#what-is-the-psa-test.

A urology nurse practitioner saw the patient later that month to evaluate the elevated PSA level. Vital signs were not recorded. The discussion included further prostate cancer workup such as a biopsy of the prostate to diagnose cancer versus monitoring the PSA level. The patient elected to have ongoing monitoring of the PSA level.

A cardiologist saw the patient six weeks later and noted progressive deterioration of the patient's heart function since the 2019 echocardiogram. The cardiologist noted that reevaluation for coronary artery disease was warranted. The cardiologist adjusted the patient's medications and ordered a nuclear medicine stress test and follow-up laboratory studies.[16] The cardiologist documented discussing the risk for abnormal heart rhythms with the patient and noted the patient was agreeable to a wearable cardioverter defibrillator (WCD) until an implantable cardiac defibrillator was "found to be warranted or not."[17]

A cardiology physician assistant saw the patient approximately five weeks later and noted the nuclear stress test had not been scheduled or completed despite multiple attempts to contact the patient.[18] As requested by the cardiology physician assistant, the cardiology nurse contacted the patient to assist in scheduling the test and clarify the medications the patient was taking. The physician assistant requested the patient follow up with the cardiologist to provide further care including guideline-directed medication treatment for heart failure, to review the stress test results when completed, and to determine whether the WCD was indicated.[19] The physician assistant documented discussing the patient with the primary cardiologist, and ordered additional medications following guideline-directed medication treatment.

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[16] A nuclear medicine stress test is imaging that uses intravenous radioactive material that shows the blood flow to the heart at rest and during exercise. This can show areas of poor blood flow or heart damage and help diagnose coronary artery disease. Mayo Clinic, "Nuclear stress test," accessed January 31, 2024, https://www.mayoclinic.org/tests-procedures/nuclear-stress-test/about/pac-20385231#:~:text=Overview,moves%20through%20the%20heart%20arteries.

[17] A WCD is a vest that can "stop an abnormal heart rhythm without anyone's help." The vest is indicated for patients at risk for sudden cardiac death and is worn when waiting for a more permanent solution, such as an implantable cardioverter defibrillator or a heart transplant. "LifeVest," Cleveland Clinic, accessed October 3, 2023, https://my.clevelandclinic.org/health/treatments/17173-lifevest; An implantable cardioverter defibrillator is a small battery-powered device placed in the chest that recognizes irregular heartbeats and provides an electric shock to correct them. Implantable cardioverter defibrillators may be recommended when a patient survives cardiac arrest, has an enlarged heart or coronary artery disease with a weakened heart. or certain irregular heart rhythms. Mayo Clinic, "Implantable cardioverter-defibrillators," accessed January 31, 2024, https://www.mayoclinic.org/tests-procedures/implantable-cardioverter-defibrillators/about/pac-20384692.

[18] A physician assistant is a credentialed member of the healthcare team "who is authorized to practice with defined levels of autonomy and to exercise independent medical decision making within their scope of practice." VHA Directive 1063(1), *Utilization of Physician Assistants (PA)*, December 24, 2013, amended May 17, 2022.

[19] Guideline-directed medical therapy provides a framework for evaluating heart failure patients, guiding testing and treatment modalities. "The 2022 guideline is intended to provide patient-centric recommendations for clinicians to prevent, diagnose, and manage patients with heart failure." Paul A. Heidenreich, et al., "2022 ACC/AHA/HFSA Guideline for the Management of Heart Failure," Journal of Cardiac Failure Vol. 28, No. 5 (May 2022): e1-e167, https://www.sciencedirect.com/science/article/abs/pii/S1071916422000768?via%3Dihub.

The patient's nuclear medicine stress test was completed three weeks later. The study was abnormal, demonstrating an area of reversible decreased blood flow and a decreased ejection fraction of 27 percent. The cardiology physician assistant alerted the cardiologist of the results and referred the patient for a coronary angiogram and cardiac catheterization to further evaluate the patient for coronary artery disease.[20]

In mid-spring an interventional cardiologist performed the coronary angiogram and cardiac catheterization, and no obstructive coronary artery disease was noted. This cardiologist recommended guideline directed medication treatment and follow-up with the cardiology physician assistant.

Two weeks later, the patient saw the cardiology physician assistant for follow-up care and denied any cardiovascular complaints except mild swelling of the feet. The patient's blood pressure and pulse were within normal limits. On examination, the provider noted the heart rate was regular and the lungs were clear. The cardiology physician assistant documented discussing medication changes with the cardiologist and questioned in the chart if a follow-up echocardiogram was indicated to assess the current ejection fraction.[21]

Two days later, the patient saw the PCP who noted improvement in the patient's complaints of leg swelling and shortness of breath. The patient's blood pressure and pulse were within normal limits. On examination, the PCP noted the patient's lungs were clear and heart rate was regular. The PCP recommended continuation of the medications and a follow-up appointment with urology for the elevated PSA level.

Three days later, the patient went to a scheduled urology appointment for follow-up on the elevated PSA level. The patient reported urinary frequency and occasional urgency but no fevers, pain, or blood during urination. The urologist noted the patient stated having chronic shortness of breath when walking on flat ground and was followed by cardiology for CHF. No vital signs were documented. On examination, the urologist noted the patient was alert, in no distress, and did not have leg swelling. The urologist discussed further workup for an elevated PSA level. The patient decided to continue to monitor the PSA level and treat as needed for symptoms. Urology follow-up was planned for one year later, or sooner if indicated.

Community hospital records from the same day as the urology appointment noted the Phoenix Fire Department responded to a 911 call at the facility requesting help for a patient with a

[20] A cardiac catheterization is a procedure used to diagnose or treat heart problems. Mayo Clinic, "Cardiac catheterization," accessed January 31, 2024, https://www.mayoclinic.org/tests-procedures/cardiac-catheterization/about/pac-20384695.

[21] The cardiologist acknowledged receipt of the note mid-July 2023.

witnessed code in a vehicle.[22] When the paramedics arrived and assessed the patient 11 minutes after the 911 call was received, the patient was noted to be pulseless, not breathing, and in ventricular fibrillation.[23] Paramedics took the patient out of the vehicle and initiated chest compressions. Resuscitation efforts included defibrillation, intubation, and use of medications to restart the heart rhythm. According to the Phoenix Fire Department records, CPR was not done prior to 911 responders arriving on scene.

The paramedics transported the patient to a community hospital and after further resuscitation in the emergency department, the patient was admitted to the intensive care unit in cardiac and respiratory failure. The patient's family requested the code status be changed to do not resuscitate and the patient died two days later.

Inspection Results

The OIG learned that approximately 11 minutes elapsed between facility staff placing a 911 call after learning of the patient's medical emergency outside of the facility's Ambulatory Care Clinic (ACC) entrance and the patient receiving BLS. The OIG identified deficiencies related to the initiation of emergency medical care, the quality of care prior to the medical emergency, and completion of comprehensive quality reviews. However, the OIG was unable to determine whether a change in care would have resulted in a different outcome for the patient.

1. Delayed Response to a Medical Emergency

"VHA is committed to providing timely and high-quality emergency medical treatment for Veterans enrolled in VA's health care system."[24] Additionally, VHA requires that medical screening examinations are provided to individuals who present at a "VA hospital or the campus of a VA hospital that has an emergency department and who requests, or on whose behalf a request is made for, an examination or treatment of a medical condition."[25] If the determination is made that an individual is experiencing a medical emergency, the VA hospital is also required to provide stabilizing treatment.[26]

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[22] A code is the summoning of professionals trained in CPR to revive a person in cardiac, respiratory, or cardiopulmonary arrest. Merck Manual Consumer Version, "Do-Not-Resuscitate (DNR) Orders," accessed February 13, 2024, https://www.merckmanuals.com/home/fundamentals/legal-and-ethical-issues/do-not-resuscitate-dnr-orders.

[23] Ventricular fibrillation is a rapid, uncontrolled, ineffective heartbeat. Mayo Clinic, "Ventricular fibrillation," accessed January 24, 2024, https://www.mayoclinic.org/diseases-conditions/ventricular-fibrillation/symptoms-causes/syc-20364523.

[24] VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023; 38 C.F.R. § 17.38 (2024).

[25] VHA Directive 1101.14; 38 U.S.C. § 1784A.

[26] VHA Directive 1101.14; 38 U.S.C. § 1784A. In instances where a VA emergency department is not able to provide stabilizing treatment, the VA facility is required to ensure the individual seeking emergency medical care is safely and appropriately transferred to another hospital.

For every minute a normal heartbeat is not restored during a cardiac arrest, the chance of survival decreases by 7 to 10 percent. The immediate initiation of cardiopulmonary resuscitation (CPR) and use of an automated external defibrillator (AED) "can double or triple" a person's chance of survival.[27] The OIG determined, through a review of Phoenix Fire Department records, that approximately 11 minutes elapsed between facility staff placing the 911 call and when Phoenix Fire Department paramedics initiated BLS. (See figure 1.)

[27] Merck Manual, "Cardiopulmonary Resuscitation (CPR) in Adults," accessed April 1, 2024, https://www.merckmanuals.com/professional/critical-care-medicine/cardiac-arrest-and-cpr/cardiopulmonary-resuscitation-cpr-in-adults?query=cpr#v925728. CPR "is an organized sequential response to cardiac arrest including recognition of absent breathing and circulation."; American Heart Association, Answers by Heart, "What Is an Automated External Defibrillator?," accessed December 5, 2023, https://www.heart.org/-/media/files/health-topics/answers-by-heart/what-is-an-aed.pdf?la=en. An AED is a "lightweight, portable device" that can help individuals who are in cardiac arrest by delivering an electric shock through the chest to the heart to restore a normal heart rhythm.

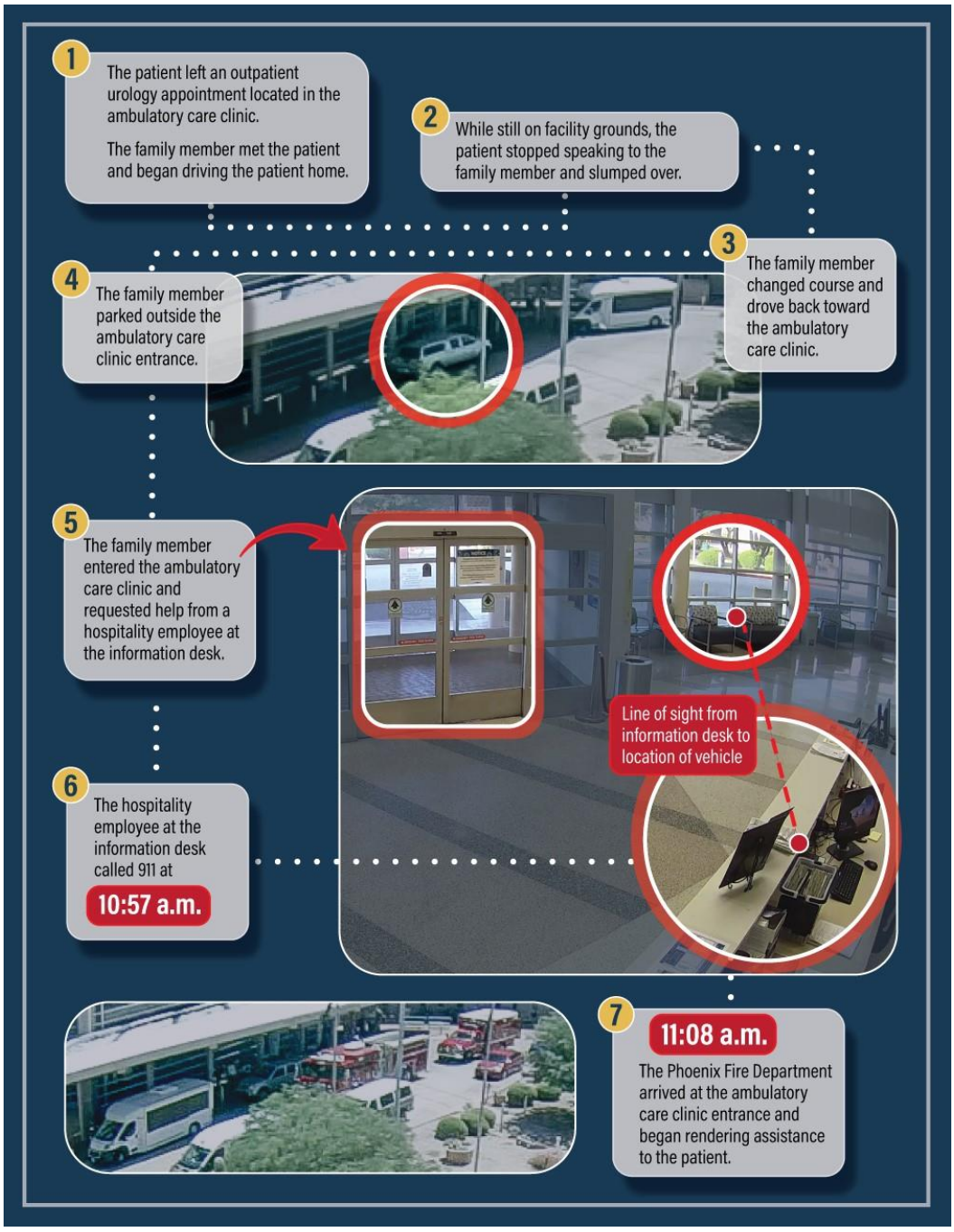

Figure 1. *The OIG timeline analysis of events.*
Note: The timeline is based on interviews, observations, facility exterior ACC video surveillance footage during the patient's medical emergency, and a facility interior ACC photograph. The family member reported moving the vehicle while awaiting medical assistance (with the patient inside) upon a request from a VA volunteer as the vehicle was parked incorrectly.
Sources: From the day of the event, VA police surveillance video and Phoenix Fire Department incident report; facility chief of police, VA police surveillance screenshot; The OIG inspection observations and interviews.

The OIG determined that facility staff did not provide emergency medical treatment to stabilize the patient following the family member's request for assistance. The OIG is unable to determine whether a change in care would have resulted in a different outcome for the patient.[28]

The OIG identified multiple factors that may have contributed to the delay:

- Deficient initiation of a rapid response
- Conflicting policies and procedures
- Absence of layperson CPR training
- Absence of a public access AED[29]

Deficient Initiation of a Rapid Response

VHA policy aims to "optimize patient safety for those requiring resuscitation" and "ensures that VHA has emergency response capability to manage cardiac arrests on VHA property."[30] This includes requirements for BLS trained clinical staff to be "available at all times for resuscitation."[31] A component of this is a rapid response system, which provides additional evaluation and treatment of unstable patients, and leads to improved patient outcomes including decreased risks of cardiac arrest and death.[32]

The facility's rapid response team "provides a safety net for patients who suddenly deteriorate" through (1) assessment and stabilization, and (2) assistance with transferring individuals to a higher level of care, if needed.[33] Additionally, facility policy states that staff who are concerned about an individual requiring immediate assistance must contact the rapid response team.[34] To initiate a rapid response, staff dial 222 and inform the operator of the location of the medical

[28] Of note, the Facility Director, the Chief of Staff, and the chief of the Emergency Department told the OIG of plans to implement a facility operated ambulance service to respond to on-campus emergencies. As of October 2023, interviews for the hiring of paramedics were occurring. Once implemented, the Facility Director explained the policy on how staff respond to medical emergencies outside the building will change.

[29] *Merriam-Webster.com Dictionary*, "layperson," accessed February 12, 2024, https://www.merriam-webster.com/dictionary/layperson. A layperson is an individual who is not an expert in a particular field.

[30] VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021.

[31] VHA Directive 1177.

[32] Geoffrey K. Lighthall, Layla M. Parast, Lisa Rapoport, and Todd H. Wagner, "Introduction of a Rapid Response System at a United States Veterans Affairs Hospital Reduced Cardiac Arrests," *Anesthesia & Analgesia* 111, no. 3 (September 2010): 679-86, https://journals.lww.com/anesthesia-analgesia/Fulltext/2010/09000/Introduction_of_a_Rapid_Response_System_at_a.15.aspx.

[33] Facility Policy Memorandum11-101, *Rapid Response Team (RRT)*, July 2, 2019. Facility rapid response team members include an intensive care unit or emergency department charge nurse; a respiratory therapist; the on-call medical team or emergency department provider; a nurse on duty; and a police officer.

[34] Facility Policy Memorandum 11-101.

emergency. The operator then activates an overhead page to alert the rapid response team.[35] Facility policy also states that the rapid response team only responds to events that occur inside buildings connected to the main hospital.[36] Further, staff should call 911 and the VA police when an individual needs medical assistance outside of these areas, including the facility's parking garage and parking lots.[37]

Per facility operator procedure, when staff call the operator to request a rapid response for a location that is not inside a building connected to the main hospital, operators are expected to notify the rapid response team, VA police, call 911, and document the call in the operator log.[38] Further, facility policy identifies that VA police are responsible for maintaining scene safety and directing emergency medical services on campus.[39]

The OIG learned that following the family member's request for assistance, a hospitality employee located at the ACC information desk attempted to obtain help as the patient required an immediate assessment.[40] The hospitality employee stated

> I got on the phone . . . I know it's not procedure, but I called to get a rapid response because I figured I could have them on their way while I call 911 for EMTs [emergency medical technicians] because I was just trying to get someone there fastest.

The hospitality employee told the OIG about dialing zero to request a rapid response informing an operator of the patient's medical emergency, and then being told "we don't do that" and being directed to call the VA police. The OIG learned the hospitality employee did not call the VA police and instead dialed 911.[41] During an OIG interview, the hospitality employee stated that calling a rapid response was not the correct procedure, and reported an awareness of the facility

[35] Facility Policy Memorandum11-101. Through email responses, the OIG learned dialing 222 at the facility connects the caller to three designated phones in the operator room. Operators are required to pause existing calls to answer 222 calls.

[36] The buildings connected to the main hospital include Laundry and Engineering (building 2), the Community Living Center (building 16), Rehabilitation (building 34), and the ACC (building 8).

[37] Facility Policy Memorandum 11-101.

[38] The manager of Health Benefits and Enrollment, who supervised the operators during the OIG inspection, reported that this document was part of a larger document, Facility Standard Operating Procedure, *Communication Center Switchboard RFMS/136E Telephone Operator SOP [Standard Operating Procedure]*, which was updated in 2021, but had been in place at the facility since approximately 2006.

[39] Facility Policy Memorandum 11-106*, Cardiopulmonary Resuscitation,* July 2, 2019, amended March 28, 2023.

[40] Facility hospitality employees assist patients with navigating the facility and provide wheelchair transport. The hospitality employee told the OIG that the patient was going in and out of consciousness.

[41] The hospitality employee told the OIG of dialing zero and not 222 for a rapid response. The OIG learned both numbers connect the caller to facility operators and all facility operators use the same procedure when responding to medical emergencies. The OIG learned that following the patient event, the chief of nutrition, hospitality, and food service provided hospitality staff with training regarding the facility rapid response team policy. Specifically, how to contact VA police in addition to 911 when responding to a medical emergency that occurs outside the building.

rapid response policy, which states employees should call 911 if an emergency occurs outside the building. However, the hospitality employee stated the attempt to call for a rapid response was made due to the medical emergency occurring so closely to the ACC entrance, "I understand it's outside, but it's really, three feet from the front door."[42]

The OIG identified two operators who were working on the day and time of the patient's medical emergency. The OIG was unable to determine why operators did not initiate a rapid response when the hospitality employee requested one. The operators did not remember the event due to the amount of time that had elapsed between the medical emergency and the OIG inspection, and the call was not documented in the operator log.

The chief of medicine service and specialty care, the chief of the Emergency Department, and the chair of the cardiopulmonary resuscitation committee expressed concerns to the OIG that the lack of timely BLS may have contributed to the patient's death. They believed a rapid response should have been activated and would have prevented the delay in the patient receiving BLS:[43]

- "That is right in front of our Ambulatory Care Clinic . . . I think that's within our rapid response team to react because [the patient's] so close."
- "If somebody had contacted the [emergency department], we would [have] probably gone down and brought [the patient] into our [emergency department] and started care right away, especially if they're unresponsive."
- "We don't actually know what's going on until we get there, we always go . . . we've gone to these . . . on the edge events . . . then paramedics get there then while we're supporting the patient."

Facility leaders told the OIG that facility policy supported calling 911 rather than a rapid response as the patient was outside the building connected to the main hospital. Facility leaders reported policy was written to call 911 in these instances due to the size of the facility campus. However, the OIG found facility leaders had a general unawareness of the exact location of the patient's medical emergency outside the ACC entrance, as most reported the medical emergency occurred either in a parking lot or parking garage (see appendix A).

During interviews, the Deputy Associate Director of Patient Care Services, the Chief of Staff, and the Facility Director acknowledged that the patient experienced a delay in receiving BLS. The Chief of Staff further stated, "where do you make the demarcation . . . Should we look at the

[42] Through review of the 911 call, the OIG learned the hospitality employee more likely than not called for assistance prior to calling 911. During the 911 call, when asked if security was with the patient, the hospitality employee told the 911 dispatcher, "I tried calling them first and they said they can't come out there." The OIG interpreted the statement to mean that the hospitality employee was referencing calling the facility operator and the rapid response team could not come.

[43] The cardiopulmonary resuscitation committee reviews each resuscitative episode of care at the facility. During the time of this inspection, the chief of pulmonary, intensive care unit, and sleep medicine was the committee chair.

policy and change the policy so that it is within 100 feet of a door? Maybe so. I'm not really sure, does that create confusion?"

Facility leaders also shared concerns that the VA police had not been contacted at the time of the patient's medical emergency, and believed the police would have taken additional measures from providing CPR to obtaining assistance from facility clinicians. However, the chief of police informed the OIG that when called to a medical emergency outside the facility, their role is "primarily as a crowd control or as an escort" for emergency medical services, which aligns with facility policy requirements.[44]

The OIG concluded that the hospitality employee recognized that although activating a rapid response for a medical emergency outside of the ACC building did not align with facility policy, this response would have provided the patient faster access to BLS. However, a rapid response was not activated, and care was delayed. The OIG is concerned that facility policy does not align with VHA requirements to "optimize patient safety for those requiring resuscitation" and ensure "emergency response capability to manage cardiac arrests on VHA property."[45]

Conflicting Policies and Procedures

VHA requires that facility policies must not contradict other VA and facility policies.[46] The US Government Accountability Office has previously identified that VA's "ambiguous policies and inconsistent processes" place patient safety and access to care at risk.[47]

The OIG learned of five facility policies and procedures instructing ACC information desk staff and operators on how to respond to medical emergencies. (See table 1.)

Table 1. Facility Medical Emergency Response Policies and Procedures

Document	Purpose	Identified Actions
Rapid Response Team*	Policy to establish staff responsibilities and provide guidance for initiating a rapid response.	• Staff call 911 and VA police when someone needs immediate medical assistance in a "parking garage, parking lot, and all other areas encompassed by

[44] Facility Policy Memorandum 11-106.

[45] VHA Directive 1177.

[46] VHA Directive 0999, *VHA Policy Management*, March 29, 2022.

[47] "About GAO," GAO, accessed March 13, 2024, https://www.gao.gov/about. GAO "is an independent, non-partisan agency that works for Congress. GAO examines how taxpayer dollars are spent and provides Congress and federal agencies with objective, non-partisan, fact-based information to help the government save money and work more efficiently."; GAO, *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas*, GAO-23-106203, April 20, 2023. The high-risk list identifies "government operations with vulnerabilities to fraud, waste, abuse, and mismanagement, or in need of transformation." VA's "ambiguous policies and inconsistent processes" was initially identified as a key area on the list in 2015. Although the U.S. Government Accountability Office identified progress, it remained on the April 2023 list.

Document	Purpose	Identified Actions
		the black metal fence demarcating the VA campus." • Staff call 222 for medical emergencies occurring in the ACC.
Cardiopulmonary Resuscitation†	Policy to optimize patient safety within the facility by ensuring capability to provide emergency response and manage cardiopulmonary arrests on property, including access to trained responders.	• Staff call 911 and VA police when someone needs assistance in a "parking garage(s), parking lots, and all other areas encompassed by the black metal fence demarcating the VA campus." • Staff call 222 for medical emergencies occurring in the ACC.
Badges‡	Employees wear informational badges to quickly identify what number to dial based on the location of the emergency. Types of emergencies are delineated through colors on the badge.	• Staff are instructed to call 911 and then call 222 for medical emergencies outside the main hospital complex. • Staff are instructed to call 222 for medical emergencies inside the hospital.
Nutrition, Hospitality, and Food Service Specific Emergency Preparedness Plan§	To provide Nutrition, Hospitality, and Food Service employees with "a quick and ready reference of the procedures to follow in the event of an emergency."	• Staff are instructed to call for help, including yelling for help and dialing 222. • Staff are to "provide first aid or render medical assistance in accordance with [their]training." • Staff initiate cardiopulmonary resuscitation, if needed. • Staff are informed AEDs "do not require extensive training to be used [and to] follow the instructions on the AED."
Telephone Operator Standard Operating Procedure‖	To provide facility operators instructions on how to respond to a request for emergent assistance.	• Operators overhead page the location of the medical emergency for a rapid response, notify VA police, and call or connect caller to 911 if the medical emergency is outside the main building.

Source: OIG analysis of the facility's policies and procedures.
*Facility Policy Memorandum 11-101.
†Facility Policy Memorandum 11-106.
‡During interviews, staff informed the OIG of the use of informational badges.
§Service Line Memorandum No. A3*, Nutrition, Hospitality, and Food Service Specific Emergency Preparedness Plan,* January 1, 2021.
‖Facility Standard Operating Procedure*, Communication Center Switchboard RFMS/136E Telephone Operator SOP [Standard Operating Procedure],* updated 2021.

The OIG found the purposes of the policies, procedures and memorandum were similar and provided staff with information on how to assist individuals experiencing a medical emergency. However, the actions identified to obtain assistance differed:

- Two policies informed staff to call 911 and VA police when a medical emergency occurs outside of buildings connected to the main hospital and for staff to dial 222 when assistance is needed in the ACC.
- One procedure provided direction for staff to call both 911 and 222 for medical emergencies outside of buildings connected to the main hospital and dial 222 when assistance is needed in the ACC.
- One memorandum advised staff to dial 222 regardless of location and to render assistance based on staff training.
- One procedure advised operators to activate the rapid response team when a medical emergency occurs outside of buildings connected to the main hospital.

The Facility Director highlighted the importance of policy when asked about leaders' oversight of staff response to medical emergencies on campus. Specifically, "to make sure that we have the appropriate policies in place. Make sure that people are familiar with the policy. Make sure people are trained to the policy. And if there's any deviation from the policy to look into why that occurred." However, facility leaders interviewed were unaware of multiple incongruent and contradicting policies and procedures instructing information desk staff on what to do in a medical emergency.

The OIG also found that two facility policies on how to respond to medical emergencies were inconsistent with VHA policy, as they failed to identify and incorporate requirements that (1) medical screening examinations must be administered to those who present and request emergency assistance at a VA hospital, and (2) if the examination reveals that the individual is experiencing a medical emergency, the VA hospital must provide stabilizing treatment.[48]

The OIG concluded that facility policies that are inconsistent with VHA requirements, in addition to facility policies and procedures that conflict with one another, likely contribute to staff's uncertainty about how to obtain assistance for an individual experiencing a medical emergency on a VA campus; this may adversely impact patient safety and access to emergency medical care.

Absence of Layperson Cardiopulmonary Resuscitation Training

VHA directs staff to provide reasonable assistance within their scope and training when responding to a medical emergency.[49] Additionally, medical center directors must ensure

[48] VHA Directive 1101.14; Facility Policy Memorandum 11-101; Facility Policy Memorandum 11-106.

[49] Assistant Deputy Under Secretary for Health for Clinical Operations, "Responses to Emergency and Non-Emergency Conditions at or on the Grounds of Medical Centers, Health Care Centers (HCC), Community-Based Outpatient Clinics (CBOCs) and Other Outpatient Centers in VHA," memorandum to Network Directors, February 16, 2016.

layperson CPR training "ranging from awareness to actual training" is available to all non-clinical staff, as non-clinical staff are often called upon to participate in initial interventions and can help increase cardiac arrest survival rates.[50]

Although VHA requires that layperson training is available to non-clinical staff, the hospitality employee told the OIG of not receiving training at the facility and expressed frustration at not being able to provide CPR to the patient. Hospitality service leaders also confirmed with the OIG that layperson training had not been offered to hospitality staff.[51]

When asked if knowledgeable of VHA's layperson training requirements, the Facility Director reported being familiar with what layperson training consisted of, but not being aware whether the training was available to non-clinical facility staff.[52] Additionally, the Facility Director shared not being involved with making layperson training decisions. The OIG confirmed layperson training was not offered to non-clinical hospitality staff.[53]

The OIG determined that the Facility Director failed to ensure non-clinical hospitality staff were offered CPR training. The OIG is concerned that the failure to ensure that CPR training is offered to layperson (non-clinical) staff may prevent participation in initial interventions during a medical emergency.

Absence of a Public Access Automated External Defibrillator

Medical center directors must ensure public access AEDs are available in high-use areas (such as lobbies) and VHA policy strongly recommends VA police cars have AEDs for use in "parking lots and other distant sites."[54] During the unannounced site visit, the OIG determined there were no AEDs in the ACC lobby or first floor hallways. The chief of healthcare technology management service provided the OIG with the location of two public access AEDs in the basement of the ACC. When asked, the Facility Director was not aware of the location of the AED in the ACC and stated, "I would hope [an AED] would be in the proximity of the lobby." Further, the OIG learned the VA police do not have AEDs in their vehicles.

The OIG discussed the need for placement of a public access AED in the ACC lobby with the VISN Network Director and the facility's Deputy Director who ultimately ensured the

[50] VHA Directive 1177. For the purposes of this report, the OIG recognizes layperson training as training needed to participate in the initial intervention of a cardiac or respiratory arrest.

[51] Service Line Memorandum No. A3, *Nutrition, Hospitality, and Food Service Specific Emergency Preparedness Plan*, January 1, 2021. Employees are instructed to "render medical assistance in accordance with your training." "Initiate cardiopulmonary resuscitation (CPR) if needed."

[52] VHA Directive 1177.

[53] The OIG's review focused on layperson training for hospitality staff. The OIG did not review layperson training availability for other non-clinical facility staff.

[54] VHA Directive 1177.

installation of an AED in the ACC lobby.[55] The OIG concluded the lack of public access to an AED limits the ability for laypersons to provide care when individuals are experiencing medical emergencies in high-use areas.

2. Quality of Care Concerns

The OIG reviewed the patient's cardiology care in the months leading up to the medical emergency and the care provided during a urology appointment prior to the medical emergency. The OIG determined there were deficiencies in the management of the patient's cardiology care and the assessment of the patient during the urology appointment.

Deficient Cardiology Management

The OIG reviewed the patient's EHR and determined that a cardiologist's plan of care for the patient included a WCD vest; however, an order was not entered into the EHR. Despite another cardiology provider identifying the WCD was not ordered, the discrepancy remained unresolved.

Per facility policy, a cardiology provider is responsible for overseeing the initiation and monitoring of a WCD. A cardiology provider orders a WCD through placement of a prosthetics consult after validating a patient is capable of managing the vest.[56] The American Heart Association considers the use of a WCD to be a class IIb recommendation for patients at increased risk for sudden cardiac death. A class IIb recommendation is defined as weak; use may be reasonable and considered, but the effectiveness is unknown or not well established.[57]

Per VHA, health record documentation is an "important element contributing to high-quality care," which facilitates "communication and continuity of care among VA medical staff members."[58] It is imperative that health record documentation is complete "as it impacts quality of patient care, patient safety, and the number of medical errors."[59] In a team setting where a

[55] The conversation occurred on December 13, 2023; the facility director was out of the office and did not participate. The chief of quality, safety, and improvement reported the AED was installed in the ACC lobby on January 17, 2024.

[56] Facility Policy Memorandum No. 11-113, *External Wearable Cardioverter/Defibrillation Device (Also Known as External Defibrillator Vest)*, August 15, 2018.

[57] Sana M. Al-Khatib, et al., "2017 AHA/ACC/HRS Guideline for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death," Circulation Vol. 138, No. 13 (September 2018): e272-e391, https://www.ahajournals.org/doi/epub/10.1161/CIR.0000000000000549; David J. Magid, et al., "Part 2: Evidence Evaluation and Guidelines Development, 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care," *Circulation* 142, (October 20, 2020): 358-365, https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000898.

[58] VHA Health Information Management, *Health Record Documentation Program Guide Version 1.1*, November 29, 2022.

[59] Tom Ebbers, et al., "The Impact of Structured and Standardized Documentation on Documentation Quality; a Multicenter, Retrospective Study," *Journal of Medical Systems* 46, (May 27, 2022), https://doi.org/10.1007/s10916-022-01837-9.

physician assistant works in collaboration with physicians, VHA requires that the physician assistant document any physician consultation within the EHR.[60]

The OIG learned that in early 2023, the patient presented to the outpatient cardiology clinic for evaluation of CHF. The cardiologist documented a discussion with the patient about the use of a WCD due to the patient's risk for abnormal heart rhythms related to CHF. The EHR documented plan of care listed a stress test and a WCD. Although the cardiologist ordered the stress test the same day, the WCD was not ordered. Approximately five weeks later, at a cardiology follow-up appointment, a cardiology physician assistant documented that the patient was scheduled to return to see the cardiologist to evaluate whether the WCD was indicated and added the cardiologist as an additional signer to the note.[61] On April 9, 2023, the cardiologist acknowledged the March 2023 note but no other action was taken. There was no further mention of a WCD in subsequent cardiology notes prior to the patient's death.[62]

When asked why a WCD was not ordered, the cardiologist told the OIG of knowing how to order a WCD but could not recall why one was not ordered for the patient. The cardiology physician assistant told the OIG of not placing a WCD order for the patient when the discrepancy was identified; this decision was based on the cardiology physician assistant's physical exam findings that the patient was "overall asymptomatic" at the follow-up appointment.

When asked about the coordination of the patient's care, the cardiologist and the cardiology physician assistant told the OIG they conversed about the patient after the March 2023 appointment. The cardiologist stated

> [The cardiology physician assistant] conveyed to me that [the patient] did not have symptoms . . . in which case we would still continue titrating [the patient's] medications, but . . . [the patient] wouldn't have a strong indication at that point for the [WCD].

However, the cardiology physician assistant told the OIG of having no recollection that the WCD was discussed with the cardiologist. The OIG noted that the cardiology physician assistant documented a consultation with the cardiologist regarding the patient's medication management

[60] VHA Directive 1063(1), *Utilization of Physician Assistants (PA)*, December 24, 2013, amended May 17, 2022.

[61] The additional signer function of the EHR is "a communication tool used to alert a clinician about information pertaining to the patient." It is designed to "allow providers to call attention to specific documents and for the recipient to acknowledge receipt of the information." Being identified as an additional signer is not equivalent to being identified as a co-signer and does not imply responsibility for the content of the note. VHA Health Information Management, *Health Record Documentation Program Guide Version 1.1*.

[62] Subsequent cardiology visits included a diagnostic cardiac catheterization post-operative follow-up appointment with the cardiology physician assistant on May 17, 2023.

in the March 2023 note, per VHA policy.[63] However, the WCD was not documented as part of the discussion and therefore, the OIG cannot determine whether the discussion occurred.[64]

The OIG concluded that the cardiologist did not order a WCD for the patient, despite documenting the treatment in the plan of care. Although both cardiology providers confirmed that a WCD was no longer indicated based on the cardiology physician assistant's evaluation of the patient during a follow-up appointment, the discrepancy between the documented plan for a WCD and the absence of a WCD order for the patient was not resolved in the EHR.

Incomplete Patient Assessment During a Urology Appointment

Prior to the medical emergency, the patient presented for an outpatient urology appointment to follow-up on abnormal lab results which revealed an elevated PSA level. During the appointment, the patient's vital signs were not taken.

Facility policy requires clinicians to document vital signs for all outpatient visits.[65] Vital signs measure essential body functions, including blood pressure, respiration rate, pulse, and body temperature.[66] Early detection of changes in vital signs prior to clinical deterioration is "key to timely intervention."[67]

The OIG reviewed the patient's urology appointment note and found no documentation of vital signs.[68] Although facility policy requires the documentation of vital signs during outpatient visits, the chief of urology and Surgical Service nurse leaders told the OIG that vital signs were historically not assessed consistently during urology appointments.[69] Surgical Service nurse leaders attributed the inconsistency to having multiple check-in processes for different types of urology clinic appointments, some of which did not involve nursing staff.[70]

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[63] VHA Directive 1063(1).

[64] The OIG learned that a quality management review of the patient's cardiology care occurred in August 2023 and resulted in a discussion with the cardiologist about documentation expectations and ordering a WCD. Therefore, the OIG did not make a recommendation.

[65] Facility Policy Memorandum HIMS [Health Information Management Service]-01, *Completion of Medical Records*, March 25, 2021.

[66] US National Library of Medicine, Medline Plus, "Vital signs," accessed May 15, 2020, https://medlineplus.gov/ency/article/002341.htm.

[67] Idar Johan Brekke, et al., "The value of vital sign trends in predicting and monitoring clinical deterioration: A systemic review," PLOS One 14, no. 1 (January 15, 2019), https://doi.org/10.1371/journal.pone.0210875.

[68] Of note, clinicians did not document the patient's vital signs at a previous outpatient urology appointment in January 2023.

[69] The urologist, who saw the patient, is also the facility's chief of urology. Through email correspondence, the OIG learned the Urology Department aligns under Surgical Services at the facility.

[70] The surgical clinic nurse manager described four types of clinic appointments: procedures, registered nurse clinic, licensed practical nurse clinic, and provider clinic. Nursing staff were not part of the check-in process for the provider clinic.

The surgical clinic nurse manager reported a formal process for capturing urology patients' vital signs had been in discussion since May 2021 and was implemented in mid-October 2023. The process involved the creation of a "vital signs station" in the clinic waiting area equipped with a machine for nursing staff to perform vital signs. The surgical clinic nurse manager attributed the delay in implementation of the new process to lack of space.[71]

The OIG concluded that assessment of the patient's vital signs was required but not completed at the outpatient urology appointment. This resulted in an incomplete assessment of the patient prior to the medical emergency. The OIG is unable to determine whether the assessment of vital signs would have indicated the patient's impending clinical deterioration. However, not assessing vital signs may have contributed to a missed opportunity for early identification of the patient's clinical decline.

3. Deficiencies in Facility Leaders' and Staff Response to a Medical Emergency

In 2018, VHA began to implement high reliability organization (HRO) concepts to promote a culture of safety.[72] VHA's journey to become an HRO is founded on a continuing commitment to harm prevention and process improvement through staff empowerment.[73] In the healthcare setting, "leadership's first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors."[74] Further, leaders' commitment to HRO is critical as, "transformative change requires the support and participation of highly visible and vocal leaders to promote and demonstrate their sustained commitment . . . through their actions." [75]

VA's core values, known as I CARE, underscore a VA employee's obligation to "care for Veterans, their families, caregivers, and survivors. They describe the organization's culture and serve as the foundation for the way VA employees should interact with Veterans."[76] The "excellence" value identifies that "VA employees will strive for the highest quality and

[71] While on site, the OIG observed the area of the urology clinic designated for obtaining vital signs.

[72] VA, VHA, "VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only," April 2023. "High reliability means evidence-based, high-quality care is consistently delivered for every patient, every time, at any facility across VHA." There are three HRO pillars: leadership commitment, culture of safety, and continuous process improvement.

[73] VHA High Reliability Organization (HRO) Reference Guide, April 2023.

[74] The Joint Commission, Sentinel Event Alert, "The Essential Role of Leadership in Developing a Safety Culture," March 1, 2017, revised June 18, 2021, https://www.jointcommission.org/-/media/tjc/newsletters/sea-57-safety-culture-and-leadership-final3.pdf.

[75] VHA High Reliability Organization (HRO) Reference Guide, April 2023.

[76] "I CARE Core Values, Characteristics, and Customer Experience Principles," VA I CARE, accessed January 25, 2024, https://www.va.gov/icare/core-values.asp. The values include integrity, commitment, advocacy, respect and excellence.

continuous improvement, and be thoughtful and decisive in leadership, accountable for their actions, willing to admit mistakes, and rigorous in correcting them."[77]

VHA policies incorporate HRO principles and I CARE values through VHA's commitment to quality health care and patient safety.[78] VHA defines quality as the delivery of "highly reliable health care services that are safe, timely, effective, efficient, equitable and patient-centered."[79] Further, "continuous quality management strengthens . . . practices to build accountability, transparency, inclusion and standardization to prevent harm, promote continuous learning and improve the quality of care and services delivered."[80]

VHA encourages facility staff to use the JPSR system, which alerts the patient safety manager of patient safety events such as close calls and adverse events.[81] After receiving a patient safety report, a patient safety manager must initiate an investigation of the event to determine whether additional reviews or actions are warranted, such as an RCA.[82] Additionally, VHA recognizes the use of an organized process such as a look-back is to identify patients that have been exposed to possible risk from clinical interactions.[83] Furthermore, VHA is committed to "disclose the occurrence of harmful adverse events . . . is consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence; it demonstrates professionalism, and respect for the patient; and is foundational to providing care."[84]

Leaders' Failure to Act Following the Event

The OIG found facility leaders were informed of the patient's medical emergency on two occasions within 10 days of the event. However, no further actions to alert the patient safety manager or perform a comprehensive review of the event were taken. The OIG is concerned that

[77] 38 C.F.R. § 0.601 (2023).

[78] VHA Directive 1050.01; VHA Directive 1004.08.

[79] VHA Directive 1050.01.

[80] VHA Directive 1050.01.

[81] VHA Directive 1050.01. A close call is "an event or situation that could have resulted in an adverse event but did not, either by chance or through timely intervention." Adverse events are "therapeutic incidents iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers." VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022.

[82] An RCA is "a process for identifying the basic causal factor(s) underlying system failures." RCA's can "uncover factors that lead to patient safety events and move organizations to deliver safer care." NCPS, *VHA National Center for Patient Safety*: Guide to Performing Root Cause Analysis, Version 9, February 2023. VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022.

[83] VHA Directive 1004.08. A look-back is used to identify "patients or staff with exposure to potential risk incurred through past clinical activities, with the explicit intent to notify them and offer care and recourse, as appropriate."

[84] VHA Directive 1004.08. Disclosures can be clinical or institutional. Clinical disclosures involve a clinician informing a patient or patient's representative "that a harmful or potentially harmful adverse event has occurred." Institutional disclosures require VA medical facility leaders and clinicians to "inform the patient or the patient's personal representative that an adverse event has occurred. .. that resulted in or is reasonably expected to result in death or serious injury and provide specific information about the patient's rights and recourse."

facility leaders' lack of response upon awareness of the event was not in alignment with HRO principles and I CARE values as the lack of action did not demonstrate a commitment to harm prevention or accountability for identifying barriers in providing effective care.

First Occurrence of Leaders' Awareness

The OIG learned through interviews that immediately after the patient's medical emergency, the hospitality employee informed the hospitality supervisor of the event and shared frustration about the lack of an internal facility response to help the patient. Additionally, the hospitality employee shared uncertainty about having access to the JPSR system and did not recall receiving training on how to enter a report.

When asked about the event, the hospitality supervisor explained that the hospitality employee was angry a rapid response was not activated when requested even though the patient was "right in front of the VA you know by the door." The hospitality supervisor commented that calling a rapid response was reasonable given the situation. The hospitality supervisor also told the OIG of not knowing how to enter a patient safety report and was not aware of any training provided to hospitality staff.

The chief of nutrition, hospitality, and food service told the OIG about learning of the patient's medical emergency from the hospitality supervisor within two days of the event.[85] The chief of nutrition, hospitality, and food service also reported that after the event, hospitality employees shared concerns regarding facility policy and having to call 911 versus a rapid response (as the event was close to the entrance of the building). The chief of nutrition, hospitality, and food service explained further concerns to the OIG

> When I found out we didn't call the police, I was a little frustrated with the team . . . but they brought up some really good points . . . I don't know the exact footage, but it's pretty close to our front door . . . and if a veteran . . . is going south [medically deteriorating] . . . perhaps we could call a rapid response or call . . . our medical emergency and let the team come to the door and make a determination.

The chief of nutrition, hospitality, and food service told the OIG about discussing the need to review the rapid response process when a patient is having a medical emergency, and identify areas for improvement with the Deputy Associate Director of Patient Care Services.[86] The chief of nutrition, hospitality, and food service shared that following the discussion, the Deputy Associate Director of Patient Services planned to get a group together but that did not occur. The

[85] During an interview, the OIG learned the hospitality supervisor reports to the chief of nutrition, hospitality, and food service.

[86] The chief of nutrition, hospitality, and food service told the OIG of contacting the Deputy Associate Director of Patient Care Services who is "the owner of the [customer service team] policy."

Deputy Associate Director of Patient Care Services told the OIG of not recalling being informed of any concerns about staff response to medical emergencies.

The OIG concluded that the hospitality employee and supervisor did not know how to enter a patient safety report and alert patient safety of their concerns; therefore, they informed their supervisors. Although immediate supervisors were notified, a patient safety report was not completed at that time; therefore, a comprehensive review of the event to assess for associated harm was not performed. Leaders' inaction upon notification of a potential patient safety event does not demonstrate commitment to HRO principles or I CARE values.

Second Occurrence of Leaders' Awareness

Nine days after the event, the family member who drove the patient to the scheduled urology appointment placed a White House Hotline complaint that stated the patient, "passed away due to no treatment from [the]local VA facility." The complaint further described details of the patient's medical emergency and the subsequent lack of facility staff response:[87]

- The patient "passed out" while still in a facility parking lot.
- The family member navigated to "the front entrance of the hospital and . . . ran to the receptionist to contact ER [emergency room] for them to help."
- An individual "showed up to tell [the family member] to move [their] truck."
- The patient was "not serviced immediately and another 911 Emergency team from outside VA came to the facility."
- "EMTs told [the family member] that [the patient being] without oxygen was not good and had no heartbeat so they had to use the AED machine to try to revive [the patient]."
- The patient "did not deserve this mistreatment and [the death] could have been prevented."

The same day, the complaint was entered into the Patient Advocacy Tracking System and assigned to a social work supervisor responsible for resolving White House Hotline complaints at the facility.[88] The next day, the social work supervisor sent two emails informing facility leaders and staff of the complaint. The first email provided a summary of the complaint to the assistant chief of Social Work Services and the Associate Director of Patient Care Services.

[87] VA News, "White House VA Hotline Now Fully Staffed and Operational Around the Clock to Service Nation's Veterans," press release, November 29, 2017, https://news.va.gov/press-room/white-house-va-hotline-now-fully-staffed-and-operational-around-the-clock-to-serve-nations-veterans. The White House VA Hotline is a direct contact line to agents "staffed 24/7 by a team of mostly Veterans or Veteran family members who have direct knowledge . . . and can use their experience to address them in the best way possible with the resources of the VA."

[88] The OIG could not identify who captured or assigned the complaint in the Patient Advocacy Tracking System because it was not documented in the report.

However, the summary did not accurately reflect the location of where the medical emergency occurred.

The second email sent later that morning to the chief of Voluntary Services also included the Associate Director for Operations, the Associate Director of Patient Care Services, and the assistant chief of Social Work Services. The email requested that the chief of Voluntary Services contact the family member to "gather more information on the situation so that the facility can review for best course of action."[89] Further, the email indicated that executive leaders were included as recipients, "given the seriousness of this report." The email did include the original White House Hotline complaint as an attachment.

The chief of Voluntary Services responded to the social work supervisor's email the same day and included the Associate Director for Operations, the Associate Director of Patient Care Services, and the assistant chief of Social Work Services. The email stated that the chief of Voluntary Services called the family member and offered condolences. Further, the chief of Voluntary Services reported

> So far, there does not appear to be any delay in the 911 call, that I can see at this point. While an unknown male in a golf cart asked [the family member] to move [the] vehicle, three different times, the First Responders were already called by [the] hospitality employee . . . The delay seems to be on the part of the First Responders.

The social work supervisor resolved the White House Hotline complaint on June 6, 2023, and indicated no further steps were needed.

Use of feedback for quality improvement is built upon the foundation of the VA I CARE values.[90] At the facility, White House Hotline complaints are captured in the Patient Advocate Tracking System where VHA requires that before resolution and closure, all concerns included in the complaint must be addressed.[91] The OIG found the social worker supervisor who facilitated the White House Hotline complaint did not assign the appropriate service line to examine and respond to the complaint. This contributed to an incomplete evaluation of all aspects of the complaint.

[89] The email also described the chief of Voluntary Services as the supervisor to ACC information desk staff.

[90] VHA Directive 1003.04, *VHA Patient Advocacy,* February 7, 2018. This directive was in effect during the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023. The 2023 directive has the same or similar language as the 2018 directive related to feedback for quality improvement.

[91] VHA Directive 1003.04. This directive was in effect during the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023. The 2023 directive has the same or similar language as the 2018 directive related to complaint resolution.

The OIG learned through interviews that although the chief of Voluntary Services was the supervisor of the volunteer who asked the patient's family member to move the vehicle during the medical emergency, the chief of Voluntary Services did not supervise the hospitality staff and does not oversee clinical care. In an OIG interview, the chief of Voluntary Services recalled being surprised when asked to call the family member and stated, "I kind of got the smallest part on the planet when it comes to [the patient's medical emergency]," but "if you ask me to do something . . . of course I would." Further recollection of responding to the complaint included a call to the family member who expressed concerns about a delay in the patient's care. The chief of Voluntary Services told the OIG of reviewing video footage of the event and stated

> I think it was like 12 minutes, 12 to 13 minutes tops from the time the call was made and the ambulance arrived . . . which I think is pretty good considering the time of day and the traffic involved. So, I didn't see anything from my administrative eyes that showed a huge problem.

The OIG determined that neither the chief of Voluntary Services nor the social work supervisor spoke with the hospitality employee involved in the event. When asked why the complaint was not assigned to someone with knowledge about responding to medical emergencies, the social work supervisor stated, "[the chief of Voluntary Services] supervises the people who responded and were complained about."[92]

Given the family member's concerns of a delay in care and the possibility of a preventable death, the OIG would expect the social work supervisor to assign the complaint to a clinical service line with oversight of emergency medical responses. However, the social work supervisor assigned the complaint to a non-clinical service line. As a result, the clinical concerns within the complaint were not addressed as VHA requires.[93]

The social work supervisor also told the OIG of notifying executive leadership of the complaint as they have, "oversight over the entire facility to be able to offer suggestions." The OIG found that facility leaders who received the social work supervisor's correspondence did not identify the seriousness of the complaint, as highlighted within the email, and take further actions. The summary of the event sent to the Associate Director for Operations, Associate Director for Patient Care Services, and the assistant chief of Social Work Services failed to identify the proximity of the patient to the ACC entrance; however, an attachment to the email included this information.

[92] Of note, this reference is made towards a volunteer shuttle car driver who had asked the patient's family member to move their vehicle during the medical emergency.

[93] VHA Directive 1003.04. This directive was in effect during the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023. The 2023 directive has the same or similar language as the 2018 directive related to complaint resolution.

When the OIG asked about the Associate Director for Patient Care Services' role upon receipt of an email containing White House Hotline complaint details, the Associate Director for Patient Care Services stated not having a role. The assistant chief of Social Work Services also reported minimal involvement and of not being responsible for deciding who is assigned to a hotline complaint. The Associate Director for Operations reported receiving the email because of overseeing Voluntary Services and determined no further action was necessary since the chief of Voluntary Services' response was appropriate.

The OIG concluded mismanagement of the White House Hotline complaint contributed to key aspects of the concerns not being addressed. Further, facility leaders' response upon awareness of the patient's medical emergency was not aligned with HRO principles and I CARE values as no actions were taken to further investigate or communicate the concerns expressed in the complaint.

Inadequate Patient Safety Review

The JPSR system is VHA's primary reporting system that captures incident reporting. Patient safety reports in the JPSR system, "provide the foundation for investigating and analyzing root causes with contributing factors to take action to prevent future events."[94] When facilitating a patient safety report, patient safety managers must

- assign investigators who are subject matter experts,
- assess the level of harm associated with the event and assign a Safety Assessment Code (SAC) score,
- track events to ensure investigations are completed timely, and
- close the JPSR report within 14 days of the reported date or the report will be marked overdue.[95]

The investigation phase of the JPSR process is key to understanding the circumstances specific to an event and gives facility staff an opportunity to learn about process gaps that if addressed, may prevent a recurrence of the event. Additionally, medical center directors must ensure the patient safety report is investigated and closed within fourteen days of entry date.[96]

[94] VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022.

[95] VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. Investigators review the event assigned to them and are responsible for a "timely and accurate investigation." A SAC score is assigned to a patient safety event using a matrix that examines "both the severity and probability of harm. The matrix is used to generate a risk score of 1, 2, or 3 (1=Lowest Risk; 2=Intermediate Risk; 3=Highest Risk)." VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022. Patient safety managers are responsible for briefing facility leadership when there is a delay in investigations.

[96] VHA Directive 1050.01.

As a result of an OIG inquiry to the facility, a risk manager emailed the chief of quality, safety, and improvement, a quality and patient safety program manager, an accreditation manager, and a patient safety manager with details of the patient's medical emergency including the location of the event as the entrance of the ACC.[97] An email conversation continued between the recipients about VHA policy requiring the assessment and stabilization of individuals who present to a VA campus requesting medical assistance.[98]

Two weeks later, the patient safety manager emailed the chief of quality, safety, and improvement directly, inquiring if a patient safety report about the patient's medical emergency should be entered into the JPSR system. The chief of quality, safety, and improvement responded that (1) a report should be placed, (2) the VISN patient safety officer should also be asked if a patient safety report should be entered, and (3) placing a report in the JPSR system "helped to show that it passed through the appropriate channels."[99]

Five days after sending the email, the patient safety manager asked the chief of quality, safety, and improvement to have someone with more information about the event enter the patient safety report and indicated awareness of patient safety concerns related to "immediate acute care during the code event." The next day, the patient safety manager opened the report and assigned two non-clinical investigators. The investigator's review was entered 48 days later, and the patient safety manager closed the report the same day.

The OIG determined the patient safety manager did not manage the patient safety report per VHA guidance.[100] The patient safety manager failed to facilitate the investigation of key aspects of the patient's medical emergency and therefore did not perform an accurate harm assessment which may have triggered further actions. Additionally, the patient safety investigation and closure within the JPSR system was not completed within VHA's established time frame.[101]

Deficient Interpretation and Analysis of the Patient Safety Report

Patient safety managers must assign investigators to a patient safety report. The investigators, who are subject matter experts for the type of event that occurred, are responsible for an accurate review of the event.[102] Once an investigator's review is complete, VHA instructs patient safety

[97] The email included a previous email chain that the social work supervisor originally sent to the chief of Voluntary Services, the associate director for operations, the Associate Director of Patient Care Services, and the assistant chief of Social Work Services on June 1, 2023, alerting recipients of the White House Hotline complaint.

[98] VHA Directive 1101.14.

[99] The OIG confirmed the patient safety manager spoke with the VISN patient safety officer. The VISN patient safety officer also recommended entering a patient safety report.

[100] VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022.

[101] A patient safety report is considered overdue 14 days after the report is entered. More than 14 days may be taken if needed to ensure a "thorough and appropriate disposition of complex events." VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022.

[102] VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022.

managers to conduct a final review of the event. This includes assigning SAC scores that match the degree of harm that occurred based upon both the severity of the incident and the probability of it happening again. SAC scores determine if further actions such as an RCA are needed.[103] Further, death resulting from acts of omission are classified as catastrophic.[104] If the severity of an event is deemed catastrophic, the SAC score is calculated as a 3 regardless of the probability of recurrence and requires an RCA.[105]

The OIG learned that despite being informed of the delay in BLS and the location of the patient's medical emergency, the patient safety manager did not incorporate that information into the patient safety report. The OIG found the patient safety manager did not assign investigators with the expertise to examine clinical aspects of the patient's care immediately prior to and during the medical emergency. As a result, the urology appointment prior to the event, the actions of staff involved in the event, and the absence of alerting facility staff to provide BLS to the patient were not reviewed.[106] When asked about the management of the patient safety report, the patient safety manager told the OIG why the police chief and deputy chief were assigned as investigators, "my initial thought process was, did the police know about it. Did they [police] respond and what would have been their [the police] responsibilities to respond."

Although the patient safety manager received details of the patient's location during the medical emergency in the patient safety report event description, the patient safety manager told the OIG of being unaware. "I don't have an understanding other than it may have been in the parking garage. My level of review did not include an exact location of the veteran." The patient safety manager also told the OIG of awareness of video surveillance of the event; however, the patient safety manager did not review the recording.

The OIG also found the patient safety manager categorized the patient's medical emergency as a close call and did not score the SAC as a 3, (highest risk).[107] When asked why the patient's medical emergency was categorized as a close call, the patient safety manager stated, "I likely

[103] VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022; VHA National Center for Patient Safety, *Guidebook for Assessing Reported Adverse Events A resource for Safety Assessment Code(SAC) Evaluation Version 2*, June 2022. The patient safety manager must assign two separate SAC scores. The actual SAC score assesses harm related to "what really happened." The potential SAC score assesses harm related to "what may have happened or what could have happened."

[104] "Safety Assessment Code (SAC) Matrix," VHA National Center for Patient Safety, accessed January 25, 2024, Safety Assessment Code (SAC) Matrix - VHA National Center for Patient Safety (va.gov). An act of omission occurs when failure to do the right thing leads to an undesirable outcome. "Patient Safety Network," Agency for Healthcare Research and Quality, accessed January 24, 2024, https://psnet.ahrq.gov/taxonomy/term/3475.

[105] "Safety Assessment Code (SAC) Matrix"; VHA Directive 1050.01.

[106] The OIG learned that a clinical expert examined the patient's previous cardiology care.

[107] The patient safety manager scored the actual SAC as a 1 (lowest risk) and the potential SAC as 2 (significant risk). VHA Directive 1050.01.

should have coded that as an adverse event . . . so . . . that is likely miscoded." The patient safety manager further explained how the SAC score was determined.

> This particular event was difficult to quantify . . . So, the scoring of the SAC was more about the frequency of not responding appropriately in the parking lot, which we have not had that many events . . . The actual harm is a moderate, may have been an increased length of stay or increased level of care . . . I don't know that I was comfortable saying . . . the potential is a catastrophic outcome when we've not seen that in other events and 911 did respond.

When the patient's proximity to the ACC entrance was clarified for the patient safety manager in an OIG interview, the patient safety manager reported that awareness of the location may have changed the SAC score.

Although the OIG was unable to determine the specific cause of the patient's death, the delay in BLS may have been a contributing factor. As VHA requires death resulting from acts of omission to be classified as catastrophic, the patient safety manager should have assigned the patient safety report a SAC score of 3 and an RCA should have been chartered to determine whether system failures contributed to facility staff not being alerted to provide emergency interventions.[108] Additionally, the OIG determined that the patient safety manager's inaccurate harm assessment also contributed to a lack of further actions such as a look-back examining the absence of facility staff led emergency interventions, which may have resulted in a disclosure.[109]

The OIG concluded that, despite having awareness of the delay in BLS and the location of the patient's medical emergency, the patient safety manager did not identify or incorporate these key details into the JPSR investigation resulting in an inaccurate harm assessment. Adequate assessments of patient safety reports can provide patients and staff with assurance that the facility is aware of identified risks and is taking measures to ensure patient safety. The OIG is concerned that the patient safety manager's deficient interpretation and analysis of the patient safety report represents a missed opportunity to perform further quality management actions.

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[108] VHA Directive 1050.01; "Safety Assessment Code (SAC) Matrix," VHA National Center for Patient Safety, accessed January 25, 2024, Safety Assessment Code (SAC) Matrix - VHA National Center for Patient Safety (va.gov). The OIG discussed these concerns with the VISN Executive Director and the Facility Deputy Director on December 13, 2023; the Facility Director was out of the office and did not participate. The OIG learned the patient safety manager transitioned to another position at the facility in February 2024. On January 30, 2024, the Associate Director of Operations informed the OIG in an interview that the Facility Director chartered an RCA. The OIG obtained the RCA charter, which indicated that the RCA began on January 17th with a March 2, 2024, completion due date.

[109] The OIG learned an institutional disclosure was attempted but not completed on October 13, 2023, approximately five months after the event, but focused on the absence of a WCD order for the patient and did not include the delay in BLS.

In October 2023, the OIG made a recommendation to the Facility Director regarding compliance with management of patient safety reports in accordance with VHA policy; therefore, a recommendation regarding JPSR system report management is not made in this report.[110]

Deficient Investigation and Closure of the Patient Safety Report

The OIG determined the patient safety manager and the Facility Director failed to ensure the facilitation of a timely review of the patient safety report. The investigation and closure of the report took 48 days, exceeding VHA's established time frame.[111] When asked about the patient safety report not being finalized timely, the patient safety manager acknowledged awareness of the delay and stated facility patient safety reports often exceed VHA time frame.[112] The patient safety manager attributed the delay to the lack of staff responsible for patient safety report management. When asked about the delay in closing the patient safety report related to the patient's medical emergency, the Facility Director stated, "I don't know the exact reason."

As the purpose of the JPSR system is to identify root causes and contributing factors of patient safety events, timely investigations increase the likelihood of credible findings as staff are more likely to accurately recall the details of an event and to be available for consultation. The OIG is concerned that delays in investigation and closure of patient safety reports may result in recurrence of patient safety events that have been reported but not investigated.

Conclusion

The OIG substantiated the patient experienced a delay in receiving BLS. The OIG also identified deficiencies in the initiation of the patient's emergency medical care, the quality of the patient's care prior to the medical emergency, and completion of comprehensive quality reviews.

Approximately 11 minutes elapsed between facility staff placing a 911 call after learning of the patient's medical emergency outside of the ACC entrance and when the patient received BLS. Multiple factors including not initiating a rapid response, conflicting policies and procedures, absence of layperson CPR training, and access to an AED may have contributed to the delay. However, the OIG was unable to determine whether a change in care would have resulted in a different outcome for the patient.

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[110] VA OIG, *Deficiencies in Quality Management Processes and Delays in the Communication of Test Results and Follow-Up Care at the Phoenix VA Health Care System in Arizona,* Report No. 22-03599-07, October 31, 2023.

[111] VHA, *National Center for Patient Safety JPSR Guidebook*, December 2022. Although VHA guidance allows for more than 14 days to close a patient safety report if necessary to complete a thorough review and appropriate disposition on a complex event, the OIG found 48 days to be excessive for a report that lacked a thorough review and appropriate disposition.

[112] The OIG did not review the average time frame in which patient safety reports are investigated and closed at the facility, and only examined the patient safety report relevant to this inspection.

Deficiencies existed in the management of the patient's care prior to medical emergency. A cardiologist did not order a WCD for the patient despite documenting the treatment in the plan of care. Although cardiology providers confirmed that a WCD was no longer indicated, the discrepancy between the documented plan for a WCD and the absence of an order was not resolved in the EHR. Additionally, the assessment of the patient during a urology appointment prior to the medical emergency was incomplete as taking vital signs, a facility policy requirement, was not performed. The absence of vital signs may have contributed to a missed opportunity for early identification of the patient's clinical decline.

After the medical emergency, the hospitality employee and supervisor did not know how to enter a patient safety report and alert patient safety of their concerns; therefore, they informed their supervisors. Although immediate supervisors were notified, a patient safety report was not completed at the time, therefore a comprehensive review of the event to assess for associated harm was not performed. In addition, mismanagement of a White House Hotline complaint related to the patient's medical emergency resulted in key aspects of the concerns not being addressed. Facility leaders' response to the medical emergency upon awareness was not aligned with HRO principles and I CARE values as no actions were taken to further investigate or communicate the concerns expressed in the complaint.

Approximately two months after the patient's medical emergency, after the patient safety manager became aware of the event, the patient safety manager did not manage a patient safety report per VHA guidance. The patient safety manager failed to facilitate the investigation of key aspects of the patient's medical emergency resulting in an inaccurate harm assessment. An accurate harm assessment may have triggered further quality management actions. Additionally, the patient safety investigation and closure in the JPSR system was not completed within VHA's established time frame, which could result in recurrence of patient safety events that have been reported but not investigated.

Recommendations 1–10

1. The Phoenix VA Health Care System Director ensures Phoenix VA Health Care System rapid response policy is in alignment with Veterans Health Administration Directive 1177, *Cardiopulmonary Resuscitation*.

2. The Phoenix VA Health Care System Director ensures Phoenix VA Health Care System policies and procedures related to responding to medical emergencies do not conflict.

3. The Phoenix VA Health Care System Director ensures Phoenix VA Health Care System policy is in alignment with Veterans Health Administration Directive 1101.14, *Emergency Medicine*.

4. The Phoenix VA Health Care System Director ensures layperson cardiopulmonary resuscitation training is offered in accordance with Veterans Health Administration Directive 1177, *Cardiopulmonary Resuscitation*.

5. The Phoenix VA Health Care System Director determines the need for, and implements placement of, public access automated external defibrillators in accordance with Veterans Health Administration Directive 1177, *Cardiopulmonary Resuscitation*.

6. The Phoenix VA Health Care System Director assesses outpatient clinic compliance with vital sign completion and documentation, identifies deficiencies, and takes action as warranted.

7. The Phoenix VA Health Care System Director reviews and assesses the need for non-clinical staff training on the use of the Joint Patient Safety Reporting system, and takes action as warranted.

8. The Phoenix VA Health Care System Director ensures complaints are reviewed and addressed in accordance with Veterans Health Administration Directive 1003.04, *VHA Patient Advocacy*.

9. The Phoenix VA Health Care System Director reviews organizational communication channels and ensures consistency with Veterans Health Administration high reliability organization principles and I CARE values.

10. The Phoenix VA Health Care System Director makes certain that investigation and closure of events placed into the Joint Patient Safety Reporting system are completed per the Veterans Health Administration's established time frame, and monitors compliance.

Appendix A: Facility Parking Map

Figure A.1. *Facility parking map showing parking lot and parking garage locations.*
Source: Copy of Facility Parking Map provided to OIG on October 10, 2023.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 9, 2024

From: Network Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

To: Director, Office of Healthcare Inspections (54HL06)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (Phoenix VA Health Care System).

2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of Phoenix VA Health Care System.

3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(*Original signed by*:)

Steven E. Braverman, MD
VISN 22 Network Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 9, 2024

From: Director, Phoenix VA Health Care System - Carl T. Hayden (644)

Subj: Healthcare Inspection—Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

To: Network Director, Desert Pacific Healthcare Network (10N22)

1. I have reviewed and concurred with the Office of the Inspector General Report (OIG), Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona.

2. I would like to thank the OIG for their thorough review of this case and recommendations on process improvements. Phoenix VA Health Care System appreciates the opportunity to partner with the OIG on our high reliability journey. We remain steadfast in our commitment to zero harm.

3. If you have additional questions or need further information, please contact the Chief of Quality, Patient and Safety.

(*Original signed by*:)

Bryan C. Matthews, MBA
Medical Center Director

Facility Director Response

Recommendation 1

The Phoenix VA Health Care System Director ensures Phoenix VA Health Care System rapid response policy is in alignment with Veterans Health Administration Directive 1177, *Cardiopulmonary Resuscitation*.

_X _Concur

____Nonconcur

Target date for completion: November 30, 2024

Director Comments

On May 3, 2024, an interdisciplinary meeting was held with participants including Clinical Education, Emergency Department clinical leadership, Medicine leadership, Nursing leadership, and Patient Safety, Quality, and Risk Management. This meeting provided an overview of the Office of Inspector General's recommendations and began the review of the Phoenix VA Health Care System (PVAHCS) Policy Memorandum No. 11-101, Rapid Response Team's (RRT) alignment with VHA Directive 1177, Cardiopulmonary Resuscitation.

The Cardiopulmonary Resuscitation Committee (CRC) has oversight for the review to ensure that the RRT's response to medical emergencies occurring outside the hospital on the main campus is fully aligned with these guidelines.

Upon completion of the policy review and revisions, the CRC will present the updated policies to nursing services, clinical education, and at the Clinical Executive Board (CEB).

To ensure ongoing policy compliance, each RRT will be analyzed by the PVAHCS Resuscitation Education Initiative (REdI) Program Coordinator in conjunction with PVAHCS Quality and Patient Safety staff. Compliance will be reported at the monthly CRC meeting.

The CRC Chairperson will present the CRC meeting minutes, which will include the compliance monitoring results, at the monthly CEB meeting. The CEB meeting minutes will be presented to the monthly Governing Council, chaired by the Medical Center Director. If the monitoring results indicate the need for additional assessment or corrective action, the CRC will coordinate these efforts.

Recommendation 2

The Phoenix VA Health Care System Director ensures Phoenix VA Health Care System policies and procedures related to responding to medical emergencies do not conflict.

_X _Concur

____Nonconcur

Target date for completion: November 30, 2024

Director Comments

On May 3, 2024, an interdisciplinary meeting was held, including Clinical Education, Emergency Department clinical leadership, Medicine leadership, Nursing leadership, and Patient Safety, Quality, and Risk Management. At this meeting, the Phoenix VA Health Care System (PVAHCS) Policy Memorandum No. 11-101, Rapid Response Team (RRT), and the PVAHCS Cardiopulmonary Resuscitation-Policy 11-106 were reviewed to ensure policies and procedures do not conflict.

PVAHCS Service Line Memorandum No. A3, Nutrition, Hospitality, and Food Service Specific Emergency Preparedness Plan-January 1, 2021, and the Facility Standard Operating Procedure (SOP) - Communication Center Switchboard RFMS/136E Telephone Operator SOP, updated 2021, will require a thorough review for congruency in responding to and communicating medical emergencies.

Upon completion of the policy reviews and revisions, the Cardiopulmonary Resuscitation Committee (CRC) will present the revised policies at the Clinical Executive Board (CEB) and the CRC meeting. Policy revisions will also be communicated by email to service chiefs, nursing leadership, and supervisors.

To ensure ongoing policy compliance, real code events and rapid response calls will be analyzed by the PVAHCS Resuscitation Education Initiative (REdI) Program Coordinator in conjunction with PVAHCS Quality and Patient Safety staff. Compliance will be reported at the monthly CRC meeting.

The CRC Chairperson will present the CRC meeting minutes, which will include the compliance monitoring results, at the monthly CEB meeting. The CEB meeting minutes will be presented to the monthly Governing Council, chaired by the Medical Center Director. If the monitoring results indicate the need for additional assessment or corrective action, the CRC will coordinate these efforts.

Recommendation 3

The Phoenix VA Health Care System Director ensures Phoenix VA Health Care System policy is in alignment with Veterans Health Administration Directive 1101.14, *Emergency Medicine*.

_X _Concur

____Nonconcur

Target date for completion: November 30, 2024

Director Comments

The Phoenix VA Health Care System (PVAHCS) Emergency Department (ED) Rapid Response Policy 11-101 will be reviewed to ensure alignment with VHA Directive 1101.14, Emergency Medicine.

Upon completion of the policy review and making the necessary revisions, the Cardiopulmonary Resuscitation Committee (CRC) will present the revised Rapid Response Policy 11-101 at the Clinical Executive Board (CEB). Subsequently, these revisions will be presented to the Governing Council chaired by the Medical Center Director.

To ensure continued policy compliance, monitoring of medical emergencies outside of the PVAHCS ED will be reviewed by the PVAHCS ED medical director in conjunction with PVAHCS Quality and Patient Safety staff.

The PVAHCS ED medical director will report compliance at the monthly CEB meeting. The CEB meeting minutes will be presented to the monthly Governing Council, chaired by the Medical Center Director. If the monitoring results indicate the need for additional assessment or corrective action, the CRC will coordinate these efforts.

Recommendation 4

The Phoenix VA Health Care System Director ensures layperson cardiopulmonary resuscitation training is offered in accordance with Veterans Health Administration Directive 1177, *Cardiopulmonary Resuscitation*.

_X__Concur

____Nonconcur

Target date for completion: November 30, 2024

Director Comments

The PVAHCS Cardiopulmonary Resuscitation Committee (CRC) will convene to review and conduct an assessment to identify locations and associated lay personnel (non-clinical), who would be appropriate to receive the American Heart Association-approved Resuscitation Quality Improvement (RQI) training. This training is designed to provide guidance for lay personnel on how to respond if a medical emergency occurs in their respective area(s).

The CRC will present the risk assessment recommendations to Clinical Education Services, which will identify appropriate lay personnel.

The training will be assigned to the appropriate lay personnel and tracked through the Talent Management System. Training compliance will be reported to the CRC by the Phoenix VA Health Care System (PVAHCS) Resuscitation Education Initiative (REdI) Program Coordinator.

The CRC Chairperson will present the CRC meeting minutes at the monthly CEB meeting. The CEB meeting minutes will be presented to the monthly Governing Council, chaired by the Medical Center Director. If the monitoring results indicate the need for additional assessment or corrective action, the CRC will coordinate these efforts.

Recommendation 5

The Phoenix VA Health Care System Director determines the need for, and implements placement of, public access automated external defibrillators in accordance with Veterans Health Administration Directive 1177, *Cardiopulmonary Resuscitation*.

_X _Concur

____Nonconcur

Target date for completion: January 17, 2024

Director Comments

The Phoenix VA Health Care System's (PVAHCS) Automated External Defibrillator (AED) placement has occurred with the addition of new PVAHCS locations.

The two main public accessible areas of the hospital are the Ambulatory Care Clinic (ACC) lobby and the Canteen. On January 17, 2024, an AED was installed in the ACC near the main entrance and information desk.

On March 14, 2024, at the Cardiopulmonary Resuscitation Committee (CRC) meeting, a follow-up discussion took place regarding the need for further AED placement.

The CRC will initiate proper coordination with the bio-medical services when new locations are added for appropriate placement/installation of AEDs.

To ensure compliance, a monthly review of the facility's AEDs and their locations will occur at the CRC meeting.

The CRC Chairperson will present the CRC meeting minutes at the monthly CEB meeting. The CEB meeting minutes will be presented to the monthly Governing Council, chaired by the Medical Center Director. If the monitoring results indicate the need for additional assessment or corrective action, the CRC will coordinate these efforts.

The Phoenix VA Health Care System requests closure of this recommendation.

OIG Comments

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

Recommendation 6

The Phoenix VA Health Care System Director assesses outpatient clinic compliance with vital sign completion and documentation, identifies deficiencies, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: November 30, 2024

Director Comments

On July 12, 2023, the Phoenix VA Health Care System (PVAHCS) Surgical Specialty clinics identified a need for vital signs stations. On October 16, 2023, vital signs stations were established. At these stations, vital signs are obtained and documented prior to the exam room visit with the provider.

To ensure continued compliance, PVAHCS Quality and Patient Safety staff will review a statistically valid sampling of Surgical Specialty clinics' patient medical records, per month, to ensure vital signs are obtained and documented prior to the exam room visit with the provider.

The Chief Nurse for Surgical Specialties clinics will provide a monthly compliance update to the Clinical Executive Board (CEB). The CEB meeting minutes will be presented to the monthly Governing Council, chaired by the Medical Center Director. If

the monitoring results indicate the need for additional assessment or corrective action, the CEB will coordinate these efforts.

Recommendation 7

The Phoenix VA Health Care System Director reviews and assesses the need for non-clinical staff training on the use of the Joint Patient Safety Reporting system, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: November 30, 2024

Director Comments

The Phoenix VA Health Care System (PVAHCS) ensures that the Patient Safety Professionals provide education at each PVAHCS New Employee Orientation (NEO) session. The orientation includes all staff, both clinical and non-clinical.

PVAHCS will provide non-clinical staff training on the Talent Management System Joint Patient Safety Reporting 131008317 (Joint Patient Safety Report System (JPSR) - Entering a Patient Safety Event).

Monthly training compliance on the use of JPSR will be reported to the monthly Quality and Patient Safety Board (QPSB) meeting by the Patient Safety Professionals.

QPSB meeting minutes are presented to the monthly Governing Council which is chaired by the Medical Center Director. If the monitoring results indicate the need for additional assessment or corrective action, the Patient Safety Professionals, in conjunction with the QPSB will coordinate these efforts.

Recommendation 8

The Phoenix VA Health Care System Director ensures complaints are reviewed and addressed in accordance with Veterans Health Administration Directive 1003.04, *VHA Patient Advocacy*.

_X _Concur

____Nonconcur

Target date for completion: September 30, 2024

Director Comments

In accordance with VHA Directive 1003.04, VHA Patient Advocacy, the Phoenix VA Health Care System (PVAHCS) will ensure Veteran complaints are received and documented in the Patient Advocate Tracking System Replacement (PATS-R) within designated timeframes outlined. The complaints are then assigned to the appropriate respective service lines to be addressed within the designated timeframe, as established by the Office of Patient Advocacy (OPA).

The resolutions received from the involved service line(s) are reviewed for accuracy by PVAHCS Patient Advocates to ensure they thoroughly address the concern(s) in accordance with Veteran Centered Complaint Resolution standards and are closed within the required timeframe.

PVAHCS will continue ensuring that Veteran complaints are properly documented, assigned, reviewed, and addressed according to the procedures outlined in VHA Directive 1003.04. The National PATS Leadership Report is accessed to indicate compliance with the process and outlier cases are reviewed for process improvement and appropriate follow-up is completed. The National PATS Leadership dashboard outlines the top five codes for review and the average number of days to close the PATS-R.

Quarterly reporting on complaint metrics and trends will be provided to the PVAHCS Patient Services Executive Board to support ongoing monitoring and opportunities for improvement.

Recommendation 9

The Phoenix VA Health Care System Director reviews organizational communication channels and ensures consistency with Veterans Health Administration high reliability organization principles and I CARE values.

_X _Concur

____Nonconcur

Target date for completion: November 30, 2024

Director Comments

The Phoenix VA Health Care System (PVAHCS) Medical Center Director ensures organizational communication is consistent with Veterans Health Administration high reliability organization (HRO) principles and I CARE values.

Bidirectional communication occurs through implementation of the tiered Daily Management System (DMS) huddles, all staff meetings, leader rounding and leadership roundtables. DMS huddles were implemented in July 2021. Information is escalated through each huddle, culminating in a daily Enterprise Huddle led by the Executive Leadership Team (ELT), which includes attendance by facility-wide Service Chiefs and Supervisors.

The HRO Lead works closely with all levels of leadership and front-line staff to further infuse HRO principles into the culture and enhance the facility's journey to high reliability. The HRO Lead meets with the ELT on a quarterly basis to review organizational communication channels and ensure consistency with VHA HRO principles and ICARE values. This is accomplished by reviewing the current state of training, leader rounding data, discussing HRO maturity matrix, and making organizational changes accordingly.

PVAHCS progression toward high reliability and promoting a safety culture is evident in the Annual All Employee Survey (AES) Patient Safety Culture Dimensions results, with a steady increase in each dimension for the last three years.

In December 2023, PVAHCS revitalized the leader rounding process to further encourage bidirectional communication, duty to speak up and reinforce Just Culture. During rounding, executive, senior and mid-level leaders ask questions that promote psychological safety including review of potential barriers and risks along with review of process improvement opportunities. Results from rounding are documented as well as tracked on a facility dashboard. These results are shared at tiered huddles and monthly leadership meetings to ensure closed loop communication.

HRO principles and training are first presented to all new staff during New Employee Orientation. Additionally, all staff are required to complete VA Core Values Training (ICARE) during employee orientation and complete a recommitment annually.

The VA Core Values Training (ICARE) annual recommitment will be monitored monthly for ongoing sustained compliance.

The HRO Lead will present compliance information to the monthly PVAHCS Organizational Health Committee (OHC). The PVAHCS OHC Chairperson provides a quarterly report to the Quality and Patient Safety Board (QPSB). The QPSB meeting minutes are presented to the Governing Council chaired by the Medical Center Director.

Recommendation 10

The Phoenix VA Health Care System Director makes certain that investigation and closure of events placed into the Joint Patient Safety Reporting system are completed per the Veterans Health Administration's established time frame, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: September 30, 2024

Director Comments

The Phoenix VA Health Care System (PVAHCS) Patient Safety Professionals ensure an initial Joint Patient Safety Reporting (JPSR) review within 24-72 hours of the occurrence, allowing for weekends and holidays. The Patient Safety Program Manager attended the May 2024 National Center for Patient Safety Educational Summit, which focused on maintaining a culture of patient safety including the investigatory and closure process for JPSR events.

Reporting of JPSR events will continue at the Daily Management Systems Tier 4 huddles for facility-wide awareness.

The PVAHCS Patient Safety Professionals will investigate and close Joint Patient Safety Report (JPSR) system investigations within 14 days as per VHA Directive 1050.01, VHA Quality and Patient Safety Programs.

The monthly investigation and closure compliance will be reported to the monthly Quality and Patient Safety Board (QPSB) meeting by the Patient Safety Professionals.

QPSB meeting minutes are presented to the monthly Governing Council which is chaired by the Medical Center Director.

OIG Contact and Staff Acknowledgments

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