Department of Veterans Affairs
Office of Inspector General

Report No. 14-00271-265

Healthcare Inspection

Emergency Department Staffing and Patient Safety Issues
VA San Diego Healthcare System
San Diego, California

September 3, 2014

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations concerning critically low registered nurse (RN) staffing levels and patient safety issues in the Emergency Department (ED) at the VA San Diego Healthcare System (system), San Diego, CA. We reviewed the following allegations: (1) there are usually three RNs after midnight, and if one RN does not come to work, RN staffing is at a dangerous level; (2) the system has no emergency plan or policy in place that addresses critically low RN staffing levels; (3) RNs who float to the ED are not oriented to the floor and will not take a patient assignment; (4) numerous Patient Event Reports (PERs) have been submitted regarding critically low RN staffing levels on the night shift, but no action has been taken; and (5) two ED patients waited over 9 hours for emergency care.

We substantiated that three RNs were on shift after midnight; however, we found that the ED nursing plan was modified in June 2013 to include an additional full-time RN on the midnight shift to cover for RN call-ins (such as for sick leave). We also found that the system utilized RNs from the system's critical care units and contracted float-pool RNs and authorized overtime to augment RN staffing in times of high patient acuity and low RN staffing.

We substantiated the allegation that the system did not have an emergency plan or policy that addressed low RN staffing levels in the ED. However, the Veterans Health Administration does not require a system policy that specifically addresses low RN staffing levels in the ED, but does require that facilities have a plan for additional RNs, providers, and support staff in times of acute overload or disaster. We found that the system had a written staffing plan for the ED designating RN staffing requirements; however, the system did not have a plan for additional RNs, providers, and support staff in times of acute patient overload or disaster.

Although we did not substantiate that RNs who floated to the ED were not oriented to the ED, we did find that some RNs reported inadequate orientation at the time of the float. We found that the system had two processes for orienting RN floats to the ED. Because the ED clinical nurse specialist did not always provide the required orientation to all RNs who floated to the ED, the ED RN provided "just-in-time" orientation or a reorientation at the time the RN floated. We determined that the "just-in-time" orientation was not always adequate to prepare the RN float; therefore, some RNs refused to accept patient assignments due to lack of familiarity with the ED environment.

We did not substantiate that numerous PERs were submitted regarding critically low RN staffing levels on the night shift but no action had been taken. We found that during FY 2013, six PERs were submitted related to short RN staffing in the ED. We also found that all PERS were reviewed and that appropriate follow-up actions were taken.

We partially substantiated the allegation that two patients waited over 9 hours for emergency care. While we confirmed that the patients waited for care, we concluded

that the ED staff completed intake assessments within a reasonable time period based on the patients' medical conditions. We also concluded that both patients were stable and could safely wait to be seen by an ED provider for further evaluation and treatment.

We recommended that the System Director implement a policy that includes an ED augmentation plan for additional RNs, providers, and support staff in times of acute overload or disaster and review orientation processes for RNs floating to the ED to ensure that the orientation provided is adequate and documented consistently.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–12 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a confidential complainant regarding critically low registered nurse (RN) staffing levels and patient safety issues in the Emergency Department (ED) at the VA San Diego Healthcare System (system), San Diego, CA.

Background

The system is part of Veterans Integrated Service Network (VISN) 22 and serves veterans in the San Diego and Imperial Valley counties. The system has 304 authorized beds and provides medical, surgical, mental health, geriatric, spinal cord injury, and advanced rehabilitation services.

The system's ED is undergoing a three-phase remodeling project and currently operates 18 patient rooms, 3 intake bays (triage space for a brief initial assessment), and 4 Same Day Clinic spaces. When the remodel is complete, the ED will have 20 patient rooms, 3 intake bays, and 2 Same Day Clinic spaces. Currently, 33.7 full-time employee (FTE) registered nurses (RNs) staff the ED. The system's ED treats between 28,000 and 32,000 patients annually.

In May 2013, the OIG's Hotline Division received allegations concerning critically low RN staffing levels and patient safety in the ED. In November 2013, the OIG received an additional allegation concerning ED patient wait times. Specifically, the allegations stated that:

- There are usually three RNs after midnight, and if one RN does not come to work, staffing is at a dangerous level.

- The system has no emergency plan or policy in place that addresses critically low RN staffing levels.

- RNs who float[1] to the ED are not oriented to the floor and will not take a patient assignment.

- Numerous Patient Event Reports (PERs)[2] have been submitted regarding the critically low RN staffing levels on nights, but no action has been taken.

- Two ED patients waited over 9 hours for emergency care.

---

[1] An RN who "floats" is a nurse who is temporarily assigned from one nursing unit to another based upon patient census and acuity.

[2] PERs are electronic patient incident reports of actual events or near misses. Any staff can enter an electronic PER, which allows anonymous reporting to the Patient Safety Manager who is responsible for follow up.

Scope and Methodology

We conducted a site visit October 30–31, 2013, and interviewed system and nurse leaders and 10 ED RN staff. We reviewed data from ED Integrated Software (EDIS),[3] PERs, and Veterans Health Administration (VHA) Support Service Center (VSSC), and Patient Advocate Reports for fiscal year (FY) 2013. We also reviewed the ED 24-hour staffing assignment sheets for 4th quarter FY 2013, Patient Intake Reports[4] and electronic health records of select patients treated in the system's ED during the 3rd and 4th quarters of FY 2013. In addition, we reviewed VHA Quality Metrics, California Nurses Association and The Joint Commission (TJC) standards, VHA and local policies, and other relevant documents. We toured the system's ED and interviewed ED clinical and administrative staff knowledgeable about the ED's internal processes.

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

---

[3] EDIS assists staff in tracking and managing the flow of patients in the ED.
[4] The Patient Intake Report captures the number of patients who are triaged hourly during each shift in the ED.

Inspection Results

Issue 1: ED RN Staffing Levels

We substantiated the allegation that the ED was usually staffed with three RNs after midnight, and if one RN did not come to work, staffing was low.

The system's ED staffing plan states RN staffing is based on the number of patient rooms in the ED and patient acuity[5] and is consistent with the California Nursing Association standards requiring a 1:4 RN-to-patient ratio for safe patient care. Nurse leaders told us that the ED was staffed for 18 beds from 7:00 a.m. to 7:30 p.m. but that after 7:30 pm, the system decreased the number of operating ED beds from 18 to 12. Staffing was adjusted for the midnight shift accordingly. During the course of the review we found that before June 2013, the system's ED staffing plan required three full-time RNs on the midnight to 7:00 a.m. shift (midnight shift). In June 2013, the staffing plan was revised to include an additional RN FTE on the midnight shift to cover for RN call-ins.

We reviewed the June–August 2013 24-hour staffing assignment sheets and determined that after implementation of the new ED staffing plan in June, four RNs were present on each midnight shift with the exception of 3 nights in July 2013 when three RNs were present for duty.

In order to augment RN staffing in times of high patient acuity and low RN staffing, nurse leaders reported that they utilized RNs from the intensive care unit (ICU) and direct observation unit (DOU),[6] contracted float pool RNs, or approved overtime. We validated this during our review of the 24-hour staffing assignment sheets. Additionally, RNs we interviewed who worked the midnight shift reported no significant concerns with RN staffing since the assignment of the additional RN FTE.

Issue 2: ED Staffing Policy

We substantiated the allegation that the system did not have an emergency plan or policy in place that addressed low RN staffing levels.

VHA requires that facilities have a written policy designating the appropriate numbers of staff (RN and provider) to provide timely care to patients presenting to the ED.[7] VHA does not require a system policy that specifically addresses low RN staffing levels in the ED; however, VHA does require that facilities have a plan for additional RNs, providers, and support staff in times of acute overload or disaster.[8] We found that the system had

---

[5] Patient acuity is the level of severity of illness. Acuity level is one of the parameters considered in patient classification systems that are designed to serve as guidelines for allocation of nursing staff.

[6] The Direct Observation Unit is a step-down unit providing a level of care between that of an ICU and an in-patient unit.

[7] VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.

[8] VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.

a written staffing plan for the ED designating RN staffing requirements. However, the system did not have a plan for additional RNs, providers, and support staff in times of acute patient overload or disaster. Nurse leaders provided us with a draft plan, which included triggers that would activate a surge staffing plan in times of acute overload. Nurse leaders reported that ED personnel were piloting the plan, and a policy would be developed based upon the outcome of the pilot.

Issue 3: ED Orientation for RN Floats

Although we did not substantiate that RNs who floated to the ED were not oriented to the unit, some RNs reported inadequate orientation at the time of the float and having refused to take a patient assignment.

TJC requires that staff receive orientation on relevant hospital-wide and unit-specific policies and procedures and that staff participate in ongoing education and training whenever staff responsibilities change.[9] TJC also requires documentation of staff participation in orientation and ongoing education and training.[10] We found that the ED clinical nurse specialist was responsible for providing ED orientation to all ICU and DOU staff RNs. Nurse leaders told us that the orientation was approximately 1 hour and that not all RNs received the orientation prior to floating. We reviewed the "Orientation for Nurses Floating to the ED" checklist and found that the orientation included: (1) emergency procedures, (2) familiarization with the physical environment, (3) documentation requirements pertaining to medication administration and order verification, (4) care note discharge instructions procedures, and (5) tasks that RN floats were not to perform.

The ED RNs working 3:30 p.m. to 7:00 a.m. reported that they were responsible for providing "just-in-time" orientation to RN floats who had not received an orientation or who needed reorientation. It was the consensus of the RNs we interviewed that "just-in-time" orientation could be cursory due to patient care demands and might not adequately prepare an RN float to perform all required tasks in the ED, especially documenting in the electronic health record. All RNs reported awareness of the orientation checklist; however, the checklist was not always completed. In addition, we were told that RN floats had, at times, refused to accept patient assignments due to their lack of familiarity with the ED environment.

Issue 4: ED Patient Safety

We did not substantiate the allegation that numerous PERs had been submitted regarding critically low RN staffing levels on nights but no action had been taken.

During FY 2013, 128 PERs pertaining to issues in the ED were submitted. Six (5 percent) pertained to low RN staffing levels; although, none of the PERs identified negative patient outcomes. In addition, the patient safety manager reviewed and appropriately followed up on all six PERs.

---

[9] TJC, *Comprehensive Accreditation Manual for Hospitals*, July 2013.
[10] ibid.

Issue 5: ED Wait Times

We partially substantiated the allegation that two patients waited over 9 hours for emergency care. Although we found that the patients waited, we determined that the ED staff completed the intake assessments[11] within a reasonable time period based on the patients' medical conditions.

VHA policy requires the use of the Emergency Severity Index (ESI) as the triage tool in the ED.[12] At the system, the ED RN (triage nurse) performs an initial assessment referred to as a "spot triage" and assigns patients an ESI level based on patient acuity and resources needed. The ESI clinically stratifies patients into five groups, from Level 1 (most urgent) to Level 5 (least urgent). While ESI levels quantify urgency, they do not mandate specific time requirements for evaluation. However, ESI Level 1 patients require immediate physician involvement upon arrival in the ED. ESI Level 2 patients should be taken to a treatment area within 10 minutes of arrival in the ED, and the ED provider notified. ESI Level 3–5 patients are less acute and are triaged based on acuity and the number of resources needed for the ED provider to reach a disposition.[13]

We reviewed the electronic health records of two patients who the complainant identified.

Patient 1. This patient presented to the ED with a complaint of bilateral arm numbness and dizziness from a spider bite. The patient was "spot triaged" in the early afternoon. The ED RN performed the intake assessment within 10 minutes of the "spot triage" with the ED physician present for the evaluation. The ED RN documented the patient's ESI Level 2 on the intake assessment note. Approximately 4 hours later, the ED RN reassessed the patient again. Eight hours after the reassessment, the ED RN documented that the patient was not in the waiting room and left without being seen.

After leaving the system, the patient was seen at a community hospital and diagnosed with hyperventilation syndrome. The community hospital physician recommended a medication used to treat anxiety which the patient preferred to have filled at the system. A staff physician provided this prescription and also discussed the patient's recent symptoms and history with the patient's psychologist after obtaining the patient's consent.

Patient 2. This patient presented to the ED with a complaint of left lower leg swelling. The patient was "spot triaged" in the early afternoon and assigned an ESI Level 3. The ED RN performed the intake assessment approximately 2 hours later and the RN reassessed the patient 2 hours after the initial assessment. From our review of the progress notes, the patient had pain for over a year since the veins were harvested from the left leg for an open heart surgery. The ED physician documented that the patient

---

[11] Intake assessment is a comprehensive assessment which includes vital signs, subjective and objective information, past medical history, allergies and medications.
[12] VHA Handbook 1101.05
[13] Emergency Severity Index, Version 4: Implementation Handbook. AHRQ Publication No. 05-0046-2. Rockville, MD: Agency for Healthcare Research and Quality, May 2005.

reported having more pain in the left lower extremity due to temporarily discontinuing gabapentin[14] and that the pain was much improved since resuming the medication. The ED provider discharged the patient approximately 8 hours after the "spot triage."

Conclusions

We substantiated the allegation that three RNs were usually on duty after midnight; however, we found that the ED staffing plan was modified in June 2013 to include an additional RN FTE on the midnight shift to cover for RN call-ins. We also found that the system utilized RNs from the ICU and DOU, contracted float pool RNs, and authorized overtime to augment staffing in times of high patient acuity and low RN staffing.

We substantiated the allegation that the system did not have an emergency plan or policy that addressed low RN staffing levels in the ED. However, VHA does not require a system policy that specifically addresses low RN staffing levels in the ED. VHA does require that facilities have a plan for additional RNs, providers, and support staff in times of acute overload or disaster.[15] We found that the system had a written staffing plan for the ED designating RN staffing requirements; however, the system did not have a plan for additional RNs, providers, and support staff in times of acute patient overload or disaster.

While we did not substantiate that RNs who floated to the ED were not oriented to the floor, some RNs reported having inadequate orientation at the time of the float and had, therefore, refused to take a patient assignment. We found that the ED clinical nurse specialist did not provide the orientation required to all ICU and DOU staff RNs who floated to the ED; instead the ED RNs had to provide "just-in-time" orientation or reorientation at the time an RN floated. We also found that the "just-in-time" orientation was brief and was not always adequate to prepare the RN float.

We did not substantiate the allegation that numerous PERs had been submitted regarding the low RN staffing levels on the midnight shift and no action had been taken. We found that during FY 2013, six PERs were submitted related to short RN staffing in the ED; all PERs were reviewed, and appropriate follow-up actions were taken.

We partially substantiated the allegation that two patients waited over 9 hours for emergency care. While we confirmed that the patients waited for care, we concluded that the ED staff completed intake assessments within a reasonable time period based on the patient's medical condition. We also concluded that both patients were stable and could safely wait to be seen by the ED provider for further evaluation and treatment.

---

[14] Gabapentin is a medication used for the treatment of neuropathic pain.
[15] VHA Handbook 1101.05.

Recommendations

1. We recommended that the System Director implement a policy that includes a plan for additional registered nurses, providers, and support staff to augment the Emergency Department in times of acute overload or disaster.

2. We recommended that the System Director review the orientation processes for registered nurses floating to the Emergency Department to ensure that the orientation provided is adequate and documented consistently.

Acting VISN Director Comments

**Department of
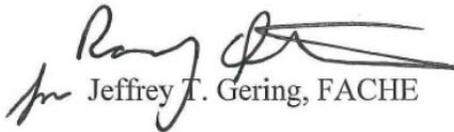Veterans Affairs**   **Memorandum**

Date: August 5, 2014

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

**Subject: Draft Report — Healthcare Inspection – Emergency Department
Staffing and Patient Safety Issues, VA San Diego Healthcare
System, San Diego, California**

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

1. I concur with the findings and recommendations for numbers 1 and 2 in
   the report: Healthcare Inspection - Emergency Department Staffing and
   Patient Safety Issues, VA San Diego Healthcare System, San Diego,
   California.

2. If you have any questions regarding our responses and actions to the
   recommendations in the draft report, please contact me at
   (562) 826-5963.

Jeffrey T. Gering, FACHE

Attachment

Acting System Director Comments

**Department of
Veterans Affairs**   **Memorandum**

Date: August 4, 2014

From: Acting Director, VA San Diego Healthcare System (664/00)

**Subject: Draft Report — Healthcare Inspection – Emergency Department
Staffing and Patient Safety Issues, VA San Diego Healthcare
System, San Diego, California**

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

1. The attached is VA San Diego Healthcare Systems' response to the
Healthcare Inspection - Emergency Department Staffing and Patient
Safety Issues.

2. Should additional review and information be requested, please contact
Dr. Sandra Solem, Associate Director, Patient Care Services/Nurse
Executive, VA San Diego Healthcare System at (858) 642-3839, or at
email address Sandra.Solem@va.gov.

FOR AND IN
THE
ABSENCE OF

Cynthia Abair, MHA

Attachment

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the System Director implement a policy that includes a plan for additional registered nurses, providers, and support staff to augment the Emergency Department in times of acute overload or disaster.

Concur

Target date for completion: December 31, 2014

System response: The following actions have been taken since June 2013 to address staffing in periods of ED surge:

- Changes were negotiated in the contract for float pool RNs to expand recruitment to include emergency nurses specifically for the ED.

- Two ICU RNs were trained specifically in emergency nursing and oriented in the unit for a three month period of time. During periods of surge, these RNs assist in the ED.

- The Emergency Department Nurse Staffing Methodology was developed nationally with planned national distribution during the fall 2014. The VASDHS [VA San Diego Healthcare System] nursing leadership requested access to the tool in February 2014. In April 2014 the VASDHS ED Unit-based Expert Panel was established. The expert panel received training from the national developers and completed required TMS [Talent Management System] training. The expert panel developed the local methodology during May and June 2014.

- A small work group of ED RN volunteers was established to work with nursing leadership to create an on-call proposal for ED RNs. The proposal has been completed and is routing for final approval.

- The ED is currently piloting an Electronic Surge Tracker based on the National Emergency Department Overcrowding Scale (NEDOCS) which is a widely used model nationally to identify ED overcrowding before surge capacity is reached. The model uses validated formulas based on variables that contribute to overcrowding in Emergency Departments. The ED charge nurse inputs variables into the calculator every two hours and a surge level is determined. There are five levels ranging from normal to surge capacity. Once the tool is validated locally, standard operating procedures will direct staff to initiate measures at levels "very busy", "surge alarm", and "over surge capacity" to effectively manage

ED overcrowding and surge. One of the measures will include activating the ED on-call RN.

Action Plan:

- The ED RN on-call proposal will be approved by nursing leadership August 2014 and presented to ELT [Executive Leadership Team] September 2014.

- The ED RN on-call proposal will be piloted beginning November 2014. A schedule for RN on-call will be posted with an SOP [Standard Operating Procedure] on activating the on-call RN.

- The ED expert panel is scheduled to present to the system expert based panel August 28, 2014.

- Presentation of the preliminary results of the ED Surge Tracker pilot is scheduled to be reported to the Inpatient Care Council August 12, 2014.

- Develop organizational standard operating procedures for surge tracker levels indicating ED overcrowding/surge and required actions with expected completion July 2015.

- Educate ED and Inpatient interdisciplinary staff on the Electronic Surge Tracker and associated SOPs during August 2015.

- Number of surge events and response will be monitored weekly for compliance and reported to Inpatient Care Council monthly.

Recommendation 2. We recommended that the System Director review the orientation processes for registered nurses floating to the Emergency Department to ensure that the orientation provided is adequate and documented consistently.

Concur

Target date for completion: December 31, 2014

System response: Several actions are in progress to manage orientation of RN floating in the inpatient areas and ED:

- Nursing leadership solicited volunteers from the critical care nursing staff to cross train in the ED. Two RNs have completed cross-training July 2013 and assist the ED CNS [Clinical Nurse Specialist] in orienting nurses from critical care areas.

- A float orientation checklist is used on off-tours to orient RNs floating to the ED. When necessary over-time is approved so that dedicated time is spent to adequately orient float RNs.

- Nursing leadership tasked development of an organizational policy on floating within the organization. The policy addresses patient safety, orientation, and documentation. The draft of the policy is currently routing for review, contribution, and approval.

Action Plan:

- In August 2014, the draft float policy will be distributed to nurse managers and unit-based councils for contribution and review.

- During September 2014, the float policy will be routed to the Nursing Practice Council and Deputy Nurse Executive for approval.

- During October 2014, VASDHS nursing staff will be educated on the policy.

- The ED and ICU/DOU nursing leadership teams will audit 100% of RN Float assignments to the ED weekly to ensure unit orientation and accurate documentation for three months following implementation of the policy. The results will be reported to the Nursing Executive Team and Shared Governance Coordinating Council monthly.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Deborah Howard, RN, MSN, Project Leader Elizabeth Burns, MSSW Glen Pickens, RN, MHSM Robert Yang, MD Katrina Young, RN, MSHL Derrick Hudson, Program Support Assistant

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Desert Pacific Healthcare Network (10N22)
Director, VA San Diego Healthcare System (664/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Barbara Boxer, Dianne Feinstein
U.S. House of Representatives: Susan Davis, Duncan D. Hunter, Darrell Issa, Scott Peters, Raul Ruiz, Juan Vargas

This report is available on our web site at www.va.gov/oig