DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland

HEALTHCARE INSPECTION | REPORT #22-01668-45 | JANUARY 25, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation that a patient received poor care in the Emergency Department at the Baltimore VA Medical Center (facility) in Maryland, which resulted in an amputation at the patient's left forearm at a non-VA hospital days later.

Patient Case Summary

In early fall 2021 (first visit), the patient, with a medical history significant for poorly controlled type II diabetes, presented to the facility's Emergency Department complaining of left hand pain with a ring stuck on the middle finger after sustaining a fall injury.[1] The patient also complained of chronic left knee pain. An Emergency Department attending physician (attending) examined the patient for swelling and tenderness of the left middle finger and after an unsuccessful attempt utilizing a ring cutter to remove the ring, called the local fire department, who successfully removed the ring.[2] The attending diagnosed the patient's condition as a sprained hand, noted that the pain improved, prescribed medications for pain, and discharged the patient home.

The following day (second visit), the patient returned to the facility's Emergency Department with continuing left hand and knee pain. A physician assistant examined the patient's left hand and observed redness, swelling, and a superficial open wound to the middle finger. The physician assistant documented in the electronic health record (EHR) the consideration between gout and cellulitis of the hand (cellulitis) as a diagnosis, the previous day's x-ray of the left hand (with interpretive findings to include "[g]eneralized soft tissue swelling about the hand"), and prescribed the patient two oral antibiotics for possible cellulitis, a tapering corticosteroid (steroid) regimen for possible gout, and pain medication.[3] The patient was instructed to "return if no improvement or symptoms are worse" and follow up with Primary Care. Of note, the patient departed the facility following the Emergency Department second visit with the prescribed pain

[1] "What is Diabetes?" National Institute of Diabetes and Digestive and Kidney Disease (NIDDK), accessed May 3, 2022, https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes. Type II diabetes, the most common form, is caused by the body's lack of insulin production or use of insulin. Insulin is a hormone that helps the body take in glucose (sugar) from the blood and is used in the treatment of diabetes, helping to regulate the body's blood sugar. The patient established care with a facility primary care provider in mid-summer 2021.

[2] *Merriam-Webster.com Dictionary*, "attending," accessed May 3, 2022, https://www.merriam-webster.com/dictionary/attending. Attendings are physicians with primary responsibility of a patient's treatment and have the responsibility of supervising another provider's patient care.

[3] Mayo Clinic, "Gout," accessed March 14, 2022, https://www.mayoclinic.org/diseases-conditions/gout/symptoms-causes/syc-20372897. Gout is a form of arthritis that presents with "sudden, severe attacks of pain, swelling, redness, and tenderness in one or more joints." Mayo Clinic, "Cellulitis," accessed March 4, 2022, https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762. Cellulitis is a common but "potentially serious" skin infection that can cause the affected skin to appear swollen and painful.

medicine in hand, but without either the oral antibiotics or the steroid. According to facility pharmacy records, these medications were mailed to the patient the next day.

Two days after the second visit, the patient presented to a non-VA emergency department and was admitted for left hand cellulitis with pain, suspected sepsis, hyperglycemic hyperosmolar state, and loss of consciousness.[4] At the time of presentation to the non-VA emergency department, the patient's laboratory studies revealed an elevated white blood cell count and glucose levels consistent with an active infection and poor control of diabetes. After being transferred to another non-VA hospital, the patient's condition quickly deteriorated further to septic shock, leading to an amputation at the left forearm four days later.[5]

Inspection Results

The OIG substantiated that the patient received poor Emergency Department care. During the second visit, the physician assistant failed to obtain laboratory studies in a patient with known diabetes and a working diagnosis of soft tissue infection of the hand. The lack of consideration of the patient's diabetic condition in this setting did not allow the physician assistant to make a comprehensive clinical assessment of the patient.[6] In addition, the physician assistant was uncertain as to a precise diagnosis and did not document seeking clinical consultation with the attending physician overseeing the physician assistant (overseeing attending), who was on the premises and would have been available to see the patient. The overseeing attending did not recall the physician assistant seeking consultation regarding the patient that day. However, after reviewing the patient's care in the EHR several days later, the overseeing attending failed to identify concerns with the physician assistant's care of the patient. These failures may have contributed to the patient's amputation. Additionally, although not allegations, the OIG determined that the patient's primary care provider (PCP) did not maintain the patient's problem list in the EHR, to include the diagnosis of diabetes. The OIG also determined that Emergency Department providers, during both visits, failed to address the patient's second chief complaint of knee pain, which contributed to the overall poor Emergency Department care received by the patient.

[4] Mayo Clinic, "Hyperglycemia in diabetes," accessed June 8, 2022, https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631. Hyperglycemic hyperosmolar state occurs when the insulin a person produces does not work properly, causing increased urination that can lead to life-threatening dehydration. Mayo Clinic, "Sepsis," accessed June 2, 2022, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214. Sepsis "occurs when the body's response to an infection damages its own tissues," impacting organ function, and is potentially life threatening.

[5] Mayo Clinic, "Sepsis," accessed June 2, 2022, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214. Sepsis can progress to septic shock, which is characterized by decreased blood flow to organs that can lead to organ failure or death.

[6] In contrast with the first visit, the physician assistant's description of the patient's physical examination included findings suggestive of a soft tissue infection of the hand.

Patients with diabetes "are more susceptible to infection," such as cellulitis. Cellulitis is a common and "potentially serious" skin infection, occurring when bacteria enter the body through a break in the skin. Cellulitis may cause the affected skin to appear swollen and patients may note pain.[7] Early identification and prompt treatment with appropriate antibiotics is critical, as cellulitis can spread through the body and "rapidly become life-threatening."[8] Effective treatment of cellulitis in people with diabetes is important to lessen the risk of long-term disability, amputation, or death.[9]

Emergency medical care providers are responsible for ordering clinically appropriate laboratory studies for patients with suspected infection, such as a white blood cell count and a blood glucose level.[10] The Veterans Health Administration (VHA) expects providers to document a patient's relevant health history and present illness, and include evidence of medical decision-making to determine a patient's diagnosis and treatment plan.[11] VHA authorizes physician assistants to be responsible for patient care but requires oversight from an attending. Should a physician assistant determine guidance is needed from an attending to provide care to a patient, that consultation must be documented by the physician assistant in the patient's EHR.[12]

According to EHR documentation, the physician assistant completed a physical examination of the patient with findings of an infected hand but did not order any laboratory studies. The physician assistant told the OIG that although laboratory studies "probably should have been done," the patient did not have a fever, the wound "didn't look that bad," and obtaining laboratory studies was not the physician assistant's typical practice. The EHR showed that the physician assistant reviewed the patient's active medications, including two medications labeled "for diabetes," but did not include diabetes in the assessment. When the OIG asked why the

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[7] Dimitrios A. Flevas, et al., "Infections of the hand: an overview," *EFORT Open Rev,* Vol. 4 (May 2019): 183-193.

[8] *Merriam-Webster.com Dictionary*, "antibiotic," accessed July 18, 2022, https://www.merriam-webster.com/dictionary/antibiotic. A substance used to treat or prevent infections. Ahmed Suparno Bahar Moni, et.al, *The Journal of Hand Surgery (Asian-Pacific Volume), Vol. 24, No. 03*, 2019 (317:322), "Diabetic Hand Infection: An Emerging Challenge," accessed March 4, 2022, https://www.worldscientific.com/doi/10.1142/S2424835519500401.

[9] Dimitrios A. Flevas, et al., "Infections of the hand: an overview." Ahmed Suparno Bahar Moni, et. al., "Diabetic Hand Infection: An Emerging Challenge."

[10] Facility memo No. 512-101/AECC-002, "Emergency Medical Care," November 2017. Mayo Clinic, "High White Blood Cell Count," accessed July 19, 2022, https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/definition/sym-20050611. A high white blood cell count is an increase in the type of blood cells that fight infections. Mayo Clinic, "High White Blood Cell Count," accessed July 19, 2022, https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/causes/sym-20050611. A high white blood cell count could indicate an infection or inflammation. Cleveland Clinic, " Blood Glucose Test," accessed July 19, 2022, https://my.clevelandclinic.org/health/diagnostics/12363-blood-glucose-test. A blood glucose test measures the amount of glucose in a person's blood to screen for diabetes. Higher glucose levels may indicate pre-diabetes or diabetes.

[11] VHA Health Information Management Office of Health Informatics, "VHA Clinical Documentation Integrity Program Guide," January 2022.

[12] VHA Directive 1063, *Utilization of Physician Assistants*, December 24, 2013.

assessment did not include the patient's diabetic condition, the physician assistant stated, "I can't answer that," but acknowledged the condition should not have been omitted from the EHR note that day. The physician assistant recalled discussing the case face-to-face with the overseeing attending given the considerations of cellulitis or gout as diagnoses based on the patient's presentation. However, the physician assistant did not document discussing the patient with the overseeing attending in the patient's EHR "probably due to rushing" while writing the assessment note.

The overseeing attending's clinical oversight of the physician assistant did not identify or intervene in the failures of the physician assistant's care plan upon supervisory review. VHA requires overseeing physicians to assure that care provided by a physician assistant is medically appropriate, and facility policy states that Emergency Department attending physicians may provide clinical oversight of a physician assistant's care through review of medical record documentation.[13]

According to the EHR, the overseeing attending's assurance of appropriate patient care took place through a review of the physician assistant's documented care of the patient, which included a list of current medications, including two diabetic medications; a physical examination of the patient's left hand with noted swelling, redness, and a "superficial open wound;" and the physician assistant's assessment and treatment plan, including oral antibiotics, a steroid regimen, and oral pain medication. The plan did not include assessment of the patient's blood sugar or other laboratory studies. The overseeing attending documented agreement with the physician assistant's assessment and care in the patient's EHR. The OIG reviewed the physician assistant's EHR entry with the overseeing attending, noting that the patient's diabetes was not documented as a consideration in the clinical assessment and treatment plan. The attending physician was asked whether consideration of the patient's diabetic condition may have changed the outcome. The attending physician responded that the patient's diabetes was not a significant consideration in the clinical decision-making. When the OIG questioned the overseeing attending whether consideration of the patient's diabetic condition may have changed the outcome, the overseeing attending responded "No," and when asked why stated, "I think whether or not the patient was a diabetic, that the major decision-making points were on the appearance of the wound."

Contrary to the overseeing attending's stated opinions, the facility's Chief of Staff and chief of Emergency Department, during interviews with the OIG, expressed concerns with the physician assistant's care. Specifically, the Chief of Staff agreed the absence of laboratory studies was a missed opportunity and the chief of Emergency Department agreed that the patient received substandard care during the second visit and, based on a review of the EHR, expressed concern about a "significant" hand infection. The patient's EHR confirmed that an institutional disclosure

[13] VHA Directive 1063. Facility memo 512-101/AECC-002.

was conducted with the patient and the patient's family member in mid-spring 2022, and outlined plans to educate Emergency Department staff on the presentation and treatment of "septic arthritis" and "infections of the hand."[14] The OIG concluded that the overseeing attending's agreement with the physician assistant's documented care led to missed opportunities for the patient to receive further assessment or additional care.

The OIG found that although the condition of diabetes was documented in the patient's EHR at the facility as far back as mid-summer 2021, the patient's problem list was not updated to include diabetes at that time and was only updated after this inspection. The Centers for Medicare and Medicaid Services require healthcare facilities to maintain an up-to-date problem list of current and active diagnoses, which provides health care professionals a way to identify, manage, and communicate patients' individual medical needs and guide decision-making for treatment.[15] The PCP told the OIG that although aware of having responsibility to update the problem list, the omission of the patient's diabetic condition was not intentional, and the patient's diabetes was documented in PCP progress notes in the EHR. However, the OIG found through interviews that Emergency Department staff relied on the problem list. The OIG determined that, had the problem list included the patient's diagnosis of diabetes, Emergency Department staff would have been more informed as to this additional risk factor for a serious infection.

The OIG found no documentation that the attending during the first visit acknowledged the patient's second chief complaint of "chronic left knee pain." During the second visit, the physician assistant acknowledged the patient's complaint of knee pain in the EHR note, but the OIG found no documentation of assessment. Emergency care services include the assessment of pain and referral for additional care as needed. If a patient presents to the Emergency Department with a "chronic non-urgent problem," the patient will be offered referral for assessment as appropriate.[16] The OIG asked the attending and the physician assistant why the patient's knee pain was not addressed. The attending responded that the patient's knee pain was chronic and not

[14] Of note, the initiation of the review of Emergency Department care for the second visit occurred in early spring 2022, shortly after the OIG announced the hotline inspection. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is an administrative process in which VA facility leader(s), with clinicians as appropriate, inform a patient or patient's representative that care received is believed to have resulted in serious injury. Also discussed are the patient's or patient's representative's option to obtain outside medical or legal advice.

[15] "EHR Incentive Program," Centers for Medicare and Medicaid Services, accessed May 9, 2022, https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/3_maintain_problem_listep.pdf. CMS defines a problem list as a list of past, current, and active diagnoses relevant to the care of a patient. Jeff Hummel and Peggy Evans. "Standardizing the Problem List in the Ambulatory Electronic Health Record to Improve Patient Care," Washington and Idaho Regional Extension Center, Qualis Health, Regional Extension Center (The Office of the National Coordinator for Health Information Technology), and National Learning Consortium, December 2012, https://www.healthit.gov/resource/standardizing-problem-list-ambulatory-ehr-improve-patient-care.

[16] Facility memo 512-101/AECC-002.

urgent, and the physician assistant recalled asking the patient which complaint was of larger concern, to which the patient reportedly replied, the hand. As one of two chief complaints that brought the patient to the facility, the OIG would have expected the patient's second chief complaint of knee pain to have been included in the physical examination and possibly considered for referral for further assessment.

The OIG made four recommendations to the Facility Director related to ensuring Emergency Department providers conduct comprehensive clinical assessments and address patients' presenting complaints; evaluation of the clinical consultation process for Emergency Department physician assistants, and the status and closure of the planned education for Emergency Department staff; and maintaining up-to-date problem lists to ensure the list reflects current and active diagnoses.

VA Comments and OIG Response

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

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Contents

Abbreviations

EHR	electronic health record
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 an allegation that a patient received poor care in the Emergency Department at the Baltimore VA Medical Center (facility), which resulted in an amputation at the patient's left forearm at a non-VA community hospital days later.

Background

The facility is part of the VA Maryland Health Care System (system), which consists of three VA medical centers: the facility, located in Central Baltimore City; Loch Raven, located in Northern Baltimore City; and Perry Point, located in Cecil County. The system, aligned under Veterans Integrated Service Network (VISN) 5, has five community-based outpatient clinics serving multiple counties and a Homeless Community Resource and Referral Center located in the Baltimore Annex. The Veterans Health Administration (VHA) classifies the facility as a level 1b complexity.[1] The facility is affiliated with the University of Maryland School of Medicine.

Diabetes Mellitus and Infections

Diabetes mellitus (diabetes) is a disease that occurs when the body does not utilize or does not produce enough insulin, resulting in high blood sugar. Elevated blood sugar may cause a multitude of health problems.[2] Patients with certain health factors and conditions, including diabetes, "are more susceptible to infection."[3] Cellulitis is a common and "potentially serious" skin infection, occurring when bacteria enter the body through a break in the skin. Cellulitis may cause the affected skin to appear swollen and patients may note pain.[4] Early identification and prompt treatment with appropriate antibiotics is critical, as cellulitis can spread through the body

[1] VHA Office of Productivity, Efficiency, and Staffing. "The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex." A level 1b facility has "medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs."

[2] "Diabetes," National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), accessed May 3, 2022, https://www.niddk.nih.gov/health-information/diabetes. *Merriam-Webster.com Dictionary*, "diabetes mellitus," accessed June 6, 2022, https://www.merriam-webster.com/dictionary/diabetes%20mellitus. *Merriam-Webster.com Dictionary*, "insulin," accessed May 31, 2022, https://www.merriam-webster.com/dictionary/insulin. Insulin is a hormone that helps the body take in glucose (sugar) from the blood and is used in the treatment of diabetes, helping to regulate the body's blood sugar.

[3] Dimitrios A. Flevas, et al., "Infections of the hand: an overview," *EFORT Open Rev,* Vol. 4 (May 2019): 183-193.

[4] Mayo Clinic, "Cellulitis," accessed March 4, 2022, https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762.

and "rapidly become life-threatening."[5] Effective treatment of hand infections, commonly including cellulitis, in people with diabetes is important to lessen the risk of long-term disability, amputation, or death.[6]

Allegation and Related Concerns

On February 2, 2022, the OIG received a complaint regarding the care a patient received at the facility's Emergency Department on consecutive days in early fall 2021. The patient was treated for removal of a ring, lodged on the patient's finger due to swelling after a fall, and continued pain, swelling, and a newly noted open wound to the finger. The OIG reviewed the complaint on February 15, 2022, noting that the patient was discharged from the Emergency Department with no scheduled follow-up and, days later, was treated at a non-VA hospital for a severe hand infection, including amputation at the patient's left forearm.

Concerned that the Emergency Department care of the patient may have contributed to the need for the amputation, the OIG opened a hotline on February 22, 2022. During the inspection, the OIG identified additional concerns related to the oversight of the Emergency Department care provided, documentation of the patient's chronic health problems, and evaluation of the patient's presenting conditions.

Scope and Methodology

The OIG initiated the inspection on March 17, 2022, and conducted a virtual site visit beginning March 28. The OIG interviewed the facility's Chief of Staff, chief of Emergency Department, patient safety manager, risk manager, and Emergency Department attending physicians (attendings), a physician assistant, a primary care provider (PCP), and nurses with knowledge of the patient's care.[7]

The OIG reviewed relevant VHA directives; facility policies and procedures; internal reviews of the patient's care, including quality management reviews and action plans; and supervisory and proficiency documentation for select Emergency Department staff. Additionally, the OIG

[5] *Merriam-Webster.com Dictionary*, "antibiotic," accessed July 18, 2022, https://www.merriam-webster.com/dictionary/antibiotic. A substance used to treat or prevent infections. Mayo Clinic, "Cellulitis," accessed March 4, 2022, https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762. Ahmed Suparno Bahar Moni, et.al, *The Journal of Hand Surgery (Asian-Pacific Volume), Vol. 24, No. 03*, 2019 (317:322), "Diabetic Hand Infection: An Emerging Challenge," https://www.worldscientific.com/doi/10.1142/S2424835519500401.

[6] Dimitrios A. Flevas, et al., "Infections of the hand: an overview." Ahmed Suparno Bahar Moni, et. al., "Diabetic Hand Infection: An Emerging Challenge."

[7] *Merriam-Webster.com Dictionary*, "attending," accessed May 3, 2022, https://www.merriam-webster.com/dictionary/attending. Attendings are physicians with primary responsibility of a patient's treatment and have the responsibility of supervising another provider's patient care.

reviewed the patient's electronic health record (EHR) and non-VA records from community hospitals from early fall through December 2021.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, 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, who was in their seventies with a medical history that included homelessness, coronary artery disease, hypertension, osteoarthritis, and poorly controlled type II diabetes, established care with a facility PCP in mid-summer 2021.[8] At the initial visit, the PCP

[8] The OIG uses the singular form of they (their) in this instance for privacy purposes. According to the patient's EHR, the patient was established in a VA housing program and resided at a local shelter. *Merriam-Webster.com Dictionary*, "coronary heart disease," accessed May 31, 2022, https://www.merriam-webster.com/dictionary/coronary%20heart%20disease. Coronary artery disease is a condition that reduces blood flow from the arteries into the heart and "typically results in chest pain or heart damage." Mayo Clinic, "high blood pressure (hypertension)," accessed May 31, 2022, https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410. Hypertension is when blood pressure, the force of blood against the artery walls, is high enough to eventually cause heart disease. Mayo Clinic, "osteoarthritis," accessed May 31, 2022, https://www.mayoclinic.org/diseases-conditions/osteoarthritis/symptoms-causes/syc-20351925. Osteoarthritis is a common form of arthritis that occurs when the tissue between the ends of the bone in a joint (cartilage) wears down over time resulting in pain, stiffness, and swelling. "What is Diabetes?" National Institute of Diabetes and Digestive and Kidney Disease (NIDDK), accessed May 3, 2022, https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes. Type II diabetes, the most common form, is caused by the body's lack of insulin production or use of insulin.

documented that the patient had a hemoglobin A1C of 14.3 percent one year prior.[9] The PCP ordered laboratory studies, and also noted the patient was prescribed two diabetic medications, alogliptin and metformin. Two months later, the PCP notified the patient that the hemoglobin A1C result of 9.2 percent was improved, but out of range and referred the patient to a pharmacist for diabetes management. On the scheduled appointment date, the pharmacist made several attempts to reach the patient but was unable to make contact because the patient was in the Emergency Department. The pharmacist requested assistance from the medical support assistant in rescheduling the appointment for a date later that month.

In early fall 2021 (first visit), the patient presented to the facility's Emergency Department complaining of left hand pain with a ring stuck on the middle finger after sustaining a fall injury. The patient also presented for the complaint of chronic left knee pain. The triage nurse assessed the patient and documented a pain level of 10.[10] An Emergency Department attending physician (attending) examined the patient for mild emotional distress as well as swelling and tenderness of the left middle finger. After an unsuccessful attempt by the attending to remove the ring with a ring cutter, the local fire department responded to a request for assistance and successfully removed the ring. The attending obtained an x-ray of the left hand and interpreted the results to show "degenerative changes but no displaced fracture."[11] The attending diagnosed the patient's condition as a sprained hand, noted an improved pain level of eight, prescribed acetaminophen for pain, and discharged the patient.

The following day (second visit), the patient returned to the facility's Emergency Department with continuing left hand pain and right knee pain.[12] The triage nurse documented that the patient was seen in the Emergency Department the previous day, and noted that the patient's pain rating was a level 10. A physician assistant examined the patient's left hand and observed redness, swelling, and a superficial open wound to the middle finger. The physician assistant documented in the EHR the previous day's x-ray of the left hand with interpretive findings to include "[g]eneralized soft tissue swelling about the hand" and consideration between cellulitis of the hand (cellulitis) and gout as diagnoses of the patient's condition. The patient received a one-time

[9] Mayo Clinic, "A1C test," accessed on May 10, 2022, https://www.mayoclinic.org/tests-procedures/a1c-test/about/pac-20384643. Hemoglobin A1C is a blood test that measures a patient's average blood glucose for the past two to three months. A common hemoglobin A1C treatment target for most people with diabetes is less than 7 percent, which is associated with lower risks of diabetes-related complications.

[10] "Resources," VHA Pain Management, accessed on October 6, 2022, https://www.va.gov/PAINMANAGEMENT/Resources.asp. Pain is scored on a scale of 0 to 10, with 0 being no pain and 10 being the most severe pain.

[11] Cleveland Clinic, "Bone Fractures," accessed May 31, 2022, https://my.clevelandclinic.org/health/diseases/15241-bone-fractures. A displaced fracture occurs when a space is created in the bone, at the breaking point, and may require surgery to correct.

[12] The OIG confirmed during an interview that the patient complained of left knee pain during the Emergency Department visits but the physician assistant later incorrectly documented right knee pain.

dose of an oral antibiotic for possible cellulitis, a corticosteroid (steroid) for possible gout, and a pain medication.[13] The patient's condition and pain level were unchanged over the course of the Emergency Department visit. The physician assistant discharged the patient with prescriptions for two oral antibiotics for possible cellulitis (cephalexin for 5 days and doxycycline for 10 days), prednisone for possible gout for 12 days, and acetaminophen with codeine for pain for 3 days. According to facility pharmacy records, the patient did not pick up the prednisone or antibiotic discharge medications prior to departing the facility. The facility pharmacy mailed the cephalexin, doxycycline, and prednisone medications to the patient the following day. Additionally, the patient was instructed to "return if no improvement or symptoms are worse" and follow up with Primary Care.

Amputation and Subsequent Outcomes

Two days after the second visit, the patient presented to a non-VA emergency department and was admitted for left hand cellulitis with pain, management of sepsis with the most likely source left hand cellulitis, hyperglycemic hyperosmolar state, and syncope (loss of consciousness).[14] After being transferred to another non-VA hospital, the patient's condition quickly deteriorated further to septic shock, leading to an amputation at the left forearm four days later.[15] During the non-VA hospital stays, the patient experienced respiratory failure and atrial fibrillation.[16] From mid-fall through December 2021, the patient had several subsequent visits at additional non-VA hospitals to treat left arm stump wound infection and persistent pain.

In mid-December 2021, following discharge from a community hospital, the patient returned to the facility's Emergency Department with concerns of bloodstream infection and was admitted

[13] Mayo Clinic, "Gout," accessed March 14, 2022, https://www.mayoclinic.org/diseases-conditions/gout/symptoms-causes/syc-20372897. Gout is a form of arthritis that presents with "sudden, severe attacks of pain, swelling, redness, and tenderness in one or more joints."

[14] Mayo Clinic, "Sepsis," accessed June 2, 2022, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214. Sepsis "occurs when the body's response to an infection damages its own tissues," impacting organ function, and is potentially life threatening. Sepsis can progress to septic shock, which is characterized by decreased blood flow to organs that can lead to organ failure or death. Mayo Clinic, "Hyperglycemia in diabetes," accessed June 8, 2022, https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631. Hyperglycemic hyperosmolar state occurs when the insulin a person produces does not work properly, causing increased urination that can lead to life-threatening dehydration.

[15] Mayo Clinic, "Sepsis," accessed June 2, 2022, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214. Sepsis can progress to septic shock, which is characterized by decreased blood flow to organs that can lead to organ failure or death.

[16] Medline Plus, "Respiratory Failure," accessed May 31, 2022, https://medlineplus.gov/respiratoryfailure.html, Respiratory failure occurs when the blood has too little oxygen, too much carbon dioxide, or both, and the body's organs may be damaged if carbon dioxide cannot be removed from the blood by breathing it out. Mayo Clinic, "Atrial Fibrillation," accessed on May 31, 2022, https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624. Atrial fibrillation is an irregular heartbeat in which the heart's upper two chambers (the atria) beat irregularly and out of coordination with the heart's lower two chambers (the ventricles). It increases the risk of stroke and other heart-related complications.

for further assessment. Although the patient did not have an active infection, the patient was experiencing emotional distress in regard to the amputation and an outpatient mental health consult was scheduled.

Inspection Results

Poor Emergency Department Care

The OIG substantiated that the patient received poor Emergency Department care during the second visit that may have contributed to the patient's amputation. The OIG found that the physician assistant failed to conduct a comprehensive clinical assessment of the patient, and the attending physician overseeing the physician assistant's care (overseeing attending) failed to identify concerns with the physician assistant's care of the patient.[17] Additionally, the OIG found that the patient's PCP did not maintain the patient's problem list in the EHR, and that Emergency Department providers failed to address the patient's second chief complaint of knee pain during both visits.

Physician Assistant's Deficiencies in the Patient's Care

The OIG found that the physician assistant failed to conduct a comprehensive clinical assessment including failure to obtain laboratory studies, consider the patient's diabetic condition as an increased risk factor of infection, and seek clinical consultation as required. According to the EHR, the physician assistant documented the patient's pain level as 10 out of 10, and noted left hand swelling, redness, and a "superficial open wound." The physician assistant considered diagnoses of cellulitis and gout, and ordered oral antibiotics, a steroid regimen, and oral pain medication.

Failure to Obtain Laboratory Studies

The OIG found no evidence that the physician assistant ordered any laboratory studies, such as a white blood cell count or glucose level, to more fully assess the patient for the presence and significance of an infection.[18]

A facility memorandum defines emergency medical care as including diagnostic studies and identifies providers as responsible for ordering clinically appropriate laboratory studies for patients.[19] The patient had poorly controlled diabetes according to the most recent laboratory

[17] In contrast with the first visit, the physician assistant's description of the patient's physical examination included findings suggestive of a soft tissue infection of the hand.

[18] Annals of Internal Medicine, "Cellulitis and Soft-Tissue Infections," accessed May 26, 2022, (acpjournals.org) https://www.acpjournals.org/doi/full/10.7326/0003-4819-150-1-200901060-01001. Clinically appropriate laboratory studies for a suspected infection, such as the patient's, include a white blood cell count and a blood glucose level.

[19] Facility memo No. 512-101/AECC-002, "Emergency Medical Care," November 2017.

studies in the EHR, and had a documented physical examination by the physician assistant with findings of an infected hand.

The physician assistant told the OIG that, in retrospect, laboratory studies "probably should have" been done but was unsure if the patient had a hand infection since the patient did not have a fever, and the wound "didn't look that bad." The physician assistant denied typically obtaining laboratory studies, stating "it's not common practice."

Two days following the patient's second visit, the patient presented to a non-VA emergency department with left hand cellulitis with pain. At the time of presentation to the non-VA emergency department, the patient's laboratory studies revealed an elevated white blood cell count and glucose levels consistent with an active infection and poor control of diabetes.[20] The patient was diagnosed with sepsis resulting from a left hand infection.

The OIG concluded that had the physician assistant obtained basic laboratory studies as part of the patient's assessment, to include white blood cell count and blood glucose, the results likely would have indicated the need for aggressive management of an infection and poorly controlled diabetes.

Failure to Incorporate the Patient's Diabetes into Assessment and Treatment Plan

The OIG found that the physician assistant did not incorporate the patient's poorly controlled diabetes into the assessment and treatment plan.

VHA expects providers to produce complete and reliable documentation of a patient's health history and present illness, including evidence of medical decision-making in determining a diagnosis and treatment plan, and outcomes of tests and treatments.[21] The Joint Commission standards state treatment decisions are dependent on analyzing information such as a patient's health history, as well as physical and functional status.[22]

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[20] Mayo Clinic, "High White Blood Cell Count," accessed July 19, 2022, https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/definition/sym-20050611. A high white blood cell count is an increase in the type of blood cells that fight infections. Mayo Clinic, "High White Blood Cell Count," accessed July 19, 2022, https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/causes/sym-20050611. A high white blood cell count could indicate an infection or inflammation. Cleveland Clinic, " Blood Glucose Test," accessed July 19, 2022, https://my.clevelandclinic.org/health/diagnostics/12363-blood-glucose-test. A blood glucose test measures the amount of glucose in a person's blood to screen for diabetes. Higher glucose levels may indicate pre-diabetes or diabetes.

[21] VHA Health Information Management Office of Health Informatics, "VHA Clinical Documentation Integrity Program Guide," January 2022.

[22] The Joint Commission E-dition, *Standards Manual*, PC 01.02.01, July 2022. "The hospital assesses and reassesses its patients."

The physician assistant reported to the OIG being aware that the patient had been in the Emergency Department the previous day but not reviewing that clinical documentation. The physician assistant treated the patient based on physical observation and the patient's report of left hand pain. According to the EHR, the physician assistant reviewed the patient's active medications, including two medications labeled "for diabetes." The OIG found no evidence of an awareness of the patient's diabetic condition in the care provided by the physician assistant. When the OIG asked why the assessment did not include the patient's diabetes, the physician assistant stated, "I can't answer that," but acknowledged diabetes should not have been omitted from the EHR note that day.

The OIG determined that, had the physician assistant considered the patient's diabetes as an additional risk factor of infection during the episode of care, the physician assistant may have recognized the seriousness and potential severity of the patient's condition.

Failure to Seek Clinical Oversight

The OIG found no documentary evidence that the physician assistant consulted with the overseeing attending regarding the patient's plan of care for the second Emergency Department visit.

VHA requires physician assistants to "practice with clinical oversight, consultation, and input by a designated collaborating physician."[23] Although a physician assistant is responsible for the patient care provided, consultation from the collaborating physician is expected when the physician assistant determines guidance is needed. The physician assistant must document any consultation in the patient's EHR.[24]

During an interview, the physician assistant reported omitting consideration of the patient's known diabetic condition as part of the assessment. The physician assistant expressed that the patient's presenting condition of either infection or inflammation caused uncertainty, so the physician assistant sought consultation from the overseeing attending who was on premises. According to the physician assistant, although the patient's condition and treatment plan was discussed with the overseeing attending, the consultation did not include mention of the patient's diabetes. The OIG found no evidence of consultation in the EHR by either the physician assistant or the overseeing attending about the patient. The physician assistant told the OIG this documentation was missing most likely due to rushing while writing the note, and the overseeing attending was unable to recall for the OIG whether consultation about the patient occurred with the physician assistant. However, the overseeing attending told the OIG there were no concerns with the physician assistant's documented care of the patient during the second visit.

[23] VHA Directive 1063, *Utilization of Physician Assistants*, December 24, 2013.
[24] VHA Directive 1063.

The OIG determined that the physician assistant failed to seek clinical oversight per VHA requirements, which prevented an opportunity for a more thorough assessment of the patient.

The OIG concluded that the physician assistant's limited clinical assessment, without laboratory studies and consideration of the patient's diabetic condition, and lack of documented consultative involvement by the overseeing attending did not support comprehensive evaluation of the patient—a person with poorly controlled diabetes with evidence of an active hand infection.

Overseeing Attending's Poor Oversight of the Physician Assistant's Care

The OIG identified concerns with the overseeing attending's clinical oversight of the physician assistant. Specifically, the overseeing attending did not identify or intervene in the failures of the physician assistant's care plan upon supervisory review.

VHA requires physicians overseeing physician assistants to assure the care provided by the physician assistant is medically appropriate. The degree of oversight provided to a physician assistant is defined by that physician assistant's scope of practice.[25] The facility emergency care memorandum states that Emergency Department attending physicians must provide clinical oversight of a physician assistant's care, such as through review of medical record documentation.[26]

The OIG learned the scope of practice for the physician assistant required Emergency Department attendings to co-sign all physical examinations, but the attending was not required to see the patient. According to the EHR, the overseeing attending served as a collaborating physician to the physician assistant's care that day and reviewed the physician assistant's care. The overseeing attending's EHR entry indicated review and agreement with the care provided as documented by the physician assistant during the second visit.[27] The physician assistant's documentation included

- a list of current medications, including two diabetic medications;
- a physical examination of the patient's left hand with noted swelling, redness, and a "superficial open wound;" and

[25] VHA Directive 1063.

[26] Facility memo 512-101/AECC-002.

[27] The overseeing attending's review of the physician assistant's care and documentation took place three days following entry of the note, which the physician assistant entered the day after the patient's second visit. The overseeing attending reported to the OIG being off duty for three days following the second visit, and reviewed the physician assistant's care as documented in the EHR upon returning for duty.

- the physician assistant's assessment and treatment plan, including oral antibiotics, a steroid regimen, and oral pain medication for a hand infection or gout, but not including assessment of the patient's blood sugar or other laboratory studies.

Although the overseeing attending did not recall consulting with the physician assistant in regard to the patient that day, the overseeing attending told the OIG that when a physician disagrees with a physician assistant's treatment, even retrospectively through medical record documentation review, "I would make an effort to reach out to the patient and figure out what the plan may need to be."

The OIG reviewed the physician assistant's EHR entry with the overseeing attending during an interview, noting that although the physician assistant documented a review of the outpatient medications, inclusive of diabetic drugs, diabetes was not included in the documented assessment and treatment plan. When the OIG questioned the overseeing attending whether consideration of the patient's diabetic condition may have changed the outcome, the overseeing attending responded "No." The overseeing attending explained, "I think whether or not the patient was a diabetic, that the major decision-making points were on the appearance of the wound." When asked if the patient's history of poorly controlled diabetes would be relevant to how the patient's care was managed, the overseeing attending responded, "I don't think the control of the diabetes played a major role in the decision-making." The OIG also inquired if it would have been reasonable for the physician assistant to have obtained laboratory studies such as a white blood cell count and a blood glucose level. The overseeing attending's opinion was "there is more stock in the clinical evaluation than the laboratory evaluation." The overseeing attending also believed "that most practicing, prudent [emergency department] physicians would have acted similarly."

Contrary to the overseeing attending's stated opinions, the facility's Chief of Staff and chief of Emergency Department expressed concerns with the physician assistant's care. When asked by the OIG about the absence of laboratory studies during the second visit, the chief of Emergency Department stated, "I would have liked to have labs on this patient." Additionally, the chief of Emergency Department agreed that the patient received substandard care during the second visit and, based on review of the EHR, expressed concern about a "significant" hand infection. The Chief of Staff recalled noting the absence of laboratory studies upon reviewing the case, and acknowledged that a finger stick could have been done due to the patient's diagnosis of diabetes. Subsequently, the Emergency Department care provided to the patient during the second visit was reviewed with follow-up action recommended and an institutional disclosure was conducted

with the patient and the patient's family member in mid-spring 2022.[28] The facility Chief of Staff outlined the facility's plan to educate Emergency Department staff on the presentation and treatment of "septic arthritis" and "infections of the hand."

The OIG concluded that the overseeing attending agreed with the physician assistant's documented care, which did not identify the patient's diabetic condition or contain laboratory studies. The lack of the overseeing attending's involvement, after review of the physician assistant's care, led to missed opportunities for more informed clinical decision-making and further care. Additionally, the OIG believes that the overseeing attending's stated position that the physician assistant provided medically appropriate care, which was not supported by facility clinical leaders, is a failure of clinical oversight.

Failure to Update Problem List

The OIG determined that the patient's PCP did not maintain the patient's problem list in the EHR to include the diagnosis of diabetes mellitus.

A problem list provides healthcare professionals a tool to identify, manage, and communicate a patient's individual medical needs and health factors, which guides decision-making for treatment.[29] The Centers for Medicare and Medicaid Services require healthcare facilities to maintain an up-to-date problem list of current and active diagnoses.[30] The problem list is a core element of the EHR because "an accurate problem list is essential to providing better individual patient care across multiple care sites."[31]

The OIG found that although the condition of diabetes was documented in the patient's EHR at the facility as far back as mid-summer 2021, the patient's problem list was not updated to include diabetes at that time and was only updated to include diabetes after this inspection. The patient's PCP told the OIG that although aware of being responsible to update the problem list,

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[28] Of note, the initiation of the review of Emergency Department care for the second visit occurred in early spring 2022, shortly after the OIG announced the hotline inspection. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is an administrative process in which VA facility leader(s), with clinicians as appropriate, inform a patient or patient's representative that care received is believed to have resulted in serious injury. Also discussed are the patient's or patient's representative's option to obtain outside medical or legal advice.

[29] Jeff Hummel and Peggy Evans. "Standardizing the Problem List in the Ambulatory Electronic Health Record to Improve Patient Care," Washington and Idaho Regional Extension Center, Qualis Health, Regional Extension Center (The Office of the National Coordinator for Health Information Technology), and National Learning Consortium, December 2012, https://www.healthit.gov/resource/standardizing-problem-list-ambulatory-ehr-improve-patient-care.

[30] "EHR Incentive Program," Centers for Medicare and Medicaid Services, accessed May 9, 2022, https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/3_maintain_problem_listep.pdf. CMS defines a problem list as a list of past, current, and active diagnoses relevant to the care of a patient.

[31] Hummel and Evans, "Standardizing the Problem List in Ambulatory EHR to Improve Patient Care."

the lack of updating was not intentional, and the patient's condition of diabetes was documented in PCP progress notes in the EHR.

However, the OIG found the problem list was a tool relied upon by staff in the Emergency Department. The OIG interviewed Emergency Department nursing staff and the physician assistant caring for the patient, and all described using the active problem list to reference the patient's medical history. Although it was not the only way described to get a patient history, when the OIG asked one Emergency Department nurse about being aware of the patient's diabetes diagnosis, the nurse replied it was not on the patient's problem list. While the patient's diabetic condition was well-documented in the EHR's Primary Care entries, the diagnosis was never incorporated into the problem list, informing Emergency Department staff of the patient's diabetic condition. Had the problem list included the patient's diagnosis of diabetes, Emergency Department staff would have been more informed as to this additional risk factor for a serious infection.

The OIG learned from the Chief of Staff that the chief of Primary Care was asked to ensure that the PCP completed this update. The Chief of Staff acknowledged that the PCP documented diabetes in EHR assessments and treatment plans but asked for the problem list update "so that everyone is well aware." Documentation in the EHR shows that in early spring 2022, the PCP updated the problem list to include diabetes.

The OIG determined that the PCP did not update the patient's problem list timely with the diagnosis of diabetes. Although a problem list is not the only way of obtaining a patient's medical history, the OIG concluded this oversight was a missed opportunity to inform Emergency Department staff during the second visit of the patient's diabetic condition as an additional risk factor of infection.

Failure to Address the Patient's Complaint of Knee Pain

The OIG found that Emergency Department providers failed to address the patient's second chief complaint of knee pain during the patient's first and second visits.

Facility policy on emergency care services includes the assessment of pain and referral for additional care as needed. If a patient presents to the Emergency Department with a "chronic non-urgent problem," the patient will be offered referral for assessment as appropriate.[32]

The OIG found no documentation that the attending during the first visit acknowledged the patient's second chief complaint of "chronic left knee pain." During the second visit, the physician assistant acknowledged the patient's complaint of knee pain in an EHR note, however, the OIG found no further documentation that addressed the patient's knee. The OIG asked the attending and the physician assistant why the patient's knee pain was not addressed. The

[32] Facility memo 512-101/AECC-002.

attending responded that as the patient's knee pain was chronic and not urgent, the focus of Emergency Department care was the patient's injured finger. The physician assistant recalled asking the patient which complaint was of larger concern, to which the patient reportedly replied, the hand; and subsequently, made the decision to focus on the hand only, despite the knee having been included as a chief complaint. The OIG would have expected the providers, at a minimum, to address the patient's additional chief complaint of knee pain through examination or referral for assessment.

The OIG concluded that the providers' failures to address the patient's knee pain contributed to the overall poor Emergency Department care received by the patient.

Conclusion

The facility's Emergency Department staff provided poor care to the patient, which may have contributed to the patient's amputation at the left forearm. Specifically, during the patient's second visit, the physician assistant did not thoroughly assess the presence of a possible hand infection, incorporate the patient's diabetic condition into the assessment and treatment decisions, and seek clinical consultation appropriately. Despite documentation acknowledging that the patient was being maintained on two drugs for the management of diabetes, the physician assistant did not assess the status of the patient's diabetic condition, which had been demonstrated to be poorly controlled approximately three weeks earlier by the PCP. Although the physician assistant was uncertain of the patient's diagnosis (cellulitis or gout) and reported seeking consultation with an overseeing attending, it was not documented in the EHR. The overseeing attending's concurrence with the physician assistant's care of the patient prohibited further assessment of the patient or additional care by the facility.

The physician assistant's deficiencies in conducting a comprehensive clinical assessment likely contributed to the patient's subsequent progressive infection and related complications. Facility leaders' response included a review of the physician assistant's care and the overseeing attending's supervision of the care and an institutional disclosure. The facility's Chief of Staff informed the patient and the patient's family that the care provided was believed to have resulted in serious injury and, therefore, outlined plans for Emergency Department staff education on the presentation and treatment of septic arthritis and hand infection.

Additional factors were found to contribute to the patient's overall poor care from the Emergency Department, however, did not likely influence the patient's outcome of amputation. Without an up-to-date EHR problem list to communicate individualized patient care needs across care settings, Emergency Department staff were not readily informed of the patient's additional risk for serious infection from diabetes. Additionally, on both Emergency Department visits, providers failed to address the patient's complaint of knee pain entirely, without assessment or referral for subsequent assessment.

The OIG made four recommendations.

Recommendations 1–4

1. The VA Maryland Health Care System Director ensures that Emergency Department providers conduct comprehensive clinical assessments and address patients' presenting complaints.

2. The VA Maryland Health Care System Director evaluates the process of clinical consultation for Emergency Department physician assistants and takes action as necessary.

3. The VA Maryland Health Care System Director evaluates the status of action plans set forth in the facility's review of the patient care from the second visit and institutional disclosure, monitoring the implementation and efficacy of action items to closure.

4. The VA Maryland Health Care System Director evaluates and strengthens the process to ensure that problem lists reflect current and active diagnoses, and takes action as necessary.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 21, 2022

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

Subj: Healthcare Inspection—Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland

To: Director, Office of Healthcare Inspections (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's draft report entitled – Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland.

2. Furthermore, I have reviewed and concur with the Medical Center Director's response and corrective actions to the recommendations. Recommendations # 1, 2, 3, and 4 are open and in progress.

3. Thank you for this opportunity to focus on continuous performance improvement. If you have any questions, please feel free to contact the VISN 5 Quality Management Officer.

(*Original signed by*:)

Raymond C. Chung
Chief Medical Officer
FOR
Robert M. Walton, FACHE
Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 17, 2022

From: Director, VA Maryland Health Care System (512/00)

Subj: Healthcare Inspection—Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland

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

1. This memorandum is in response to the Office of Inspector General's draft report entitled Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland. I have reviewed and concur with the findings and recommendations outlined in the report.

2. The VA Maryland Health Care System is submitting an initial response to Recommendations 1 through 4. Recommendations 1 through 4 will remain open and in progress.

3. Please contact me if you should have any further questions.

(*Original signed by*:)

Jonathan R. Eckman, P.E.
Director, VAMHCS

Facility Director Response

Recommendation 1

The VA Maryland Health Care System Director ensures that Emergency Department providers conduct comprehensive clinical assessments and address patients' presenting complaints.

Concur.

Target date for completion: October 2023

Director Comments

The VA Maryland Health Care System (VAMHCS) Director, in conjunction with the VAMHCS Chief of Staff (COS), will ensure that monthly chart reviews of 30 Emergency Department (ED) charts will be done to monitor that ED providers conduct clinical assessments appropriate to emergency standards of care and address patients' presenting complaints (starting in Q1 FY 2023) to ensure 90% compliance sustained over six months or two quarters. The VAMHCS COS, or appropriate designee, will present the data quarterly to the Executive Quality Council (EQC).

Recommendation 2

The VA Maryland Health Care System Director evaluates the process of clinical consultation for Emergency Department physician assistants and takes action as necessary.

Concur.

Target date for completion: October 2023

Director Comments

The VAMHCS Director, in conjunction with the VAMHCS COS will evaluate the process of clinical consultation for Emergency Department Physician Assistants. The VAMCHS will do a retrospective review from April 1, 2022, to October 30, 2022, to identify any concerns and trends that would be in an action plan that would be activated at a time when Physician Assistants are re-incorporated in a future practice model in the ED.

Recommendation 3

The VA Maryland Health Care System Director evaluates the status of action plans set forth in the facility's review of the patient care from the second visit and institutional disclosure, monitoring the implementation and efficacy of action items to closure.

Concur.

Target date for completion: January 2023

Director Comments

The VAMHCS Director, in conjunction with the VAMHCS COS, completed an Institutional Disclosure (ID) and educational plan as outlined in the ID to educate ED staff on the presentation and treatment of "septic arthritis" and "infections of the hand." Action Plan outlined in the ID will be completed by November 30, 2022. Peer Reviews were completed on the two providers involved on April 6, 2022. Both peer review reports were presented to the Peer Review Committee on April 28, 2022. Identified action plans for both providers were completed on May 5, 2022, and May 16, 2022. The Root Cause Analysis completed and presented to the Executive Leadership Team on July 11, 2022, and entered into the SPOT System July 14, 2022. Action items have been completed, outcome measures are still in progress.

Recommendation 4

The VA Maryland Health Care System Director evaluates and strengthens the process to ensure that problem lists reflect current and active diagnoses, and takes action as necessary.

Concur.

Target date for completion: October 2023

Director Comments

The VAMHCS COS will ensure that VAMHCS clinical staff are educated on the importance of the Problem List being accurate and up to date by December 30, 2022, through the Executive Council of the Medical Staff, Peer Review Committee and Service-level EQC and Departmental Meetings. The VAMHCS COS will ensure monthly chart reviews of 30 ED charts will be completed to monitor that the Problem List for Veterans presenting to the ED with a diagnosis of Diabetes Mellitus is current and contains active diagnoses (starting in Q1 FY 2023) to ensure 90% compliance sustained over six months or two quarters. Actions taken as a result of the chart reviews will be tracked through to resolution and reported. The VAMHCS COS, or appropriate designee, will present the data quarterly to the EQC.

OIG Contact and Staff Acknowledgments

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