US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in a Female Patient's Emergency Care at the Martinsburg VA Medical Center in West Virginia

Healthcare Inspection | **24-02359-123** | **May 21, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations of deficiencies in the emergency department care provided to a female patient who presented with "near constant" vaginal bleeding to the Martinsburg VA Medical Center (facility) Emergency Department and required transfer to another hospital for a higher level of care.

The OIG found deficiencies in the quality of care provided to the patient, opportunities to evaluate the equipment for gynecologic exams, avoidable delays in the patient's transfer to a higher level of care, and additional patient transport concerns. The OIG also identified failures in leaders' response to a factfinding involving emergency department nursing care and transportation concerns.

Deficiencies in Emergency Department Care

The OIG substantiated that a female patient who presented to the facility emergency department with vaginal bleeding did not receive care consistent with evidence-based clinical standards. The OIG found no deficiencies in care provided by emergency department physicians but identified multiple deficiencies in nursing care as well as lapses in communication between emergency department team members.

The OIG found that emergency department physicians performed a physical examination, including pelvic examination of the patient, and subsequently ordered an imaging study that confirmed a mass suspicious for cervical cancer.[1] The physicians provided treatment appropriate to the patient's condition and ensured clinical stability prior to transferring the patient to a community hospital for further gynecologic care. However, the OIG is concerned about lapses in communication between physician 1 and nurse 1 regarding patient monitoring, delayed initiation of a blood transfusion, and delayed laboratory results.

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

The OIG found the patient's nursing care did not meet evidence-based clinical standards or adhere to facility policy.[2] Specifically, nurse 1 failed to monitor vital signs, assess blood losses, enter required and expected documentation into the electronic health record, follow facility standard operating procedures (SOPs) for blood transfusion, or provide nursing care with sensitivity and dignity.

Nurse 1 failed to reassess the patient's vital signs during an initial assessment and instead documented the vital signs taken by the triage nurse about two and a half hours earlier. In addition, nurse 1's assessment noted the patient's self-reported vaginal bleeding during the previous hour but had no further documentation of monitoring of the patient's ongoing blood loss during her episode of care in the emergency department. Failure to appropriately monitor and assess vital signs and ongoing blood loss increased the patient's risk for serious adverse clinical events requiring more aggressive intervention.[3]

The emergency department physician ordered a "stat" blood transfusion, which was delayed by more than two hours. During an interview, nurse 1 was unable to recall why more than two hours elapsed after receiving notification that the blood was available before picking it up from the laboratory. Nurse 1 also failed to follow facility transfusion procedure by transfusing the blood at a rate too high for the patient's intravenous line size.[4] When asked about the rapid rate of transfusion, nurse 1 reported being told to transfuse the patient at "full drip"; however, the OIG found no corresponding orders in the electronic health record (EHR) and staff interviews did not corroborate this statement. Transfusion rate guidelines are intended to manage the risk of adverse transfusion reactions, and nurse 1's deviation from the facility's transfusion procedures placed the patient at increased risk for complications.

Nursing staff reported concerns regarding nurse 1's management of the patient to the acting nurse manager, who reviewed the patient's chart and relayed the concerns to the chief of ambulatory care nursing service. The chief of ambulatory care nursing service removed nurse 1

[2] Facility SOP VHA-V05-613-NUR-SOP-ED-0002, *Assessment of Vital Signs in the Emergency Department*, July 1, 2020; Facility SOP VHA-V05-613-NUR-SOP-GEN-0010, *Blood and Blood Product Transfusion*, December 29, 2021; Facility MCP [Medical Center Policy] 11-015, *Women Veterans' Services*, December 1, 2020; VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023. VHA Directive 1330.01 (6), *Health Care Services for Women Veterans,* amended September 9, 2022. The policies contain the same or similar language regarding caring for women veterans with dignity and sensitivity; Maria A. Amritzer et.al, "A New Perspective on Missed Nursing Care in the Emergency Department: A Descriptive Cross-Sectional Study," *Journal of Emergency Nursing* 50, no. 3 (May 2024): 392–402, https://doi.org/10.1016/j.jen.2023.12.006; Janice J. Twiss, "A new look at abnormal uterine bleeding," *The Nurse Practitioner* 38, no. 12 (December 2013): 22–30, https://doi.org/10.1097/01.npr.0000437574.76024.ef; Tazeen Abbas and Abbas Husain, "Emergency Department Management of Abnormal Uterine Bleeding in the Nonpregnant Patient," *Emergency Medicine Practice* 23, no. 8 (August 1, 2021): 1–20, https://pubmed.ncbi.nlm.nih.gov/34310092/.

[3] Idar Johan Brekke et al., "The value of vital sign trends in predicting and monitoring clinical deterioration: A systemic review," *PLoS ONE* 14, no. 1 (January 15, 2019), https://doi.org/10.1371/journal.pone.0210875.

[4] Facility SOP VHA-V05-613-NUR-SOP-GEN-0010, "Blood and Blood Product Transfusion," December 29, 2021.

from patient care until the patient care concerns were fully investigated.[5] During the investigation, nurse 1 was moved to the intensive care unit in a nonpatient care role.

The risk manager reported reviewing complaints about the patient's care and brought concerns to facility leaders. The Chief of Staff ordered a factfinding, and staff external to the facility were appointed to conduct the investigation.[6] The factfinding determined that "the management and documentation by [nurse 1] did not meet applicable standards of care."[7]

Approximately four months after the patient's episode of care, nurse 1 was placed on an orientation and "action plan" to return to patient care in the intensive care unit.[8] An additional four months later, nurse 1 was placed on a performance improvement plan; Nurse 1 subsequently transferred to the facility's long-term care unit prior to completion of the performance improvement plan.

The OIG is concerned that failure to monitor nurse 1's progress through completion of the performance improvement plan and lack of oversight continuity to ensure quality of care deficiencies have been sufficiently remediated could place other patients at risk.

Alleged Unavailability of Items Needed for Gynecologic Exam

The OIG did not substantiate that the emergency department lacked the appropriate instruments, supplies, and exam table to perform the gynecologic exam but found that the emergency department's gynecologic cart was not utilized by some providers due to emergency department providers reported concerns of discomfort for patients.

[5] The acting nurse manager reported seeking guidance from human resources regarding potential administrative actions and receiving guidance that any actions would need to wait until the conclusion of the factfinding. The acting nurse manager described efforts to update the emergency department's onboarding education to include training relevant to women's health, including the gynecology cart and supplies. Another nursing service leader also described efforts to provide women's health training for emergency department staff by partnering with women's health staff to obtain training, including a pelvic exam simulator; however, the nursing service leader reported few emergency department staff utilized the training tool.

[6] Factfinding reviews are tools VHA uses to complete a "systematic, thorough and objective analysis of evidence, documented in a manner that clearly conveys the facts, the evidence from which those facts are ascertained and the investigator's conclusions about disputed matters." VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021; VA can use a factfinding "... when taking administrative actions, including disciplinary actions." VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

[7] Facility memorandum, "Martinsburg Fact Finding Investigation," March 8, 2023. The factfinding detailed multiple deficiencies, including deficiencies in assessment and documentation of vital signs and blood loss, delay in blood transfusion, and failure to follow facility protocol for blood transfusion.

[8] The action plan included training on blood transfusion policy and procedures, observed blood transfusion administration to ensure policy adherence and education reinforcement, and education on the care and treatment of actively bleeding patients.

During an unannounced inspection, the OIG found that the emergency department was equipped with a gynecology cart stocked with recommended instruments, equipment, and supplies for conducting gynecologic examinations.[9]

Physician 1, who conducted the pelvic exam, reported not using the gynecologic cart with footrests for the patient's exam, and instead using an alternate method to position the patient for the gynecologic examination due to the perception that the cart positioning was uncomfortable for patients. The OIG noted the alternative positioning method reported by physician 1 was described in clinical literature to position patients for gynecologic examination when the examination bed is not equipped with footrests.[10]

While the OIG concluded that the emergency department was equipped with the necessary equipment and supplies to conduct a gynecologic exam as required by Veterans Health Administration (VHA) policy, the provider's report of not using the cart due to perceived patient discomfort suggests a need to evaluate the functionality of the equipment.[11]

Delays in Patient Transport by Facility Fire Department

The OIG determined that avoidable fire department transport issues delayed the patient's transfer to a higher level of care by approximately six hours and increased the risk of patient harm.

During interviews, two assistant fire department chiefs told the OIG that lack of staff and the inability to mandate overtime caused the transport delay. The OIG's analysis of the fire department schedule indicated that staffing resources were adequate to provide transport at the time of the physician's transfer order and dispatching a transport crew would have been in compliance with fire department minimum staffing requirements, with overtime required if the transport crew did not return to the facility prior to the end of the shift.[12] The OIG's review of position descriptions for firefighter paramedic, emergency medical technician, and transport

[9] Facility MCP 11-015, *Women Veterans' Services*, December 1, 2020.

[10] G. Richard Braen and John Kiel, "Gynecologic Procedures," chapter 57 in *Roberts and Hedges' Clinical Procedures in Emergency Medicine and Acute Care*, Elsevier, 2019, 1211–1224, ISBN 9780323354783; Margaret Klein, Mary Taylor Winsten, and Samuel Winsten, "Obstetrics and Gynecology in the Emergency Department," chapter 29 in *The Emergency Department Technician Handbook*, Elsevier, 2024. ISBN 978-0-323-83002-7.

[11] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023. The policies contain the same or similar language regarding the requirement for VA emergency departments to have the ability to perform a gynecologic examination at all times.

[12] VHA Directive 7718, *Fire Department Services at VA Medical Facilities and Domiciliaries*, June 19, 2020. VHA requires a minimum staffing level of four firefighters on duty 24 hours a day; fire department transport staff are not included in the count for minimum staffing coverage. The OIG reviewed the "Fire Department Emergency Medical Services Patient Care Report" and estimated total trip time as approximately 5 hours and 20 minutes. While it is not possible to assert that travel time would have been the same had the transport taken place at the time of the original transfer order (2:20 a.m.) rather than the following morning (8:00 a.m.), the duration suggests that a transport crew may have been able to accomplish the transport within the remaining time on shift.

paramedic revealed that they included language for mandatory overtime under these circumstances. In addition, the chief of facility management services, who provides direct oversight to the fire department, acknowledged that "confusion" about ordering mandatory overtime existed, but clarified that all fire department staff can be mandated to work overtime when needed for emergent situations.

During the inspection, the OIG learned of additional patients who experienced delayed transport to a higher level of care.[13] The OIG concluded that fire department leaders' practices were incongruent with facility policy and facility leaders' expectations regarding mandatory overtime. The ongoing lack of clarity concerning mandating overtime may have contributed to continued emergent patient transport delays.

The OIG found that facility leaders failed to assess transport delay concerns identified during the factfinding. While staff arranging emergency transports were instructed to report patient safety concerns through appropriate channels when transport was unavailable or delayed, incidents related to transport delays were not thoroughly evaluated. During an interview, the chief of facility management services described a process for reviewing reports related to patient transport delays that did not independently evaluate the adequacy of available staffing, which resulted in missed opportunities to recognize practices that contributed to delayed emergent transports.

While the facility initiated a formal review to address patient transport challenges in May 2023, as of June 2024, recommended policy and protocols identified from the review had not yet been approved by facility leaders.

The OIG made 10 recommendations to the Facility Director related to emergency department communication, adherence to VHA and facility policies, review of implemented actions to ensure quality of care concerns are remediated, evaluation of emergency department equipment for gynecologic examinations, review of overtime practices for staff providing emergency transports, and review of transportation concerns.

[13] ST-elevation myocardial infarction (STEMI) is a severe type of heart attack that "has a greater risk of serious complications and death." Cleveland Clinic, "STEMI Heart Attack," accessed September 3, 2024, https://my.clevelandclinic.org/health/diseases/22068-stemi-heart-attack.Thrombus is a blood clot that can cut off the flow of blood to organs causing a critical medical emergency. Cleveland Clinic, "Thrombosis," accessed October 1, 2024, https://my.clevelandclinic.org/health/diseases/22242-thrombosis.

VA Comments

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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Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

ALS	advanced life support
BLS	basic life support
CT	computed tomography
EHR	electronic health record
EMT	emergency medical technician
FMS	facility management services
JPSR	joint patient safety reports
OIG	Office of Inspector General
SOP	standard operating procedure
STEMI	ST-elevation myocardial infarction
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations of deficiencies in emergency department care provided to a female patient who presented with "near constant" vaginal bleeding to the Martinsburg VA Medical Center (facility) Emergency Department and required transfer to another hospital for a higher level of care.

Background

The facility, part of Veterans Integrated Service Network (VISN) 5, includes seven community-based outpatient clinics in West Virginia, Virginia, and Maryland. The Veterans Health Administration (VHA) classifies the facility as a complexity level 1c.[1] From October 1, 2022, through September 30, 2023, the facility served 39,097 unique patients, of which 3,618 were women veterans. The facility has 398 operating beds: 67 hospital, 141 community living center, and 190 domiciliary/transitional residence. The facility also has a VA fire department.[2]

Facility Fire Department Ambulance Transport

In addition to fire safety and protection duties, the facility fire department (fire department) operates an ambulance service for off-campus basic life support (BLS) and advanced life support (ALS) patient transports.[3] Fire department staffing includes firefighters and transport staff, both include emergency medical technician paramedics (paramedics) or emergency medical technicians (EMTs). According to VHA policy, a minimum of four trained firefighters must be on duty at the facility 24 hours per day to respond to on-campus emergencies. The firefighters can function as transport staff; however, transport staff cannot be counted toward meeting the minimum required on-duty staffing for firefighters.[4]

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[1] VHA Office of Productivity, Efficiency, and Staffing (OPES), "VHA Facility Complexity Model," October 1, 2023. The VHA Facility Complexity Model categorizes each medical facility by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; level 3 facilities are the least complex.

[2] VHA Directive 7718, *Fire Department Services at VA Medical Facilities and Domiciliaries*, June 19, 2020.

[3] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[4] VHA Directive 7718.

Allegations and Related Concerns

The OIG opened a healthcare inspection to evaluate allegations that

- a female patient presented for emergency care with complaints of "near constant" vaginal bleeding and received care that was inconsistent with evidence-based clinical standards of care during emergency department evaluation and treatment; and
- the emergency department did not have the appropriate instruments, supplies, and exam table equipped with footrests to perform a gynecologic exam.

In addition, the OIG identified the following concerns:

- delays in transporting the patient to a community hospital for a higher level of care,
- additional patient transport concerns, and
- failures in facility leaders' response to a factfinding involving emergency department nursing care and transportation.

Scope and Methodology

The OIG initiated the inspection on June 5, 2024, and conducted an unannounced site visit June 24–26, 2024. Virtual interviews were conducted following the site visit.

The OIG interviewed a family member of the patient; facility leaders (Director, Associate Director, Chief of Staff, emergency department medical director, chief facilities management services, fire department chief and assistant chiefs, lab supervisor, chief nurse, emergency department nurse manager and nurse supervisor); and relevant facility staff (emergency department physicians and nurses, the risk manager, the patient safety manager, an administrative officer of the day, veterans experience officer, fire department firefighter and transport staff, and women veterans program manager).

The OIG reviewed relevant VHA and facility policies and procedures, electronic health records (EHRs), Joint Patient Safety Report (JPSR) data, Patient Advocate Tracking System data,

organizational charts, training records, committee meeting minutes, email communications, quality and management reviews, transport logs, and staffing schedules.[5]

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, as amended, 5 U.S.C. §§ 401–424. 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 was in her sixties and postmenopausal with a medical history that included five full term pregnancies, surgery for ectopic pregnancy, and an abnormal pap test in 2010. The EHR documentation demonstrated a gap in VA care from 2010 to 2023.

In early 2023, the patient presented in the early evening to the facility emergency department for a complaint of vaginal bleeding for three days that had been "near constant" and described

[5] "The Joint Patient Safety Reporting (JPSR) system is the Veterans Health Administration (VHA) patient safety event reporting system and database." "JPSR as a user-based reporting system is capturing real time incident reporting data from all VHA care sites." VHA, *National Center for Patient Safety JPSR Business Rules and Guidebook*, July 2020. This guidebook was in effect during the events discussed in this report. It was replaced by VHA, *National Center for Patient Safety JPSR Guidebook*, December 2023. The guidebooks contain the same or similar language related to the JPSR system; The Patient Advocate Tracking System is a computer platform that tracks patient complaints for all VA medical facilities. VHA Directive 1003.04; *VHA Patient Advocacy*, February 7, 2018. This directive was in effect during the events discussed in this report. It was rescinded and replaced by VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023. The policies contain the same or similar language related to Patient Advocate Tracking System data.

soaking through several sanitary pads daily.[6] The patient also complained of one to two days of weakness, fatigue, lightheadedness, and dizziness as well as a loss of about 20 pounds over the last year. Additionally, the patient reported mild lower abdominal pain. The triage nurse documented the patient had an elevated heart rate with otherwise normal vital signs and assigned an emergency severity index score of 3.

An emergency department physician (physician 1) ordered laboratory studies and completed a physical exam. On physical exam, physician 1 noted the patient was alert and "comfortable-appearing" with mild tenderness and a palpable "soft ball-sized" mass in the lower left abdomen. With a female nurse chaperone present, physician 1 performed a pelvic examination and noted a "large amount of blood" with clots in the uppermost section of the vagina near the cervix and reaccumulation of blood after using gauze to absorb it.[7] Physician 1 received a report of the patient's complete blood count results showing anemia and ordered two units of blood for the patient's transfusion. Physician 1 determined the patient had an exacerbation of chronic vaginal bleeding, and planned to give intravenous fluid, obtain a computed tomography (CT) scan of the abdomen and pelvis, and reevaluate the patient.

A technician changed the patient's intravenous line and obtained blood work for blood crossmatching. Approximately two and a half hours after the patient's triage assessment, an emergency department nurse (nurse 1) documented the patient's vital signs from triage and that the patient had no pain and had used one sanitary pad in the last hour.

Physician 1 received the patient's chemistry results with a critically high blood sugar and documented a plan to treat the patient with intravenous fluid and insulin. Subsequently, physician 1 made diagnoses of severe vaginal bleeding and new onset diabetes. The patient received two intravenous fluid boluses for fluid resuscitation and underwent the CT scan.

At approximately 11:00 p.m., physician 1 documented requesting assistance from the patient flow coordinator with transferring the patient to another facility with gynecology services and documented giving care transition information to the oncoming emergency department physician (physician 2).

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[6] Vaginal bleeding is a symptom that does not distinguish the source of the bleeding, which may come from the vagina, cervix, or uterus. For the purposes of this report, vaginal bleeding is used to encompass bleeding from any of the above sources (vagina, cervix, or uterus). Medical literature defines postmenopausal bleeding as vaginal bleeding that occurs a year or more after a woman's menses have ceased. Danette B. Null, Christy M Weiland, Alicia R. Camlibel, "Postmenopausal bleeding: First steps in the workup, *The Journal of Family Practice*, October 2012, 61(10):597-604. https://www.mdedge.com/familymedicine/article/64874/womens-health/postmenopausal-bleeding-first-steps-workup; Nicole Cimino-Fiallos and Pamela L. Dyne, "Emergency Gynecologic Considerations in the Older Woman," *Emergency Medicine Clinics of North America*, May 1, 2023, 41(2):395-404. https://doi.org/10.1016/j.emc.2023.01.004; "Geriatric Gynecology," *Emergency Medicine Clinics of North America*, 2012, 30:1007–1019. http://dx.doi.org/10.1016/j.emc.2012.08.011.

[7] Facility policy requires a female chaperone for all breast and pelvic exams regardless of the provider's gender. Facility MCP [Medical Center Policy] 11-015, *Women Veterans' Services*, December 1, 2020.

Over the next few hours, nurse 1 and physician 2 documented treating the patient with blood transfusions and insulin, and that the patient maintained normal vital signs.

At 2:20 a.m., a patient flow coordinator confirmed that a community hospital emergency department accepted the patient for transfer, and the patient would be transported by the fire department. At 2:22 a.m., the patient flow coordinator documented the fire department was not able to transport the patient. The radiologist reading the patient's CT scan documented notifying physician 2 at 2:49 a.m. that the CT scan showed appendix changes consistent with appendicitis and a mass in the lower uterus and cervix consistent with cancer. During the hours awaiting transport, nurse 1 and physician 2 documented continuing treatments, including giving an antibiotic, and the patient maintained normal vital signs.

Over the next couple of hours, staff notes documented attempts to find alternate transport, including helicopter, but no transport company, including the facility fire department, accepted the patient's transport. At about 5:00 a.m., the patient flow coordinator noted the fire department called with a plan to transport the patient at 8:00 a.m. An emergency department nurse (nurse 2) documented the patient departed the emergency department at 8:49 a.m. for transport to a community hospital.

At the community hospital, a surgeon determined the patient did not have clinical appendicitis. A gynecologist admitted the patient to the hospital, and the patient underwent biopsy of the uterine and cervical mass revealing cervical cancer. A gynecologic oncologist developed a plan for the patient to undergo an outpatient positron emission tomography (PET) scan to assist in further treatment planning.

Inspection Results

The OIG found deficiencies in the quality of care provided to a female patient who presented to the facility emergency department, opportunities to improve equipment for gynecologic exams, avoidable delays in the patient's transfer to a higher level of care, and additional patient transport concerns. The OIG also identified failures in leaders' response to the concerns.

1. Deficiencies in Emergency Department Care

The OIG substantiated that a female patient who presented to the facility emergency department with "near constant" vaginal bleeding did not receive care consistent with evidence-based clinical standards. The OIG found no deficiencies in care provided by emergency department physicians but identified multiple deficiencies in nursing care as well as lapses in communication between emergency department team members.

VHA policy sets minimum requirements to ensure all enrolled women veterans are cared for with dignity and sensitivity by staff members and specifies

> All staff members providing emergent/urgent care treatment to women veterans should have sufficient training and expertise to care for women presenting with issues such as, but not limited to … acute vaginal bleeding ….[8]

In a 2014 letter, the Under Secretary for Health instructed VHA facilities to

> develop and implement written policies and processes (i.e. standard operating procedures) for managing obstetric and gynecologic emergencies that clearly describe on-site capabilities and processes/protocols for emergent patient transfer.[9]

Facility policy mirrors VHA policy and specifies that the facility

> provide high quality, timely, accessible, and comprehensive inpatient and outpatient health care to eligible women while ensuring an environment that maintains privacy, dignity, and security.[10]

Physicians Followed Evidence-Based Clinical Standards for Care

The OIG did not substantiate that the evaluations and treatments provided by physicians were outside of evidence-based clinical standards for care. The OIG determined the emergency department physicians appropriately managed the patient's vaginal bleeding. However, the OIG is concerned about lapses in communication between the emergency department team; specifically physician 1 failed to follow up with nurse 1 on the: lack of patient monitoring documentation, delay in initiation of the blood transfusion, and delayed "stat" laboratory results.[11]

In cases of abnormal vaginal bleeding, emergency physicians evaluate for life-threatening complications and obtain gynecologic consultation as needed.[12] The American College of Obstetricians and Gynecologists recommends a pelvic examination be performed when a

[8] VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023. VHA Directive 1330.01(6), *Health Care Services for Women Veterans*, February 15, 2017, amended September 9, 2022. The policies contain the same or similar language regarding caring for women veterans with dignity and sensitivity.

[9] VHA Under Secretary for Health's Information Letter, IL 10-2014-10, "Guidance on Emergency Medical Services for Women," April 15, 2014; VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023. The policies contain the same or similar language regarding processes for management of gynecologic emergencies and emergent patient transfer.

[10] Facility MCP 11-015, *Women Veterans' Services*, December 1, 2020.

[11] These issues are discussed further in the report.

[12] Joelle Borhart, "Emergency Department Management of Vaginal Bleeding in the Nonpregnant Patient," *Emergency Medicine Practice*, 15, no. 8 (August 2013), https://pubmed.ncbi.nlm.nih.gov/24044770/.

patient's medical history or symptoms, including abnormal bleeding, indicate a need for an examination.[13]

Emergency department staff deliver care in a fast-paced environment to patients with varying severity of conditions, and the care delivery requires complex communication despite many distractions and disruptions.[14] Physicians and nurses must have the ability to communicate and interact in a clear and concise manner in the emergency department's dynamic environment and frequently update one another regarding changing patient situations.[15] The complexity of care in emergency departments along with the need for frequent and rapid communication makes emergency departments potentially high risk for patient safety incidents.[16]

The OIG found the physical and pelvic examinations and the treatments provided to the patient by emergency department physicians were appropriate to the patient's condition. The physicians ensured clinical stability prior to transferring the patient to a community hospital for further gynecologic care.

The OIG is concerned about communication lapses between the emergency department team, including physician 1. The OIG would have expected physician 1 to communicate and follow up with emergency department staff about patient monitoring, delayed initiation of blood transfusion following laboratory notification of blood availability, and delayed stat laboratory results.[17] Decreased communication in a rapid-paced environment, like the emergency department, puts patients at risk for adverse clinical outcomes.

Nurse Failed to Follow Evidence-Based Clinical Standards for Care

The OIG substantiated that the nursing care provided did not meet evidence-based clinical standards and was not in compliance with facility policy. Specifically, nurse 1 failed to monitor vital signs, assess blood losses, enter required and expected documentation into the EHR, follow facility standard operating procedures (SOPs) for blood transfusion, and provide nursing care with sensitivity and dignity.

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[13] Committee on Gynecologic Practice, "ACOG Committee Opinion No. 557: Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women," *Obstetrics & Gynecology*, 2013, reaffirmed 2024, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/04/management-of-acute-abnormal-uterine-bleeding-in-nonpregnant-reproductive-aged-women.

[14] Sara Amaniyan et al., "Learning from Patient Safety Incidents in the Emergency Department: A Systemic Review," *The Journal of Emergency Medicine* 58, no. 2 (February 2020): 234–44, https://doi.org/10.1016/j.jemermed.2019.11.015.

[15] Charmaine Cunningham, "'GAMING' Communication Between Doctors and Nurses: Understanding the Interactions in the Emergency Department," *International Emergency Nursing* 58 (September 1, 2021): 101065, https://doi.org/10.1016/j.ienj.2021.101065.

[16] Amaniyan et al., "Learning from Patient Safety Incidents in the Emergency Department: A Systemic Review."

[17] These issues are discussed further in the report below.

Emergency department nurses are an essential part of a patient's care team. Lapses in nursing care present patient safety risks and are associated with lower quality of care. Nursing assessment and care includes obtaining relevant history, identifying signs of need for urgent intervention, evaluating a patient's condition including symptoms and vital signs, providing patient care based on assessment findings and physician orders, managing diagnostic tests or orders timely, and reassessing at appropriate intervals to monitor for deterioration in a patient's condition and response to interventions.[18]

Deficiencies in Assessment and Documentation of Vital Signs

Assessment of vital signs helps determine the acuity of a patient's care needs and detect signs of clinical deterioration.

The facility standard operating procedure for emergency department nursing instructs vital signs are to be obtained during the triage assessment and specifies

> Patients' vital signs are to be reassessed based on ESI [emergency severity index] level … Reassessment includes, at minimum, blood pressure, pulse, respiratory rate, pulse oximetry, and pain score …
>
> ESI [emergency severity index] 3 (Urgent): Continuous cardiac monitoring at nursing discretion. Vital signs recorded in electronic medical record no less frequently than every 2 hours for the first 4 hours and every 4 hours if clinically stable and upon discharge, transfer, or admission.[19]

The triage nurse documented the patient's vital signs shortly after the patient's arrival to the emergency department and assigned the patient an emergency severity index level 3.[20] In nurse 1's initial assessment of the patient, nurse 1 failed to reassess the patient's vital signs; rather, nurse 1 documented the vital signs taken by the triage nurse about two and a half hours earlier. Nurse 1 documented the next assessment of vital signs about six hours after triage when administering the first blood transfusion.

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[18] Maria A. Amritzer et.al, "A New Perspective on Missed Nursing Care in the Emergency Department: A Descriptive Cross-Sectional Study," *Journal of Emergency Nursing* 50, no. 3 (May 2024): 392–402, https://doi.org/10.1016/j.jen.2023.12.006.

[19] Facility standard operating procedure VHA-V05-613-NUR-SOP-ED-0002, *Assessment of Vital Signs in the Emergency Department*, July 1, 2020.

[20] Emergency severity index scores are used to sort patients into five groups, reflecting "clinically meaningful differences in physiological and psychological stability based on the assessment of vital signs and projected resource needs." Emergency Nurses Association, *Emergency Severity Index Handbook Fifth Edition* Version 5, 2023 Edition. Emergency Nurses Association, *Emergency Severity Index (ESI). A Triage Tool for Emergency Department Care*, Version 4, 2020 Edition. Unless otherwise specified, the 2023 Emergency Severity Index tool contains the same or similar language regarding the Emergency Severity Index tool as the 2020 edition.

The charge nurse reported interactions with nurse 1 during the patient's episode of care, including inquiring about nurse 1's observations of the patient's bleeding, whether nurse 1 intended to place the patient on a monitor, whether nurse 1 talked to the laboratory, and whether nurse 1 followed up with the physician regarding the patient's condition.[21] Per the charge nurse, nurse 1 responded with the intent to place the patient on a monitor but had not done so when the charge nurse inquired. The charge nurse also reported providing a wheelchair for the patient's movement around the emergency department given patient safety risk with the patient actively bleeding, after observing the patient getting up and walking, and noting this to nurse 1. The charge nurse told the OIG of having instructed nurse 1 to document all care given to the patient. Following the patient's episode of care, the charge nurse checked nurse 1's documentation in the EHR for the patient's visit and noted that the documentation by nurse 1 was "minimal."

Based on the patient's emergency severity index level of 3, the OIG would have expected, at a minimum, vital sign documentation at triage, two hours, and four hours; instead the patient had vital signs completed at triage and six hours.[22] Failure to appropriately monitor the patient's vital signs led to missed opportunities for nurse 1 to evaluate the patient's clinical status, increasing the risk for missing signs of clinical deterioration and need for further intervention.[23]

Deficiencies in Assessment and Documentation of Blood Loss

Clinical literature references evidence-based clinical standards for care and states that clinical staff should evaluate a patient's bleeding history and ongoing blood loss.[24] Soiling clothes, passing clots, feeling of a "flooding" sensation, using double sanitary pads, and changing sanitary pads at night or more frequently than every one to two hours demonstrates an abnormal bleeding pattern or excessive bleeding.

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[21] Facility documentation described the purpose of the charge nurse as streamlining "emergency department flow and improv[ing] throughput [patient flow], safety and satisfaction by coordinating patient flow and staff assignments." Core duties specified for emergency department charge nurses included, but were not limited to; posting staff assignments; conducting huddles; coordinating bed assignments for admissions with the administrative officer of the day, nursing officer of the day, and patient flow coordinator; completing shift report and handoff; monitoring Emergency Department Integration Software (EDIS) to balance assignments and prioritize high acuity patients; ensuring completion of interfacility transfer paperwork to be sent to the accepting hospital with the patient; and reporting patient safety concerns. Documentation also noted the expectation for non-day shift charge nurses to maintain direct patient care assignments.

[22] Review of facility documentation showed nurse 1's completion of emergency department orientation competency skills assessment included location and discussion of documentation requirements for each level of the emergency severity index.

[23] Idar Johan Brekke, et al., "The value of vital sign trends in predicting and monitoring clinical deterioration: A systemic review," PLoS ONE 14, no. 1 (January 15, 2019), https://doi.org/10.1371/journal.pone.0210875.

[24] Janice J. Twiss, "A new look at abnormal uterine bleeding," *The Nurse Practitioner* 38, no. 12 (December 2013): 22–30, https://doi.org/10.1097/01.npr.0000437574.76024.ef; Tazeen Abbas and Abbas Husain, "Emergency Department Management of Abnormal Uterine Bleeding in the Nonpregnant Patient," *Emergency Medicine Practice*, August 2021, 23(8):1–18.

In nurse 1's initial EHR note for the patient, entered about three hours after the patient arrived in the emergency room, nurse 1 documented the patient's self-reported vaginal bleeding with one sanitary pad used during the previous hour. The OIG's review of the EHR showed no further documentation of monitoring of ongoing blood loss during the patient's episode of care in the emergency department.

Nurse 1 told the OIG that the patient and her family member reported that the patient was "bleeding a lot" but nurse 1 did not perceive that to be the case. Nurse 1 claimed to have asked how many pads the patient soaked through but reported "it was very difficult to count the amount of the pads," which had been discarded. Nurse 1 reported the patient's family member and a certified nursing assistant changed pads and helped the patient with cleansing in the bathroom. Nurse 1 concluded that the patient's bleeding was not excessive, since the patient's clothes were clean and no blood was seen on the bed linens.

During an interview with the OIG, the patient's family member described repeatedly requesting clean supplies from emergency department staff to replace blood-soaked pads during the patient's episode of care. A certified nursing assistant (nursing assistant), who was assigned to assist in the emergency department later that night, told the OIG that the patient "went through some sanitary pads … probably like every 10 minutes." The nursing assistant reported relaying the information that the patient was using a large quantity of sanitary pads to the charge nurse and nurse 1 because the registered nurse is responsible for documenting patient blood loss in the EHR. During an interview, the charge nurse reported asking nurse 1 about the volume and nature of the patient's bleeding and noted that nurse 1's response indicated a lack of direct observation and only reflected information that was relayed by others. The charge nurse told the OIG that, despite reminding nurse 1 of the need to monitor and document the patient's status in the EHR, when the charge nurse later reviewed nurse 1's notes, documentation had been "minimal."

The OIG concluded that nurse 1 failed to follow evidence-based clinical standards for care and facility policy for assessment and documentation during the patient's time in the emergency department. Failure to appropriately monitor and assess the patient's ongoing blood loss increases the risk for serious adverse clinical events requiring more aggressive intervention.[25]

Delay in Blood Transfusion

The OIG found that nurse 1 failed to pick up the two units of blood for the patient's transfusion from the laboratory timely, resulting in delayed administration of the patient's blood transfusion by more than two hours, despite the treatment being ordered by the emergency room physician as stat. Stat medical orders should be completed quickly or immediately, meaning the blood should have been picked up as soon as available and administered.

[25] Idar Johan Brekke, et al., "The value of vital sign trends in predicting and monitoring clinical deterioration: A systemic review," January 15, 2019.

Documentation on the patient's blood transfusion record form shows that the laboratory notified the emergency department that the two units of blood were available three minutes after the results of the blood crossmatch tests ordered by physician 1 were confirmed by the laboratory technician. However, signatures documenting the laboratory technician issuing the blood and nurse 1 receiving the blood show that more than two hours elapsed before nurse 1 picked up the blood from the laboratory after notification was made to the emergency department. During an interview, Nurse 1 was unable to recall why more than two hours elapsed between the laboratory's notification that blood was available and picking up the blood from the laboratory.

The patient's EHR documented staff efforts over a period of approximately three and a half hours to identify a hospital with necessary gynecologic services that would accept transfer of the patient. Documentation indicated that one of the hospitals contacted declined to accept the transfer, believing the patient was not stable for transfer, despite the facility physician's assessment otherwise. At the time of that declination, the patient had not finished receiving the ordered blood transfusion. For a blood transfusion ordered stat, the OIG would have expected nurse 1 to retrieve the blood from the laboratory immediately or enlist assistance with obtaining the blood after the emergency department was notified the blood was available, thus initiating the blood transfusion in accordance with the stat order. While the OIG cannot determine whether the decision to accept transfer would have been different if the patient's blood transfusion had been completed, the OIG is concerned that the delay in initiating the transfusion may have delayed the patient's emergent transfer to another hospital for necessary gynecologic care.

Deficiencies in Adherence to Facility Protocol for Blood Transfusion

The OIG determined nurse 1 failed to follow facility procedure for blood product transfusion by transfusing too large of a blood volume too rapidly for the patient's intravenous line size.

The facility nursing standard operating procedure for blood transfusion states a pretransfusion evaluation should include

> (6) Establish or confirm a patent IV [intravenous line] access. A 20g [gauge] is recommended.
>
> (7) … [T]hese are the recommended IV's [intravenous lines] and rates for the gauge used …
>
> (c) 20g [gauge] -14g [gauge] ≤ 300 ml [milliliters] per hour.[26]

The SOP specifies that "Infusion must be started within 30 minutes of procuring blood" and includes the following administration guidelines

[26] Intravenous line gauge numbers are inversely related to size, with smaller gauges indicating larger catheters. Facility SOP VHA-V05-613-NUR-SOP-GEN-0010, *Blood and Blood Product Transfusion*, December 29, 2021

> (a) Initiate blood infusion at 75 ml per hour … Increase rate after 15 minutes when there are no signs of a reaction and to ensure the completion of the unit within 4 hours.
>
> 1. Infusion of Red Blood Cells is not to exceed 300 ml per hours *[sic]* …[27]

After occlusion of the patient's original intravenous line, an emergency department technician placed a new 20-gauge intravenous line in the patient's left arm. The OIG found on review of records that the transfusions for both units of blood were started within the required 30 minutes of nurse 1 procuring the blood from the laboratory. However, nurse 1 infused the first unit of blood of 500 milliliters over 65 minutes and the second unit of blood of 500 milliliters over 45 minutes.[28] Both blood units were infused too rapidly, resulting in infusion times significantly shorter than specified by facility policy.[29]

When asked about the rapid rate of transfusion, nurse 1 reported being told to transfuse the patient at "full drip" to complete the transfusion prior to the patient's transfer. However, review of EHR documentation found no orders supporting transfusion rate exceeding facility policy and staff interviews did not corroborate reported instruction for rapid transfusion. Further, the blood transfusion record showed that nurse 1 completed transfusion of the first unit of blood and began transfusion of the second unit prior to a receiving hospital being identified for the patient's transfer.

Guidelines for transfusion rates are intended to manage the risk of adverse transfusion reactions. Nurse 1's deviation from the facility's standard transfusion procedures placed the patient at increased risk for transfusion-associated circulatory overload and hemolysis of red blood cells.

Deficiencies in Sensitivity and Dignity in Care for Women Veterans

The OIG identified an additional concern related to the lack of sensitivity and dignity in care provided to the patient.

VHA policy states "all staff members assume the responsibility of caring for women Veterans with dignity and sensitivity."[30] VHA policy also directs that emergency department staff

[27] Facility SOP VHA-V05-613-NUR-SOP-GEN-0010.

[28] Review of facility documentation showed nurse 1's completion of an annual competency skills assessment for blood transfusion within the year preceding the patient's episode of care, including location of facility policies and nursing standard operating procedures for blood transfusion and identification of the rate of infusion for blood products.

[29] Memorandum, "Martinsburg Fact Finding Investigation," March 8, 2023. The OIG findings are consistent with the facility factfinding that determined "the management and documentation by [nurse 1] did not meet applicable standards of care," including deficiencies in blood transfusion policy and procedures and failure to follow facility protocol for blood transfusion.

[30] VHA Directive 1330.01(6); VHA Directive 1330.01(7).

competencies should include "sufficient training and expertise to care for women presenting with issues such as … acute vaginal bleeding."[31]

During an OIG interview, the patient's family member described poor communication and a lack of sensitivity or care for the patient's personal hygiene needs related to the ongoing vaginal bleeding. The family member explained, "I did all the bedside care that [the patient] needed [in the emergency department]. I changed the bed pads. I went and looked for the supplies in her room … asked for more diapers or something to contain the blood." The family member shared that staff in the emergency department were not responsive to the patient's condition, stating, "I felt like none of them took it seriously, almost as if we were over exaggerating the blood loss." The family member stated nurse 1 "wasn't very clear … didn't understand what was going on and it was almost like [nurse 1] was disgusted … to deal with this blood. And it was almost like we were pushed to the side until the transfer." The patient's family member also reported not receiving any assistance attending to the patient's hygiene needs until the nursing assistant was assigned to the emergency department later that night, noting, "I was very appreciative of [the nursing assistant], because there is no way I would have been able to help [the patient] stand and try to clean her off at the same time."

During an interview with the OIG, nurse 1 reported not having previous experience taking care of a patient with vaginal bleeding. When asked about the care nurse 1 provided for the patient, nurse 1 stated, "I went upstairs to look … for the blood to transfuse her, and I did the transfusion, the blood transfusion. Um, and that's pretty much that I, everything I done with her because … they were a little bit uncomfortable me being a man and she was like having female issues." However, in speaking with the patient's family member, the OIG was told the patient and family never expressed a desire to change nurses or a preference for a female nurse. Nurse 1 acknowledged that the patient's family member asked for "stuff to clean [the patient]," and reported "I went to the back to try to find out some female towels and, and we didn't have those, so I had to tell the charge nurse, [who] called the NOD [nursing officer of the day]." The nursing officer of the day obtained the requested supplies. However, nurse 1 indicated that a nursing assistant was the one who assisted the patient. The OIG noted that the nursing assistant's reported shift did not start in the emergency department until approximately 3.5 to 4 hours after the patient was placed in an emergency treatment room.

Although the OIG did not find that the identified deficiencies resulted in an adverse clinical outcome for the patient, staff's lack of attentiveness and sensitivity affected the patient's comfort level and her perception of the quality of care received at the facility.

[31] VHA Directive 1330.01 (6). VHA Directive 1330.01 (7). The policies contain the same or similar language regarding training and expertise to care for women.

Leaders' Failures to Fully Address Deficiencies in Nursing Care

While actions were taken in response to identified deficiencies in nurse 1's practice, the OIG found failures in processes to ensure that deficiencies had been fully addressed and risks mitigated.

The acting nurse manager for the emergency department described learning of concerns about the patient's care from emergency department nursing staff and reviewing documentation from the patient's episode of care over the following 24 to 48 hours. The acting nurse manager reported identifying concerns regarding deficiencies in the nursing care provided, and seeking guidance from the chief of ambulatory care nursing service. Two days later, following the patient's episode of care, the chief of ambulatory care nursing service removed nurse 1 from patient care until allegations of patient care concerns were fully investigated.[32] Nurse 1 was moved to the intensive care unit in a capacity that did not include direct patient care.

The risk manager reported reviewing complaints about the patient's care and brought concerns to facility leaders. Approximately two weeks later, the Chief of Staff ordered a factfinding, and staff external to the facility were appointed to conduct the investigation.[33] The factfinding report, dated March 8, 2023, determined that "the management and documentation by [nurse 1] did not meet applicable standards of care."[34]

Interviews and documentation received from the facility showed that nurse 1 began orientation to return to patient care in the intensive care unit approximately four months after the patient's episode of care, and two months after the factfinding concluded. Documentation included an "action plan" during intensive care unit orientation, which specified training on blood transfusion policy and procedures, observed blood transfusion administration to ensure policy adherence and education reinforcement, and education on the care and treatment of actively bleeding patients. A memorandum documenting a performance improvement plan and counseling program was issued to nurse 1 approximately four months later, which documented identified competency

[32] The acting nurse manager reported seeking guidance from human resources regarding potential administrative actions, and receiving guidance that further actions would need to wait until the conclusion of the factfinding. The acting nurse manager described efforts to update the emergency department's onboarding education to include training relevant to women's health, including the gynecology cart and supplies. Another nursing service leader also described efforts to provide women's health training for emergency department staff, partnering with women's health for training materials, including use of a pelvic exam simulator; however, the nursing service leader reported few utilized the training tool.

[33] Factfinding reviews are tools VHA uses to complete a "systematic, thorough and objective analysis of evidence, documented in a manner that clearly conveys the facts, the evidence from which those facts are ascertained and the investigator's conclusions about disputed matters." VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021; VA can use a factfinding "… when taking administrative actions, including disciplinary actions." VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

[34] Memorandum, "Martinsburg Fact Finding Investigation," March 8, 2023. The factfinding detailed multiple deficiencies, including deficiencies in assessment and documentation of vital signs and blood loss, delay in blood transfusion, and failure to follow facility protocol for blood transfusion.

concerns, prior adjustments to nurse 1's intensive care unit orientation plan, and the extension of nurse 1's intensive care unit orientation for an additional 90 days to provide "opportunity for training and demonstration competency [*sic*] in the critical care environment." Prior to completion of the 90-day performance improvement plan or completion of intensive care unit orientation, nurse 1 transferred to the facility's long-term care unit. Nurse 1's intensive care unit orientation paperwork documented the plan ending prior to completion and nurse 1's reassignment to a different clinical area. Subsequent documentation indicated that nurse 1 completed orientation for the long-term care unit.

The facility was unable to provide documentation of nurse 1's successful completion of the performance improvement plan. The OIG is concerned that failure to monitor nurse 1's progress through completion of the identified performance improvement plan and lack of oversight continuity to ensure quality of care deficiencies have been sufficiently remediated could place other patients at risk.

Delay in Laboratory Results

The OIG found that the laboratory did not communicate critical results within the required time frame for tests ordered stat by physician 1.

Facility policy specifies priorities for laboratory testing as stat, urgent, or routine, and states

> STAT: This category involves LIFE-THREATENING SITUATIONS when tests must be done immediately with no delay … Results of testing under these circumstances will be available within thirty minutes to one hour after accessioned, depending on tests ordered.[35]

Documentation in the patient's EHR showed physician 1 placed a laboratory order for a basic metabolic panel, entered as stat priority, at 6:18 p.m. The facility laboratory received the blood for testing at 6:25 p.m. The test results were released and communicated to physician 1 at 10:48 p.m., more than four hours after laboratory staff received the stat order.

Physician 1 indicated that such a delay in laboratory results was "very unusual." During interviews with emergency department staff, the OIG was told that most emergency department orders are entered as stat priority. Both physician 1 and the facility's chief supervisory medical technologist reported the emergency department had been very busy at the time the orders were placed, which was during a weekend evening shift. The facility's chief supervisory medical technologist noted that two technicians were working in the laboratory at that time, and the need to retrieve blood from the blood bank also required one of the technician's time. The chief supervisory medical technologist told OIG that laboratory staffing, combined with the volume of

[35] Facility MCP 113-009, *Laboratory Performance Priorities*, March 01, 2023.

patients in the emergency department, could have delayed completion of the stat labs, but noted that a number of other unknown factors could have contributed.

As previously noted in regard to the delayed blood transfusion, one hospital declined to accept the patient, citing concerns about her stability for transfer. At the time of that declination, about two and a half hours after the initial critically high blood sugar result, the patient had received two infusions of intravenous fluids and intravenous insulin for treatment of diabetes and had normal vital signs. At the time of declination, the patient had no documented recheck of the blood sugar level. Shortly after the transfer was declined, the patient's blood sugar recheck showed improvement. While it cannot be determined whether the decision to accept transfer would have been different if the patient's critically high blood sugar result and treatment had been completed earlier, the OIG is concerned that the delay in the laboratory results and subsequent treatment may have contributed to the delay in the patient's emergent transfer to another hospital.

The facility's chief supervisory medical technologist stated that the laboratory's quality standard is completion of 95 percent of stat orders within one hour. Laboratory performance is audited quarterly and reported to the facility's Quality and Patient Safety Council. The OIG reviewed quarterly audits of the facility laboratory's turnaround time for stat orders from October 2022 through September 2023, finding that performance generally met the 95 percent standard. Because the OIG determined that the facility routinely monitors the laboratory's turnaround time for stat orders, and the laboratory's performance generally met the expected standard, the OIG did not make a recommendation related to this finding.

2. Alleged Unavailability of Items Needed for Gynecologic Exam

The OIG did not substantiate that the emergency department did not have the appropriate instruments, supplies, and exam table to perform the gynecologic exam. However, the OIG found that the emergency department's gynecologic cart was not utilized by some providers due to the emergency department providers' perceived discomfort for the patient.

VHA policy states "every VA [emergency department] and [urgent care center] should have the ability to perform a gynecologic examination at all times and should have at least one gynecologic examination table or a stretcher that is adaptable for a gynecologic exam (i.e.,

stirrup availability)."[36] VHA policy also requires that "Necessary gynecologic examination supplies should be available 24 [hours a day] / 7 [days a week]."[37]

During the unannounced inspection, the OIG found that the emergency department was equipped with a gynecology cart stocked with recommended instruments, equipment, and supplies for conducting gynecologic examinations.[38] Emergency department nursing staff demonstrated to the OIG team how the cart's hinged foldable footrests and drop-down extension feature bridges with the emergency department bed. (see figure 1)

Figure 1. *Gynecologic cart equipped with supplies, instruments, and footrests. Source: Facility; Martinsburg, West Virginia; June 26, 2024.*

[36] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023. The policies contain the same or similar language regarding the requirement for VA emergency departments to have the ability to perform a gynecologic examination at all times. While the 2023 policy does not specifically address the examination table, the 2023 policy indicates that information on "recommended medical, pharmacy, and laboratory equipment supplies" were relocated to the Emergency Medicine SharePoint. The "Recommended Equipment Supplies for VA Emergency Departments" guidance document on the Emergency Medicine SharePoint specifies "Exam table or cart with stirrups."

[37] VHA Directive 1330.01 (6). VHA Directive 1330.01 (7). The policies contain the same language regarding the requirement for VA Emergency Departments and Urgent Care Centers to have at least one gynecologic examination table or a stretcher adaptable for a gynecologic exam as well as necessary gynecologic examination supplies available 24 hours a day, 7 days per week.

[38] Facility MCP 11-015, *Women Veterans' Services*, December 1, 2020. "Appendix A—Suggested VA Emergency Department (ED) and Urgent Care Clinic (UCC) Gynecology Equipment, Tests and Supplies."

Physician 1, who conducted the pelvic exam, reported having the recommended equipment and supplies at the time of the patient's visit. The nurse chaperone indicated that a gynecologic instrument was not initially available, but the nursing officer of the day located and retrieved the instrument from another area. Emergency department staff told the OIG that contacting the nursing officer of the day was a standard practice during after-hours to retrieve needed equipment or supplies from other areas of the hospital, if not readily available or stocked in the emergency department.

Following the patient's episode of care, a nursing leader reported implementing an inventory of equipment and supplies to ensure the gynecologic cart was appropriately stocked with necessary supplies and equipment and items were reviewed for expiration on a regular basis. The OIG observed the checklist was present in the gynecology cart during the inspection.

Physician 1 reported not using the gynecologic cart with footrests for the patient's exam explaining, "it has stirrups where the patient can put their feet in … and they have to slide down to the edge of the bed, but there's a bar that they would kind of be sitting on … it's uncomfortable for the patient." Physician 1 added "Ideally we would have beds that have stirrups attached to them … then the patient is still in the bed, feet in the stirrups and … they don't have an uncomfortable bar that they have to be lying on for several minutes." See figure 2.

Figure 2. *Gynecologic cart with hinged extension bar.*
Source: Facility; Martinsburg, West Virginia; June 26, 2024.

Physician 1 reported using an upside-down bed pan to create a "ramp effect" to position the patient for the examination instead of using the gynecologic cart. This alternative method of

positioning a patient to conduct a gynecologic examination when the examination bed is not equipped with footrests is described in clinical literature.[39]

The OIG concluded that the emergency department was equipped with a gynecology cart, stocked with necessary instruments and supplies that provided footrests to conduct a gynecologic exam, as required by VHA policy. However, staff reported not using the cart due to emergency department providers' perceived discomfort for the patient, which suggests a need to evaluate the functionality of the equipment for conducting gynecologic examinations with dignity and comfort.

3. Delays in Patient Transport by Facility Fire Department

The OIG determined that avoidable fire department transport issues delayed the patient's transfer to a higher level of care. During the inspection, facility staff told the OIG about concerns regarding delays in emergency transport affecting other patients.

According to VHA policy, interfacility transfers may be necessary to provide patients access to needed specialty providers and care. "VHA is responsible for ensuring that transfers into and out of its medical facility are carried out … under circumstances which provide maximum safety for patients." Facility directors are responsible for ensuring the timeliness and safety of patient transfers.[40]

Delay in Transport for the Patient

The OIG determined that fire department transport issues caused a delay in the transfer of the patient from the facility emergency department to a higher level of care. The OIG found that multiple factors affected the timeline of transfer; however, the delay in the patient's transport to the receiving hospital by the fire department staff could have been avoided and increased the risk of patient harm.

The OIG learned of an approximately six-hour delay from the time the receiving hospital agreed to accept the patient to when the fire department arrived to transport the patient from the emergency department. At 2:20 a.m., the receiving hospital agreed to accept the patient for transfer. Administrative staff contacted fire department staff to request transport and the patient flow coordinator documented at 2:23 a.m. that the fire department could not transport the patient "due to overtime for the drivers." Over the next six hours administrative and clinical staff

[39] G. Richard Braen and John Kiel, "Gynecologic Procedures," chapter 57 in *Roberts and Hedges' Clinical Procedures in Emergency Medicine and Acute Care*, Elsevier, 2019. ISBN 9780323354783; Margaret Klein, Mary Taylor Winsten, and Samuel Winsten, "Obstetrics and Gynecology in the Emergency Department," chapter 29 in *The Emergency Department Technician Handbook,* Elsevier, 2024. ISBN 978-0-323-83002-7.

[40] VHA Directive 1094, *Inter-Facility Transfer Policy,* January 11, 2017

documented multiple unsuccessful attempts to secure alternative ground or air transport for the patient (see figure 3).

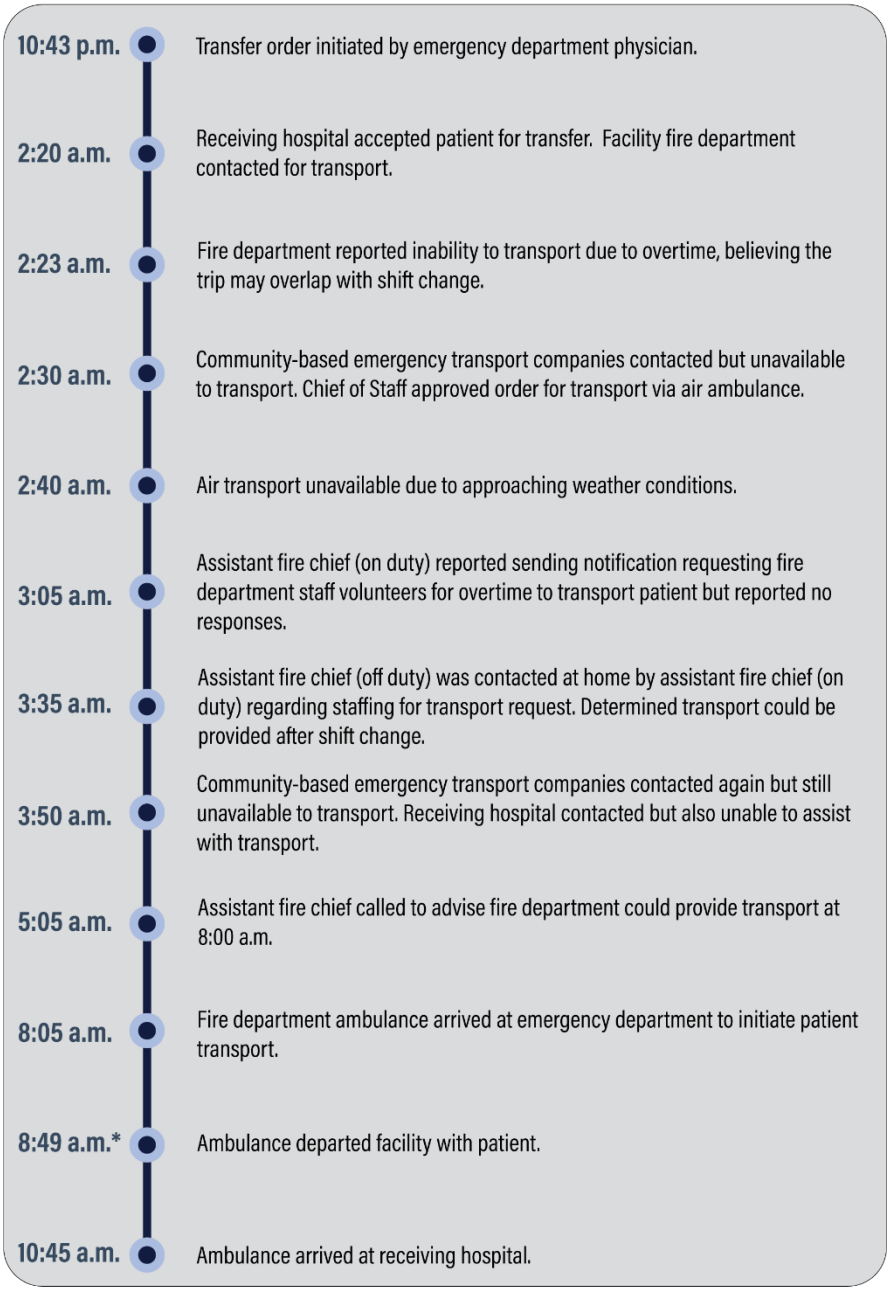

Figure 3. *Timeline of events regarding emergent patient transport.*
Source: OIG review of EHR and facility documentation related to transport and interviews.
**The OIG noted a discrepancy between the time the transport was reported as departing the facility in the patient's EHR (8:49 a.m.) and the transport time documented by the fire department transport staff (8:25 a.m.).*

Fire department leaders told the OIG that lack of available fire department staff was the reason for the transport delay. An assistant fire chief told the OIG, "There wasn't anybody to send …" The fire department chief and an assistant fire chief stated that transport time to the receiving hospital was an "eight hour" round trip, and if the transport was accepted, staff would not be able to return before the end of the shift.[41] Additionally, the assistant chiefs reported not being able to require fire department staff to work overtime for transports. The fire department chief reported not having a policy that specified the reported rules for overtime, and that past events led assistant chiefs and staff to believe that overtime could not be mandated for non-fire related events such as emergency department patient transports. The fire department chief and an assistant chief explained this perception was related to union involvement when fire department staff members had been mandated to work past their scheduled shift for patient transport approximately 10–14 years prior.

An assistant fire chief stated that time required to transport the patient would have extended past the shift change and two fire department staff had military duty following their shift. The assistant fire chief also reported that, due to fire department staff leaving for military duties, fire department staffing would have fallen below required minimum staffing if other fire fighters on duty at the time had transported the patient and did not return by the end of the shift.[42] The assistant fire chief stated that a request for volunteers to work overtime to transport the patient was sent to fire department staff who were not on duty; no one responded to the request.[43]

An OIG analysis of the fire department schedule indicated that staffing resources were adequate to provide transport at the time of the order to transport and in compliance with minimum staffing requirements. The OIG reviewed the "Fire Department Emergency Medical Services (EMS) Patient Care Report" and estimated total trip time as approximately five hours and 20 minutes.[44] While it is not possible to assert that travel time would be the same had the transport taken place at the time of the original order (2:20 a.m.) rather than the following morning (8:00 a.m.), the duration suggests that a transport crew may have been able to accomplish the transport within the remaining time on shift.

[41] For the purposes of this report, *fire department staff* refers to firefighters whose primary responsibilities are fire suppression; however, they are also EMTs or paramedics and can provide emergency medical transport. This also includes staff within the fire department who are EMTs or paramedics whose primary responsibility is emergent patient transport.

[42] VHA Directive 7718. VHA requires a minimal staffing level of four firefighters on duty 24 hours a day, despite staffing absences for leave time or staffing shortage; other fire department personnel are not included in the count for minimum staffing coverage.

[43] An assistant fire chief explained that the fire department uses an app to send out requests to fire department staff who receive an alert on their phones explaining the need. Off duty fire department staff may respond to notify the fire department of their availability.

[44] The fire department transport crew documented responding at 8:00 a.m., arriving at the facility emergency department at 8:05 a.m., departing the facility at 8:25 a.m., arriving at the receiving hospital at 10:45 a.m., and departing the receiving hospital for the return trip at 11:00 a.m.

The OIG found no evidence to support fire department leaders' practice of not mandating overtime. The OIG's review of fire department position descriptions found both the firefighter paramedic and EMT positions stated, "Employee is subject to recall after a normal tour of duty in the event of an emergency … May be required to work overtime as the mission requires." The transport paramedic position description states, "Mandatory overtime may be required due to run times that may extend beyond normal scheduled work hours." Additionally, human resources staff informed the OIG that no records were on file indicating union involvement regarding overtime within the fire department. Further, the OIG reviewed the union contract, which stated that "when the Department mandates unplanned overtime, employees are expected to work overtime," along with specific guidance on how overtime should be mandated.[45]

The chief of facility management services (FMS), who provides direct oversight to the fire department, told the OIG of the expectation to mandate overtime when needed for emergent situations and all fire department staff can be mandated to work overtime. The chief of FMS added that a number of years ago there had been disagreements between fire department leaders and the union regarding what constituted an emergent situation for overtime purposes. Though the issue with the union was resolved, the chief of FMS acknowledged "confusion" about mandatory overtime use existed. The chief of FMS stated a process to mandate overtime was in place and supervisors should be empowered to do so.

Facility leaders confirmed that prohibiting mandated overtime was not consistent with facility policy. The Associate Director, who provides senior level oversight to the fire department, told the OIG, "you do what's right for the patient, and if that's mandating overtime, that's mandating overtime, as long as it's safe for the employee …" The Chief of Staff acknowledged confusion about overtime and stated fire department staff can work overtime and should be mandated to work overtime for emergent transports. The Facility Director asserted that mandating overtime for patient transports is case specific, and the decision should evaluate several factors, including patient and staff safety. The Facility Director also reported having the belief that if the patient had a life-threatening emergency, overtime would not have prevented facility staff from providing the care that was needed, and further stated prohibition of mandating overtime was not in accordance with facility policy.

Due to the fire department supervisors' perceived inability to mandate overtime for emergent patient transports, the patient's transfer to a higher level of care was delayed for approximately six hours until fire department staff arrived to transport the patient following the shift change.

[45] VA-NAGE Master Agreement.

Additional Transport Delays Reported

During the inspection, the OIG learned of additional patients who experienced delayed transport to a higher level of care.

Transport Delay for ST-Elevation Myocardial Infarction Patient

A patient presented to the facility emergency department in early summer 2023 while experiencing a cardiac emergency and needed emergent transport for procedural intervention.

On review of the EHR, the OIG learned the patient presented to the emergency department at 6:42 a.m. with complaints of chest pain. An electrocardiogram (EKG) was completed and the patient was diagnosed as experiencing an ST-elevation myocardial infarction (STEMI), a severe type of heart attack that "has a greater risk of serious complications and death."[46] The American Heart Association recommends a treatment goal time of 90 minutes or less from first medical point of contact to the procedural intervention when a patient presents to a hospital with percutaneous coronary intervention (PCI) capability or 120 minutes with immediate transfer from a non-PCI-capable facility to a PCI-capable hospital.[47] The patient was managed in the emergency department for approximately an hour while awaiting fire department shift change before being transported to a community hospital for emergent medical care (see figure 4).[48] Due to the delay in transport, 147 minutes elapsed between the STEMI diagnosis and initiation of the procedure, falling outside the American Heart Association's recommended time frame for intervention.[49]

[46] Cleveland Clinic, "STEMI Heart Attack, What is a STEMI?" https://my.clevelandclinic.org/health/diseases/22068-stemi-heart-attack, accessed September 3, 2024.

[47] Patrick T. O'Gara et al., "2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines," *Circulation* 127, no. 4 (January 2013), https://doi.org/10.1161/CIR.0b013e3182742cf6.

[48] National Heart, Lung and Blood Institute, "During Cardiac Catheterization," accessed September 4, 2024, https://www.nhlbi.nih.gov/health/cardiac-catheterization/during. A catheterization laboratory, also known as a cath lab, is usually located in a hospital and is comparable to a small operating room where evaluation and treatment is conducted on the heart.

[49] O'Gara et al., "2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines."

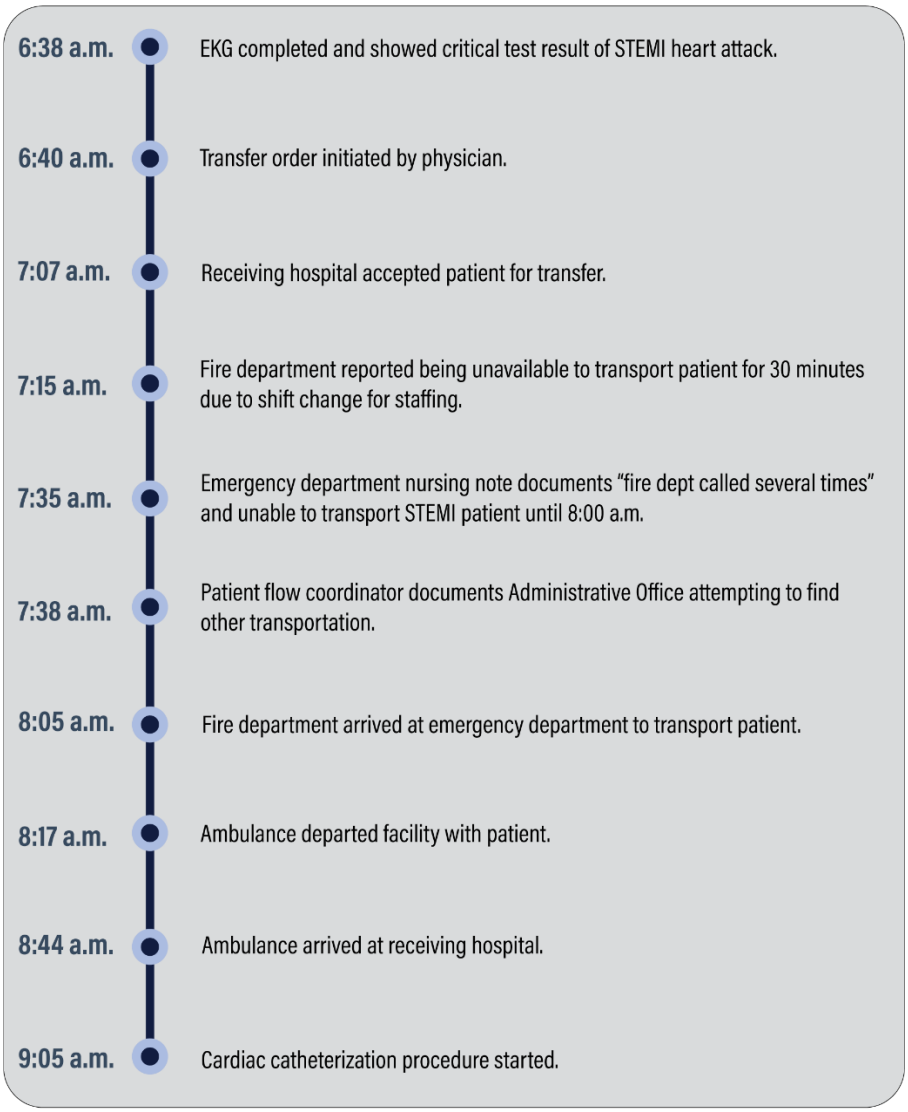

Figure 4. *Timeline of events regarding emergent transport for STEMI patient.*
Source: OIG review of EHR and facility documentation related to transport.

An emergency department physician identified patient safety concerns related to the delay in transport for the patient and told the OIG of reporting those concerns to the director of the emergency department. The emergency department physician also shared the email communication, which stated

> The standard of care … was not met due to the delay in EMS response surely contributing to unnecessary cardiac injury, which may be permanent and non-reversible … It seems that corrective actions have not taken place to prevent these EMS delays … Something needs to be done so that reliable and predictable EMS services are available.

The OIG reviewed documentation of fire department staffing schedules and transports. The OIG determined that the department had sufficient staffing to transport the patient at the time of the order and maintain required minimum staffing levels had staff been mandated to stay past the end of shift to complete the emergent transport. The OIG concluded that fire department leaders' practices were incongruent with facility policy and facility leaders' expectations regarding overtime. The ongoing lack of clarity concerning mandating overtime may have contributed to continued emergent patient transport delays.

Transport Delay for Abdominal Pain Patient

A patient presented to the facility emergency department in summer 2023 with abdominal pain and was identified as needing emergent transfer for a higher level of care.

Review of the patient's EHR showed that the patient was triaged in the emergency department at 6:32 a.m. for abdominal pain and diagnosed with splenic vein thrombus and superior mesenteric artery thrombus. Thrombus is a blood clot that can cut off the flow of blood to organs causing a critical medical emergency.[50] Documentation showed that the patient was transported with another patient who was being transferred to the same receiving facility, at 5:03 p.m. via the facility Veteran Transportation Service's Dual Use Vehicle (DUV) Medical Ambulance Bus, with a fire department paramedic accompanying the patients.[51] The patient was managed in the emergency department for nearly six hours while awaiting transport (see figure 5).

[50] Cleveland Clinic, "Thrombosis," accessed October 1, 2024, https://my.clevelandclinic.org/health/diseases/22242-thrombosis.

[51] VHA Directive 1695(1), *Veterans Transportation Services*, September 18, 2019, amended November 11, 2022. "VTS is a program through which the Department of Veteran Affairs (VA) directly transports Veterans and other persons to or from VA or VA-authorized facilities and other places for the purposes of examination, treatment, or care."; VHA Directive 0320.07, *Dual Use Vehicle (DUV) Program*, June 18, 2018. According to the VHA directive, a DUV is manufactured according to VHA specifications with the ability to transport patients, including patients in wheelchairs and stretchers, and can be restructured to accommodate "emergent patient evacuation transport."

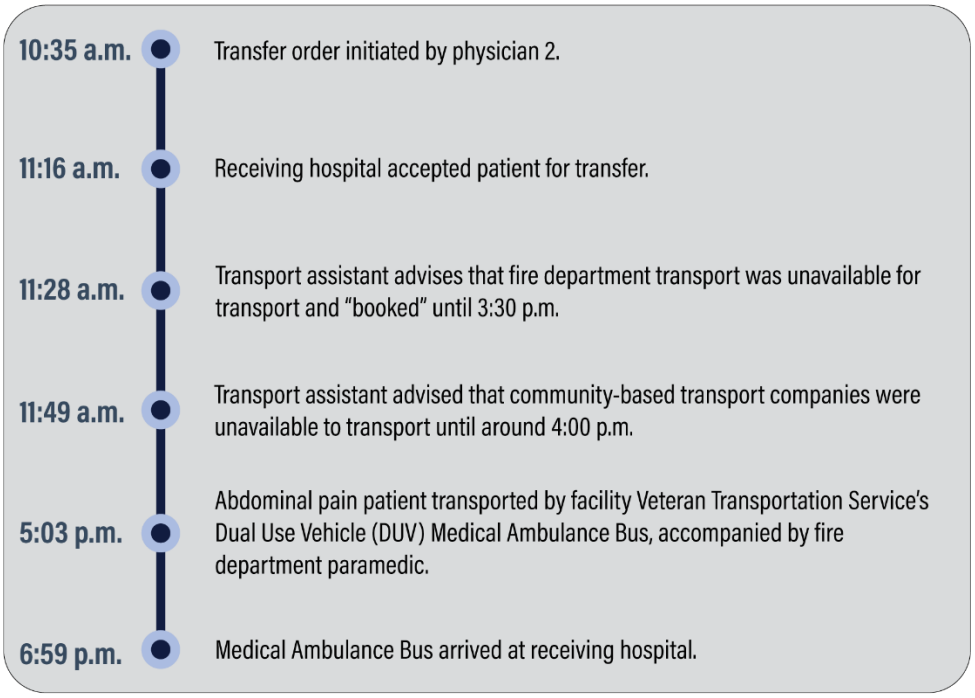

Figure 5. *Timeline of events regarding emergent transport for abdominal pain patient.*
Source: OIG review of EHR and facility documentation related to transport.

The OIG reviewed the documentation of fire department staffing schedule and transports the date of the patient's emergency department visit.

A list of transports, provided by the facility, showed that one fire department ambulance was off station from approximately 8:00 a.m. to 4:40 p.m. for a patient transport. The fire department completed a one-hour trip for a non-urgent patient transport at 1:40 p.m.[52]

The OIG determined that the fire department had sufficient staffing to provide transport at the time of the transport order for the patient. Based on available documentation, the OIG was unable to determine why the fire department did not accept the transport at the time of the transport order or why the patient's transport was not prioritized over the non-urgent transport. An EHR review showed that physicians continued care for the patient in the emergency department for nearly six hours after the receiving hospital accepted the patient before the patient was transported. The OIG would have expected that the emergency physician's order to transport this patient to a higher level of care for a critical diagnosis would have been prioritized and this patient transported before non-urgent patient transports.

[52] An assistant fire chief indicated that the facility operates three ambulances, two of which may be used for off-site transports.

Failures in Facility Leaders' Response to Transport Concerns

The OIG found that leaders missed opportunities to improve transport processes and collaboration between fire department staff and emergency providers by addressing differing perceptions regarding emergency transports. Reports of patient safety concerns related to transport delays were not thoroughly evaluated, resulting in missed opportunities to recognize practices that resulted in delayed emergent transports and clarify policy related to overtime. The facility initiated a review to address patient transport challenges in May 2023; however, as of June 2024, recommended policy and protocols identified from the review had not yet been approved by facility leaders.

Leaders' Failures to Fully Address Identified Transport Delay

The OIG found that facility leaders failed to assess the transport delay concerns identified during the factfinding.

The factfinding identified a "[d]elay in transport of patient due to inability to confirm mode of transportation," and concluded that the reviewers were "[u]nable to determine if fire department met responsibilities to provide ambulance transportation at [2:30 a.m.] due to inability to determine regulations regarding crew duty times as supporting documentation was not provided."[53]

The Chief of Staff, who approved the request for air transport, recalled understanding that the fire department could not provide the transport because the receiving hospital was "a couple hours away" and "while they had some folks available, that those folks couldn't make that run because of the fact that they were, either had been working all day, and they were … beyond the time … that they could continue to work. There was a maximum allotted time that they could actually do that run." The Chief of Staff recalled that follow-up actions on transportation focused instead on clarifying responsibilities and how communications regarding transports would be managed, noting there were "multiple calls from multiple different people."

While reporting that the facility reviewed transport issues, the Associate Director clarified that the review was not related to the factfinding for the patient with vaginal bleeding rather assessing transport from "the bigger picture level" due to decreased availability of community-based transport options following COVID-19. When interviewed, the Facility Director indicated being unfamiliar with the factfinding or any associated actions, deferring follow-up to the Chief of Staff.

The OIG concluded that facility leaders missed an opportunity to review and address fire department transport practices. Had facility leaders followed up on the transport concern

[53] Memorandum, "Martinsburg Fact Finding Investigation," March 8, 2023. The factfinding referenced "Fire Department representative stated DOT [Department of Transportation] requirements prevented use of VA ambulance which was otherwise available."

identified in the factfinding, they may have identified service leaders' confusion about the ability to mandate overtime for emergent transports and clarified facility policy.

Leaders' Failure to Thoroughly Evaluate Reports of Transport Delays

The OIG learned that staff arranging emergency transports were instructed to enter reports of patient safety concerns through appropriate channels when transport was unavailable or delayed.

The OIG reviewed patient safety concerns related to transport delays involving the emergency department, reported from October 1, 2022, through June 30, 2024. The OIG found multiple reports were entered by staff citing a delay in patient transport, which also referenced fire department staff availability, a delay in transport due to shift change, and one entry specifically referenced being told the fire department was not being allowed to mandate overtime (the patient with vaginal bleeding).[54]

Documentation showed that the chief of FMS was assigned to review the majority of the reported transport concerns. The majority of the chief of FMS's responses referenced lack of available fire department staff to conduct transports due to need to maintain minimum on-site staffing, crews being committed or out on other transport runs at the time of the order, gaps in ALS level coverage, and contract transport options being unavailable. Some responses documented only that in-house resources were exhausted and transport occurred when resources were available. One review, which did not correspond to the patients referenced within this report, noted that the transport should have been accomplished, and the chief of FMS noted providing guidance to fire department leads and supervisors concerning transport availability and timing.

The chief of FMS described the process for reviewing patient transport delays, indicating following up with the fire department chief, assistant chief, or officer on duty at the time of the event to get their perspective on what happened, and noting occasional need to reach out to the paramedic or EMT who helped facilitate the transport for additional details. The chief of FMS indicated then entering that information into a tracking system and submitting it back to the patient safety manager. The OIG concluded that the chief of FMS's investigation of transport delays did not independently verify or evaluate adequacy of staffing to complete transports and instead relied on what fire department leaders said. This resulted in a failure to identify the concerns in the fire department's transport dispositioning practices.

The Chief of Staff confirmed that there is a process in place for facility leaders to receive reports from the patient safety manager and reported reviewing aggregate data related to patient transport events. The Facility Director reported awareness of reports of patient safety concerns

[54] The OIG's review encompassed reports from October 1, 2022, through June 30, 2024, identifying 16 that related to lack of available transport and transport delays from the first three quarters of fiscal year 2024, and 17 from fiscal year 2023.

related emergency transport delays and indicated concerns about reduced community-based resources for emergency transport, adding that challenges with access to consistent, reliable transportation was not unique to the facility.

The OIG concluded that had further inquiry into the reported transport concerns been conducted by the assigned leader, the issue of lack of clarity regarding fire department overtime practices, which contributed to continued instances of delayed emergent transport from the emergency department, may have been discovered.

Review of Facility Transport Challenges

The Chief of Staff advised the OIG that, due to numerous reports of patient safety concerns related to transport issues, leaders chartered a workgroup to look for solutions. The Associate Director reported that transport concerns were related to lack of community-based transport resources, and the workgroup was tasked with clarifying criteria and protocols for the facility's various transportation options. The patient safety manager, who led the workgroup, noted that transport delays had been an issue for years, and worsened in the past couple of years due to community-based transport companies that the facility had relied on going out of business after COVID.[55]

The OIG reviewed documentation provided by the facility workgroup regarding "several recent transportation issues," which addressed contributing factors creating challenges within the transportation process and established an action plan to address the challenges.

During an interview, the patient safety manager described the team's approach, starting with identification of available patient transportation resources, and then evaluating the criteria for use of each of those modes of transport. The workgroup identified a need to establish policy with guidance covering all modes of transportation utilized at the facility and to develop clear criteria for clinical staff to assure the mode of transportation requested was commensurate to the level of care needed by the patient. The workgroup developed specific criteria for each identified method of transport, then worked to develop a transport protocol, outlining an algorithm to be used in conjunction with a provider's clinical judgment, to guide decisions regarding modes of transport based on a patient's condition and urgency of transfer. The patient safety manager reported that the workgroup's findings and recommendation had been presented to facility leaders, who requested the protocol be reviewed by the emergency department medical director for clinical review and approval before moving forward to put the processes into place.

Additionally, the patient safety manager noted the workgroup discussed the need for additional fire department staffing to offset loss of community-based transport resources, and also made a

[55] The workgroup included the safety manager, veteran transport services mobility manager, emergency medical services program coordinator within the fire department, patient flow coordinator, transportation assistant, emergency department nurse manager, intensive care unit nurse manager, and the facility patient safety manager, who served as the team's advisor.

recommendation for the facility to obtain a stretcher van for transport of patients who were being transported via BLS ambulance but could have been transported without need for BLS resources.[56] The OIG reviewed position requests and learned the Facility Director approved hiring of additional fire department staff in May 2023.[57] The patient safety manager noted leaders requested the workgroup provide additional data to support the recommendation for purchasing or renting a stretcher van for non-emergent transport.

At the time of the OIG site visit in June 2024, the patient safety manager told the OIG that recommended policy and protocols identified by the workgroup had not yet been approved by facility leaders. The OIG concluded that clear guidance for facility staff on transport resources, criteria, and protocols may improve transport processes, better preserve availability of emergent transport resources, and reduce incidence of delays in emergent transports for patients who require this level of care.

Conclusion

The OIG substantiated that a female patient who presented to the facility emergency department with vaginal bleeding received care that failed to meet evidence-based clinical standards for care. The OIG found no deficiencies in care provided by emergency department physicians but noted lapses in communication between the emergency department team and identified deficiencies in nursing care.

Nurse 1 failed to monitor and document the patient's vital signs and assess and document the patient's history of blood loss as well as ongoing blood loss volume in a patient with active bleeding. Nurse 1 failed to collect the blood for the patient's transfusion, which was ordered stat, from the laboratory for more than two hours after the laboratory's notification that the blood was available, delaying the patient's blood transfusion. Nurse 1 also failed to follow facility procedure for blood product transfusion by transfusing the blood at a rate too high for the patient's intravenous line size. The OIG also identified concerns about the lack of sensitivity and dignity in the care provided to the patient.

The OIG did not substantiate that the emergency department did not have the appropriate instruments, supplies, and exam table to perform the gynecologic exam. However, the OIG found that the emergency department's gynecologic cart was not utilized by some providers due to the providers' perceived discomfort for the patient, which suggests a need to evaluate the functionality of the equipment.

[56] The OIG reviewed email correspondence and found the chief of FMS alerted quality management staff in late January 2023 that the "most reliable" contracted transport company was scheduled to close in less than a week and closure would affect transport services.

[57] The Facility Director told the OIG that fire department staff and recruitment efforts of EMTs and paramedics were ongoing in response to closure of community transport.

The OIG found avoidable delay in the patient's transfer to a higher level of care and, during the inspection, learned of delays in emergency transports for other patients. The fire department supervisors' perceived inability to mandate overtime for emergent patient transports was inconsistent with facility policy and contributed to transport delays.

While facility leaders initiated a review of concerns raised about the patient's quality of care, the OIG identified concerns regarding sufficiency of leaders' response to identified deficiencies. While actions were taken in response to findings regarding Nurse 1's practice, the OIG found failures in processes to ensure that deficiencies had been fully addressed and risks mitigated. The OIG is concerned that failure to monitor nurse 1's progress through completion of performance improvement plan and lack of oversight continuity to ensure quality of care deficiencies have been sufficiently remediated could place other patients at risk. Facility leaders also failed to assess the transport delay concerns identified during the factfinding, despite the report citing inability to determine if the fire department met responsibilities due to a failure to provide supporting documentation. The OIG noted this as a missed opportunity to review and address fire department transport practices and clarify facility policy.

The OIG found multiple reports of concerns involving patient transport delays were assigned to the chief of FMS, who's review of the incidents did not independently verify staffing data or identify concerns with the fire department's transport dispositioning practices noted in the cases described within this inspection report. Facility leaders initiated a workgroup focused on the facility's transport processes in response to the multiple reported transport concerns and reduction of community-based transport resources. As of June 2024, recommended policy and protocols identified from the workgroup had not yet been approved by leaders.

Recommendations 1–10

1. The Martinsburg VA Medical Center Director reviews communication between emergency department staff to ensure timely patient care coordination, and takes action as warranted.

2. The Martinsburg VA Medical Center Director ensures emergency department nurses monitor, assess, and document patient care as required by Veterans Health Administration and Martinsburg VA Medical Center policy, and monitors compliance.

3. The Martinsburg VA Medical Center Director ensures processes are in place to ensure blood transfusions are administered according to policy, and monitors compliance.

4. The Martinsburg VA Medical Center Director conducts a review of actions implemented as a result of the factfinding to include administrative actions and performance improvement plans and ensures quality of care concerns have been remediated, and takes action as warranted.

5. The Martinsburg VA Medical Center Director evaluates the functionality of emergency room equipment, including an exam table with footrests, for conducting gynecologic examinations with dignity and comfort, and takes action as warranted.

6. The Martinsburg VA Medical Center Director reviews concerns related to fire department overtime practices, takes action as appropriate, and follows up to ensure compliance.

7. The Martinsburg VA Medical Center Director reviews the transport delay for the abdominal pain patient, and takes action as appropriate.

8. The Martinsburg VA Medical Center Director reviews the factfinding related to transportation concerns, ensures an adequate review is conducted, and takes action as warranted.

9. The Martinsburg VA Medical Center Director ensures all reported patient safety concerns related to emergency transport delays are investigated to identify root causes and contributing factors that require action to prevent future events.

10. The Martinsburg VA Medical Center Director ensures clear guidance is in place for clinical and administrative staff on the use of facility emergent and non-emergent transport resources.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 28, 2025

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

Subj: Healthcare Inspection—Deficiencies in a Female Patient's Emergency Care at the Martinsburg VA Medical Center in West Virginia

To: Director, Office of Healthcare Inspections (54WH00)
Executive Director, Office of Integrity and Compliance (10OIC)

1. I have reviewed and concur with the Office of Inspector General's (OIG's) draft report entitled - Deficiencies in a Female Patient's Emergency Care at the Martinsburg VA Medical Center in West Virginia.

2. Furthermore, I have reviewed and concur with the Medical Center Director's actions to the recommendations. Recommendations # 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 will remain open and in progress.

3. Should you require any additional information please contact the VISN 5 network office.

(*Original signed by:*)

Robert M. Walton, FACHE

[OIG comment: The OIG received the above memorandum from VHA on April 4, 2025, and an updated action plan on May 8, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 26, 2025

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

Subj: Healthcare Inspection—Deficiencies in a Female Patient's Emergency Care at the Martinsburg VA Medical Center in West Virginia

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

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Inspection—Deficiencies in a Female Patient's Emergency Care at the Martinsburg VA Medical Center in West Virginia. Martinsburg VA Medical Center concurs with the recommendations and will take corrective action.

2. Should you need further information, contact the Chief of Quality Management.

3. We thank you for the opportunity to continue strengthening our high-quality health care activities.

(*Original signed by*:)

Kenneth W. Allensworth, FACHE
Medical Center Director/CEO

[OIG comment: The OIG received the above memorandum from VHA on April 4, 2025, and an updated action plan on May 8, 2025.]

Facility Director Response

Recommendation 1

The Martinsburg VA Medical Center Director reviews communication between emergency department staff to ensure timely patient care coordination, and takes action as warranted.

__X__Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

Medical Center personnel contacted the National Center for Organization Development and the local Equal Employment Opportunity Manager in February 2025 to provide resources and training for all Emergency Department (ED) staff relating to teamwork and communication. Joint staff meetings, led by the ED Nurse Manager and the ED Medical Director, commenced in March 2025 and will continue each month thereafter. Communication tips and lessons learned will remain a standing item on the staff meeting agenda to facilitate interdisciplinary team discussion and improvements. To measure the effectiveness of these interventions, 30 chart reviews will be completed by ED clinical leadership each month to identify delays, if any, caused by communication breakdowns. This review will include, at a minimum, ED care episodes resulting in greater than 6-hour delays to disposition as well as transfers from the ED to a higher level of care. ED leadership will address Identified improvement opportunities with staff involved via just-in-time refresher training or through other action, as justified, by a just culture algorithm. Review results and follow-up actions will be reported through governance, beginning with the ED committee, and then to the facility's Medical Executive Committee, which is called Executive Council of Medical Staff-Performance Improvement (ECMS-PI). This initiative will be monitored for 6 months with a target compliance rate of 90%.

Recommendation 2

The Martinsburg VA Medical Center Director ensures emergency department nurses monitor, assess, and document patient care as required by Veterans Health Administration and Martinsburg VA Medical Center policy, and monitors compliance.

__X__Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

ED nursing leadership will complete monthly reviews on five low-volume/high-risk conditions. These audits may include a variety of conditions or interventions, such as moderate sedation, blood transfusion, patients presenting with suicidal/homicidal ideations, stroke symptoms (Code Stroke), myocardial infractions (Code Heart), and/or care of female Veterans with vaginal bleeding. The results of the review will be reported to the ED Committee monthly and reported to ECMS-PI quarterly. This initiative will be monitored for 6 months.

Recommendation 3

The Martinsburg VA Medical Center Director ensures processes are in place to ensure blood transfusions are administered according to policy, and monitors compliance.

__X__Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

The ED Nurse Manager will provide blood transfusion simulation training for all ED nursing staff in fiscal year (FY) 2025 and maintain a current blood transfusion reference binder for ED staff to use. A chart review will be conducted on all blood transfusions. Results will be reported to the ED Committee monthly and reported to ECMS-PI quarterly. The target compliance rate that blood transfusions were administered according to policy will be 90% and action taken as warranted if the compliance rate is not met.

Recommendation 4

The Martinsburg VA Medical Center Director conducts a review of actions implemented as a result of the factfinding to include administrative actions and performance improvement plans and ensures quality of care concerns have been remediated, and takes action as warranted.

__X__Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

The Risk Manager will facilitate a review of the fact finding with involved senior leaders to review administrative actions and performance improvement plans. The Risk Manager will monitory any unfinished actions from the fact finding and will report to the Quality Patient Safety (QPS) Council until closed.

Recommendation 5

The Martinsburg VA Medical Center Director evaluates the functionality of emergency room equipment, including an exam table with footrests, for conducting gynecologic examinations with dignity and comfort, and takes action as warranted.

__X__Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

The Women's Health Program Manager will evaluate the functionality of the gynecological cart and provide subject matter expertise regarding continued use of or need for replacement of the equipment. The results of the evaluation(s) and any recommendations identified during the evaluation will be reported to the ED committee and reported to ECMS-PI. Any approved actions will be followed to closure by the responsible group.

Recommendation 6

The Martinsburg VA Medical Center Director reviews concerns related to fire department overtime practices, takes action as appropriate, and follows up to ensure compliance.

__X__Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

The Martinsburg VAMC is one of the only VA Medical Centers to use and require ambulance crews. The Martinsburg VA Fire Department supervisors received training about overtime practices. There will be ongoing re-training by March 31, 2025, to include manager's ability to assign work and to mandate overtime when needed ensuring compliance with Collective Bargaining Unit guidance and VHA policy. Attendance will be documented. The Chief of Facilities Management will review the transports for compliance, as needed.

Recommendation 7

The Martinsburg VA Medical Center Director reviews the transport delay for the abdominal pain patient, and takes action as appropriate.

__X__Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

The Martinsburg VA Medical Center Director assigned the Risk Manager to lead a focused review of the abdominal pain patient to include a chart review and staff interviews to determine the root cause of the transport delay and development of any appropriate corrective actions The action plan will be implemented and completed with a target closure of October 2025. The action plan and status updates shall be reported to the facility Quality and Patient Safety Committee monthly until closed.

Recommendation 8

The Martinsburg VA Medical Center Director reviews the factfinding related to transportation concerns, ensures an adequate review is conducted, and takes action as warranted.

__X__Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

The Risk Manager will facilitate a review of the fact finding with involved senior leaders prior to the close of March 2025. The Risk Manager will monitor any unfinished actions and report to QPS Council and track until closure.

Recommendation 9

The Martinsburg VA Medical Center Director ensures all incidents related to emergency transport delays are investigated to identify root causes and contributing factors that require action to prevent future events.

__X__Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

The Martinsburg VAMC completed a Healthcare Failure Mode and Effort (HFMEA). HFMEA with multidisciplinary leadership on September 19, 2024, and the current plan is being implemented. The HFMEA categorized all available transportation options by level of care and/or applicability. Staff education is in progress in the ED with all staff. Updates in education will be reported to QPS Council until all staff have been trained.

Recommendation 10

The Martinsburg VA Medical Center Director ensures clear guidance is in place for clinical and administrative staff on the use of facility emergent and non-emergent transport resources.

__X__Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

The Martinsburg VAMC completed a HFMEA with multidisciplinary leadership on September 19, 2024, and the current plan is being implemented. The HFMEA categorized all available transportation options by level of care and/or applicability. Staff education is in progress in the ED with all staff. Updates in education will be reported to QPS Council until all staff have been trained.

Glossary

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

accessioned. To record in order of acquisition.[58]

advanced life support. "A set of life-saving medical procedures" used to "stabilize critical patients who may have suffered a life-threatening event … while preparing them for transport to a hospital in a pre-hospital setting, like an ambulance or another emergency vehicle."[59]

basic life support. "A set of life-saving medical procedures performed in the early stages of an emergency," with a goal to "maintain the life functions of a person who is having a medical emergency … until more advanced medical care can be provided."[60]

basic metabolic panel. A common test that measures several aspects of the blood, often used by healthcare providers to assess general health or diagnose, screen for and monitor certain health conditions.[61]

blood transfusion. A procedure in which the blood of a donor is transferred to a patient, through a vein. It may be used to replace blood lost or when an illness prevents the body from properly making blood. [62]

cervical cancer. A growth of abnormal malignant cells that starts in the cervix. [63]

cervix. "A fibromuscular organ that links the uterine cavity to the vagina." The cervix is positioned between the bladder anteriorly and the bowel posteriorly.[64]

chaperone. A person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. [65]

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[58] *Merriam-Webster.com Dictionary*, "accessioned," accessed January 8, 2025, https://www.merriam-webster.com/dictionary/accessioned.

[59] Red Cross, "ALS vs BLS: Which Certification is Right for Me?" accessed October 10, 2024, https://www.redcross.org/take-a-class/bls-training/difference-between-als-and-bls.

[60] Red Cross, "ALS vs BLS: Which Certification is Right for Me?" accessed October 10, 2024, https://www.redcross.org/take-a-class/bls-training/difference-between-als-and-bls.

[61] Cleveland Clinic, "Basic Metabolic Panel (BMP)," accessed October 1, 2024, https://my.clevelandclinic.org/health/diagnostics/22020-basic-metabolic-panel-bmp.

[62] Mayo Clinic, "Blood transfusion," accessed October 18, 2023, https://www.mayoclinic.org/tests-procedures/blood-transfusion/about/pac-20385168.

[63] Johns Hopkins Medicine, "Cervical cancer," accessed January 6, 2025,https://www.hopkinsmedicine.org/health/conditions-and-diseases/cervical-cancer.

[64] Walter Prendiville and Rengaswamy Sankaranarayanan, "Anatomy of the uterine cervix and the transformation zone," Colposcopy and Treatment of Cervical Precancer – NCBI Bookshelf, 2017, https://www.ncbi.nlm.nih.gov/books/NBK568392/.

[65] VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017.2.15, amended May 14, 2023.

computed tomography scan. A machine which "uses X-rays and computers to produce images of a cross-section of your body. It takes pictures that show very thin 'slices' of your bones, muscles, organs, and blood vessels so that healthcare providers can see your body in great detail." [66]

electrocardiogram. A quick test that records the electrical signals in the heart to check the heartbeat, that can help diagnose heart attacks and irregular heartbeats, called arrhythmias.[67]

emergency severity index. The emergency severity index is an emergency department five-tiered, structured triage assessment tool used by nurses that categorized patients into five groups for triage, from 1 (most urgent) to 5 (least urgent).[68]

fluid resuscitation. A common medical intervention where fluids are administered to restore and maintain intravascular volume and hemodynamics in patients who have significant fluid loss.[69]

hemolysis. The breaking apart of red blood cells, which can be a clinical complication from blood transfusion. The breaking apart of red blood cells can release potassium into the plasma with the potential to cause renal and cardiovascular clinical complications.[70]

pap test. A procedure in which cells are collected from the cervix for testing. The test is frequently used to check for cervical cancer.[71]

patient safety incident. "An event or circumstance that could have resulted, or did result, in unnecessary harm to a patient."[72]

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[66] Cleveland Clinic, "CT (Computed Tomography) Scan," accessed November 23, 2022, https://my.clevelandclinic.org/health/diagnostics/4808-ct-computed-tomography-scan.

[67] Mayo Clinic, "Electrocardiogram (ECG or EKG)," accessed November 13, 2024, https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983#dialogId5841820.

[68] Emergency Nurses Association, *Emergency Severity Index Handbook, 5th Edition*, Version 5, 2023 Edition. Emergency Nurses Association, *Emergency Severity Index (ESI). A Triage Tool for Emergency Department Care*, Version 4, 2020 Edition.

[69] "Fluid Resuscitation in the Critically Ill," American College of Emergency Physicians, accessed November 21, 2024, https://www.acep.org/criticalcare/newsroom/newsroom-articles/july2018/fluid-resuscitation-in-the-critically-ill/.

[70] Ana Maria Miranda Martins Wilson, Maria Angelica Sorgini Peterlini, Mavilde da Luz Goncalves Pedreira. "Hemolysis risk after packed red blood cells transfusion with infusion pumps," *Revista Latino-Americana de Enfermagem* 26, (2018): 3053, https://doi.org/10.1590/1518-8345.2625.3053.

[71] Mayo Clinic, "Pap smear," accessed October 24, 2024, https://www.mayoclinic.org/tests-procedures/pap-smear/about/pac-20394841.

[72] World Health Organization, "Conceptual Framework for the International Classification for Patient Safety, Version 1.1," January 2009, https://www.who.int/publications/i/item/WHO-IER-PSP-2010.2.

percutaneous coronary intervention. A procedure that uses a small balloon to reopen a blocked coronary artery to increase blood flow. PCI may be used as a treatment for heart attack to quickly open a blocked artery, which can "help minimize heart damage."[73]

positron emission tomography. A procedure that uses a small amount of radioactive sugar injected into a vein to identify cancer cells within the body. After the injection, a scanner is used to make detailed, computerized pictures of the body. [74]

stat. A term derived from the Latin word *statim*, meaning "immediately," used primarily in medicine indicating an order to be completed without delay.[75]

transfusion-associated circulatory overload. A complication of a blood transfusion that occurs when the blood vessels are overwhelmed with too much fluid. The fluid can leak out into the lungs, making it difficult to breathe, and requiring immediate treatment.[76]

vital signs. Measure essential body functions, including blood pressure, respiration rate, pulse, and body temperature. [77]

[73] Cleveland Clinic, "Percutaneous Coronary Intervention," accessed January 13, 2025, https://my.clevelandclinic.org/health/treatments/22066-percutaneous-coronary-intervention.

[74] National Cancer Institute, "Definition of PET scan," accessed June 17, 2019, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/pet-scan.

[75] The Britannica Dictionary, "stat," accessed October 24, 2024, https://www.britannica.com/dictionary/stat.

[76] John W. Semple, Johan Rebetz, and Rick Kapur, "Transfusion-associated circulatory overload and transfusion-related acute lung injury," *Transfusion Medicine*, (2019), 133, no.17, 1840-1853.https://doi.org/10.1182/blood-2018-10-860809.

[77] US National Library of Medicine, Medline Plus, "Vital signs," accessed September 11, 2024, https://medlineplus.gov/ency/article/002341.htm.

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