



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Postoperative Care
Concerns for a Vascular
Surgical Patient at the
Martinsburg VA Medical
Center

West Virginia



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senator Joe Manchin to review the postoperative care of a patient (Patient) who had vascular surgery at the Martinsburg VA Medical Center (Facility), West Virginia.

In mid-2017, the Patient had an ultrasound¹ which revealed, and computed tomography angiography² confirmed, the presence of an approximately 7 centimeter (cm) abdominal aortic aneurysm (AAA).³ The Patient saw the Facility's vascular surgeon who recommended an endovascular aneurysm repair (EVAR) and performed the procedure approximately two weeks later.⁴ The OIG found that, in general, the Patient's immediate postoperative care was proper. However, the OIG had concerns with the Patient's management when the Patient presented to the community based outpatient clinic (CBOC) 10 days after the EVAR with signs and symptoms of a known vascular procedure complication.

On postoperative day (POD) 10, after determining the Patient was experiencing a medical emergency, the Petersburg CBOC Patient Aligned Care Team (PACT) staff did not ensure coordination of the Patient's subsequent care. Staff told the OIG that they offered the Patient ambulance transport to a nearby non-VA hospital (non-VA hospital C). However, non-VA hospital C did not have the level of care needed to treat the Patient's toe ischemia⁵ with developing gangrene.⁶ In addition, once PACT staff learned the Patient was seeking emergency medical care at a non-VA hospital closer to home (non-VA hospital A), they did not ensure the exchange of healthcare information with a documented telephone call or paperwork describing the clinically pertinent information. Veterans Health Administration (VHA) requires⁷ each PACT staff member be responsible for managing communications and facilitating safe transitions of patients between the PACT's site of care and other healthcare settings. Care coordination processes must ensure that relevant information is communicated to involved providers and that health record information is made accessible to involved providers timely.

¹ Ultrasound imaging is a diagnostic technique using sound waves to produce images of internal body structures.

² Computed tomography angiography is a type of specialized x-ray which can show cross-sectional images of the body and uses dye to assess the inside of arteries.

³ AAA is a balloon-like dilatation which can occur when the wall of the abdominal aorta weakens.

⁴ EVAR is a procedure where a surgeon places a graft inside the weakened area of the aorta, reinforcing it and allowing greater blood flow to the lower extremities. An EVAR also reduces stress on the weakened aortic wall and keeps the aneurysm from rupturing.

⁵ Ischemia occurs when oxygen delivery to tissues is reduced due to decreased blood flow.

⁶ Gangrene is a condition occurring when blood supply becomes inadequate to support viable tissue.

⁷ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, Amended on May 26, 2017.

OIG inspectors found deficiencies in VHA policy compliance⁸ with the lack of policy or standard operating procedure (SOP) on the management of health emergencies in the CBOC, and inconsistent health record documentation for the Patient. The Petersburg CBOC did not have a policy or SOP to handle health emergencies. VHA requires⁹ each CBOC to have a local policy or SOP defining the management of health emergencies.

On POD 10, Petersburg CBOC PACT staff did not ensure accurate patient health record documentation that contained clinically-relevant statements. The CBOC PACT registered nurse documented in the electronic health record (EHR) that “I will call report to ED [at non-VA hospital A] as requested by patient and family;” however, the EHR contained no documentation that the registered nurse called non-VA hospital A. The primary care provider (PCP) examined the Patient but did not document specifics of, or planned care for, the Patient's toe ischemia with developing gangrene. The PCP placed no telephone calls. These omissions did not likely change the Patient’s course and ultimate clinical outcome. However, VHA requires¹⁰ the scope of documentation in the health record to reflect accurate and clinically-relevant statements and be comprehensive enough to provide continuity of care and be concise and complete.

The OIG made three recommendations to the Facility Director related to coordination of care processes, development of a policy or SOP, and health record documentation.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 11–14 for the Directors’ comments.) The OIG will follow up on the planned actions until they are completed.



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

⁸ VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004. This Handbook was in place at the time of the events described in this report. This Handbook was rescinded and replaced by VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017, and contains same or similar language related to CBOC policy or SOP for health and mental health emergencies; VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

⁹ VHA Handbook 1006.1.

¹⁰ VHA Handbook 1907.01.

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Abbreviations

AAA	abdominal aortic aneurysm
CBOC	community based outpatient clinic
CES	cholesterol embolization syndrome
cm	centimeter
ED	emergency department
EHR	electronic health record
EVAR	endovascular aneurysm repair
OIG	Office of Inspector General
PACT	patient aligned care team
PCP	primary care provider
POD	postoperative day
RN	registered nurse
SOP	standard operating procedure
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senator Joe Manchin regarding the postoperative care of a patient (Patient) who had vascular surgery at the Martinsburg VA Medical Center (Facility), Martinsburg, West Virginia.

Background

The Facility, part of Veterans Integrated Service Network (VISN) 5, provides a comprehensive range of services, including internal medicine, surgery, audiology and speech pathology, dental, nursing home, nutrition, podiatry, prosthetics, women's health, mental health, and rehabilitation medicine. The Facility, along with associated community based outpatient clinics (CBOC),¹¹ served over 35,616 veterans in fiscal year 2016. The Facility operates 461 beds, including 67 inpatient beds, 265 domiciliary beds, 8 Compensated Work Therapy Transitional Residents beds, and 121 community living center beds. The Facility is affiliated with the George Washington University School of Medicine, the West Virginia School of Osteopathic Medicine, and West Virginia University Medical and Dental Schools.

The Petersburg CBOC is one of seven CBOCs operating under the Facility's oversight. It is located in Petersburg, West Virginia, a rural area that is approximately 98 miles from the Facility. CBOC staff provide primary care and behavioral health services. Providers may refer patients requiring specialty care to the Facility.¹²

Patient Aligned Care Team and Care Coordination

As required by Veterans Health Administration (VHA), the Petersburg CBOC follows the VHA Patient Aligned Care Team (PACT) model.¹³ The PACT is a team of healthcare professionals who provide comprehensive primary care in partnership with patients, and manage and coordinate comprehensive healthcare services consistent with agreed upon goals of care. Care coordination involves working across care settings and accessing healthcare providers and other

¹¹ A CBOC is a healthcare site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted; VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004. This Handbook was rescinded and replaced by VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017 and contains same or similar language related to the definition of a CBOC.

¹² <https://www.martinsburg.va.gov/locations/petersburg.asp>. (The website was accessed on October 20, 2017.)

¹³ <https://www.martinsburg.va.gov/locations/petersburg.asp>. (The website was accessed on October 20, 2017.)

services, and includes open communication among health care providers, legally permissible exchange of health care information, and logistical integration of desired care encounters.¹⁴

Abdominal Aortic Aneurysm

An abdominal aortic aneurysm (AAA) is a balloon-like dilatation which can occur when the wall of the abdominal aorta weakens. The indication for urgent management of a patient's AAA is well-defined. AAA diameter is accepted as the best predictor of rupture risk. AAA repair does not have a single threshold diameter generalized to all patients; however, evidence shows 5.5 centimeters (cm) as a reasonable threshold for surgical repair in an "average patient," and repair may be indicated at smaller aneurysmal sizes. According to research, an increased AAA diameter has greater rupture risk. An AAA with a diameter of 7 cm–8 cm has a 20–40 percent rupture risk per year.¹⁵

Endovascular Aneurysm Repair

An endovascular aneurysm repair (EVAR) is a procedure in which a surgeon places a graft inside the weakened area of the aorta, reinforcing it and allowing greater blood flow to the lower extremities. An EVAR also reduces stress on the weakened aortic wall and keeps the aneurysm from rupturing.

Vascular procedures have a risk for graft and limb thrombosis.¹⁶ Limb occlusion can result in acute or chronic limb ischemia.¹⁷ Lower extremity ischemia after aortic reconstructions is a well-recognized result of atheroemboli¹⁸ and occurs in 3 to 10 percent of patients.¹⁹

Request for Review

At the request of Senator Joe Manchin, the OIG conducted a healthcare inspection to review the Patient's postoperative care after vascular surgery at the Facility.

¹⁴ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, Amended on May 26, 2017.

¹⁵ David C. Brewster, MD, et al., "Guidelines for the treatment of abdominal aortic aneurysms, Report of a subcommittee of the Joint Council of the American Association for Vascular Surgery and Society for Vascular Surgery," *Journal of Vascular Surgery* 2003; 37:1106-17.

¹⁶ Thrombosis occurs when blood clots block blood vessels.

https://www.hopkinsmedicine.org/healthlibrary/conditions/hematology_and_blood_disorders/thrombosis_85,P00105. (The website was accessed on March 13, 2018.)

¹⁷ Ischemia occurs when oxygen delivery to tissues is reduced due to decreased blood flow.

¹⁸ Atheroemboli are particles, typically composed of cholesterol, that move through blood vessels and become lodged in vessels too small for further advancement.

¹⁹ Robert S. Dieter, MD, RVT, et al., "Complications of EVAR, Is endovascular aneurysm repair still worth the trouble?," *Endovascular Today* January 2009: 54-58.

Scope and Methodology

The OIG initiated the review in September 2017 and conducted site visits to the Facility and the Petersburg CBOC on September 19–20, 2017. OIG inspectors interviewed the Acting Facility Director; Acting Chief of Staff; Associate Director, Patient Care Services; Chief, Quality Management; Risk Managers; ED provider; and surgeon. OIG inspectors interviewed the Petersburg CBOC PACT staff on duty at the time of the Patient’s CBOC encounter including the Primary Care Provider (PCP), Registered Nurses (RN), and Licensed Practical Nurse. OIG inspectors also consulted with a VHA vascular surgeon and interviewed the Patient.

OIG inspectors reviewed relevant documents including Facility policies, and VHA directives and handbooks. OIG inspectors reviewed the Patient’s electronic health record (EHR) for care provided May 3 to September 20, 2017, including relevant non-VA care medical records.

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.

Case Summary

In mid-2017, the Patient's assigned PCP saw the Patient who was mid 60s at the Petersburg CBOC for a routine follow-up appointment. The PCP obtained a routine screening ultrasound for an AAA.²⁰ A few weeks later, the ultrasound revealed an AAA approximately 7 cm, confirmed by computed tomography angiography,²¹ with "a large amount of thrombus²² within the aneurysm." The next day, the Patient saw the Facility's vascular surgeon who recommended an EVAR and performed the procedure approximately two weeks later. The vascular surgeon documented that the Patient "tolerated the procedure well without complications." On the second postoperative day (POD), the vascular surgeon described the Patient as "stable and doing well," "LEs [lower extremities] perfused," with a subjective pain score of "1/10" and discharged the Patient to home with medication prescribed for pain if needed.²³

On POD 3, the Patient went to the Facility's Emergency Department (ED) describing "pain in both feet" despite taking pain medication. The ED physician noted that "neither foot is cold" though the "left foot slightly cooler than right." The ED physician performed a Doppler ultrasound to distal arteries in the feet and revealed a strong signal at the left posterior tibial artery and at the right dorsalis pedis artery.²⁴ The ED physician telephoned the vascular surgeon and discussed the Patient's presentation and findings, and the vascular surgeon agreed to see the Patient within 48 hours. During the POD 5 visit, the vascular surgeon documented "excellent" underlying distal blood flow bilaterally by examination and by Doppler ultrasound signals, and the Patient rated the pain 2 out of 10. The vascular surgeon described the toe tips as "dusky" but the feet were "warm to touch," and considered the Patient to be making "satisfactory progress."

On POD 10, the Patient, accompanied by a family member, presented to the PACT at the Petersburg CBOC for a same day appointment due to worsening foot pain and the inability to walk. The Patient's assigned PCP saw the Patient and described the toes as "swollen and darkened, red to black," with skin "breakdown" at the feet, but with distal pulses present. The PCP noted the Patient to be confined to a wheelchair as "[the Patient] cannot walk because of the

²⁰ Ultrasound imaging is a diagnostic technique using sound waves to produce images of internal body structures.

²¹ Computed tomography angiography is a type of specialized x-ray which can show cross sectional images of the body and uses dye to assess the inside of the arteries.

²² Thrombus is a blood clot, in this case referring to blood clot observed within the dilated portion of the weakened aortic wall.

²³ Pain rating scale of 0-10 is 0 being no pain and 10 being the highest pain.

²⁴ Doppler ultrasound utilizes high frequency sound waves to estimate blood flow through blood vessels. A strong signal indicates blood flow at the arterial level. The distal arteries in the feet are the posterior tibial and dorsalis pedis arteries. The posterior tibial artery carries blood to the underside of the foot; its pulse is usually felt on the inside of the posterior portion of the foot. The dorsalis pedis artery carries blood to the top of the foot; its pulse is usually felt over the mid-portion of the top of the foot.

pain.” The PCP’s clinical assessment was “osteoarthritis” but the PCP also documented that, considering the recent EVAR, ischemic disease could not be ruled out.

The PCP entered in the EHR a non-VA emergency care consult for a Doppler ultrasound to be performed at a non-VA hospital (non-VA hospital A) and advised the Patient to return to the clinic in one month. The PCP documented in the EHR “patient [family member] insists on taking veteran to [non-VA hospital B] for care.”

At non-VA hospital A, an ED provider documented the Patient had “...vascular compromise with nonblanching lesions on [the Patient’s] toes...Therefore, the patient may have suffered a shower of small arterial emboli as a complication of the surgery thus compromising [the Patient’s] distal most vessels. The concern at this time, is the possible underlying infection.” The Patient was diagnosed with cellulitis and vascular compromise of the lower extremities and was transferred, the same day, to a non-VA hospital 80 miles away (non-VA hospital B) for a higher level of care.

At non-VA hospital B, the Patient saw a vascular surgeon who diagnosed the Patient with atheroembolism of the toes due to the EVAR procedure. On POD 14, the Patient had an amputation of the left second, third, and fourth toes at the metatarsals. The amputated bones contained osteomyelitis²⁵. The treatment for the osteomyelitis required a multi-week course of three antibiotics. As of late 2017, the Patient continued outpatient care of the foot with non-VA providers in vascular surgery and infectious diseases.

²⁵ Osteomyelitis is a bone infection.

Inspection Results

Issue 1: Postoperative Follow-up Care

The OIG found that, in general, the Patient's immediate postoperative care was proper. However, the OIG had concerns with the Patient's management when the Patient presented to the community based outpatient clinic (CBOC) 10 days after the EVAR with signs and symptoms of a known vascular procedure complication.

Following completion of the surgery, the Patient described foot pain as "the first thing" after regaining consciousness. On POD 2, the Facility's vascular surgeon described the Patient as "stable and doing well." At that time, the Patient had a subjective pain score of "1/10" and was discharged to home with a medication prescribed for pain if needed. On POD 3, the Patient went to the Facility's ED where the ED physician performed a Doppler ultrasound to distal arteries in the feet and revealed a strong signal at the left posterior tibial artery and at the right dorsalis pedis artery. On POD 5, the Facility's vascular surgeon examined the Patient and documented "excellent" underlying distal blood flow bilaterally by examination and by Doppler ultrasound signals, and the Patient rated the pain 2 out of 10.

The foot pain worsened in succeeding days as reflected by the physical examination with toe ischemia with signs and symptoms of developing gangrene apparent by POD 10. On that day, providers detailed intense pain, inability to walk, "left foot bluish," "toes swollen and darkened, red to black," and "cold to touch." However, the PCP documented the distal pulses as being present on examination. The clinical combination of developing gangrene with intact distal pulses reflected a pathology selectively affecting blood flow to small vessels with larger vessels remaining unobstructed.

The Patient's clinical condition after the EVAR was consistent with cholesterol embolization syndrome (CES).²⁶ CES is characterized by waves of atheroemboli typically composed of cholesterol that move through blood vessels and become lodged in vessels too small for further advancement. CES can occur after invasive arterial procedures, such as an EVAR. End-organ damage in CES results from mechanical occlusion and inflammatory response in the destination arteries, in this case the small arteries of the toes.²⁷ Although not a prerequisite for CES, the Patient's preoperative imaging showed "a large amount of thrombus within the aneurysm," a possible source of the emboli.

²⁶ The Patient's evolving clinical condition did not involve the lower extremities' large arteries but was affecting the small arteries, consistent with the pathology of CES.

²⁷ Adriana Quinones and Muhamed Saric "The cholesterol emboli syndrome in atherosclerosis," *Curr Atheroscler Rep.* Apr 2013;15(4):315.

CES has no specific laboratory test for diagnosing or assessing the condition.²⁸ Arterial imaging would not likely have been helpful with the Patient because the distal pulses in the Patient's feet remained intact and the developing gangrene was apparent on physical examination.

CES has no specific accepted therapy. Management consists of supportive care and general measures to address atherosclerosis and arterial ischemia²⁹ On POD 14 the Patient had amputations of three toes and was noted to have osteomyelitis in the amputated bone. The OIG could not determine if earlier toe amputations would have prevented osteomyelitis.

Although the OIG found that in general, the Patient had adequate postoperative care, OIG inspectors identified the following deficiencies at the Petersburg CBOC: care coordination, health emergency policy, and accurate health record documentation.

Issue 2: Care Coordination

On POD 10, after determining the Patient was experiencing a medical emergency, Petersburg CBOC PACT staff did not ensure coordination of the Patient's subsequent care. The Petersburg CBOC PACT staff failed to

- Facilitate a safe transition between the Petersburg CBOC and a non-VA hospital equipped to treat the Patient's toe ischemia with developing gangrene, and
- Communicate relevant information and provide health record information to providers at the hospital upon learning where the Patient planned to seek emergency treatment.

VHA policy requires that each PACT staff member is responsible for managing communications and facilitating safe transitions of patients between the PACT's site of care and other health care settings, such as an ED and hospital. VHA also requires that care coordination processes must ensure that relevant information is communicated to involved providers and that health record information is made accessible to involved providers in a timely manner.³⁰

Failure to Facilitate a Safe Transition

Although not documented in the EHR, when interviewed the PCP reported recommending to the Patient to have an ambulance transport to nearby non-VA hospital (non-VA hospital C), and recommended the Patient go to non-VA hospital B. The PCP outlined to the OIG that if staff called an ambulance, the Patient would have been transported to non-VA hospital C. The PCP

²⁸ Saric Muhamed and Kronzon Itzhak "Cholesterol embolization syndrome," *Current Opinion in Cardiology*. Nov 2011; 26(6):472-479.

²⁹ Curr Opin Cardiol. 2011.

³⁰ VHA Handbook 1101.10(1).

said that the Patient and family member declined the offer of transportation to non-VA hospital C and elected to drive themselves to non-VA hospital A about 40 miles away from the CBOC.

The Patient reported to the OIG that the PCP may have discussed taking an ambulance to non-VA hospital C, and that the Patient and family member wanted to go to non-VA hospital A because it was closer to home. The Patient discussed being seen at non-VA hospital A and transported by ambulance to non-VA hospital B.

The Acting COS, and the PACT PCP and nursing staff interviewed by OIG inspectors stated the Patient was experiencing a medical emergency on POD 10. The EHR contains no documentation that PACT staff offered the Patient emergency transportation to a hospital that was equipped to treat the Patient's emergency medical condition.³¹ The PACT staff provided the OIG with phone numbers for three local ambulance companies, and OIG inspectors confirmed with two of the companies that they would have provided transport services for the Patient to any hospital as directed by the physician.³²

Failure to Ensure the Communication of Relevant Patient Information

The PACT RN documented in the Patient's EHR "...[family member]is present and is taking [the Patient] directly to [non-VA hospital A] and would like clinic to call ahead to let them know [the Patient] is coming. I will call report to ED as requested by patient and family." However, the EHR contains no documentation that the PACT RN made a call. When interviewed the PACT RN reported calling non-VA hospital A and did not know why the EHR did not contain documentation. When interviewed the PCP reported not contacting non-VA hospital A about the Patient.

The PACT staff outlined that if an ambulance transported the Patient, the pertinent EHR documentation would have been copied and sent with the Patient to the receiving hospital. While the staff documented in the EHR that the Patient was going with family for emergency care, they did not send medical information with the Patient. These omissions, however, did not likely change the Patient's course and ultimate clinical outcome.

³¹ Although not documented, non-VA hospital C that staff offered emergency transport to did not have a level of care that was needed to treat the Patient's toe ischemia with developing gangrene.

³² Two of the ambulance companies confirmed they would have provided transport to non-VA hospital B, which had the necessary level of care for the Patient. The third ambulance company did not respond to the OIG.

Issue 3: Process for Management of Health Emergencies

The Petersburg CBOC did not have a policy or standard operating procedure (SOP) for the management of health emergencies. During the OIG team's visit to the Petersburg CBOC, the staff did not provide, and the Facility's Chief of Quality Management confirmed the CBOC did not have a policy or SOP for the management of health emergencies.

VHA requires each CBOC to have a local policy or SOP defining how health emergencies are handled.³³

Issue 4: Health Record Documentation

The CBOC PACT staff did not ensure accurate health record documentation that contained clinically-relevant statements for the Patient.

On POD 10, the PCP examined the Patient but did not document specifics of, or planned care for, the Patient's toe ischemia with developing gangrene. Additionally, the PCP documented a different hospital location that the Patient was going to for care after being evaluated at the CBOC. The PCP documented in the progress note that the Patient's family member insisted on taking the Patient to non-VA hospital B; however, the PCP entered an ED consult for non-VA hospital A. The PACT RN did not document the completion of a call to non-VA hospital A when the Patient and family member left the CBOC for further care.

VHA requires the scope of documentation in the health record to reflect accurate and clinically-relevant statements and be comprehensive enough to provide continuity of care and be concise and complete.³⁴

Conclusion

The OIG found that, in general, the Patient's immediate postoperative care was proper. However, the OIG had concerns with the Patient's management when the Patient presented to the community based outpatient clinic (CBOC) 10 days after the EVAR with signs and symptoms of a known vascular procedure complication.

After the EVAR, the Patient's clinical condition was consistent with CES, which has no accepted specific therapy. Management consists of supportive care and general measures to address atherosclerosis and arterial ischemia. On POD 14, the Patient had amputations of three toes and

³³ VHA Handbook 1006.1 was in place at the time of the events described in this report. This Handbook was rescinded and replaced by VHA Directive 1229 and contains same or similar language related to CBOC policy or SOP for health and mental health emergencies.

³⁴ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

was noted to have osteomyelitis in the amputated bone. The OIG could not determine if earlier toe amputations would have prevented osteomyelitis.

On POD 10, after determining the Patient was experiencing a medical emergency, Petersburg CBOC PACT staff did not ensure coordination of the Patient's subsequent care. Staff failed to facilitate a safe transition between the Petersburg CBOC and a non-VA hospital equipped to treat the Patient's toe ischemia with developing gangrene. Staff did not communicate relevant information or provide health record information to providers at the non-VA hospital upon learning where the Patient planned to seek emergency treatment.

The OIG found deficiencies in VHA policy compliance with the lack of policy or SOP on the management of health emergency in the CBOC and inconsistent health record documentation for this patient. The Petersburg CBOC did not have a policy or SOP to handle health emergencies, and the Petersburg CBOC PACT staff did not ensure accurate patient health record documentation that contained clinically-relevant statements.

The OIG made three recommendations.

Recommendations 1–3

1. The Martinsburg VA Medical Center Director evaluates the coordination of care processes at the Petersburg Community Based Outpatient Clinic and takes action as necessary based on the findings.
2. The Martinsburg VA Medical Center Director ensures the development and implementation of a policy or standard operating procedure for the management of health emergencies at the Petersburg Community Based Outpatient Clinic, and Petersburg Community Based Outpatient Clinic staff receive training on the policy or standard operating procedure.
3. The Martinsburg VA Medical Center Director evaluates the Petersburg Community Based Outpatient Clinic Patient Aligned Care Team patient health record documentation for accurate and clinically-relevant statements and takes action as necessary based on the findings.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 28, 2018

From: Acting Director, VA Capitol Health Care Network (10N5)

Subj: Healthcare Inspection— Postoperative Care Concerns for a Vascular Surgical Patient, Martinsburg VAMC, West Virginia

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, Postoperative Care Concerns for a Vascular Surgical Patient, Martinsburg VA Medical Center (VAMC), West Virginia. Further, I have reviewed and concur with the Martinsburg VAMC, Medical Center Director's response to the findings and recommendations.
2. Thank you for this opportunity to focus on continuous performance improvement. If you have any questions, please feel free to contact the VISN 5 Office at 410-691-1131.

(Original signed by:)

Raymond Chung, M.D.

Acting Director, VA Capitol Health Care Network

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 27, 2018

From: Director, Martinsburg VA Medical Center (613/00)

Subj: Healthcare Inspection— Postoperative Care Concerns for a Vascular Surgical Patient, Martinsburg VAMC, West Virginia

To: Acting Director, VA Capitol Health Care Network (10N5)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, Postoperative Care Concerns for a Vascular Surgical Patient, Martinsburg VAMC, West Virginia.
2. The Martinsburg VA Medical Center has developed action plans to address the three recommendations. The recommendations will strengthen our process to deliver consistent quality care to our Veterans.

(Original signed by:)

Kenneth W Allensworth
Associate Medical Center Director

for

Timothy J. Cooke

Comments to OIG's Report

Recommendation 1

The Martinsburg VA Medical Center Director evaluates the coordination of care processes at the Petersburg Community Based Outpatient Clinic and takes action as necessary based on the findings.

Concur.

Target date for completion: August 31, 2018

Director Comments

In May 2018 Primary Care Leadership reinforced via email, to all providers and front line staff the importance of provider to provider and nurse to nurse handoff to ensure optimum coordination of care. Each inter and intra facility transfer should be documented within the electronic medical record and include details of the hand-off to the receiving facility as well as transportation options provided to the Veteran and/or family. The Chief of Staff will direct a review of patient transfers from the Petersburg CBOC to a higher level of care to ensure coordination of care is clearly documented with a minimum compliance of ninety percent (90%) over a ninety (90) day period. Primary Care leadership will continue to reinforce and tailor educational opportunities as needed for all CBOC staff. Any outliers or issues of non-compliance will be elevated to the Chief of the Service immediately.

Recommendation 2

The Martinsburg VA Medical Center Director ensures the development and implementation of a policy or standard operating procedure for the management of health emergencies at the Petersburg Community Based Outpatient Clinic, and Petersburg Community Based Outpatient Clinic staff receive training on the policy or standard operating procedure.

Concur.

Target date for completion: June 30, 2018

Director Comments

The Primary Care Service has developed a Standard Operating Procedure (SOP) for the identification and management of medical emergencies in all CBOCs. This SOP was reviewed in December 2017 by all applicable Administrative and Clinical Service Chiefs and officially implemented in January 2018. Prior to implementation, all CBOC providers and front line staff received education regarding clinical responsibilities and treatment of medical emergencies. On June 21, 2018 education reinforcement will occur via teleconference with the Petersburg CBOC

staff. Emphasis will be placed on transparency and communication between internal and external caregivers to ensure Veterans receive immediate and appropriate clinical treatment for medical emergencies. Owing to this most recent event, training will be repeated and reinforced for all CBOC staff, not just Petersburg, as well as being included in staff orientation.

Recommendation 3

The Martinsburg VA Medical Center Director evaluates the Petersburg Community Based Outpatient Clinic Patient Aligned Care Team patient health record documentation for accurate and clinically-relevant statements and takes action as necessary based on the findings

Concur.

Target date for completion: September 30, 2018

Director Comments

The Chief of Staff reviewed documentation expectations during the June 2018 Medical Staff meeting. The Chief of Staff will direct a random chart audit to review the quality of care provided at the Petersburg CBOC by all providers and nurses to ensure clinical interventions are clearly documented with a minimum compliance of ninety percent (90%) over a ninety 90-day period. Appropriate follow-up reviews will be conducted via peer review or FPPE [Focused Professional Practice Evaluation³⁵] for cause.

³⁵ The OIG inserted the term Focused Professional Practice Evaluation within brackets for reader clarification. Focused Professional Practice Evaluation (FPPE) is used for the new provider and the provider who requests new privileges, as well as when professional practice concerns are identified. VHA Handbook 1100.09, Credentialing and Privileging, October 15, 2012. This directive expired October 30, 2017 and has not been updated.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Maryland: Benjamin L Cardin, Chris Van Hollen
Virginia: Tim Kaine, Mark R. Warner
West Virginia: Shelley Moore Capito, Joe Manchin III
U.S. House of Representatives:
Maryland: John K. Delaney, Jamie Raskin
Virginia: Barbara Comstock, Bob Goodlatte
West Virginia: Evan Jenkins, David B. McKinley, Alexander X. Mooney

The OIG has federal oversight authority to review the programs and operations of VA medical facilities. OIG inspectors review 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 leadership on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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