DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

NOV 27 2012

In Reply Refer To:

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M. Street, NW, Suite 300
Washington, DC 20036-4505

RE: OSC File Nos. DI-10-3763
DI-10-3889
DI-11-0048
DI-11-0967
DI-11-3203
DI-11-3558
DI-12-0023

Dear Ms. Lerner:

Consistent with the agreement you reached on August 31, 2012, with General Counsel Will A. Gunn, we hereby request that your office use, for the public file, the enclosed redacted versions of the Department's reports responding to allegations at facilities of the Department of Veterans Affairs (VA).

If you have any questions about this request, please contact Jennifer Gray or Kathleen Heaphy in the Office of General Counsel at 202-461-7634 or 202-834-1869.

Sincerely yours,

Walter A. Hall
Assistant General Counsel

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

July 1, 2011

The Honorable William E. Reukauf
Associate Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW
Washington, DC 20036

RE: OSC File DI-11-0048

Dear Mr. Reukauf:

I am responding to your letter regarding allegations against the Department of Veterans Affairs Togus Medical Center in Augusta, Maine. The specific allegations were made by an anonymous whistleblower at that medical center who charged that nurses there frequently failed to follow mandated procedures, endangering the health and safety of patients. The whistleblower further alleged that a physician failed to respond to an inpatient rapid response request, which dereliction contributed to the death of the patient 2 days later.

I asked the Under Secretary for Health to review this matter and take any actions deemed necessary under title 5 U.S.C. § 1213(d)(5). He, in turn, directed the Office of the Medical Inspector (OMI) to investigate the disclosures and report its findings. The OMI review is contained in the enclosed Final Report and is submitted for your review. The OMI did not substantiate any of the allegations made by the whistleblower and found no evidence of any violation of law, rule, regulation, or mismanagement, or danger to patients, and made no recommendations in response to these allegations. The OMI did, however, make a general recommendation that medical center staff receive additional policy training on Inpatient Rapid Response Teams. The medical center will develop an action plan in response to this recommendation, and the OMI will monitor the action plan until completion.

Sincerely,

Eric K. Shinseki

Enclosure

OFFICE OF THE MEDICAL INSPECTOR

Report to the
Office of Special Counsel
OSC File Number DI-11-0048

Department of Veterans Affairs
Togus Medical Center
Augusta, Maine

Veterans Health Administration
Washington, DC

Report Date: June 16, 2011
2011-D-401

Executive Summary

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate a complaint lodged with the Office of Special Counsel by an anonymous whistleblower at the Department of Veterans Affairs (VA) Togus Medical Center, Augusta, Maine (hereafter, the Medical Center). The whistleblower alleged that: (1) nurses at the Medical Center frequently failed to follow established procedures for transferring patients from one medical unit to another by not using proper "handoffs." Handoff is the process of transferring the responsibility of care for a patient from one caregiver to another in order to ensure patient safety and continuity of care. The whistleblower alleged that Veteran 1 was transferred to the medical-surgical unit after undergoing a pacemaker insertion without adequate handoff communications that should have included information about the Veteran's elevated blood pressure. The whistleblower further alleged that (2) the Nurse Manager was aware of the problems with handoff communication in the case of Veteran 1 and numerous others. The whistleblower also alleged that (3) improper "handoffs" are a persistent problem that threatens the health and safety of VA patients. The whistleblower additionally alleged that (4) a physician failed to respond to a call for an inpatient rapid response team (IRRT) for Veteran 2. The whistleblower also alleged that (5) this failure to respond caused a delay in critical treatment and contributed to Veteran 2's death 2 days later and that the Medical Center should have but did not report this as a sentinel event. The OMI conducted a site visit at the Medical Center on March 29-30, 2011.

Summary of Conclusions

The OMI did not find evidence of any violation of law, rule, or regulation, nor did we find evidence of gross mismanagement or substantial and specific danger to public health and safety. The OMI did not find evidence that nurses failed to follow mandated procedures for using the proper format during handoff communication; there was no evidence of this either in the case of Veteran 1 or in other cases. While the OMI did find evidence that the Nurse Manager for 3 North (3N) was aware of the receiving nurse's concern that the handoff was inadequate, the Nurse Manager's followup of this matter revealed evidence that the handoff communication had been adequate. The OMI found no evidence that the 3N Nurse Manager was aware of numerous cases of handoff communication done without using the required format.

The OMI did not find evidence that a physician failed to respond to the request for an IRRT, leading to a delay in treatment for Veteran 2. Since the physician responded to the IRRT, his "failure to respond" could not have contributed to the Veteran's death 2 days later. Since this allegation was not substantiated, there was no indication for reporting the incident as a sentinel event. However, the OMI did find inadequate documentation of IRRT interventions by the Special Care Unit nurse, the nephrology nurse practitioner, and the IRRT physician.

Summary of Recommendations

The Medical Center should provide additional training about its IRRT policy to all staff involved in the process, including training about required documentation. Documentation should be monitored for compliance, and non-compliance should be addressed appropriately.

Report to the Office of Special Counsel

I. Summary of Allegations

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate a complaint lodged with the Office of Special Counsel by an anonymous whistleblower at the Department of Veterans Affairs (VA) Togus Medical Center, Augusta, Maine (hereafter, the Medical Center). The whistleblower alleged that: (1) nurses at the Medical Center frequently failed to follow established procedures for transferring patients from one medical unit to another by not using proper "handoffs." Handoff is the process of transferring the responsibility of care for a patient from one caregiver to another in order to ensure patient safety and continuity of care. The whistleblower alleged that Veteran 1 was transferred to the medical-surgical unit after undergoing a pacemaker insertion without adequate handoff communications that should have included information about the Veteran's elevated blood pressure. The whistleblower further alleged that (2) the Nurse Manager was aware of the problems with handoff communication in the case of Veteran 1 and numerous others. The whistleblower also alleged that (3) improper handoffs are a persistent problem that threatens the health and safety of VA patients. The whistleblower additionally alleged that (4) a physician failed to respond to a call for an inpatient rapid response team (IRRT) for Veteran 2. The whistleblower also alleged that (5) this failure to respond caused a delay in critical treatment and contributed to Veteran 2's death 2 days later and that the Medical Center should have but did not report this as a sentinel event. The OMI conducted a site visit at the Medical Center on March 29-30, 2011.

II. Facility Profile

The Medical Center is a 67-bed facility, with general medicine, surgical, intermediate and mental health beds; one medical-surgical unit, 3 North (3N), has 23 operating beds and an average daily census of 16, and the other, 3 South (3S), has 15 with an average daily census of 12. The Specialty Care Unit (SCU) has 8 operating beds. The medical-surgical units are covered by a group of staff and fee-basis physicians.

III. Conduct of the Investigation

An OMI team consisting of the Medical Inspector and a Medical Investigator (both physicians), the Special Assistant to the Medical Inspector and a Clinical Program Manager (both registered nurses) conducted the site visit. The OMI toured one of the inpatient medical-surgical units, interviewed individuals, and reviewed policies, procedures, and reports related to patient handoff communications and rapid response alarms. A full list of the documents reviewed by the OMI is in the Attachment. The OMI held an entrance and exit briefing with Medical Center leadership.

During the site visit, the OMI interviewed the following individuals in person: (b)(6) (b)(6), Chief of Staff; (b)(6) Nurse Executive; (b)(6) Acting Director, Continuous Improvement; Patient Safety Manager; (b)(6) hospitalist; (b)(6) ., hospitalist; (b)(6) hospitalist; (b)(6) (b)(6) Patient Care Coordinator; (b)(6) Post Anesthesia Care Unit; (b)(6)

[redacted], RN Post Anesthesia Care Unit; [redacted] RN Specialty Care Unit; [redacted], RN Specialty Care Unit; [redacted], RN Emergency Department; [redacted], NP for Nephrology Service; [redacted] RN Day Surgery; [redacted] Nurse Manager, 3 North; [redacted] RN 3 North; [redacted] RN 3 North; [redacted] RN 3 North; [redacted] RN 3 North; [redacted] Nurse Manager, 3 South; [redacted] RN 3 South; [redacted] RN 3 South; [redacted] RN 3 South; and [redacted], RN 3 South.

The OMI was unable to interview the whistleblower because this individual wished to remain anonymous.

The OMI ***did substantiate*** allegations when the facts and findings supported that the alleged events or actions took place. The OMI ***did not substantiate*** allegations when the facts showed the allegations were unfounded. The OMI ***could not substantiate*** allegations when there was no conclusive evidence to either sustain or refute the allegations.

IV. Summary of Evidence Obtained from the Investigation

Allegation #1

Nurses at the Medical Center frequently failed to follow established procedures for transferring patients from one medical unit to another by not using proper "handoffs."

Findings

Handoff is the process of transferring the responsibility of care for a patient from one caregiver to another in order to ensure patient safety and continuity of care. All pertinent patient information, including the patient's clinical history, current condition, and treatment plan, is communicated during the handoff process. The Joint Commission requires health care organizations to use a standardized approach to handoff communication, including the opportunity to ask and respond to questions, and read or repeat patient information. As a result, VA's National Center for Patient Safety developed a standardized handoff guide (National Center for Patient Safety Handoff Guide) for use. This handoff tool incorporates the SBAR format, which is:

S-Situation: What are the relevant patient issues? Situation information includes the Veteran's demographics (name, social security number, age, date of admission), the clinical service and providers overseeing the Veteran's care, the admission diagnosis, procedures done since admission, and a brief clinical summary.

B-Background: What is relevant in this Veteran's medical history? A review of the Veteran's relevant medical and surgical history is communicated. Medications, code status, and social support network are also reported.

A-Assessment: What is the assessment of the Veteran's condition? The findings from the most recent head-to-toe assessment are reported. This assessment includes the presence of any

wounds, drains, intravenous lines, and current diet, as well as the Veteran's most recent vital signs, any concerns, and diagnostic testing information.

R-Recommendation: What should be done? Any orders, treatments, procedures, consultations that are outstanding will be discussed, as will indicated followup measures.

Handoff communication is to occur whenever there is a change in caregivers (i.e., change of shift, transfer of care to another medical team), transfer of the patient (intrafacility and external), in association with performed procedures, and whenever there is any change in the patient's condition, as described in the Medical Center's Nursing Procedure 188P-09-1, *Handoff Communication.* The whistleblower alleged that staff frequently failed to follow the mandated procedure for handoff and cited the case of Veteran 1 as a specific example.

Veteran 1 is a 60-year-old male with a history of peripheral vascular disease, coronary artery disease with subsequent heart surgery (2007), diabetes requiring blood glucose control with insulin, hypertension controlled with medication, elevated blood lipid levels, and first degree heart block.[1] On (b)(6) 2010, the Veteran was seen in the outpatient clinic for routine followup; at this time his heart rate was noted to be 32 beats per minute with a BP of 150/75.[2] An electrocardiogram (EKG) revealed sinus bradycardia with third degree or complete heart block.[3] Otherwise, the Veteran remained asymptomatic; he was alert and oriented to his surroundings, and denied any complaints of dizziness or other discomfort.

On (b)(6) 2010, the Veteran underwent insertion of a pacemaker for the treatment of his complete heart block. At 8:11 a.m., prior to the start of the procedure, his BP was 172/86, and during the procedure, it ranged from 150/80 to 190/75. Following the procedure he was transferred to the PACU at 1:30 p.m.; during his stay there, his BP ranged from 175/95 to 195/75. Once the Veteran's condition met the criteria for discharge, the PACU nurse gave a telephonic handoff report to the nurse who would be caring for the Veteran on 3N. Per review of the Veteran's medical record and the OMI's interview of the PACU transferring nurse, this report included information about the procedure the Veteran had undergone, his vital signs, history of hypertension, and diagnostic tests completed in the PACU. The 3N nurse who received this handoff is no longer employed at the Medical Center and was not available for an interview. The Veteran was transferred to 3N at 3:15 p.m. At 4:20 p.m. his BP was 214/114, for which he received a dose of lisinopril (an angiotensin converting enzyme inhibitor, used to treat

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[1] First-degree heart block, or first-degree AV block: electrical impulses are usually generated in the upper chambers of the heart, known as atria. In first degree block, these impulses move more slowly than normal from the upper chambers to the lower chambers of the heart. Usually this condition does not require treatment.

[2] A normal resting heart rate for an adult ranges from 60 to 100 beats per minute.
BP is expressed in millimeters of mercury (mm/Hg); ranges of BP are:
Normal: 115 or lower/75 or lower
Prehypertension: 120/80-139/89
Hypertension: 140 or greater/90 or greater

[3] Third degree or complete heart block: the heart's electrical signal does not pass from the upper chambers to the lower chambers of the heart. As a result, the impulses originate in the lower chambers (ventricles) of the heart instead of the upper chambers (atria). The impulses generated in the lower chambers are usually very slow and can't generate the signals needed to maintain full functioning of the heart muscle, leading to a much slower heart rate, and at times, a low blood pressure and change in mental status.

high blood pressure), which brought his BP down to 193/101 at 4:49 p.m.; 188/94 at 6:22 p.m.; and 154/90 at 9:37 p.m.

Conclusion

The OMI did not substantiate the allegation that staff failed to follow established procedures for transferring patients from one medical unit to another by not using proper "handoffs." The OMI did not substantiate inadequate handoff communication for Veteran 1. Information given during the handoff communication is documented in the medical record and does reflect use of the SBAR format.

Recommendation

The OMI makes no recommendation regarding this allegation.

Allegation #2

The Nurse Manager was aware of the problems with handoff communication in the case of Veteran 1 and numerous others.

Findings

In his interview with the OMI, the Nurse Manager said he was aware of the receiving nurse's concerns that the handoff was inadequate because the SBAR format was not used; the Nurse Manager's documented follow up of the matter revealed that the SBAR format had been utilized, the appropriate patient information had been communicated to the receiving nurse, and the handoff communication was complete and appropriate. The Nurse Manager reviewed documentation of the Veteran's handoff completed by the sending and receiving nurses, obtained verbal and written accounts of the handoff from both nurses, and concluded that the issues was not one of failure to use the SBAR format during handoff communication, but failure of the sending nurse to telephone the unit immediately prior to transferring the Veteran to the floor.

The Nurse Manager also reviewed the medical records of other Veterans who were transferred, and spoke with other nursing staff about handoff communication, and did not find evidence the SBAR format was not being used for handoff communication on a consistent basis.
The OMI found that the Nurse Manager investigated this event appropriately and found no evidence that the Nurse Manager was aware that staff had failed to use the SBAR format in handoff communications for numerous Veterans.

Conclusions

The OMI did substantiate the allegation that the Nurse Manager was aware of the concern that handoff communication for Veteran 1 was not done in SBAR format. However, OMI concludes that the Nurse Manager investigated the event appropriately and that the SBAR format was in fact used.

The OMI did substantiate that the Nurse Manager for 3N was aware of the concern that handoff communication was not done in SBAR format for numerous Veterans. The Nurse Manager looked into this concern but found no evidence it was true. See Allegation #3 below.

Recommendation

The OMI makes no recommendation regarding this allegation.

Allegation #3

Improper "handoffs" are a persistent problem that threatens the health and safety of VA patients.

Findings

Documentation of use of the SBAR format is not required, per Nursing Procedure 188P-09-1, Handoff Communication. Thus, a record review alone would not be an accurate reflection of the complete use of the SBAR format. Nonetheless, there was ample evidence to support substantial compliance with the SBAR format in the records. The OMI reviewed the medical records of 20 Veterans who were transferred to or from a medical-surgical unit during September and October of 2010 for documentation of SBAR format usage. Despite the fact that there is no requirement to document the use of SBAR format, 70 percent of the records contained documentation indicating the SBAR format was used. OMI conducted interviews with 14 bedside nursing staff, and all were familiar with the SBAR requirements and stated uniformly that they use the SBAR format for handoff communication.

Conclusion

The OMI did not substantiate the allegation that in numerous cases nurses fail to use the SBAR format for handoff communication.

Recommendation

The OMI makes no recommendation regarding this allegation.

Allegation #4

A physician failed to respond to a call for an inpatient rapid response team (IRRT) for Veteran 2.

Findings

When a patient shows signs of imminent clinical deterioration, a team of clinicians, the IRRT, is summoned to the bedside to immediately assess and treat the patient with the goal of preventing cardiac arrest, death, or transfer to intensive care unless absolutely necessary. The Medical

Center's IRRT consists of a hospitalist (during weekdays), the physician officer of the day (during off-tours), an SCU nurse, a respiratory therapist, the registered nurse who determined the need for the IRRT, and the PCC. According to the Medical Center's IRRT policy, Circular 00-08-45(11), licensed staff on the inpatient units can request the IRRT when any of the following conditions are present:

1. Respiratory distress or threatened airway: the patient's respiratory rate is greater than 36 breaths per minute or less than 8 breaths per minute,
2. Acute change in the patient's oxygen saturation or breathing pattern: oxygen saturation of less than 85% for more than 5 minutes,[4]
3. Acute change in the patient's systolic blood pressure: less than 80 or greater than 200 mm Hg, or heart rate: less than 40 or greater than 140 beats per minute,
4. Acute change in the level of consciousness,
5. New onset of a diminished urine output of less than 50 milliliters in 4 hours,
6. New, repeated, or prolonged seizures,
7. Sudden loss of movement or weakness of face, arms, or legs,
8. Uncontrolled pain, and
9. Failure to respond to treatment of the above criteria.

The whistleblower alleged that an IRRT physician failed to respond to a call for an IRRT for Veteran 2. Veteran 2 was an 81-year-old male with a history of coronary artery disease, diabetes, chronic kidney disease, chronic atrial fibrillation, colon cancer, and thrombocytopenia. On (b)(6) 2010, he was evaluated in the ED for nausea and vomiting of 3 weeks duration. He was diagnosed with progression of his chronic kidney disease and was admitted as a patient of the Nephrology Service for further evaluation of his worsening kidney function.

On (b)(6) 2010, one stool specimen tested positive for occult blood. The Veteran was then evaluated by a gastroenterology (GI) physician. Additional questioning revealed a history of two episodes of bright red blood per rectum prior to admission and of intermittent nausea. A clinical diagnosis of diabetic gastroparesis was made; however, direct visualization with an esophagogastroduodenoscopy (EGD) was recommended.[5] On (b)(6) 2010, the GI physician performed an EGD on Veteran 2.[6] Following the procedure, Veteran 2 was transferred to the PACU and then to 3N, and given medications intended to eliminate nausea and to improve gastric motility; however, he remained nauseated.

Veteran 2's care was supervised by the nephrology team. On (b)(6) the nephrology NP was covering for the nephrology attending physician, and at 3:00 p.m. was asked by the staff nurse to evaluate the Veteran for nausea and abdominal pain.[7] Before the NP arrived, the staff nurse returned to the Veteran's bedside, was unable to arouse him, and placed an emergency call

[4] Oxygen saturation is a measure of how much oxygen the blood is carrying as a percentage of the maximum it can carry.
[5] Diabetic gastroparesis is delayed gastric emptying caused by damage to the autonomic nerves; this is a potential complication of long-term diabetes.
[6] An esophagogastroduodenoscopy (EGD) involves visually examining the lining of the esophagus, stomach, and upper duodenum with a flexible fiber optic endoscope.
[7] This staff nurse is no longer employed at the Medical Center and therefore unavailable for interview.

for the IRRT. The NP arrived first, followed by the physician named in the complaint, a respiratory therapist, an SCU nurse, the PCC (a nurse), and several additional staff nurses. The physician's presence at the rapid response event is documented on the IRRT quality assurance document completed by the PCC during the efforts of the team, and this physician's presence is also noted in the Nursing IRRT note in the medical record.

Conclusion

The OMI did not substantiate the allegation that the physician failed to respond to the request for an IRRT. However, the OMI did find inadequate documentation of the event in the IRRT note entered by the SCU nurse. Additionally, there is inadequate documentation by the nephrology NP detailing the events of the IRRT. The physician did not enter a note describing his participation in the IRRT.

Recommendations

The OMI makes no recommendations regarding this allegation; however, the Medical Center should provide additional training about its IRRT policy to all staff involved in the process, including training about required documentation. Documentation should be monitored for compliance, and non-compliance should be handled appropriately.

Allegation #5

The physician's failure to respond caused a delay in critical treatment and contributed to Veteran 2's death 2 days later and that the Medical Center should have but did not report as a sentinel event.

Findings

As discussed above, at about 3:30 p.m. on (b)(6) 2010, Veteran 2 developed a serious medical condition which required calling the IRRT. The IRRT assembled at the patient's bedside, and appropriate medical care was administered. Both the nephrology NP and the IRRT physician responded to the call. The NP, who was covering for nephrology, oversaw treatment for the Veteran's significant change in condition. An EKG was completed and assessed by the hospitalist and the NP. Diagnostic laboratory tests demonstrated an elevated troponin level; the NP relayed this information to the IRRT physician.[8] The Veteran was diagnosed with a myocardial infarction (MI). The IRRT physician consulted with the intensive care physician, and made arrangements for the Veteran's transfer to the SCU, which took place at 4:42 p.m. Treatment for the MI included medication, monitoring, and additional diagnostic testing.

The Veteran's troponin levels continued to rise, and subsequent EKGs indicated the Veteran's cardiac condition was worsening. A cardiologist performed a bedside cardiac echocardiogram, which showed a significant reduction in the heart's ability to pump. While these findings suggested an extensive MI, it was unclear whether the rising troponin levels were an indication

[8] Elevated troponin levels are present in cases of myocardial necrosis which is indicative of a myocardial infarction.

of an extensive infarction or a result of his worsening kidney function. The next day, he was transferred to the cardiology service at the VA Medical Center West Roxbury Division, Boston, Massachusetts, for an urgent cardiac catheterization. Upon admission to West Roxbury, the Veteran continued to experience nausea. The physicians caring for him attributed the nausea to his ongoing, untreated renal failure. While it was noted that a cardiac catheterization would be necessary, it would be preferable to do so in the absence of renal failure; therefore, the decision was made to initiate hemodialysis.

The following day (b)(6) the Veteran received his first hemodialysis treatment. Approximately 20 minutes after the treatment began, he developed ventricular tachycardia.[9] Hemodialysis was stopped. The Veteran developed ventricular fibrillation, followed by a cardiac arrest. Upon admission to West Roxbury, the Veteran had requested that, if medically indicated, he not be resuscitated. The Veteran's wishes were honored, and his condition was treated with medications only. He did not regain cardiac activity and was pronounced dead at 12:19 p.m.

The Medical Center determined that the Veteran's death was not a sentinel event.

Conclusion

The OMI did not substantiate the allegation that there was a delay in critical treatment that led to Veteran 2's death 2 days after the IRRT event, because there was no delay in his critical treatment. The OMI concurs that the events of Veterans 2's care should not be classified as a sentinel event.

Recommendation

The OMI makes no recommendation regarding this allegation.

[9] Ventricular tachycardia is a fast heart rhythm that originates in one of the lower chambers of the heart (ventricles). This is a potentially life-threatening heart rhythm because it may lead to cardiac arrest and death.

Summary of Conclusions

The OMI did not find evidence of any violation of law, rule, or regulation, nor did we find evidence of gross mismanagement or substantial and specific danger to public health and safety. The OMI did not find evidence that nurses failed to follow mandated procedures for using the SBAR format during handoff communication; there was no evidence of this either in the case cited by the whistleblower or in other cases. While the OMI did find evidence that the Nurse Manager for 3N was aware of the receiving nurse's concern that the handoff was inadequate, the Nurse Manager's followup of this matter revealed evidence that the handoff communication had been adequate. The OMI also found no evidence that the 3N Nurse Manager was aware of numerous cases of handoff communication done without using the SBAR format.

The OMI did not find evidence that a physician failed to respond to the request for an IRRT, leading to a delay in treatment for the Veteran. Since the physician responded to the IRRT, his "failure to respond" could not have contributed to the Veteran's death 2 days later. Since this allegation was not substantiated, there was no indication for reporting the incident as a sentinel event. However, the OMI did find inadequate documentation of the IRRT interventions by the SCU nurse, the nephrology NP, and the IRRT physician.

Summary of Recommendations

The Medical Center should provide additional training about its IRRT policy to all staff involved in the process, including training about required documentation. Documentation should be monitored for compliance, and non-compliance should be dealt with appropriately.

Attachment

Documents Reviewed

Agency for Healthcare Research and Quality (2006). AHRQ Patient Safety Network-Rapid Response Systems, retrieved from http://psnet.ahrq.gov.

Institute for Healthcare Improvement (2005). Improvement Report: Reducing cardiac arrest with a rapid response team, retrieved from www.ihi.org.

Togus VA Medical Center Nursing Procedure 118P-09-1, February 19, 2009. *Handoff Communication.*

Togus VA Medical Center Circular 00-08-45 (11), September 23, 2008. *Inpatient Rapid Response Team.*

Veterans Health Administration (VHA) National Center for Patient Safety, *SBAR Handoff Guide*

VHA Handbook 1050.01, May 23, 2008, *VHA National Center for Patient Safety Improvement Handbook*