



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Delay in a Patient's  
Emergency Department  
Care at the Malcom Randall  
VA Medical Center in  
Gainesville, Florida



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding a patient's Emergency Department care and inadequate Emergency Department staffing levels at the Malcom Randall VA Medical Center (facility) in Gainesville, Florida.

In summer 2020, the OIG received an anonymous complaint alleging that a patient's care was delayed and mismanaged in the facility's Emergency Department, resulting in the patient's death. The complainant also alleged that facility leaders ignored complaints of inadequate nurse staffing levels in the Emergency Department.

The Veterans Health Administration (VHA) requires the use of the five tier Emergency Severity Index (ESI) triage system by registered nurses performing triage in VHA emergency departments.<sup>1</sup> The ESI system provides a structured tool for emergency department triage nurses to use when assigning an ESI level to patients.<sup>2</sup> ESI level 1 is used for patients who need immediate lifesaving intervention and level 2 for high-risk patients who should not wait to be seen.<sup>3</sup> These patients are unable to remain in the waiting room for any length of time and a "bed needs to be found."<sup>4</sup> ESI levels 3, 4, and 5 are used for patients who can wait to be seen and differ based on the number of resources the patient will need.<sup>5</sup>

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<sup>1</sup> VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016.

<sup>2</sup> Emergency Nurses Association, *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care*, Version 4, 2020 Edition.

<sup>3</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*. "A high-risk patient is one whose condition could easily deteriorate or who presents with symptoms suggestive of a condition requiring time-sensitive treatment. This is a patient who has a potential threat to life, limb, or organ." Three questions are used to determine whether patients meet ESI level 2 criteria. If any question is answered yes, the patient should be assigned an ESI level 2: Is this a high-risk situation? Is the patient confused, lethargic or disoriented? Is the patient in "severe pain" or "distress"?"

<sup>4</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

<sup>5</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

## Synopsis of Patient Case Summary

The patient underwent a laparoscopic right hemicolectomy in summer 2020 after being rescheduled due to the COVID-19 pandemic.<sup>6</sup> According to operative documentation, the patient did not experience surgical complications. Facility surgical staff determined the patient was stable and was discharged home on the third postoperative day. On the tenth postoperative day, the patient contacted the facility call center and reported not eating in two days due to abdominal distension and vomiting. Between postoperative day 10 and the patient's death on postoperative day 15, facility surgical staff had several phone conversations with the patient, including three occasions when facility surgical staff instructed the patient to seek urgent medical attention. The patient presented to non-VA hospitals in the community on the first and second occasion, and to the facility's Emergency Department on the third occasion.

On the day of the patient's death, the patient presented to the facility's Emergency Department and was triaged as an ESI level 3 by a nurse, evaluated by a nurse practitioner, and was returned to the waiting room. During the next hour, the patient yelled "I cannot breathe" and the nurse provided supplemental oxygen via nasal canula. Just over an hour after the patient arrived at the facility's Emergency Department, the patient fell forward out of a chair and a code blue was initiated. The patient was taken to an examination room and was noted to be unresponsive and cyanotic with agonal breathing. The patient was admitted to the Surgical Intensive Care Unit and died later that day.

## OIG Findings

The OIG substantiated that the patient's Emergency Department care was deficient and mismanaged, which may have resulted in a delay in care. The OIG found the nurse and nurse practitioner failed to consider all reasonable causes of the patient's shortness of breath, communicate with the patient's surgeon, and assign an ESI level 2 to the patient. Even with these failures, the OIG was unable to determine if more expeditious care would have affected the patient's mortality.

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<sup>6</sup> Mayo Clinic, "Colectomy," accessed July 31, 2020, <https://www.mayoclinic.org/tests-procedures/colectomy/about/pac-20384631>. Merck Manual Professional Version, "Laparoscopy," accessed November 3, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/diagnostic-and-therapeutic-gastrointestinal-procedures/laparoscopy>. Merriam-Webster, "Laparotomy," accessed November 3, 2020, <https://www.merriam-webster.com/dictionary/laparotomy>. National Cancer Institute, "Anastomosis," accessed November 3, 2020, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/anastomosis>. A hemicolectomy is a surgical procedure to remove the right or left side of the colon and may be performed to remove unresectable precancerous colon polyps. A hemicolectomy may be performed via a laparotomy or a laparoscopy. Possible complications of hemicolectomy surgery include bleeding, infection, blood clots, and leaking at the site of bowel anastomosis. World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it*, accessed on January 7, 2021, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The nurse assigned the patient an ESI level 3; however, the OIG determined that the nurse's documentation of diffuse constant abdominal pain of 8 out of 10, labored breathing, pale complexion, and history of recent abdominal surgery supported assignment of an ESI level 2. The nurse attributed the patient's shortness of breath to wearing a mask and to an abdominal hernia. The OIG did not find evidence in the electronic health record (EHR) or in interviews that consideration was given to the patient's postoperative status as a contributing factor for the patient's shortness of breath.

The nurse and nurse practitioner informed the OIG that had the patient been assigned an ESI level 2, the patient would still have been sent to the waiting room as an Emergency Department room was not available. Emergency Department staff reported that the facility did not have a policy that prohibited ESI level 2 patients from remaining in the waiting room. Facility practice was to place ESI level 2 patients in a room, but if none were available, patients would be sent to the waiting room. The OIG determined that this practice conflicted with guidance from the Emergency Nurses Association to move ESI level 2 patients out of the waiting room and provide immediate care.<sup>7</sup> Placing patients in emergency department rooms instead of the waiting room allows for intravenous access to be started, vital signs to be monitored, and for a physician to be assigned to assess the patient. However, the OIG was unable to determine if the patient would have been seen by a physician prior to coding and if so, whether immediate treatment would have changed the outcome.

The nurse practitioner reported reviewing the patient's EHR briefly and saw the surgeon's note asking the patient to present to the facility's Emergency Department for evaluation. However, the nurse practitioner did not contact the facility surgeon upon the patient's arrival and assessment. Although communication between facility Emergency Department staff and surgical staff is not required, it may have improved the patient's Emergency Department triage.

The OIG determined that the nurse and the nurse practitioner involved in the patient's triage met education, experience, and training standards necessary to work in the Emergency Department. The OIG also determined that facility staff initiated and completed patient safety reporting and focused reviews related to the patient's death as required.

The OIG did not substantiate inadequate levels of nursing staff in the Emergency Department during the week of the patient's death or that facility leaders received complaints regarding Emergency Department nurse staffing levels. Facility documents showed adequate levels of registered nurses worked in the facility Emergency Department each shift during the week of the patient's death. During interviews, facility leaders acknowledged awareness of various staffing challenges within the Emergency Department, but none reported specific complaints regarding insufficient numbers of nurses assigned to the Emergency Department.

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<sup>7</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

The OIG did not identify deficiencies in the patient's preoperative, operative, or postoperative management amid the COVID-19 pandemic. The OIG determined that the patient's surgery was postponed in accordance with the facility restrictions during the COVID-19 pandemic.

The OIG made two recommendations to the Facility Director related to ESI level 2 patients not remaining in the Emergency Department waiting room and evaluation of quality reviews to determine if additional reviews are needed due to failures identified in this report in the patient's pre-code Emergency Department care.

## Comments

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



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## Abbreviations

CT	computerized tomography
EHR	electronic health record
ESI	Emergency Severity Index
OIG	Office of Inspector General
PCP	primary care provider
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding a patient's Emergency Department care and inadequate Emergency Department staffing levels at the Malcom Randall VA Medical Center (facility) in Gainesville, Florida. The OIG also evaluated an identified concern related to a surgical procedure the patient underwent within three weeks of death.

## Background

The facility is one of two medical centers that comprise the North Florida/South Georgia Veterans Health System, part of Veterans Integrated Service Network (VISN) 8, the Sunshine Healthcare Network, along with three large multi-specialty outpatient clinics, and eight small community-based primary care outpatient clinics. It is a tertiary care facility and active teaching hospital with an extensive array of specialty services. The Veterans Health Administration (VHA) classifies the facility as level 1a.<sup>1</sup> From October 1, 2018, through September 30, 2019, the North Florida/South Georgia Veterans Health System served 144,526 patients and had a total of 597 operating beds, including 300 hospital beds, 76 domiciliary beds, and 221 Community Living Center beds. The facility's Emergency Department contains 24 beds and served 52,795 patients between October 1, 2018, and September 30, 2019.

## Procedures Involving the Colon

*Underlined terms are hyperlinks to a glossary.*

A [colonoscopy](#) is a procedure performed for colon cancer screening and for the evaluation and diagnosis of diseases of the large intestine.<sup>2</sup> [Colon polyps](#) found during a colonoscopy procedure are typically removed and evaluated.<sup>3</sup> There are several types of colon polyps. [Adenomatous polyps](#) are precancerous and removing the polyps during a colonoscopy procedure prevents them from transforming into colon cancer.<sup>4</sup> If colon polyps cannot be completely excised during a colonoscopy procedure due to their size, location, or characteristics such as being flat, or sessile,

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<sup>1</sup> The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, and educational and research missions. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex. (The website was accessed July 13, 2020, and is an internal VA website not publicly accessible).

<sup>2</sup> Smir Gupta, et al., "Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer" *Gastrointestinal Endoscopy*, vol. 91, No. 3: 2020, accessed August 4, 2020, [Recommendations for Follow-Up After Colonoscopy and Polypectomy](#).

<sup>3</sup> Merck Manual Professional Version, "Polyps of the Colon and Rectum," accessed August 12, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/tumors-of-the-gastrointestinal-tract/polyps-of-the-colon-and-rectum?query=colon%20polyps#>.

<sup>4</sup> Merck Manual, "Polyps of the Colon and Rectum."

surgery may be required.<sup>5</sup> A [hemicolecotomy](#) is a surgical procedure to remove the right or left side of the colon and may be performed to remove unresectable precancerous colon polyps.<sup>6</sup> A hemicolecotomy may be performed via a [laparotomy](#) or a [laparoscopy](#).<sup>7</sup> Possible complications of hemicolecotomy surgery include bleeding, infection, blood clots, and leaking at the site of bowel [anastomosis](#).<sup>8</sup>

## Emergency Department Triage

VHA requires the use of the five tier Emergency Severity Index (ESI) triage system by registered nurses performing triage in VA emergency departments.<sup>9</sup> The ESI system provides a structured tool for emergency department triage nurses to use when assigning an ESI level to patients.<sup>10</sup> ESI level 1 is used for patients who need “immediate lifesaving intervention.”<sup>11</sup> Level 2 is used for high-risk patients who should not wait to be seen.<sup>12</sup> These patients are unable to remain in the waiting room for any length of time and a “bed needs to be found.”<sup>13</sup> Three questions are used to determine whether patients meet ESI level 2 criteria. If any question is answered yes, the patient should be assigned an ESI level 2:

1. Is this a high-risk situation?
2. Is the patient confused, lethargic, or disoriented?
3. Is the patient in “severe pain” or “distress”?<sup>14</sup>

ESI levels 3, 4, and 5 are used for patients who can wait to be seen and differ based on the number of resources the patient will need.<sup>15</sup>

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<sup>5</sup> Merck Manual, “Polyps of the Colon and Rectum.”

<sup>6</sup> Mayo Clinic, “Colectomy,” accessed July 31, 2020, <https://www.mayoclinic.org/tests-procedures/colectomy/about/pac-20384631>.

<sup>7</sup> Merck Manual Professional Version, “Laparoscopy,” accessed November 3, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/diagnostic-and-therapeutic-gastrointestinal-procedures/laparoscopy>. Merriam-Webster, “Laparotomy,” accessed November 3, 2020, <https://www.merriam-webster.com/dictionary/laparotomy>.

<sup>8</sup> National Cancer Institute, “Anastomosis,” accessed November 3, 2020, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/anastomosis>.

<sup>9</sup> VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

<sup>10</sup> Emergency Nurses Association, *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care*, Version 4, 2020 Edition.

<sup>11</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

<sup>12</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*. “A high-risk patient is one whose condition could easily deteriorate or who presents with symptoms suggestive of a condition requiring time-sensitive treatment. This is a patient who has a potential threat to life, limb, or organ.”

<sup>13</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

<sup>14</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

<sup>15</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

## Allegations and Related Concerns

In summer 2020, the OIG received an anonymous complaint alleging that a patient's care was delayed and mismanaged in the facility's Emergency Department resulting in the patient's death. The complainant also alleged that facility leaders ignored complaints of inadequate nurse staffing levels in the Emergency Department.

In addition, the OIG reviewed the allegations and the patient's electronic health record (EHR) and had concerns regarding the impact of the COVID-19 pandemic on the scheduling and quality of the patient's hemicolectomy surgery in 2020.<sup>16</sup>

## Scope and Methodology

The OIG initiated the inspection in July 2020 and conducted interviews the week of August 17, 2020.

The OIG team interviewed the Facility Director, Chief of Staff, Associate Director of Patient Care Services, Chief of Quality Management, Chief Emergency Services, Emergency Department Nurse Manager, Emergency Department and general surgery staff involved in the patient's care, risk managers, and the Patient Safety Manager.

The OIG team reviewed relevant VHA and facility policies, the patient's EHR from fall 2018 through summer 2020, the patient's code blue sheet and associated reviews, facility investigations and quality review documents, committee meeting minutes, emails, and organizational charts. The OIG team also reviewed facility Emergency Department patient flow, bed count, nurse staffing methodology, nurse schedules, competency and training documents, and the floor plan along with a virtual tour of the department.

As the complaint was anonymous and did not delineate a time frame for inadequate nurse staffing levels, the OIG chose to review staffing levels the week (Monday to Friday) of the patient's death and expand the scope of the inspection if problems were found.

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

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<sup>16</sup> World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it*, accessed January 7, 2021, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

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, Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). 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.

## Patient Case Summary

The patient, a smoker in their 60s, lived in rural Florida, approximately four hours from the facility.<sup>17</sup> The patient had a history of [chronic obstructive pulmonary disease](#) and a left hemicolectomy secondary to [diverticulitis](#) with abscess at a non-VA hospital in the fall of 2018. At a summer 2019 primary care office visit, the patient reported an enlarged abdomen that began two months after hemicolectomy surgery. The primary care provider reviewed the patient's [computerized tomography](#) (CT) scan report that showed laxity of the anterior abdominal wall, [atherosclerosis](#) in the abdominal vasculature, and constipation. The primary care provider documented an examination finding of a large, reducible, [ventral hernia](#) and referred the patient to a general surgeon. The primary care provider also prescribed medication for smoking cessation. The patient was seen in the facility's General Surgery Clinic for evaluation of the ventral hernia and expressed the desire to have the hernia repaired. Several months later, the patient reported having quit tobacco. A surgeon (surgeon 1) ordered a CT scan of the abdomen to reassess the hernia and referred the patient for a colonoscopy due to a recent positive [fecal immunochemical test](#) (FIT) test.

The patient underwent a colonoscopy procedure in early 2020 by a community care physician with the findings of multiple colon polyps, most of which were removed. Two large polyps in the [cecum](#) were biopsied but could not be completely excised. A pathology report revealed that all of the polyps, including the large polyps in the cecum, were [tubular adenomas](#). The community care physician who performed the colonoscopy assessed that the patient "may benefit from EMR [[endoscopic mucosal resection](#)] of the cecal polyps or completion [colectomy](#)."

The primary care provider reviewed the community care colonoscopy findings, and alerted Surgeon 1 to the results. Surgeon 1 acknowledged the colonoscopy results and recommended the patient be reevaluated in the General Surgical Clinic to determine need for colectomy and

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<sup>17</sup> The OIG uses the singular form of they (their) in this instance for privacy purposes.

planning for hernia repair surgery. Approximately two months after the community care colonoscopy, the patient attended a surgical clinic appointment at the facility and was referred for a repeat colonoscopy to evaluate the unresectable cecal colon polyps.

The following week, the patient underwent a colonoscopy by Surgeon 2 with findings of “a few medium polyps in the cecum; resection not attempted” due to their size and location, as well as additional polyps in other areas of the colon that were removed and sent for pathology evaluation. The pathology report diagnosed tubular and [tubulovillous adenomas](#). In a letter to the patient, Surgeon 2 explained the pathology results of precancerous colon polyps and noted the plan for right hemicolectomy.

The patient's hemicolectomy surgery was scheduled the week after the colonoscopy but was canceled due to the COVID-19 pandemic. The next month, the patient's primary care provider noted the plan was for “surgery as soon as able after virus restrictions lift.” The patient's hemicolectomy surgery was scheduled two months later.

Four days prior to surgery, the patient's routine preoperative test for COVID-19 was negative. Surgeon 3 performed the patient's [laparoscopic](#) right hemicolectomy as scheduled, in late spring 2020. The operative note stated there were no complications during the procedure and estimated 25 milliliters of blood loss. The patient was admitted to the facility for routine postoperative care.

On the first postoperative day, a nurse informed the surgical team that the patient's pain was not well controlled, and that the patient had rectal bleeding. Surgeon 1 attributed blood in the bowel movements to “oozing from staple line which will stop on its own” and assessed that the [hematocrit](#) trended down “slightly” with a plan to monitor the patient. Subcutaneous heparin, administered for prevention of [deep venous thrombosis](#), was discontinued.

On the second postoperative day, the patient's hematocrit continued to decline and a blood transfusion was ordered. The surgical resident physician assessed that the patient was [hemodynamically stable](#) but acknowledged the drop in hematocrit. The patient was transfused with one unit of blood (packed red blood cells).

On the third postoperative day, the surgical resident physician documented that the patient's bloody bowel movements had improved, the hematocrit was stable after the blood transfusion, pain was better controlled, and the patient was tolerating a clear liquid diet. The patient was discharged in stable condition.” A follow-up telephone appointment with Surgeon 3 was scheduled for two weeks after discharge. Post-discharge in-home physical therapy was ordered and scheduled, but a note entered the day after discharge indicated the patient refused these services.

On the eighth postoperative day, Surgeon 3 informed the patient by phone that the pathology report of the surgically removed section of colon showed tubular adenomas and a sessile, [serrated lesion](#) of the cecum. The patient reported having bowel movements, tolerating meals,

and improving postoperative pain. The patient agreed to cancel the surgical follow-up telephone appointment scheduled approximately a week later, and to schedule the ventral hernia repair surgery.

On the tenth postoperative day the patient contacted the facility call center and reported having not eaten in two days due to abdominal distension and vomiting. A nurse advised the patient to call 911, but the patient declined and reported a plan to go to a non-VA emergency department.

That day, the patient received care in a non-VA emergency department, where staff contacted the facility to initiate transfer of the patient to the facility. The facility's Emergency Department physician accepted the patient for transfer; however, the patient left the non-VA Emergency Department against medical advice before the transfer could occur.

On the eleventh postoperative day, the patient informed facility surgical staff of leaving the non-VA emergency department prior to transfer to the facility as the patient was "frustrated because they were taking too long to transfer." The patient continued to have severe abdominal pain, and a facility surgeon recommended the patient call 911. The patient was admitted to a second non-VA hospital. A CT scan, completed on the day of admission, showed a [small bowel obstruction](#) and [pneumoperitoneum](#). A non-VA surgeon attributed the finding of pneumoperitoneum to the patient's recent abdominal surgery, and assessed that surgical intervention was not indicated. The patient was treated with [bowel rest](#), intravenous hydration, antibiotics, and analgesics.

On the thirteenth postoperative day, the patient, whose condition had improved, was discharged home from the second non-VA hospital with a plan to continue antibiotics and follow up with the VA surgeon as an outpatient. Surgeon 3 documented a phone call with the patient who reported being discharged home after conservative treatment of symptoms at the non-VA hospital. Surgeon 3 concluded the conversation with a plan to call the patient later in the week for follow-up.

On the fifteenth postoperative day, at 9:31 a.m., Surgeon 3 followed up with the patient by phone. When the patient reported continued abdominal pain, Surgeon 3 advised the patient to come to the facility's Emergency Department "immediately for evaluation, labs," and abdominal and pelvic CT scan. The patient agreed.

The patient checked in to the facility's Emergency Department four hours later at approximately 1:30 p.m. At 1:45 p.m., the Emergency Department triage nurse documented the patient rated abdominal pain as an 8 out of 10, was pale, and had labored respiratory effort. The patient's vital signs were noted as: blood pressure 95/61 millimeters of mercury, pulse 71 beats per minute, temperature 97.4 degrees, respiratory rate 20 breaths per minute, and pulse oximetry 97 percent. The triage nurse assigned an ESI level of 3. A nurse practitioner responsible for a medical screening exam assessed the patient with "abdominal pain s/p [status post] colectomy" and

documented a plan of “labs.” The physical exam of the abdomen documented “large ventral hernia noted.”

In a progress note initiated at 2:41 p.m., the Emergency Department triage nurse documented the “patient began yelling I cannot breathe” and supplemental oxygen was provided via nasal canula. In a second progress note, initiated at 2:43 p.m., the Emergency Department triage nurse documented that the patient “stopped yelling and fell forward out of wheelchair,” appeared “dusky,” with a “weak and thready” pulse. A [code blue](#) was initiated and the patient was taken to an examination room and was noted to be unresponsive and [cyanotic](#) with [agonal](#) breathing. An Emergency Department physician placed an [intraosseous line](#) and [femoral central line](#) after noting the patient did not have intravenous access, and the patient was [intubated](#). The patient was admitted to the Surgical Intensive Care Unit and remained critically ill, requiring mechanical ventilation and intravenous medication to support blood pressure. A test for COVID-19 was negative.

A CT scan completed at 5:45 p.m. showed extensive [thrombus](#) in the aorta with [infarction](#) of multiple organs including the small bowel, kidney, spleen, and liver, and pneumoperitoneum compatible with intestinal perforation. The surgical team assessed the CT findings as a “fatal diagnosis” and that further intervention was “futile.” Surgeon 1 informed the patient’s family member by phone of the patient’s condition. The patient’s family member indicated the patient would not want “aggressive” intervention. The surgeon informed the patient’s family member that the patient “may not survive through the night.” The patient passed away at 11:20 p.m. There was no evidence in the EHR that an autopsy was completed.

## Inspection Results

### 1. The Patient's Emergency Department Care

The OIG substantiated that the patient’s Emergency Department care was deficient and mismanaged, which may have resulted in a delay in care. The OIG was unable to determine if more expeditious care would have affected the patient’s mortality.

To evaluate these allegations, the OIG reviewed the care the patient received in the Emergency Department, the nurse and nurse practitioner competency and training documents, and required reviews the facility conducted as a result of the patient’s death.

#### Emergency Department Triage

According to facility staff, the Emergency Department triage process involves both a registered nurse and an advanced registered nurse practitioner. The registered nurse completes an initial triage and assigns an ESI level to patients. The advanced registered nurse practitioner completes an initial medical screening and may order labs or imaging prior to the patient being assigned to a room and physician.

The triage nurse informed the OIG that emergency department triage assessments and determination of ESI levels are based on patient's responses to screening questions and patient's self-reported medical histories. The nurse indicated that there is not time during triage to review patients' EHRs. The nurse practitioner reported reviewing the patient's EHR briefly and saw the surgeon's note asking the patient to present to the facility Emergency Department for evaluation. However, the nurse practitioner did not contact the facility surgeon upon the patient's arrival and assessment. The nurse practitioner reported typically not contacting the treating specialist prior to the completion of lab and imaging tests. Although communication between Emergency Department and surgical staff is not required, it may have improved the patient's Emergency Department triage.

Facility staff indicated that the COVID-19 pandemic did not impede access to the facility's Emergency Department on the day of the patient's visit. Patients were screened for COVID-19 at the entrance to the Emergency Department and asked to wear a mask into the facility. The OIG learned in interviews that several patients complained about the requirement to wear a mask and reported difficulty breathing when masked.

The nurse informed the OIG that the patient complained of shortness of breath after exiting a vehicle and, due to the COVID-19 pandemic, was asked to wear a mask. The nurse attributed the patient's shortness of breath to wearing a mask and to the abdominal hernia. The OIG did not find evidence in the EHR or in interviews that consideration was given to the patient's postoperative status as a contributing factor for the patient's shortness of breath.

The nurse assigned the patient an ESI level 3 and the patient returned to the waiting room. However, the OIG determined that the nurse's documentation of diffuse constant abdominal pain of 8 out of 10, labored breathing, pale complexion, and history of recent abdominal surgery supported assignment of an ESI level 2.

The nurse and nurse practitioner informed the OIG that had the patient been assigned an ESI level 2, the patient would still have been sent to the waiting room as no beds were available in the Emergency Department. Emergency Department staff reported that the facility did not have a policy that prohibited ESI level 2 patients from remaining in the waiting room. Facility practice was to place ESI level 2 patients in a room but if none were available, patients were sent to the waiting room. The OIG determined that this practice conflicted with guidance from the Emergency Nurses Association to move ESI level 2 patients out of the waiting room and provide immediate care.<sup>18</sup> According to facility staff, placing patients in emergency department rooms, instead of the waiting room, allows for intravenous access to be started, vital signs to be monitored, and for a physician to be assigned to assess the patient. The OIG was unable to

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<sup>18</sup> Emergency Nurses Association, *Emergency Severity Index (ESI)*.

determine if the patient would have been seen by a physician prior to the code and if so, whether immediate treatment would have changed the outcome.

The OIG found the nurse and nurse practitioner failed to consider all other reasonable causes of the patient's shortness of breath, communicate with the patient's surgeon, and assign an ESI level 2 to the patient. Even with these failures, the OIG was unable to determine if more expeditious care would have affected the patient's mortality.

## **Triage Staff Competency**

The OIG determined that the nurse and the nurse practitioner involved in the patient's triage met education, experience, and training standards necessary to work in the Emergency Department.

VHA requires nurses and advanced practice providers working in emergency departments to have prior experience in emergency medicine or critical care, possess certifications in basic life support and advanced cardiac life support, and complete training specific to work in emergency departments. Triage nurses in VA emergency departments must have training on use of the five tier ESI triage system and competency validation.<sup>19</sup>

A review of the nurse's training records documented competency in the effective use of emergency department nursing protocols including ESI and triage as well as the required certifications in life support. Similarly, a review of the education, experience, and credentials for the nurse practitioner documented compliance with VHA requirements.

## **Facility Reviews**

The OIG determined that facility staff initiated and completed patient safety reporting and reviews related to the patient's death as required, including reviews of Emergency Department and Surgical Department care.

VHA requires that all adverse events are reported to the Patient Safety Manager.<sup>20</sup> Once reported, the Patient Safety Manager determines the type of review that is warranted.<sup>21</sup> Completed quality reviews are important to ensure "that the way in which VA care is delivered is safe, timely, effective, efficient and patient-centered."

Facility staff reported required aspects of the patient's Emergency Department visit to the Patient Safety Manager in accordance with VHA policy.<sup>22</sup> Following receipt of the report, the Patient

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<sup>19</sup> VHA Directive 1101.05(2).

<sup>20</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. VHA defines adverse events as "adverse occurrences directly associated with care or services provided" within the jurisdiction of a VHA facility. A close call is an event or situation that could have, but did not, result in an adverse event.

<sup>21</sup> VHA Handbook 1050.01.

<sup>22</sup> VHA Handbook 1050.01.

Safety Manager and quality management staff initiated timely reviews as required. In addition, required aspects of the patient's surgical care were reviewed.

## 2. Emergency Department Nurse Staffing

The OIG did not substantiate inadequate levels of nursing staff in the Emergency Department during the week of the patient's death or that facility leaders received complaints regarding Emergency Department nurse staffing levels.

VHA requires facility leaders to appoint a unit-based expert panel to develop a nurse staffing plan using a standardized national staffing methodology process at least every two years.<sup>23</sup> The national process describes how to determine unit nursing workload, compare target workload hours to similar facilities, and calculate the full-time employees needed to operate the unit.<sup>24</sup> The completed unit-based expert panel package should include a narrative justification, replacement calculator, full-time employee calculator, and any "additional tools used to collect unit specific data."<sup>25</sup>

VHA requires the presence of at least two registered nurses and suggests the presence of a third registered nurse for triage in emergency departments during all hours of operation.<sup>26</sup> A subject matter expert from VHA Central Office confirmed that, in addition to a triage nurse, an optimally functioning emergency department can operate with one registered nurse to four beds. This minimum requirement would equate to the facility's Emergency Department having at least seven registered nurses working to operate the 24 beds.

Facility leaders convened an expert panel in February 2020 to establish nurse staffing levels in the Emergency Department. The panel used a VHA emergency department nurse staffing calculator to determine the total nurses needed to operate the department. The calculator took into account requirements from the national staffing methodology process including a replacement factor, along with facility Emergency Department metrics such as total annual admissions and discharges, and median length of stay in minutes.<sup>27</sup> The panel determined that the Emergency Department continued to need a total of 49.9 registered nurses to provide direct patient care, in addition to the Emergency Department nurse manager and assistant nurse manager who are in indirect care positions.<sup>28</sup>

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<sup>23</sup> VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017.

<sup>24</sup> VHA Directive 1351.

<sup>25</sup> VHA Directive 1351.

<sup>26</sup> VHA Directive 1101.05(2).

<sup>27</sup> VHA Directive 1351. A replacement factor accounts for sick leave, education offerings, annual leave, holidays, and systems improvement activities.

<sup>28</sup> VHA Directive 1351. Direct care is care that is considered patient or resident centered. "Direct care staff responsibilities are defined as all patient or resident-centered nursing activities performed by staff assigned to the patient or resident." Examples include patient assessment, treatment planning, and coordination of care.

The facility's Emergency Department uses a staggered staffing pattern to account for changes in the number of patients seeking services during the day. The Associate Director of Patient Care Services reported that prior to the pandemic, they aimed to have 15 registered nurses to operate during peak hours and seven registered nurses to operate during off peak hours, although the required minimal levels were much lower.<sup>29</sup> Facility nursing leaders reported that during the pandemic, fewer patients presented to the Emergency Department reducing the need for staff at peak hours down to 10 or 11 registered nurses. At times, the assistant nurse manager and Emergency Department nurse clinical educator functioned in direct care roles, which is an option if additional nursing staff are needed.

The facility's Emergency Department had 47.9 registered nurses to provide direct patient care in the month of the patient's death. During the week of the patient's death, 35 registered nurses were scheduled to work. There was adequate staffing the day the patient was seen in the Emergency Department. The number of registered nurses on duty during the week of the patient's death averaged 10.6 during peak hours and 6.4 during non-peak hours.

During interviews, facility leaders acknowledged awareness of various staffing challenges within the Emergency Department, but none reported specific complaints regarding insufficient numbers of nurses assigned to the Emergency Department. Rather, concerns centered on health technicians being pulled from the Emergency Department to sit with patients on other units, the lack of staff to transport patients for tests, a reduction in providers related to the pandemic response, and nursing staff being detailed out for investigations or disciplinary reasons.

The OIG found the Emergency Department had adequate nurse staffing and no indication facility leaders received complaints about the nurse staffing during the week of the patient's death.

### **3. The Patient's Surgical Care**

The OIG did not identify deficiencies in the patient's preoperative, operative, or postoperative management amid the COVID-19 pandemic.

#### **Preoperative and Operative Management**

The OIG determined that the patient's surgery was postponed in accordance with the facility restrictions during the COVID-19 pandemic.

Due to the COVID-19 pandemic, the facility continued to provide surgical services for patients with urgent needs but did not offer non-urgent surgeries from approximately mid-March to mid-May 2020. Once elective surgeries resumed, facility surgeons reviewed all canceled non-urgent surgeries and prioritized their rescheduling based on acuity.

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<sup>29</sup> The OIG was informed that the facility Emergency Department experiences the highest use from 10:00 a.m. to 8:00 p.m.

The patient's hemicolectomy surgery was canceled as the surgery was non-urgent because the patient did not have a cancer diagnosis. Facility surgeons informed the OIG that the patient's surgery was prioritized during rescheduling. Two months after the canceled surgery, facility staff contacted the patient to reschedule the surgery for the next month.

The patient underwent a laparoscopic right hemicolectomy as scheduled. According to EHR documentation, the patient did not experience complications during surgery.

## **Postoperative Management**

VHA and facility policy do not provide specific guidance for the management of post-hemicolectomy patients, leaving the choice for interventions and discharge timing to the clinical judgment of the patient's surgeons.

Several facility surgical staff informed the OIG that in general, a patient could be discharged post-hemicolectomy once the patient can ambulate, tolerate a liquid or full diet, no longer requires intravenous pain medication, has stable vital signs, is voiding, and has return of bowel function. Facility surgical staff reported that patients are typically discharged three to five days post-hemicolectomy, and patients are scheduled for an outpatient surgical follow-up appointment one to two weeks post-surgery to assess progress.

Following surgery, the patient was admitted to a facility inpatient bed. Facility surgical staff determined the patient was stable and ready for discharge home on the third postoperative day as the patient's condition had improved, bowel functioning had returned, and the patient was tolerating a diet. Facility surgical staff informed the OIG that the patient's discharge did not need to be expedited due to COVID-19.

Between postoperative day eight and the patient's death on postoperative day 15, facility surgical staff had several phone conversations with the patient, including three occasions when facility surgical staff instructed the patient to seek urgent medical attention. The patient presented to non-VA hospitals in the community on the first and second occasion, and a family member drove the patient approximately four hours from the patient's home to the facility's Emergency Department on the third occasion.

Staff at the first non-VA hospital initiated the patient's transfer to the facility, but the patient left against medical advice before the transfer could occur. Staff at the second non-VA hospital admitted the patient; however, did not initiate a transfer to the facility. Facility surgical staff informed the OIG that they spoke with the staff at the second non-VA hospital and asked that the patient be transferred to the facility if the patient had more than postoperative pain. The patient was discharged to home. Based on the patient's accounts of the second non-VA hospitalization, a member of the facility surgical staff reported difficulty understanding what treatment the patient had received. Once home, the patient reported continued abdominal pain and a facility surgeon

advised the patient to come to the facility's Emergency Department "immediately" for evaluation, labs, and abdominal and pelvic CT scan.

Facility surgical staff described making multiple attempts to explain that the patient could potentially have a life-threatening condition and the importance of receiving urgent medical attention. Facility surgical staff did not know why multiple attempts were needed to engage the patient. However, facility surgical staff offered a potentially complicating factor, the patient lived in a rural area of Florida and not close to the facility's main hospital. Facility surgical staff described the area of the patient's home as rural with limited specialty surgical services available in the community.

The OIG did not identify deficiencies in preoperative, operative, or postoperative care provided to the patient by facility surgical staff.

## Conclusion

The OIG substantiated that the patient's Emergency Department care was deficient and mismanaged, which may have resulted in a delay in care. The nurse assigned the patient an ESI level 3. However, the OIG found the nurse and nurse practitioner failed to consider all reasonable causes of the patient's shortness of breath, communicate with the patient's surgeon, and assign an ESI level 2 to the patient. Even with these failures, the OIG was unable to determine if more expeditious care would have affected the patient's mortality.

Emergency Department staff reported that the facility did not have a policy that prohibited ESI level 2 patients from remaining in the waiting room. Facility practice was to place ESI level 2 patients in a room but if none were available, patients were sent to the waiting room. The OIG determined that this practice conflicts with guidance from the Emergency Nurses Association to move ESI level 2 patients out of the waiting room and provide immediate care. Placing patients in emergency department rooms, instead of the waiting room, allows for intravenous access to be started, vital signs to be monitored, and for a physician to be assigned to assess the patient. The OIG was unable to determine if the patient would have been seen by a physician prior to the code if assigned an ESI level 2 and placed in a room.

The nurse and the nurse practitioner involved in the patient's triage met education, experience, and training standards necessary to work in the Emergency Department. The OIG also determined that facility staff initiated and completed patient safety reporting and focused reviews related to the patient's death as required.

The OIG did not substantiate inadequate levels of nursing staff in the Emergency Department during the week of the patient's death or that facility leaders received complaints regarding Emergency Department nurse staffing levels. Facility documents showed adequate levels of registered nurses were scheduled to work and worked in the facility's Emergency Department each shift during the week of the patient's death.

The OIG did not identify deficiencies in the patient's preoperative, operative, or postoperative management amid the COVID-19 pandemic. The patient's surgery was postponed in accordance with the facility restrictions during the COVID-19 pandemic.

## **Recommendations 1–2**

1. The North Florida/South Georgia Veterans Health System Director evaluates processes and implements a requirement as necessary that Emergency Severity Index level 2 patients do not remain in the Emergency Department waiting room.
2. The North Florida/South Georgia Veterans Health System Director evaluates if additional quality reviews are needed due to failures identified in this report regarding the patient's pre-code Emergency Department care, and takes action as indicated.

## Appendix A: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: April 27, 2021

From: Director, VISN 8, Sunshine Healthcare Network (10N08)

Subj: Healthcare Inspection—Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida

To: Director, Office of Healthcare Inspections (54HL05)  
Director, GAO/OIG Accountability Liaison office (VHA 10BGOAL Action)

1. I have reviewed the response provided by the Medical Center Director regarding allegations of a delay in the Emergency Department of the North Florida, South Georgia VA Healthcare System in Gainesville, FL. I concur with the recommendations and the Healthcare System Director's response.
2. If you have additional questions or need further information, please contact the VISN 8 Quality Management Officer/Chief Nursing Officer.

*(Original signed by:)*

Miguel H. LaPuz, M.D., MBA

Network Director, VISN 8

## Appendix B: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: April 16, 2021

From: Director, North Florida/South Georgia Veterans Health System (573/00)

Subj: Healthcare Inspection—Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida

To: Director, VISN 8, Sunshine Healthcare Network (10N08)

1. I have reviewed and concur with findings and the recommendations in the report of the Healthcare Inspection review.
2. Corrective action plans have been established with completion dates, as detailed in the attached report.

*(Original signed by:)*

Thomas Wisniewski, MPA, FACHE

Director

## Facility Director Response

### Recommendation 1

The North Florida/South Georgia Veterans Health System Director evaluates processes and implements a requirement as necessary that Emergency Severity Index level 2 patients do not remain in the Emergency Department waiting room.

Concur.

Target date for completion: 5/28/2021

### Director Comments

The Chief Nurse, Critical Care is responsible for assuring that facility emergency department procedures include the requirement to move ESI level 2 patients out of the waiting room and to treatment area for immediate care.

The emergency department SOP [standard operating procedure] is being revised to clearly outline that ESI 2 patients will be taken to the treatment area and provided immediate care.

### Recommendation 2

The North Florida/South Georgia Veterans Health System Director evaluates if additional quality reviews are needed due to failures identified in this report regarding the patient's pre-code Emergency Department care, and takes action as indicated.

Concur.

Target date for completion: 4/30/21

### Director Comments

The North Florida/South Georgia Veterans Health System Director has evaluated the quality reviews regarding pre-code Emergency Department care and the following actions have been taken.

All emergency department nursing staff have completed additional on-line ESI training to assure successful implementation of the ESI program. Sustainment of ESI accuracy is monitored through chart audits.

High Reliability and Just Culture principles are being reinforced with all ED [Emergency Department] staff through VISN led trainings and ongoing HRO [high reliability organization] efforts.

## Glossary

*To go back, press "alt" and "left arrow" keys.*

**adenomatous polyps.** A growth of tissue inside the colon which can be cancerous.<sup>30</sup>

**agonal.** Describes characteristics associated with the act of dying. Agonal breathing is characterized by gasping or labored breathing.<sup>31</sup>

**anastomosis.** A procedure to join the healthy ends of the bowel after surgical removal of the diseased section.<sup>32</sup>

**atherosclerosis.** An accumulation of fatty deposits in the walls of arteries leading to reduced blood flow.<sup>33</sup>

**bowel rest.** Nothing by mouth.

**cecum.** A blind pouch at the beginning of the large intestine located on the right side of the abdomen.<sup>34</sup>

**chronic obstructive pulmonary disease.** A condition, often due to smoking tobacco, that results in limitation of airflow to the lungs and is characterized by symptoms of coughing and shortness of breath.<sup>35</sup>

**code blue.** The declaration of a medical emergency with the summoning of medical personnel and equipment to attempt cardiopulmonary resuscitation of a patient experiencing a cardiac arrest or respiratory failure.<sup>36</sup>

**colectomy.** Surgical removal of the colon. Colectomy may be indicated when a patient has multiple precancerous polyps, especially if those polyps cannot be completely removed via colonoscopy.<sup>37</sup>

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<sup>30</sup> Mayo Clinic, "Colon Polyps," accessed November 18, 2020, <https://www.mayoclinic.org/diseases-conditions/colon-polyps/symptoms-causes/syc-20352875>.

<sup>31</sup> Merriam-Webster, "Agonal," accessed October 27, 2020, <https://www.merriam-webster.com/dictionary/agonal>.

<sup>32</sup> National Cancer Institute, "Anastomosis," accessed November 3, 2020, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/anastomosis>.

<sup>33</sup> Mayo Clinic, "Arteriosclerosis/atherosclerosis," accessed November 18, 2020, <https://www.mayoclinic.org/diseases-conditions/arteriosclerosis-atherosclerosis/symptoms-causes/syc-20350569>.

<sup>34</sup> Merriam-Webster, "Cecum," accessed September 15, 2020, <https://www.merriam-webster.com/dictionary/cecum>.

<sup>35</sup> Merck Manual, "Chronic obstructive pulmonary disease," accessed August 11, 2020, <https://www.merckmanuals.com/professional/pulmonary-disorders/chronic-obstructive-pulmonary-disease-and-related-disorders/chronic-obstructive-pulmonary-disease-copd?query=copd#>.

<sup>36</sup> Merriam-Webster, "Code blue," accessed September 16, 2020, <https://www.merriam-webster.com/medical/code%20blue>.

<sup>37</sup> Mayo Clinic, "Colectomy," accessed July 31, 2020, <https://www.mayoclinic.org/tests-procedures/colectomy/about/pac-20384631>.

**colonoscopy.** An examination of the colon using a small video camera attached to a long tube which is introduced through the rectum. The exam is used to investigate intestinal symptoms, screen for colon cancer, and to look for polyps.<sup>38</sup>

**computerized tomography.** A type of imaging study that utilizes computers to put together X-ray images taken from many angles around an area of the body to create cross-sectional images of bones, blood vessels, and soft tissues.<sup>39</sup>

**cyanotic.** Blue or purple discoloration of the skin due to a lack of oxygenated blood.<sup>40</sup>

**deep venous thrombosis.** A blood clot in the veins particularly of the lower extremity. Postoperative patients are at higher risk of developing deep venous thrombosis due to immobility. Interventions to prevent deep venous thrombosis are to minimize immobility, administer blood thinners such as heparin, or utilize pneumatic compression devices.<sup>41</sup>

**diverticulitis.** Inflammation or infection of diverticula in the colon. Diverticula are small outpouchings of the mucosa, or inner lining, of the colon. Diverticulitis causes abdominal pain and may be complicated by an abscess. Treatment varies depending on the severity of diverticulitis and may include antibiotics or surgery.<sup>42</sup>

**endoscopic mucosal resection.** A special procedure done through an endoscope by a gastroenterologist to remove abnormal tissue, such as colon polyps, from the large intestine. Endoscopic mucosal resection is a less invasive alternative to surgery.<sup>43</sup>

**fecal immunochemical test.** One of several tests used to screen for colon cancer. Fecal immunochemical tests detect the presence of blood in the stool.<sup>44</sup>

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<sup>38</sup> Mayo Clinic, "Colonoscopy," accessed November 18, 2020, <https://www.mayoclinic.org/tests-procedures/colonoscopy/about/pac-20393569>.

<sup>39</sup> Mayo Clinic, "Computerized tomography," accessed December 1, 2020, <https://www.mayoclinic.org/...0scan%20combines%20a%20series.blood%20vessels%20and%20soft%20tissues%20inside%20your%20body>.

<sup>40</sup> Merriam-Webster, "Cyanotic," accessed November 18, 2020, <https://www.merriam-webster.com/dictionary/cyanotic>.

<sup>41</sup> Merck Manual, "Deep venous thrombosis," accessed September 15, 2020, <https://www.merckmanuals.com/professional/cardiovascular-disorders/peripheral-venous-disorders/deep-venous-thrombosis-dvt?query=dvt>.

<sup>42</sup> Merck Manual, "Colonic Diverticulitis," accessed March 26, 2021, [Colonic Diverticulitis - Gastrointestinal Disorders - Merck Manuals Professional Edition](#).

<sup>43</sup> Mayo Clinic, "Endoscopic mucosal resection," accessed July 24, 2020, <https://www.mayoclinic.org/tests-procedures/endoscopic-mucosal-resection/about/pac-20385213>.

<sup>44</sup> Centers for Disease Control and Prevention, "Colorectal Cancer Screening Tests," accessed August 11, 2020, [https://www.cdc.gov/cancer/colorectal/basic\\_info/screening/tests.htm](https://www.cdc.gov/cancer/colorectal/basic_info/screening/tests.htm).

**femoral central line.** The insertion of a catheter into the femoral vein in the groin to provide access to the blood stream and can be used to administer medications, nutrition, to draw blood, or to measure blood flow.<sup>45</sup>

**hematocrit.** The ratio of blood cells to the total volume of blood.<sup>46</sup>

**hemicolectomy.** A surgical excision of part of the colon.<sup>47</sup>

**hemodynamic stability.** Stable or normal blood pressure and heart rate.<sup>48</sup>

**infarction.** Injury or death of tissue due to inadequate blood supply especially as the result of obstruction by a blood clot.<sup>49</sup>

**intestinal obstruction.** A blockage of the small intestine and causes symptoms of abdominal pain and vomiting. On imaging exams, such as an abdominal x-ray or CT scan, the small bowel appears dilated and filled with air or fluid. Treatment includes placement of a nasogastric tube to drain the stomach and intravenous fluids. In severe cases of bowel obstruction, surgery may be necessary.<sup>50</sup>

**intraosseous line.** Insertion of a needle into a bone for the purpose of introducing intravenous fluids or medications. This is often performed during emergency situations or when other options for intravenous access are not readily available.<sup>51</sup>

**intubation.** The introduction of a tube into the windpipe to assist in breathing.<sup>52</sup>

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<sup>45</sup> Saint Luke's Health System, "Central Line," accessed November 18, 2020, <https://www.saintlukeskc.org/health-library/central-line-central-venous-access-device#>.

<sup>46</sup> Merriam-Webster, "Hematocrit," accessed September 16, 2020, <https://www.merriam-webster.com/dictionary/hematocrit>.

<sup>47</sup> Merriam-Webster, "Hemicolectomy," accessed September 10, 2020, <https://www.merriam-webster.com/medical/hemicolectomy>.

<sup>48</sup> Merriam-Webster, "Hemodynamic," accessed January 27, 2021, <https://www.merriam-webster.com/dictionary/hemodynamic>.

<sup>49</sup> Merriam-Webster, "Infarction," accessed September 15, 2020, <https://www.merriam-webster.com/dictionary/infarction>.

<sup>50</sup> Merck Manual, "Intestinal obstruction," accessed October 27, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/acute-abdomen-and-surgical-gastroenterology/intestinal-obstruction>.

<sup>51</sup> West Virginia Department of Health and Human Resources, "ALS procedural treatment protocol intraosseous placement," accessed November 18, 2020, <https://www.wvoems.org/media/336446/8201%20intraosseous%20placement.pdf>.

<sup>52</sup> National Heart, Lung, and Blood Institute, "Ventilator/Ventilator Support," accessed December 15, 2020, <https://www.nhlbi.nih.gov/print/4965>.

**laparoscopic colectomy.** When a surgeon makes several small incisions in the abdomen and passes a video camera and surgical tools through the incisions “to remove all or part of the colon.”<sup>53</sup>

**laparoscopy.** Surgical instruments are inserted through the abdominal wall through small openings and carbon dioxide is infused into the peritoneal cavity to distend the abdomen and allow visualization of the abdominal contents.<sup>54</sup>

**laparotomy.** Refers to a surgical incision of the abdomen.<sup>55</sup>

**pneumoperitoneum.** The presence of air in the peritoneal cavity.<sup>56</sup>

**polyps of the colon and rectum.** Masses of tissue that protrudes into the inside of the intestine.<sup>57</sup>

**serrated adenomas.** A more aggressive type of precancerous colon polyp.<sup>58</sup>

**thrombus.** A blood clot within a blood vessel.<sup>59</sup>

**tubular adenomas.** Polyps of the large intestine that are precancerous. These polyps are removed during a colonoscopy procedure.<sup>60</sup>

**tubulovillous adenomas.** Polyps of the large intestine that are precancerous. These polyps are removed during a colonoscopy procedure.<sup>61</sup>

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<sup>53</sup> Merck Manual, “Colectomy,” accessed July 30, 2020, <https://www.mayoclinic.org/tests-procedures/colectomy/about/pac-20384631>.

<sup>54</sup> Merck Manual, “Laparoscopy,” accessed November 3, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/diagnostic-and-therapeutic-gastrointestinal-procedures/laparoscopy>.

<sup>55</sup> Merriam-Webster, “Laparotomy,” accessed November 3, 2020, <https://www.merriam-webster.com/dictionary/laparotomy>.

<sup>56</sup> Merriam-Webster, “Pneumoperitoneum,” accessed September 16, 2020, <https://www.merriam-webster.com/medical/pneumoperitoneum>.

<sup>57</sup> Merck Manual, “Polyps of the colon and rectum,” accessed August 12, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/tumors-of-the-gastrointestinal-tract/polyps-of-the-colon-and-rectum>.

<sup>58</sup> Merck Manual, “Polyps of the colon and rectum,” accessed August 12, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/tumors-of-the-gastrointestinal-tract/polyps-of-the-colon-and-rectum>.

<sup>59</sup> Merriam-Webster, “Thrombus,” accessed September 15, 2020, <https://www.merriam-webster.com/dictionary/thrombus>.

<sup>60</sup> Merck Manual, “Polyps of the colon and rectum,” accessed August 12, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/tumors-of-the-gastrointestinal-tract/polyps-of-the-colon-and-rectum>.

<sup>61</sup> Merck Manual, “Polyps of the colon and rectum,” accessed August 12, 2020, <https://www.merckmanuals.com/professional/gastrointestinal-disorders/tumors-of-the-gastrointestinal-tract/polyps-of-the-colon-and-rectum>.

**ventral hernia.** A protrusion of abdominal contents through an area of weakness in the midline of the abdominal wall. This can occur in the area of an incision from prior abdominal surgery. Many hernias are asymptomatic and do not require intervention. Symptomatic hernias are treated by surgery. Hernias are diagnosed by a clinical examination.<sup>62</sup>

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<sup>62</sup> ClevelandClinic, "Ventral Hernia," accessed December 15, 2020, <https://my.clevelandclinic.org/health/diseases/16531-ventral-hernia>.

## OIG Contact and Staff Acknowledgments

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