US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of a Patient's Care in the Intensive Care Unit at the Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina

Healthcare Inspection | **25-03401-257** | **August 31, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations concerning nursing practice, poor quality of patient care, and inadequate provider staffing in the intensive care unit (ICU) at the Wm. Jennings Bryan Dorn VA Medical Center (facility) in Columbia, South Carolina.[1] The OIG also evaluated the care in the ICU for one patient identified by the complainant, system vulnerabilities identified during the inspection, and facility leaders' response to clinical care and system concerns. The OIG initiated the inspection on July 29, 2025, conducted an on-site visit from August 26 through 28, 2025, and completed additional virtual interviews through October 2, 2025.

The patient, in their mid-seventies, underwent a right carotid endarterectomy in early 2025 and was monitored overnight in the ICU. The next morning, the vascular surgeon noted new left-sided weakness and ordered a routine neurology consult. Afternoon imaging confirmed acute ischemic stroke (AIS). The patient was transferred to a non-VA hospital for a thrombectomy, a procedure not available at the facility, and died three weeks later.[2]

Because of the seriousness of the identified patient safety risks, the OIG issued a preliminary result advisory memorandum October 8, 2025, to Veterans Health Administration (VHA) leadership before completion of the inspection to facilitate immediate mitigation efforts.[3] This report provides an update to the preliminary result advisory memorandum to reflect the final inspection findings.

Major Findings

Evaluation and Management of Patient's Suspected AIS

The OIG substantiated that the patient suffered a postoperative AIS and that delays occurred in obtaining imaging, neurology consultation, and transfer to a non-VA hospital capable of providing advanced stroke care. The delays resulted from failures to implement rapid stroke evaluation and treatment processes required by VHA policy and supported by American Heart Association/American Stroke Association guidelines.[4]

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

[2] The OIG did not assess care provided outside VHA, as such care fell beyond the scope of this review.

[3] VA OIG, *Concerns Around Acute Ischemic Stroke*, Preliminary Results Advisory Memorandum No. 25-03401-11, October 14, 2025.

[4] VHA Directive 1155(1); William J. Powers, et al., "Guidelines for the Early Management of Patients With Acute Ischemic Stroke:2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association," updated with Shyam Prahakaran et al., "2026 Guideline for the Early Management of Patients With Acute Ischemic Stroke: A Guideline From the American Heart Association/American Stroke Association."

The team identified multiple operational vulnerabilities that contributed to risk within the ICU. These included unclear processes and policy guidance for responding to inpatient AIS events, ineffective integration of TeleCritical Care services for surgical ICU patients, and inconsistent nursing documentation of neurological assessments.

ICU Provider Staffing, Privileging, and Access to the Electronic Health Record

The OIG also substantiated that ICU coverage gaps were filled by staff without current critical care privileges and that contracted ICU physicians sometimes lacked electronic health record access at shift start. However, no patient harm was identified directly related to these findings.

Facility Response to Clinical Care and System Vulnerabilities

The OIG found facility quality management reviews of the incident did not ensure system issues were escalated for further quality management activities as recommended by VHA. The review process did not engage sufficient subject matter expertise to evaluate stroke care, scoring of the incident did not trigger a root cause analysis, and peer reviews did not refer identified system issues for additional quality management activities.

Impact on Veterans

Stroke is a leading cause of death in the United States. A foundational principle of acute stroke care is the concept that "time is brain," which "emphasizes that human nervous tissue is rapidly lost as stroke progresses and emergent evaluation and therapy are required." Every minute an ischemic stroke goes untreated, the brain loses about 2 million nerve cells.[5]

The vascular surgeon's delayed management of suspected AIS was not aligned with established American Heart Association/American Stroke Association guidelines and VHA requirements for the rapid evaluation and management of AIS. This, combined with the absence of an effective facility management plan for inpatients experiencing AIS, contributed to a fragmented and delayed response to the patient's neurological changes.

Collectively, these shortcomings, along with other OIG findings, reflect weaknesses in AIS care and facility leader oversight that adversely affected the timeliness and reliability of care provided during a time-sensitive medical emergency.

[5] Jeffery L. Saver, "Time Is Brain—Quantified," *Stroke* 37, no. 1 (January 2006): 263-266, https://doi.org/10.1161/01.STR.0000196957.55928.ab. Although published in 2006, this article's message continues to align with current objectives for rapid stroke response and care.

Key Recommendations

The OIG made seven recommendations to the Facility Director related to access to continuous critical care after hours for all patients on the ICU, provider notification parameters, compliance with VHA AIS requirements, the clarification of roles and responsibilities for on-site intensivists and TeleCritical Care in the care of surgical admissions, ICU provider privileging, electronic health record access for contract ICU physicians, and review of the case.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan to improve ICU patient care and enhance quality management processes (see appendixes E and F).[6] In response to recommendation 3, the facility took steps to fully comply with VHA Directive 1155(1), including issuing updated policies, implementing telestroke services, conducting mock code stroke simulations, and completing stroke education and training for staff. Based on information provided, the OIG considers recommendation 3 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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[6] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

Contents

Abbreviations

AHA/ASA	American Heart Association/American Stroke Association
AIS	acute ischemic stroke
CPRS	Computerized Patient Record System
CT	computed tomography
EHR	electronic health record
ICU	intensive care unit
JPSR	Joint Patient Safety Reporting
MAP	mean arterial pressure
OIG	Office of Inspector General
PSM	patient safety manager
RCA	root cause analysis
RN	registered nurse
SAC	safety assessment code
SOP	standard operating procedure
TeleCC	TeleCritical Care
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations concerning nursing practice, poor quality of patient care, and inadequate provider staffing in the intensive care unit (ICU) at the Wm. Jennings Bryan Dorn VA Medical Center (facility) in Columbia, South Carolina.[7] The OIG also evaluated the care in the ICU for one patient identified by the complainant, system vulnerabilities identified during the inspection, and facility leaders' response to clinical care and system concerns. The OIG initiated the inspection on July 29, 2025, conducted an on-site visit from August 26 through 28, 2025, and completed additional virtual interviews through October 2, 2025.

During the inspection, the OIG identified a serious patient safety risk related to the facility's management processes for acute ischemic stroke (AIS). Specifically, Medical Center Policy (MCP) 544-111-1, *Acute Ischemic Stroke*, along with its associated processes for guiding staff responses to inpatient AIS, were unclear. Furthermore, these processes did not align with Veterans Health Administration (VHA) policy or evidence-based professional practice standards.[8] These concerns were communicated to Veterans Integrated Service Network (VISN) and facility leaders during the on-site visit, prompting immediate corrective actions.[9] Facility leaders reported revising the facility's AIS policy, updating the facility's stroke designation from a stroke supporting facility to primary stroke center, finalizing a facility stroke committee charter, and updating a terms of service agreement with the VA National Telestroke Program.[10] On October 8, 2025, the OIG issued a preliminary result advisory memorandum to further inform VHA leaders and support mitigation of similar risks across the enterprise (see appendix B).[11] This report updates the preliminary result advisory memorandum to reflect the final inspection findings.

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

[8] VA OIG, *Concerns Around Acute Ischemic Stroke*, Preliminary Results Advisory Memorandum No. 25-03401-11, October 14, 2025.

[9] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[10] VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke*, November 22, 2024, amended August 22, 2025. VA medical centers may be designated as a Comprehensive Stroke Center, Primary Stroke Center, Limited Hours Stroke Facility, or a Supporting Stroke Facility, depending on the level of expert personnel, technology, and clinical services available to care for patients presenting with stroke.

[11] VA OIG, *Concerns Around Acute Ischemic Stroke*.

Background

The Columbia VA Health Care System, part of VISN 7 at the time of this inspection, includes the facility and seven community-based outpatient clinics. VHA classifies the facility as level 1b, indicating high complexity.[12] The facility has 106 hospital beds, 8 ICU beds, and 46 community living center beds. The facility provides a wide range of healthcare services, including primary care, surgical and specialty care, geriatrics, and extended care. From October 1, 2024, through September 30, 2025, the facility served 98,344 patients.

The facility's ICU admits patients with conditions requiring critical care services, including postoperative care and recovery.[13] From October 1, 2023, through June 30, 2025, the facility's ICU had an average daily census of four patients. At the time of inspection, the facility ICU had one full-time intensive care physician (intensivist), one full-time nurse practitioner, and 18 contract ICU physicians assigned to help provide coverage 24 hours a day, 7 days a week.

Acute Stroke Overview

Stroke is a leading cause of death in the United States and is categorized into two types: ischemic and hemorrhagic, with ischemic strokes accounting for most cases.[14] A foundational principle of acute stroke care is the concept that "time is brain," which "emphasizes that human nervous tissue is rapidly lost as stroke progresses and emergent evaluation and therapy are required." Every minute an ischemic stroke goes untreated, the brain loses about 2 million nerve cells.[15]

An article by the American Heart Association/American Stroke Association (AHA/ASA) reported that about half of strokes that occur in hospitalized patients (inpatients) are associated with cardiac or neurovascular procedures, particularly within 24 hours post-procedure.[16] During

[12] VHA Office of Productivity, Efficiency, & Staffing (OPES), "Data Definitions VHA Facility Complexity Model," October 1, 2023; VHA Office of Productivity, Efficiency, and Staffing (OPES), *VHA Facility Complexity Model Fact Sheet*, December 15, 2017. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. A level 1b facility has "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs."

[13] Columbia VA Health Care System Standard Operating Procedure (SOP) 544-118-5, *ICU Operations Manual*, January 13, 2022.

[14] "Stroke," Mayo Clinic, accessed November 24, 2025, https://www.mayoclinic.org/diseases-conditions/stroke/symptoms-causes/syc-20350113; Centers for Disease Control and Prevention, "Mortality in the United States, 2023," accessed November 26, 2025, https://www.cdc.gov/nchs/products/databriefs/db521.htm.

[15] Jeffery L. Saver, "Time Is Brain—Quantified," *Stroke* 37, no. 1 (January 2006): 263-266, https://doi.org/10.1161/01.STR.0000196957.55928.ab. Although published in 2006, this article's message continues to align with current objectives for rapid stroke response and care.

[16] Amre Nouh, et al., "Identifying Best Practices to Improve Evaluation and Management of In-Hospital Stroke: A Scientific Statement from the American Heart Association," *Stroke* 53, no. 4 (April 2022): e165-e175, https://doi.org/10.1161/STR.0000000000000402.

this period, close monitoring is essential as post-procedural strokes can cause severe disability or death if not addressed immediately.[17]

Given the critical importance of timely stroke care, VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke*, requires VA medical centers' AIS plans to include a structured and reliable protocol for obtaining emergency stroke consultations. The directive is based on guidelines that emphasize the need to rapidly identify and treat AIS.[18] The directive outlines requirements for AIS management plans, including plans for emergent transfers to a hospital capable of providing AIS care, and defines stroke center designations based on available personnel, technology, and clinical services.[19]

Allegations and Related Concerns

On February 3, 2025, a confidential complainant contacted the OIG with allegations that care in the ICU was not safe and provided the name of one patient who received care in the facility's ICU. According to the allegation, following a carotid endarterectomy, ICU nurses did not complete required neurological assessments on the patient "for over 16" hours. Additionally, an ICU nurse entered two neurological assessments in the patient's electronic health record (EHR) "after the fact" and not at the time the assessments were completed. The patient suffered a stroke and required transfer to a non-VA hospital for further care.

Additionally, the complainant alleged

- ICU nurses are "not required to complete critical care competencies";

[17] Scott R. Levin, et al., "Postoperative disability and one-year outcomes for patients suffering a stroke after carotid endarterectomy," *Journal of Vascular Surgery* 78, no. 2 (August 2023): 413-422, https://doi.org/10.1016/j.jvs.2023.04.002; Liqi Shu, et al., "Perioperative Stroke: Mechanisms, Risk Stratification, and Management," *Stroke* 56, no. 9, (May 30, 2025): 2798-2809, https://doi.org/10.1161/STROKEAHA.125.051673.

[18] VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke*, November 22, 2024, amended August 22, 2025. The policies contain similar language unless otherwise noted; William J. Powers, et al., "Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association," *Stroke* 50, no. 12 (December 2019): e344–e418, https://doi.org/10.1161/STR.0000000000000211, was updated with Shyam Prabhakaran et al., "2026 Guideline for the Early Management of Patients With Acute Ischemic Stroke: A Guideline From the American Heart Association/American Stroke Association," *Stroke* 0, no. 0 (January 26, 2026): e00-e00, https://doi.org/10.1161/STR.0000000000000513. The AHA/ASA periodically updates subject matter expert consensus guidelines for the treatment of AIS based on review of current medical literature, the most recent update being 2026. The guidelines contain similar language for the topics discussed in this report unless otherwise noted. The requirements set forth in VHA Directive 1155(1) are based on AHA/ASA evidenced-based guidelines and recommendations for the care of stroke, including the need for timely diagnostic imaging and treatment and protocol requirements.

[19] VHA Directive 1155(1). Formal stroke teams are required at sites designated as Comprehensive Stroke Centers, Primary Stroke Centers, or Limited Hours Stroke Facilities.

- ICU nurses disregard provider orders and exceed their scope of practice;
- ICU provider shortages have resulted in reliance on contract ICU physicians (a term that, in this report, refers to both non-VA physicians contracted through staffing agencies and individual physicians hired directly by VA to provide coverage) without EHR access; and
- the chief of cardiology, chief of medicine, and Chief of Staff, who are not "ICU providers," (a term the OIG interpreted to mean licensed independent providers without critical care privileges for the purpose of this report) were the designated attending physicians in the facility's ICU on multiple occasions, creating challenges for nursing staff in obtaining appropriate clinical support.

The OIG reviewed the clinical care provided during the patient's ICU admission, including the vascular surgeon's management of the patient's suspected AIS; ICU provider staffing, privileging, and access to the EHR; and facility leaders' and staff's response to clinical care and system vulnerabilities.

The OIG also identified concerns related to the reporting of abnormal vital signs, TeleCritical Care (TeleCC) and on-site intensivist services resources for surgical ICU patients, and documentation requirements for neurological assessments in the ICU.

Scope and Methodology

The OIG initiated the inspection on July 29, 2025, conducted an on-site visit August 26 through 28, 2025, and completed additional virtual interviews through October 2, 2025.

The OIG interviewed the confidential complainant; staff from VHA's National TeleCC program office; and select current and former staff including facility executive leaders, service leaders, providers, nurses, quality and safety staff, and other facility staff knowledgeable of the related events and processes.

The OIG reviewed relevant VHA directives, standard operating procedures (SOPs), and guidebooks; facility policies and procedures; medical staff bylaws; a term of service agreement; and regulatory and clinical guidelines. The review also included facility organizational charts and staffing documents, provider credentialing and privileging files, nurse competencies and training records, committee charters and minutes, quality and performance data outcomes, external accreditation survey reports, VHA program office review reports, administrative and quality review activities, action plans, and other relevant documents. Additionally, the OIG reviewed EHR documentation from February 2022 through March 2025 of the patient identified in the complaint.

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 shows it is more likely than not that the event or action occurred. Conversely, the OIG does not substantiate an allegation when the available evidence shows it is more likely than not that the event or action did not occur. 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 inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of the Inspectors General on Integrity and Efficiency's standards.[20] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and take full responsibility for the content of the publication. All references are for original source material, not AI-generated content. Office of Healthcare Inspections inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "*Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*"[21]

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.

[20] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[21] Executive Office of the President, Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," Memorandum for the Heads of Executive Departments and Agencies, M-21-21: § 4(a), April 3, 2025.

Patient Case Summary

The patient was in their mid-70s and had a medical history that included hypertension, diabetes, obesity, and hyperlipidemia.[22] In early 2025, the patient presented to the facility for scheduled right carotid endarterectomy surgery to treat right, high-grade, asymptomatic, carotid artery stenosis. At the end of the surgery, the vascular surgeon used a doppler ultrasound device to confirm normal blood flow in the carotid artery. The patient emerged from anesthesia and was assessed by the vascular surgeon to be "neurologically intact." At this point, the vascular surgeon considered the operation a success and without complications. After a brief, uneventful stay in the postanesthesia care unit, the patient was transferred to the intensive care unit (ICU) at approximately 5:00 p.m. for close observation overnight. The vascular surgeon wrote orders for admission to the ICU, specifying the frequency of vital sign checks and neurological assessments. An ICU registered nurse (RN 1) cared for the patient at the time of admission to the ICU. The vascular surgeon and the family visited the patient in the ICU at 5:30 p.m., during which time there were no concerns documented in the EHR. RN 1 gave report to another ICU registered nurse (RN 2) at approximately 7:00 p.m.[23]

From early evening until shortly after midnight, the patient had hypotension, at times over 40 points (mmHg) below their baseline blood pressure [as defined by the mean arterial pressure (MAP)] reading (figure 1).[24]

[22] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[23] "Report," also called "handoff," is a structured, focused, professional communication of relevant clinical information shared by the clinical staff member who is completing a period of care of a patient with the member of the clinical staff who will be assuming care of that patient. It includes a summary of the most recent important clinical events and anticipated concerns to prioritize the oncoming staff member's attention.

[24] The patient's "baseline" blood pressure reading on arrival to the hospital the morning before scheduled surgery was 135/91 mmHg, MAP of 106 mmHg.

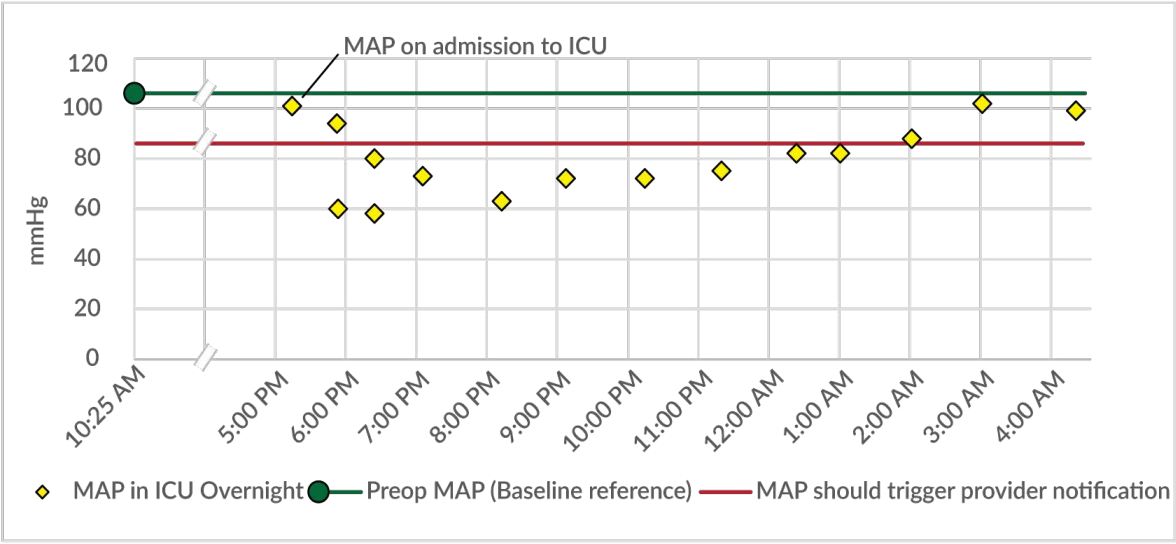

Figure 1. *Graph of the patient's MAP overnight in the ICU. The patient's baseline MAP (on arrival to hospital) prior to surgery (green) and the threshold for provider notification (red) are shown as references. Source: OIG analysis of EHR patient data.*

There is no evidence in the EHR or nursing documentation that the vascular surgeon was notified by either RN 1 or RN 2 of the hypotension. Overnight, RN 2 documented performing neurological assessments, which did not indicate a focal neurological deficit or other concerns.

On the morning after surgery, RN 1 received a report from RN 2 and resumed care of the patient at approximately 7:00 a.m. ICU nursing documentation at 8:00 a.m. did not note any concerns about the patient's course or condition. However, the vascular surgeon documented at 8:33 a.m. that the patient was "[v]ery groggy," favoring the right side with weakness in the left arm, and "slow movement on the left side." The vascular surgeon detailed plans to keep the patient in the ICU, obtain a neurology consultation "today," and re-evaluate the patient "later this afternoon." The vascular surgeon placed a routine order for surgical critical care consultation at 8:29 a.m., indicating in the order "Surgical Critical Care is to participate in the care of the patient." The vascular surgeon also placed a routine order for a neurology consultation at 8:37 a.m., indicating that the patient had a right carotid endarterectomy the day before and now had weakness on the left side. There is no documentation in the EHR that the vascular surgeon directly contacted either a neurologist or a surgical critical care consultant. The vascular surgeon did not order any radiologic imaging at that time.

See figure 2 for further details of significant events after the patient experienced a change in neurological status.

Two hours later, the surgical critical care inpatient consultation order was electronically canceled by a physician in the department of surgery with the explanation "[t]here is no surgical intensivist available at this time." At 12:09 p.m., the neurology consultant documented that the patient was sleepy and minimally responsive, had a left arm and leg that were "flaccid" and without significant movement, and that "the clinical picture is very much suggestive [of] … stroke."[25] A carotid duplex study was performed by the cardiology service at 12:23 p.m., which demonstrated "no [blood] flow" and thrombosis in the right internal carotid artery, consistent with "total occlusion." The vascular surgeon placed an order for a computed tomography angiogram (CT angiogram) of the head and neck at 1:03 p.m., followed by an order for a non-contrast head computed tomography scan (head CT scan); both were completed by 1:57 p.m. Final interpretations of the radiologic imaging were made by the attending radiologist just over an hour later demonstrating AIS with "complete" occlusion of the right internal carotid artery extending from the neck into the head. The results of the CT angiogram and head CT scan were communicated directly to the vascular surgeon at 3:25 p.m. The neurology consultant and vascular surgeon discussed treatment options and planned to transfer the patient to a non-VA hospital for further stroke care. The vascular surgeon ordered the transfer of the patient to a non-VA hospital at 3:32 p.m., and the patient was transferred at 5:15 p.m. The patient underwent a thrombectomy of the right internal carotid artery and middle cerebral artery by interventional neuroradiology at the non-VA hospital on the day of transfer. Although the patient was awake after the procedure, there remained significant left hemiparesis requiring maximum assistance with any activity. The patient continued to be hospitalized at the non-VA hospital for the acute stroke and died three weeks later.[26]

Facility leaders performed an institutional disclosure of the adverse event in early March to the patient's spouse.

Inspection Results

The OIG conducted a review of all allegations received; the analysis of allegations not substantiated by the OIG are summarized in appendix A and not included in detail in the report.

1. Evaluation and Management of Patient's Suspected AIS

The OIG substantiated that the patient suffered a postoperative acute ischemic stroke (AIS). As a result, the patient required transfer to a non-VA hospital for advanced stroke interventions and subsequently died 21 days later. The OIG found the vascular surgeon's actions taken after recognizing a change in neurological status were not aligned with established VHA policy and

[25] In an interview, the neurology consultant reported serving as the chief of neurology and the sole working neurologist on staff at the facility at the time of the inspection. While having multiple roles at the facility, this physician is referred to as the neurology consultant throughout the report.

[26] The OIG did not assess care provided outside VHA, as such care fell beyond the scope of this review.

American Heart Association/American Stroke Association (AHA/ASA) guidelines for the rapid evaluation and management of AIS. This, combined with existing vulnerabilities with the facility's AIS response processes, contributed to a significant delay in initiating stroke evaluation and care for the patient.

The OIG found that facility leaders did not implement a process to ensure staff efficiently managed the patient's suspected AIS, as required by VHA. According to interviews, facility leaders had been aware of gaps in the inpatient stroke process for over four years but had not established a process in accordance with VHA Directive 1155(1).[27]

Additionally, the OIG found that the patient's ongoing low blood pressure in the ICU was not communicated to the vascular surgeon, noted potential underuse of TeleCC services for surgical ICU patients, and identified unclear requirements for nursing documentation of neurological assessments.

Actions Taken by the Vascular Surgeon

Patients with suspected AIS must be managed in accordance with VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke,* which is based on AHA/ASA guidelines, and requires immediate stroke expertise consultation, direct communication of clinical urgency, and urgent brain imaging—typically a head CT scan or magnetic resonance imaging—to guide time-sensitive treatment. Head CT scans are usually preferred to evaluate patients with suspected AIS as they can be completed and interpreted within minutes.[28] VHA Directive 1232, *Consult Management*, specifies that *stat* consults are required for urgent care needs and that providers must directly notify the consulting service; *routine* consults are appropriate only for non-urgent evaluations.[29]

The AHA/ASA recommend that patients are transferred to an appropriate facility as rapidly as possible to minimize delays in care when advanced stroke interventions, such as thrombectomy, are not locally available.[30] VHA Directive 1155(1) requires facilities without advanced stroke services to maintain current transfer agreements and protocols.[31]

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[27] VHA Directive 1155(1).

[28] VHA Directive 1155(1); William J. Powers et al., "Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association, updated with Shyam Prahakaran et al., "2026 Guideline for the Early Management of Patients With Acute Ischemic Stroke: A Guideline From the American Heart Association/American Stroke Association."

[29] VHA Directive 1232, *Consult Management*, November 22, 2024.

[30] William J. Powers et al., "Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association."

[31] VHA Directive 1155(1).

The OIG found that the vascular surgeon did not take effective action to promptly obtain brain imaging, despite recognizing the potential for AIS early in the morning after surgery. In interviews, RN 1 and RN 2 reported attempting to mobilize the patient at approximately 7:00 a.m. the morning after surgery, noting that the patient refused, but there were no signs of neurological deficits. Through EHR reviews, the OIG found that at 8:33 a.m., the vascular surgeon evaluated the patient, documented new neurological concerns, and planned to obtain a neurology consult "today" with reassessment later in the afternoon. The vascular surgeon did not document directly communicating urgency to the neurology consultant and entered the order for the consult as "routine." Imaging orders, including a carotid duplex ultrasound and CT angiogram of the head and neck, were not placed until approximately four hours after the neurological changes were first noted. Consequently, the imaging results confirming AIS were not available for over six hours, delaying essential diagnostic information needed to determine treatment options.

Figure 2 provides a timeline of significant events.

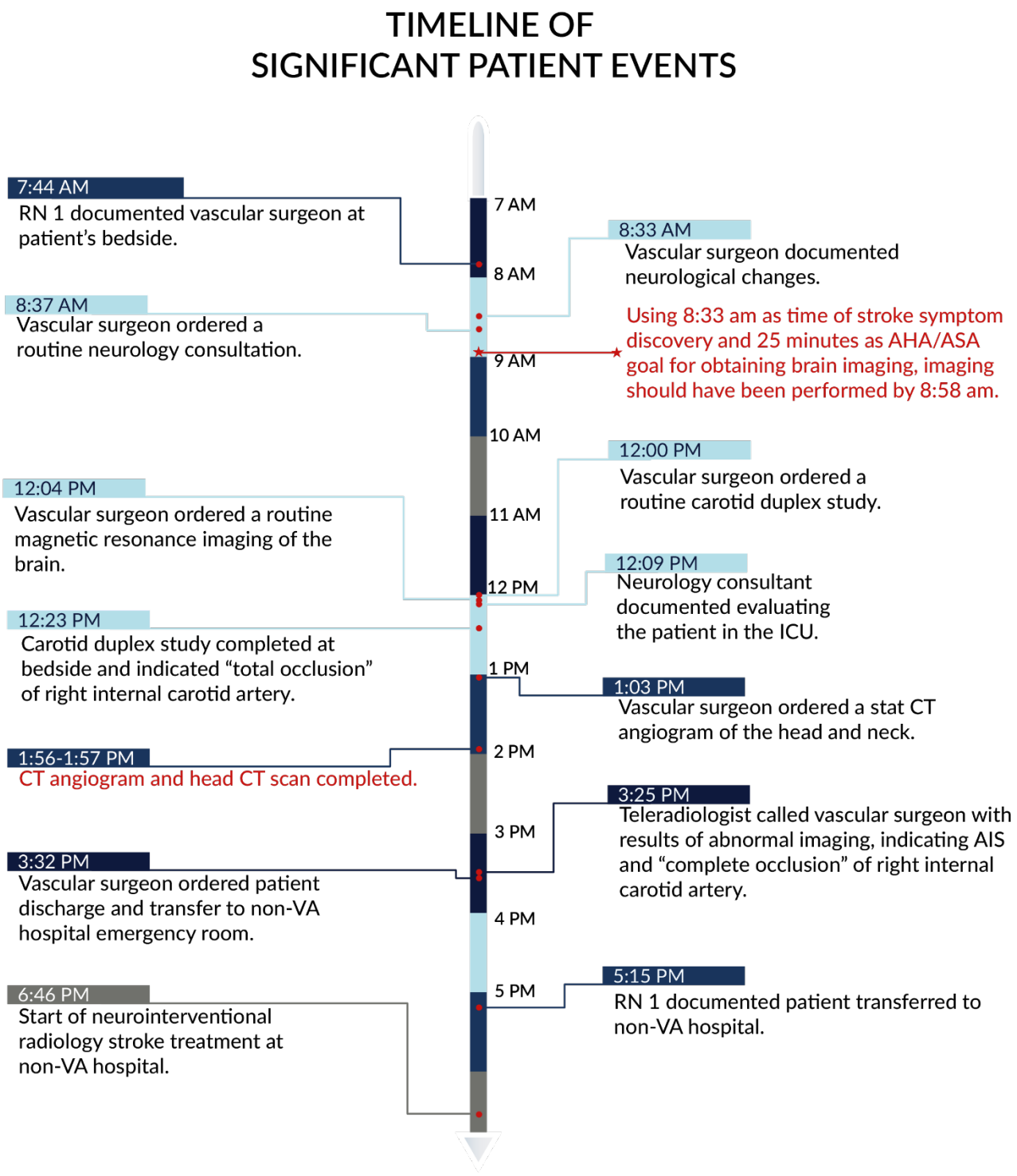

Figure 2. *Timeline of significant patient events.*
Source: OIG review and analysis of the patient's EHR and Susan Ashcraft et al., "Care of the Patient with Acute Ischemic Stroke (Prehospital and Acute Phase of Care): Update to the 2009 Comprehensive Nursing Care Scientific Statement," Stroke 52, no. 5 (May 2021): e164-e178, https://doi.org/10.1161/STR.0000000000000356.

Both the vascular surgeon and neurology consultant reported that the patient was not a candidate for thrombolytic therapy due to recent surgery and therefore required a thrombectomy—an intervention not available at the facility. Transfer to a non-VA hospital ultimately occurred more than eight hours after the first signs of stroke, far exceeding AHA/ASA recommendations for urgent neurology consultation and brain imaging, and rapid transfer when needed.[32]

Review of Facility AIS Management Process

VHA Directive 1155(1) requires VA medical centers to develop an AIS management plan that is grounded in AHA/ASA best practices designed to reduce delays and optimize response including:

- Standardized response protocols, such as a "code stroke" response process and a formal stroke team.
- Rapid initiation of brain imaging upon recognition of AIS signs and symptoms.
- Protocols that provide access to thrombolytic therapy or thrombectomy.
- Plans for emergent transfer to a VA or non-VA hospital facility capable of providing AIS care.[33]

Medical Center Policy (MCP) 544-111-1, *Acute Ischemic Stroke*, outlines the facility's AIS plan and identifies the facility as a "stroke supporting facility with limited capability for comprehensive acute stroke care."[34] Staff are directed to initiate a "code stroke" for all potential AIS treatment candidates to activate a stroke team that includes VA National Telestroke Program neurologists.[35] Per the policy, the stroke team is to respond to suspected AIS and is responsible for determining patient eligibility to "receive acute stroke therapy."[36] The policy requires that "all" suspected AIS patients be treated in the facility's emergency department for evaluation by the telestroke neurologists.[37] The policy also requires written interhospital transfer agreements and identifies "official" transfer agreements as "pending" with a local non-VHA hospital system. The policy notes that acute stroke patients will be transferred to either a local non-VHA hospital

[32] William J. Powers et al., "Guidelines for the Early Management of Patients With Acute Ischemic Stroke:2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association."

[33] VHA Directive 1155(1). William J. Powers et al., "Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association."

[34] Columbia VA Health Care System, MCP 544-111-1, *Acute Ischemic Stroke*, November 22, 2021.

[35] Columbia VA Health Care System, MCP 544-111-1.

[36] Columbia VA Health Care System, MCP 544-111-1.

[37] Columbia VA Health Care System, MCP 544-111-1.

or one of two "backup hospitals," depending on patient treatment needs.[38] The Facility Director, Chief of Staff, and the Associate Director of Patient Care Services are responsible for ensuring adherence to policies and procedures as identified in the policy.[39]

Although, as written, MCP 544-111-1 covers both inpatient and outpatient settings, the OIG found the policy was insufficiently implemented across the facility. Some facility leaders, providers, and ICU nursing staff interviewed by the OIG reported that code stroke activation and stroke team support were not available on inpatient units. Despite the policy requiring all suspected AIS patients to be treated in the emergency department, in practice, inpatients were not transferred to the emergency department for stroke care.[40] Patients admitted to inpatient units (including the ICU) did not have access to the telestroke neurologists as outlined in the policy.[41] The OIG communicated initial concerns regarding these vulnerabilities in the facility's AIS management plan to facility leaders and delineated them in the OIG's Preliminary Result Advisory Memorandum published in October 2025. Further, the OIG found that the facility did not have formalized interhospital transfer agreements with local non-VA hospitals for the treatment of patients in need of definitive stroke treatment, as required by VHA Directive 1155(1).[42] Facility leaders have begun taking steps to address the OIG's concerns and resolve system vulnerabilities that prevent efficient and effective AIS response.

The OIG found inadequate implementation of the facility policy contributed to the lack of timely, evidence-based care, due to lack of standardized stroke protocol. Had a formal inpatient code stroke protocol been in place, the staff would likely have initiated a protocol of rapid imaging, timely neurology evaluation, and expedited transfer, reducing delays in accessing definitive stroke treatment. The vascular surgeon reported being unaware, prior to this event, of how the facility managed inpatient strokes and acknowledged that an inpatient stroke pathway could have improved access to imaging, neurology involvement, and transfer for definitive stroke care. RN 1 explained that although nurses are empowered to do so, ICU nursing staff rarely initiate a code stroke. The discrepancies in the vascular surgeon and RN 1's understanding of inpatient code stroke processes underscores important gaps in facility AIS process communication and preparedness.

Facility leaders were aware of deficiencies in the inpatient stroke process before the OIG site visit. When interviewed, the Chief of Staff and the Associate Director of Patient Care Services recognized that the facility stroke policy did not apply to the entire facility, as telestroke evaluations were limited to the emergency department. Although attempts to expand telestroke

[38] Columbia VA Health Care System, MCP 544-111-1.
[39] Columbia VA Health Care System, MCP 544-111-1.
[40] Columbia VA Health Care System, MCP 544-111-1.
[41] Columbia VA Health Care System, MCP 544-111-1.
[42] VHA Directive 1155(1); Columbia VA Health Care System, MCP 544-111-1.

services to inpatient units began in 2020, facility leaders reported these efforts were not approved at that time. The Associate Director of Patient Care Services reported that the process for inpatient stroke management had been discussed, and it was determined that these patients could effectively be managed as long as consistent and stable providers remained in the ICU. However, according to the Associate Director of Patient Care Services the facility lost several critical care and pulmonary physicians from late 2022 through mid-2023 and the beginning of 2024, and contract physicians primarily provided ICU coverage. The Associate Director of Patient Care Services reported that as a result, the facility identified the need to implement a definitive process to expand telestroke services to inpatient units and explained that the former Chief of Staff initiated this effort with assistance from the chief of neurology. A stroke committee was formed which, according to the chief of neurology, has made slow progress on policy revisions.

The OIG concluded that the vascular surgeon's management of suspected AIS delayed timely definitive intervention and was not aligned with established AHA/ASA guidelines and VHA requirements for the rapid evaluation and management of AIS. The OIG's findings revealed the absence of an effective facility management plan for inpatients experiencing AIS, which contributed to a fragmented and delayed response to the patient's neurological changes.

Additional Findings

Upon reviewing the patient's care, the OIG found the patient's persistent low blood pressure readings in the ICU, prior to presenting with physical symptoms concerning for acute stroke, were not communicated to the vascular surgeon. The OIG also identified concerns that TeleCC services may not be utilized effectively for surgical patients in the ICU.

Additionally, while the OIG did not substantiate that ICU nursing staff omitted neurological assessments for over 16 hours during the patient's admission (appendix A), the OIG identified concerns that requirements for documenting patient's neurological assessments in the ICU were unclear.

Reporting of Abnormal Vital Signs

Columbia VA Health Care System Standard Operating Procedure (SOP) 544-118-45, "Vital Sign Assessment And Documentation (Including Pulse Oximetry & ECG [electrocardiogram] Monitoring) In Acute Care Units," requires nurses to notify providers when vital signs fall outside ordered parameters.[43] In the absence of such orders, the policy defines standard thresholds for contacting the provider, including when blood pressure deviates by 20 points

[43] Columbia VA Health Care System SOP 544-118-45, *Vital Sign Assessment and Documentation (Including Pulse Oximetry and ECG Monitoring) In Acute Care Units,* February 2, 2022. The SOP includes a systolic blood pressure <100mmHg or MAP <60mmHg in the definition of an unstable patient and requires physician notification if blood pressure falls more than 20mmHg below the patient's baseline; the SOP also provides specific guidance for surgical patients including required provider notification for any systolic blood pressure <100mmHg or any diastolic blood pressure <50mmHg.

(mmHg) from the patient's baseline.[44] Because hypotension after carotid artery procedures may be associated with an increased risk for stroke, close monitoring of postoperative patient blood pressure is essential to prevent complications.[45]

After the patient's surgery, the vascular surgeon placed admission orders delineating the frequency vital sign measurements (including blood pressure) were to be conducted in the ICU; however, the order did not include parameters for provider notification. ICU nurses documented multiple hypotensive readings over nearly seven hours that met policy criteria for provider notification. The OIG found the patient experienced multiple episodes of hypotension during the first night in the ICU, with blood pressure measurements falling at times 40 points (mmHg) below the patient's baseline, and no evidence in the EHR that the vascular surgeon was contacted as required by facility policy.

The OIG concluded, in the absence of written parameters for provider notifications in the ICU admission orders, ICU nursing staff did not follow facility policy regarding reporting the patient's hypotension. Although the OIG could not determine the extent to which the prolonged hypotension may have contributed to the patient's subsequent postoperative AIS, hypotension after vascular procedures is associated with increased risk of complications.[46]

ICU TeleCC Resources

The VHA National TeleCC Program Office establishes ICU TeleCC category designations based on the availability of on-site intensivists. These categories range from Category A, for facilities without 24-hour on-site intensivist coverage, to Category E, designated for specialized ICU populations. Each ICU affiliated with TeleCC receives a category designation reflecting its specific critical care resources (see appendix C for an explanation of all categories of care).[47] At the time of the inspection, the facility held a category D designation.

TeleCC staff collaborate with on-site ICU teams according to these categories, accessing patient data through specialized software, which provides real-time monitoring and generates alerts for abnormal vital signs, such as severe low blood pressure.[48]

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[44] Columbia VA Health Care System, *Vital Sign Assessment and Documentation (Including Pulse Oximetry and ECG Monitoring) In Acute Care Units*.

[45] Vincent J. Noori et al., "Risk Factors and Impact of Postoperative Hypotension after Carotid Artery Stenting in the Vascular Quality Initiative," *Journal of Vascular Surgery* 73, no. 3 (2021): 975–82, https://doi.org/10.1016/j.jvs.2020.06.116.

[46] Vincent J. Noori et al., "Risk Factors and Impact of Postoperative Hypotension after Carotid Artery Stenting in the Vascular Quality Initiative."

[47] VA National Tele-Critical Care Program, "Categories of Tele-Critical Care Management," November 1, 2023.

[48] VA National Tele-Critical Care Program, "Categories of Tele-Critical Care Management."

ICU admissions may be managed under a *closed* model, with an intensivist directing all patient care, or an *open* model, where the admitting provider retains responsibility.[49] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in any Clinical Setting,* requires a written plan be in place that defines responsibilities for each service line involved in the care of a surgical patient in the ICU.[50] Interviews with facility leaders and staff revealed that the ICU employs a *hybrid* admission model—medical patients are admitted and managed by the on-site ICU intensivist, while surgical patients are admitted and managed by their individual surgeon. ICU providers reported that the intensivist consults or co-manages surgical patients only when requested, a practice that occurs infrequently. In most cases, the admitting surgeon alone is responsible for patient assessments and care decisions, as consultation with the intensivist is not mandatory. The acting chief of surgery explained that the admitting surgeon, while responsible for the patient, may not be physically on-site overnight.

Given the facility's ICU Category D designation, TeleCC is available upon request of the on-site clinical staff. However, due to the ICU's hybrid admission model, surgical patients admitted to the ICU may require support more consistent with Category A ICUs, where TeleCC is proactively involved. The VA National TeleCC Program Office's guidance for Category D facilities specifies 24/7 on-site intensivist coverage, with TeleCC staff available for assistance when requested, when primary teams are occupied, or when emergency support is necessary. [51] In contrast, Category A facilities do not have on-site intensivist coverage; in those settings, TeleCC providers conduct daily rounds and review all ICU admissions.[52]

Additionally, the OIG's review of the patient's EHR confirmed that a TeleCC nurse documented the patient's ICU admission in the EHR shortly after arrival; however, there was no evidence that the TeleCC nurse participated in any aspect of the patient's ICU care after documenting this initial administrative admission note. TeleCC software generated two "Severe Low" blood pressure alerts soon after admission. The OIG found no evidence that TeleCC staff notified facility ICU staff, nor did ICU nursing staff document receiving an alert from or requesting the assistance of TeleCC. The OIG noted that guidance provided by the VHA National TeleCC Program Office does not include instructions for TeleCC staff to notify facility ICU staff when such alerts occur. [53]

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[49] Peter Almenoff, et al., "Intensive Care Services in the Veterans Health Administration," *Chest* 132, no. 5 (November 5, 2007): 1455-1462, https://doi.org/10.1378/chest.06-3083; VHA Office of Specialty Care Services Healthcare Analysis & Information Group (HAIG), "2019 VHA Critical Care Survey Report," January 2022.

[50] VHA Directive 1220 (1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in any Clinical Setting,* May 13, 2019*,* amended February 11, 2020.

[51] VA National Tele-Critical Care Program, "Categories of Tele-Critical Care Management."

[52] VA National Tele-Critical Care Program, "Categories of Tele-Critical Care Management."

[53] VA National Tele-Critical Care Program, "Categories of Tele-Critical Care Management."

The OIG concluded that, although the ICU holds a Category D TeleCC designation, the critical care resources for facility surgical ICU admissions are more closely aligned with a Category A level of TeleCC support, as attending surgeons are not routinely in house 24/7, and both on-site 24/7 intensivist coverage and TeleCC involvement are provided to surgical ICU patients only upon request. Surgical patients admitted to the facility ICU may benefit from these resources.

Documentation of ICU Neurological Assessments

VHA SOP, VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, And Standards of Care Standard Operating Procedure (SOP)," requires that nursing documentation be recorded and signed immediately after the care event or observation. When immediate documentation is not possible, the author must adjust the time in the EHR to reflect when the event occurred.[54] Further, when not completed during the tour of duty, the author should clearly identify late entries by including the date and time of the observation and the reason for the delay.[55]

The facility's ICU uses two systems for documentation: VA's Computerized Patient Record System (CPRS) and the Clinicomp Clinical Information System, also known as Essentris.[56] Essentris is used in the ICU for certain patient information, but not all Essentris entries are transferred to CPRS, the primary EHR, which can limit visibility for other care team members.[57] As the dual-system documentation approach has been found to create redundancy, VHA discourages duplicate documentation to preserve time for patient care. [58]

The OIG reviewed VHA and facility policies (Appendix D) and found that two of the facility policies recognize ICU nurses may use Essentris to document notes not required by VHA-ONS-NUR-22-01 to be documented in CPRS (Columbia VA Health Care System SOP 544-118-107, "Clinicomp Documentation System," and SOP 544-118-5, "ICU Operations Manual"). However, none of the policies reviewed by the OIG clearly stated where or when ICU nurses are to document neurological assessments.[59] The OIG learned that RN 2 documented neurological

[54] VHA SOP, VHA-ONS-NUR-22-01, *VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, And Standards of Care Standard Operating Procedure (SOP),* September 20, 2022, revised September 10, 2024.

[55] VHA SOP, *VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, And Standards of Care Standard Operating Procedure (SOP)*.

[56] Columbia VA Health Care System SOP 544-118-107, *Clinicomp Documentation System*, October 29, 2021.

[57] Columbia VA Health Care System, *Clinicomp Documentation System*; VHA Office of Specialty Care Services Healthcare Analysis & Information Group (HAIG), "2019 VHA Critical Care Survey Report."

[58] VHA SOP, *VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, And Standards of Care Standard Operating Procedure (SOP)*; VHA Office of Specialty Care Services Healthcare Analysis & Information Group (HAIG), "2019 VHA Critical Care Survey Report."

[59] VHA SOP, *VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, And Standards of Care Standard Operating Procedure (SOP)*; Columbia VA Health Care System, *Clinicomp Documentation System*; Columbia VA Health Care System, SOP 544-118-5, *ICU Operations Manual*, January 13, 2022.

assessments overnight in Essentris. About two weeks after the patient's transfer, RN 2 entered three neurological assessments in CPRS that had been conducted during the patient's ICU stay and documented in Essentris at that time. During an interview, RN 2 acknowledged not documenting specific neurological assessments in CPRS in real time during the original shift, believing that the every four-hour neurological assessments entered in Essentris covered required documentation of the neurological assessments. RN 2 reported being encouraged by a nurse manager to retroactively enter the duplicate neurological assessments as late entries in CPRS.

The OIG concluded that the lack of clear policy guidance on where ICU nurses should document neurological assessments creates inconsistent practices and fragmented patient records. While the OIG acknowledges documentation practices did not contribute to this patient's postoperative stroke, ineffective documentation practices may delay identification and communication of changes in patient condition among care team members and increase the risk of adverse outcomes.

2. ICU Provider Staffing, Privileging, and Access to the EHR

The OIG substantiated that a shortage of full-time staff ICU providers on the facility medical ICU led facility leaders to utilize VA facility providers without critical care privileges to provide ICU coverage when VA and contract ICU physicians were not available. The OIG also substantiated that some of the contract ICU physicians hired for ICU coverage had inconsistent access to the EHR.

ICU Provider Staffing and Privileging

VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, and VHA Directive 1100.21(1), *Privileging*, requires that VHA providers are formally credentialed and privileged before providing patient care.[60] Credentialing verifies a provider's education, training, licensure, and professional history, while privileging defines the specific clinical services the provider is approved to perform based on the relevant experience identified during the credentialing process.[61] Privileges are not uniform and must be tailored to each provider's specialty, training, and demonstrated competence. Providers with newly granted or additional privileges must undergo a Focused Professional Practice Evaluation to verify competency before full independent practice, and all privileged providers are continually monitored through Ongoing Professional Practice Evaluations to ensure safe, quality care. [62]

[60] VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, September 15, 2021, amended September 11, 2024; VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 26, 2023.

[61] VHA Directive 1100.20(2).

[62] VHA Directive 1100.21(1).

According to VHA Directive 1100.21(1), no provider should provide patient care without approved, current, facility-specific privileges.[63] It is the responsibility of the provider to request modifications to clinical privileges when needed and facility leaders must follow medical staff bylaws and reprivileging processes if a provider seeks new or expanded privileges.[64] If a provider practices without privileges due to administrative oversight, it is treated as a lapse in privileges. When a lapse in privileges is identified, facilities must follow the required procedures to address the lapse, ensure no provider delivers patient care without current, specialty-specific privileges, and use internal monitoring controls to prevent future lapses.[65]

The OIG found that facility leaders did not follow VHA policy and ensure that all VA facility providers supplementing the provider schedule and delivering care in the ICU had current critical care privileges. The OIG learned that the ICU was staffed with one full-time VA intensivist, one full-time VA nurse practitioner, and 18 contract ICU physicians. The former chief of pulmonary and critical care medicine, who reported leaving the facility in July 2025, told the OIG that other VA facility physicians, who were not intensivists, were sometimes used to supplement coverage as ICU providers when facility intensivists and contract ICU physicians were not available.[66] The OIG reviewed the ICU provider schedule for January 2025 through July 2025, and relevant provider privilege files, and found documentation of intermittent coverage by VA facility non-intensivist physicians who did not have current critical care privileges. The OIG also found that the ICU nurse practitioner, who had no specific critical care privileges, was scheduled to work shifts as the sole ICU provider. Because these VA facility non-intensivist physicians and the ICU nurse practitioner did not hold critical care privileges, they were not subject to verification of relevant ICU training and experience, and subsequent critical care Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation monitoring processes.

The former chief of pulmonary and critical care medicine and chief of medicine reported being aware of the practice of filling ICU coverage gaps with VA facility non-intensivist physicians. During an interview, the Chief of Staff reported recently becoming aware that these physicians were covering shifts in the ICU. The Chief of Staff explained the lapse was discovered by the facility credentialing team, who then began steps to initiate the process to grant the providers the appropriate privileges. The OIG followed up with the facility and learned that as of May 2026, the ICU had two full-time VA intensivists, two vacancies, and a permanent chief of pulmonary and critical care medicine. The facility continues to utilize c ontract ICU physicians to assist with

[63] VHA Directive 1100.21(1).

[64] VHA Directive 1100.21(1).

[65] VHA Directive 1100.21(1).

[66] At the time of the site visit, the chief of medicine reported this position was vacant and described covering the responsibilities of the position. The OIG used the term "facility non-intensivist ICU physicians" to describe non-intensivist members of the facility medical staff who were periodically assigned duties as the responsible physician in the ICU.

ICU coverage needs and no longer permits the nurse practitioner to work in the ICU without an on-site privileged ICU physician.

The OIG concluded that facility leaders did not follow established VHA requirements for ensuring all providers were credentialed and privileged to provide critical care. Facility leaders acknowledged the need to make changes and are working to ensure adequate ICU coverage consistent with VHA standards.

Access to EHRs

VHA Health Information Management (HIM), *Health Record Documentation Program Guide Version 1.3*, February 13, 2025, identifies patient health record documentation as important to ensure communication and evaluation for immediate treatment and continuity of care."[67] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, requires medical facility health care providers to complete and sign EHR documentation within defined time frames.[68] The capacity to record and view patient data, via access to the EHR, is an essential component of patient care in the ICU setting.[69]

The OIG learned that contract ICU physicians assigned to cover the ICU were, at times, unable to access the EHR upon reporting to work due to their computer network access being disabled. According to the VA Office of Information and Technology (OIT), End User Operations/Local OIT Account Management Playbook, user network accounts are disabled after extended periods of inactivity.[70] As a result, upon returning to the facility for a shift, the providers would need to have access restored. The Chief of medicine and Chief of Staff reported this would require providers to use workarounds, such as having other providers enter orders, until access issues were resolved. A VA intensivist explained that these providers experienced greater delays to resolution during evening and weekend shifts, due to limited information technology support services available to assist the providers. Provider and nursing staff interviewed supplied varied answers when asked to describe the frequency of access issues and the severity of impact,

[67] VHA Health Information Management (HIM), *Health Record Documentation Program Guide Version 1.3*, February 13, 2025.

[68] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021, amended December 11, 2023.

[69] "Electronic Health Records," Centers for Medicare & Medicaid Services, accessed April 13, 2026, https://www.cms.gov/priorities/key-initiatives/e-health/records#:~:text=The%20EHR%20can:%20*%20Automate%20access%20to,Patients%20well%20informed%20to%20take%20better%20decisions; John C. Marshall et al., "What is an intensive care unit? A report of the task force of the World Federation of Societies of Intensive and Critical Care Medicine," *Journal of Critical Care* 37, (February 2017): 270-276, http://dx.doi.org/10.1016/j.jcrc.2016.07.015.

[70] VA Office of Information and Technology (OI&T), *End User Operations/Local OIT Account Management Playbook, Version 3.6.9*, March 22, 2026.

reporting some providers had complete lack of access to EHRs and were unable to enter medical orders for patient care.

The OIG reviewed Joint Patient Safety Reporting (JPSR) system reports to determine whether there were reported patient safety concerns related to EHR access issues in the ICU. The review of reports from June 2024 through May 2025 identified no associations between the patient safety concerns and providers without access to EHRs. The patient safety manager (PSM) and some current and former facility leaders reported being aware of EHR access issues with some ICU providers, but none identified it as a critical issue. The chief of quality reported having no knowledge of the issue. While facility leaders did not have a process to resolve the access challenge at the time of the inspection, the chief of medicine acknowledged the problem and articulated the need to create a plan to mitigate the issue.

The OIG concluded that although aware of the issues with access, facility leaders did not have a process to prevent disruptions to EHR access for contract ICU physicians resuming work after periods of inactivity. Although facility leaders and staff reported these disruptions were infrequent and did not present a critical patient safety concern, the inability to access EHRs can interfere with the delivery of patient care.

3. Facility Response to Clinical Care and System Vulnerabilities

The OIG found that despite first becoming aware of concerns with the patient's AIS care and facility AIS management processes at the time of the event, facility leaders did not ensure systems issues identified through quality management reviews of the patient's care were referred for further quality management activities as recommended by VHA.

The VHA Office of Quality and Patient Safety and National Center for Patient Safety relays in directive and guidebooks that investigation of patient safety events using the JPSR system is essential to understanding what occurred and determining appropriate corrective actions.[71] Facility PSMs assign patient safety reports to investigators with subject matter expertise and, after an investigation, conduct a final review.[72] This review includes assigning a safety assessment code (SAC) score for both actual and potential risk, considering the reasonable worst-case outcome.[73] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, requires a root cause analysis (RCA) when the potential risk is scored as catastrophic, meaning

[71] VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023, updated to *JPSR Guidebook Version 6.0*, October 1, 2025. The guidebooks contain similar language unless otherwise identified; VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation Version 8*, December 2023.

[72] VHA National Center for Patient Safety, *JPSR Guidebook Version 6.0*.

[73] VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation Version 8*.

"death or major permanent loss of function … not related to the natural course of the patient's illness."[74]

VHA Directive 1190(1), *Peer Review for Quality Management*, describes peer review as a part of the quality management process to evaluate the clinical care provided by an individual provider. System issues identified during peer review should be referred for additional quality management activities.[75]

As a part of the inspection, the OIG reviewed facility quality management documents, including a JPSR submitted shortly after the event in early 2025 and peer reviews of the care provided to the patient by facility staff. The OIG found that the PSM assigned several investigators to review the JPSR but did not obtain sufficient clinician subject matter expertise to evaluate the stroke care provided immediately after the patient's neurological decline. Consequently, the quality management process did not include an evaluation of whether stroke care met VHA and AHA/ASA guidelines and facility leaders did not review the inpatient stroke process. Additionally, the PSM did not recognize the lack of timely stroke care as a potential catastrophic event and, therefore, did not assign a SAC score that triggered an RCA. Conducting an RCA could have identified potential system issues and informed corrective strategies to prevent recurrence.

The OIG also found that peer reviews were completed in June 2025 to evaluate the clinical care provided by the staff involved; however, process or system issues not appropriate for peer review were not referred and addressed using other types of quality management activities, as suggested by VHA Directive 1190(1), *Peer Review for Quality Management*.[76] As a result, systems issues related to the inpatient AIS management process that were identified during the peer review remained unaddressed at the time of the OIG site visit. Had peer review committee staff referred these system issues for additional quality management review, facility leaders could have ensured corrective actions were taken.

The OIG concluded that insufficient quality management reviews hindered facility leaders' ability to recognize care deficiencies, assess system vulnerabilities, and implement timely corrective actions following the patient's AIS event. By not effectively applying required review processes, such as securing appropriate clinical expertise, assigning an appropriate SAC score, initiating an RCA, and by not referring system issues for further evaluation as suggested, facility leaders missed critical opportunities to strengthen patient safety and prevent similar occurrences.

[74] VHA Directive 1050.01(1); VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation Version 8*.

[75] VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

[76] VHA Directive 1190(1).

Conclusion

The OIG concluded that the vascular surgeon did not provide timely or coordinated evaluation and management of the patient's postoperative neurological deterioration, and that critical elements of the inpatient stroke response did not conform to VHA requirements or recognized professional guidelines. These deficiencies were compounded by systemic vulnerabilities, including the absence of an effective inpatient stroke process that delayed the patient's diagnostic imaging, specialty consultation, and transfer.

The inspection also identified inadequate reporting of significant hypotension, ineffective utilization of TeleCC resources, and unclear documentation requirements for neurological assessments. While the OIG could not determine whether the patient's hypotension contributed to the patient's postoperative stroke, prolonged hypotension after vascular procedures increases the risk of adverse outcomes. Additionally, surgical patients admitted to the facility ICU may benefit from resources more aligned with those provided to Category A level of TeleCC support. While documentation practices did not contribute to the patient's postoperative stroke, ineffective documentation may delay communication of changes in patient condition and increase the risk of adverse outcomes.

The OIG concluded that facility leaders permitted physicians without critical care privileges to cover ICU shifts and allowed a nurse practitioner without critical care privileges to function as the sole on-site provider during portions of the coverage schedule. Gaps in quality management processes limited the facility's ability to identify system issues and vulnerabilities, initiate appropriate review mechanisms, and implement corrective actions. Collectively, these shortcomings reflect weaknesses in AIS care and facility leader oversight that adversely affected the timeliness and reliability of care provided during a time-sensitive medical emergency. The facility is actively addressing these concerns by developing action plans to improve ICU patient care, achieve full compliance with stroke center protocols, verify ICU provider qualifications and EHR access, and enhance quality management processes.

Recommendations 1–7

1. The Wm. Jennings Bryan Dorn VA Medical Center Director ensures that all patients admitted to the intensive care unit receive access to continuous critical care, particularly after hours, and clearly defines the role and responsibilities of the on-site intensivist and TeleCritical Care in the care of surgical intensive care unit admissions.

2. The Wm. Jennings Bryan Dorn VA Medical Center Director ensures that in the absence of patient-specific orders for vital sign parameters that warrant provider notification, intensive care unit nurses adhere to facility policy for provider notification parameters.

3. The Wm. Jennings Bryan Dorn VA Medical Center Director reviews VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke*, August 22, 2025, and ensures the facility is in full

compliance with current stroke center designation requirements, including protocols for inpatient stroke response, diagnostic imaging, consultation, and transfer processes.

4. The Wm. Jennings Bryan Dorn VA Medical Center Director clarifies the qualifications for provider coverage in the intensive care unit and ensures all intensive care unit providers are appropriately privileged to deliver care in the intensive care unit prior to providing care.

5. The Wm. Jennings Bryan Dorn VA Medical Center Director determines whether providers delivered patient care in the intensive care unit without approved, current, facility-specific privileges and, if so, completes required reviews and assessments in accordance with Veterans Health Administration requirements.

6. The Wm. Jennings Bryan Dorn VA Medical Center Director creates a process ensuring contract ICU physicians covering in the intensive care unit have access to the electronic health record for documentation and order writing from the start of their tour.

7. The Wm. Jennings Bryan Dorn VA Medical Center Director reviews this patient's case and any associated quality management reviews, and if gaps are identified, develops an action plan to ensure quality management processes are completed in accordance with relevant Veterans Health Administration quality management directives.

Appendix A: Unsubstantiated Allegations and the Related Analysis and Findings

1. Allegation: ICU nursing staff omitted neurological assessments for over 16 hours during the patient's admission.	**Finding**: Not substantiated. The OIG found documentation in the patient's EHR that showed ICU nurses recorded neurological assessments throughout the night following surgery.

On the patient's admission to the ICU, the vascular surgeon ordered neurovascular assessments to be done

- on patient arrival,
- every 2 hours for the first 4 hours,
- every 4 hours for the next 12 hours, and
- then "per Unit Protocol or [provider] order."

Two ICU RNs cared for the patient:

- RN 1 documented neurological assessments at 5:15 p.m., 5:30 p.m., and 6:19 p.m. RN 1 documented the 5:15 p.m. and 6:19 p.m. notes in Essentris and the 5:30 p.m. note in CPRS.
- RN 2 took over later that evening and documented four separate neurological assessments in Essentris overnight (at 7:00 p.m., 8:43 p.m., 11:27 p.m., and 03:03 a.m.).

Neither RN 1 nor RN 2 recorded or reported a focal neurologic deficit in the patient during their shifts. Although RN 2 documented some Essentris neurological assessments slightly earlier or later than the schedule ordered by the vascular surgeon, the OIG found the documentation still met the intent of the order and contradicts the original allegation that there was no neurological documentation in the EHR for over 16 hours.

2. Allegation: ICU nurses are "not required to complete critical care competencies."	**Finding**: Not substantiated. The OIG found evidence that the ICU nurses completed required critical care specific competencies.

The facility Competency Assurance Program Standard Operating Procedure (SOP) (544-118-801) requires "a detailed unit specific competency/orientation checklist is completed for each orientee to ensure baseline competence in the assigned area." Continued competence may be assured through various methods such as in-services, educational offerings, annual proficiency, needs assessments, and annual competency checklists. The immediate supervisors are responsible to maintain staff competency forms in a "6-part personnel folder." [77]

The OIG's document review found that ICU nurse personnel folders contain both general and area specific competencies that are completed upon hire or transfer to the ICU, and annual

[77] Columbia VA Health Care System SOP 544-118-801, *Competency Assurance Program*, February 4, 2022.

competencies and training were assured. The critical care nurse educator told the OIG in an interview of a process to select ongoing competencies based on area-specific quality metric indicators, high-risk, low-volume occurrence skills, new products or processes, and unit staff unput.

3. Allegation: ICU nurses are "not following provider orders" for starting, monitoring, or titrating medications, and are "practicing outside of their scope."	**Finding**: Not substantiated. The OIG did not find evidence indicating ICU nurses are not following medication administration processes or are practicing out of scope.

The Joint Commission standards require that hospitals safely administer medications and specify elements of performance for orders and administration, including titration of doses.[78] The Joint Commission also requires specifications for the provision of care including assessment and reassessment of patients.[79] During accreditation surveys the Joint Commission evaluates if the standards are met, and when deficiencies are found the hospital completes a plan for follow-up actions and demonstrates evidence of standards compliance within required time frames.

The OIG's document review showed that ICU medication management and provision of care standards deficiencies were found in previous surveys, and the facility implemented corrective action plans as required for remediation. The OIG did not find any facility deficiencies related to nursing medication management or provision of care standard issues in the ICU as a finding in the latest survey report.

The OIG interviewed a nurse leader who reported that there is an ongoing audit process in place in the ICU for nursing practice that includes remediation actions to address any individual deficiencies found. The nurse leader also reported not having awareness of issues that nurses are practicing out of scope.

4. Allegation: ICU nursing care is "unsafe" and "patients are not monitored or assessed appropriately leading to poor outcomes and increased mortality rates."	**Finding**: Not substantiated. The OIG found no evidence that ICU nursing care directly contributed to poor outcomes or increased mortality rates for ICU patients.

The OIG learned that the facility tracks, reports, and reviews quality assurance data metrics including those related to ICU patient mortality and infection control.

The OIG's document review showed that the facility ICU quality metrics did not identify poor patient care outcomes and increased mortality as alleged. The OIG found there is no indication from outcome data, as measured by the previous rolling 12 months of data prior to the

[78] The Joint Commission, *Standards Manual, E-dition*, MM.06.01.01, MM.04.01.01, July 1, 2025.
[79] The Joint Commission, *Standards Manual, E-dition*, PC.01.02.01, July 1, 2025.

inspection, that the ICU delivers substandard intensive care, as the overall outcomes were not significantly different from the national VHA enterprise ICU data.

The OIG also reviewed facility ICU patient safety reports from June 1, 2024, through May 28, 2025, and did not find a trend of poor patient outcomes or poor nursing care. The OIG interviewed the PSM who reported not being aware of ICU nurse care related trends, and that more in depth reviews would be triggered if there were repeated JPSR reports of nurses not following orders or of events leading to patient harm.

5. Allegation: The practice of using VA staff physicians who are not "ICU providers" to cover ICU provider shifts has allegedly resulted in challenges for nursing staff in obtaining appropriate clinical support.[80]	Finding: Not substantiated. The OIG did not substantiate that the practice of using VA staff physicians who are not "ICU providers" to cover ICU provider shifts resulted in challenges for nursing staff in obtaining appropriate clinical support.

During an interview, the OIG asked the PSM about general ICU-related concerns; the PSM did not report any specific patient safety concerns related to the use of noncritical care privileged VHA providers in the ICU. When asked a similar question, the chief of quality management did not recall receiving any specific concerns related to providers in the ICU. Facility leaders and staff acknowledged that occasional provider coverage gaps were filled by noncritical care privileged VHA providers but did not support allegation. To evaluate whether the practice impacted patient safety, OIG conducted a review of ICU patient safety reports from June 1, 2024, through May 28, 2025; none of the reports reviewed were related to providers who lacked critical care privileges in the ICU.

[80] The OIG interpreted not "ICU providers" to mean licensed independent providers without critical care privileges.

Appendix B: Preliminary Result Advisory Memorandum

October 8, 2025

PRELIMINARY RESULT ADVISORY MEMORANDUM

TO:	Dr. Steven L. Lieberman, Acting Under Secretary for Health Veterans Health Administration (10)
FROM:	Dr. Julie Kroviak, Principal Deputy Assistant Inspector General, in the role of Acting Assistant Inspector General, VA Office of Inspector General, Office of Healthcare Inspections (54)
SUBJECT:	Concerns around Acute Ischemic Stroke Practice

This preliminary results advisory memorandum communicates a serious patient safety risk due to acute ischemic stroke (AIS) management practices at the Wm. Jennings Bryon Dorn VA Medical Center (facility).[81] During a healthcare inspection, the VA Office of Inspector General (OIG) identified that the facility's AIS practices did not align with either Veterans Health Administration (VHA) or facility policy, resulting in delayed diagnosis, evaluation, treatment, and disposition for patients with symptoms of stroke. Concerns identified on-site were communicated to both Veterans Integrated Service Network and facility leaders during the on-site visit on August 28, 2025. Facility leaders took immediate steps to address the concerns and provided the OIG with documentation on interim actions taken.

Given the critical nature of the issue, the OIG is broadly sharing this preliminary finding to ensure other VHA facilities have information to proactively address similar vulnerabilities across the enterprise. A full inspection report will be published.

VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke*, dated November 22, 2024, requires VA medical center directors to ensure "an organized and consistent protocol for obtaining emergent stroke consultation" with "a clear understanding of who is tasked to respond to such

[81] VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke*, November 22, 2024, amended August 22, 2025. "Acute ischemic stroke (AIS) is a medical emergency caused by a blood clot restricting blood flow to a region of the brain. Unless blood flow is restored quickly, brain cells in the affected region will die."

emergencies, and in what timeframe."[82] Failure to implement a clear process for inpatient AIS management significantly increases the risk of catastrophic disability or death for patients. Standardized processes, such as formal code stroke response, are key to providing inpatients this time-sensitive care.[83]

At the time of the site visit, Medical Center Policy (MCP) 544-111-1, *Acute Ischemic Stroke*, dated November 22, 2021, established facility procedures for the care of patients with symptoms of AIS.[84] The OIG found that the existing facility policy contained reference to

- a "stroke team" as "responsible for determining patient eligibility to receive acute stroke therapy";
- a code stroke protocol for response to patients with suspected AIS throughout the facility, which would include imaging, neurology evaluations, treatment, and transfer to a community hospital [non-VA] if needed;
- instructions that "all patients" with suspected AIS will be treated in the facility emergency department; and
- consultation with neurologists from the VA National Telestroke Program for evaluation of patients with AIS symptoms. [85]

The OIG found current practice contradicted facility policy. During interviews, facility leaders, providers, and intensive care unit (ICU) nursing staff explained that a stroke team or code stroke protocol was not available on the inpatient units, including the ICU. A facility leader and service chiefs also told the OIG that inpatients with suspected AIS are not transported to the emergency department for evaluation and treatment. Additionally, facility leaders reported that VA National Telestroke Program neurologists were only available to evaluate patients with suspected AIS in the facility's emergency department.

During the course of the inspection, the OIG found that facility ICU staff did not efficiently respond to, evaluate, and disposition a patient with symptoms suggestive of an acute stroke. Following staff's initial concern for an acute stroke, the patient's radiology imaging was not completed immediately, and an evaluation by a neurologist was not done until several hours later. In delaying these actions, the transfer of the patient to a non-VA hospital stroke center for a

[82] VHA Directive 1155(1). American Heart Association/American Stroke Association, "Guidelines for the Early Management of Patients With Acute Ischemic Stroke:2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association," *Stroke* 50, no. 12 (December 2019): e344–e418, doi: 10.1161/STR.0000000000000211. American Heart Association/American Stroke Association guidelines set evidenced-based guidelines and recommendations for the care of stroke, including the need for timely diagnostic imaging and treatment and protocol requirements.

[83] Andrea M. Kuczynski, et al., "The In-Hospital Code Stroke: A Look Back and the Road Ahead," *The Neurohospitalist* 0, no. 0 (2024): 1-9, https://journals.sagepub.com/doi/10.1177/19418744241298035. A code stroke is an "emergency team-based response" protocol like a cardiac arrest response protocol, or code blue.

[84] Medical Center Policy (MCP) 544-111-1, *Acute Ischemic Stroke*, November 22, 2021.

[85] Medical Center Policy (MCP) 544-111-1. A stroke team is an "interdisciplinary team responsible for determining patient eligibility to receive acute stroke therapy."

higher level of intervention was also delayed. A protocol for transfer of AIS inpatients to a non-VA hospital when emergent stroke care is not available at the facility is essential for facilitating timely treatment.

At the time of the site visit, the OIG advised facility leaders to take corrective actions by September 5, 2025. The facility responded as requested, submitting documentation that indicated leadership had developed and approved a new inpatient stroke standard operating procedure, conducted staff education, planned mock drills, and intended to revise MCP 544-111-1.

The OIG's inspection of the facility remains ongoing. A comprehensive analysis of this and any additional findings will be included in the final report, following completion of standard review processes.

In the meantime, the OIG continues to engage with facility leadership, monitor updates to policies and action plans, and assess the adequacy of the response to this concern in the final report.

Appendix C: Categories of Care and Corresponding TeleCC Services Provided

TeleCC Category	Intensivist Coverage	TeleCC Coverage Provides
A	No Bedside Intensivist	• Admission reviews and/or critical care notes for all ICU admissions • TeleCC support for decompensating/unstable patients • Daily rounds and notes for ICU patients • Emergency support via early warning alert activation • Support for scheduled nursing/provider simulation training • Best practice expectation for bedside to TeleCC sign-out
B	Intermittent Intensivist	• Admission review/critical care notes during times without intensivist coverage • Support for unstable patients • Daily rounding when requested or when attendings are unavailable • Emergency response via early warning alert activation • Support for simulation training • Best practice expectation for bedside to TeleCC sign-out
C	Resident/Learner Teams	• Critical care consultation to learners/residents/fellows (learners) • Ensures respect for chain of command between learners and attendings • Support when learners are unavailable or in emergencies • Admission review and patient discussions with learners when attendings not present • Camera/mobile cart review for unstable patients • Emergency response via early warning alert activation • Support for simulation training • Best practice expectation for bedside to TeleCC sign-out
D	24/7 On-site intensivist	• Assessment/assistance when requested or when bedside teams are engaged elsewhere • Emergency support via early warning alert activation • Support for simulation training • Best practice expectation for bedside to TeleCC sign-out
E	Specialized Populations	• Communication via telephone or audiovisual connection before evaluation except in emergencies • Patient assessments when primary teams are busy • Emergency support via early warning alert activation • Support for simulation training • Best practice expectation for bedside to TeleCC sign-out

Source: VA National TeleCC Program Office, "Categories of Tele-Critical Care Management."

Appendix D: VHA and Facility Requirements for Nursing Documentation

Requirement Source	OIG Review Comments
VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," September 20, 2022, revised September 10, 2024	The SOP identifies that a frequent documentation note and other enterprise standard approved scales and tools are available in CPRS. The OIG found that a supplemental neurological assessment template is included in the frequent documentation note and some of the tools or scales available are applicable to neurological assessments. Although available, the SOP does not identify these in the required notes to be documented in CPRS by ICU nurses. The policy does not address neurological documentation in Essentris.
Columbia VA Health Care System SOP 544-118-107, *Clinicomp Documentation System*, October 29, 2021	This SOP specifically discusses documentation in Essentris that must be followed by ICU staff and discusses the documentation of required initial assessment at the beginning of the tour of duty followed by reassessments every four hours for the remainder of the tour. The SOP does not clearly identify where neurological assessments are to be documented.
Columbia VA Health Care System, MCP 544-118-21, *Patient Assessment/Reassessment*, December 26, 2021	This policy identifies that in the ICU a nursing assessment and reassessments will be completed at regularly specified times and based upon factors such as patient condition or related to the patient's course of treatment. The policy does not address neurological documentation in Essentris.
Columbia VA Health Care System, SOP 544-118-5, *ICU Operations Manual*, January 13, 2022	The policy identifies the "ICU reassessment progress note in the electronic medical record will be used to document patient conditions and statistics while in the ICU." The policy also identifies that CPRS and Essentris is used for documentation and provides access to patient information in the ICU.

Source: VA OIG analysis of VHA and Columbia VA Healthcare System nursing policies.

Appendix E: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 30, 2026

From: Executive Director, Department of Veterans Affairs (VA) Health Services Area 2.4

Subj: VA Office of Inspector General (OIG) Report, Healthcare Inspection—Review of a Patient's Care in the Intensive Care Unit at the Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina (VIEWS 14945914)

To: Director, Office of Healthcare Inspections (54HL05)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Inspection—Review of a Patient's Care in the Intensive Care Unit at the Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I reviewed the action plan provided by the facility and concur with the response.

2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

3. Should you have any questions or require further information, please contact the Regional Quality Management Officer.

(*Original signed by:*)

Kevin P. Amick MBA, MHRM (SES)

[OIG comment: The OIG received the above memorandum from VHA on July 31, 2026.]

Appendix F: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 30, 2026

From: Acting Medical Center Director, Columbia VA Health Care System (544)

Subj: VA Office of Inspector General (OIG) Report, Healthcare Inspection—Review of a Patient's Care in the Intensive Care Unit at the Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina (VIEWS 14945914)

To: Executive Director, Health Service Area 2.4

1. The Columbia VA Health Care System appreciates the Office of Inspector General team for its review of this matter involving a patient's care in the intensive care unit and the associated facility systems review.
2. The Medical Center has reviewed the report findings and recommendations concerning inpatient stroke response, ICU staffing and privileging, access to the electronic health record, and quality management follow-up processes.
3. During the inspection period, facility leaders initiated multiple corrective actions to strengthen stroke care processes, including revision of the Acute Ischemic Stroke policy, development of a dedicated inpatient stroke protocol, staff education, mock code stroke drills, updated terms of service with the VA National Telestroke Program, and expanded stroke committee oversight.
4. The Columbia VA Health Care System is committed to completing these actions, monitoring compliance through established oversight mechanisms, and sustaining improvements in patient safety, stroke response, critical care operations, and quality management processes.
5. The Medical Center appreciates the OIG's review and respectfully requests consideration of the revisions detailed in the attached facility response to ensure the final report accurately reflects the evidentiary record, corrective actions completed or underway, and the distinction between substantiated findings, and allegations not supported by the available evidence.

(*Original signed by*:)

Jeffrey A. Soots
Acting Medical Center Director
Columbia VA HCS

[OIG comment: The OIG received the above memorandum from VHA on July 31, 2026.]

Facility Director Response

Recommendation 1

The Wm. Jennings Bryan Dorn VA Medical Center Director ensures that all patients admitted to the intensive care unit receive access to continuous critical care, particularly after hours, and clearly defines the role and responsibilities of the on-site intensivist and TeleCritical Care in the care of surgical intensive care unit admissions.

_X_ Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

The facility has taken action to clarify intensive care unit (ICU) coverage expectations and strengthen access to continuous critical care services. The Chief of Surgery issued ICU Admission Standards, establishing clear requirements for surgical providers admitting patients to the ICU when they do not hold Intensive Care/Critical Care privileges. Under this standard, surgical providers must hold ICU admission privileges through the usual credentialing and privileging process, obtain mandatory documented consultation from a local intensivist or telehealth/tele-ICU critical care provider, and provide a daily warm handoff to evening/night tele-ICU staff or the intensivist. This departmental standard strengthens after-hours continuity of critical care, clarifies the role of on-site and tele-ICU oversight in surgical ICU admissions, and further reduces ambiguity in the escalation and accountability framework for ICU patients.

In addition to clarifying provider qualifications, the facility has revised stroke and inpatient escalation workflows so that staff have defined processes for rapid specialty consultation, imaging, and transfer when patients demonstrate acute neurologic change. The Acute Ischemic Stroke Care Plan, Inpatient Stroke standard operating plan (SOP), Emergency Department (ED) Telestroke SOP, and supporting Telestroke checklist and flow maps now establish 24/7 pathways for stroke identification, code activation, Telestroke consultation, imaging, and transfer. These actions strengthen after-hours access to specialty support and reduce ambiguity regarding escalation responsibilities for ICU and inpatient teams.

Effective January 6, 2026, the Department of Medicine issued ICU Admission Standards that define the qualifications and admission requirements for Medical ICU coverage. Under this standard, providers without intensivist privileges may only admit to the ICU when they hold internal medicine admission privileges and obtain mandatory documented intensivist consultation through on-site intensivist coverage or telehealth/Tele-ICU support. The SOP also defines pulmonary and cardiology fellowship completion as intensive care fellowship

equivalents for the Department of Medicine, with any other training reviewed at the discretion of the Chief of Medicine.

To sustain compliance, the Chief of Staff, Chief of Surgery, Chief of Medicine, ICU leadership, and relevant service chiefs will continue to review ICU schedules, ICU admissions, documentation of required intensivist consultation, and use of escalation pathways for high-risk patients. Ongoing monitoring will focus on confirming that all patients admitted to the ICU have timely access to critical care oversight, particularly after hours, and that the roles of on-site providers and telehealth support remain clearly defined in practice. These requirements reinforce that ICU participation is limited to appropriately qualified and privileged providers, and that intensivist or Tele-ICU oversight is required when the admitting provider does not independently hold critical care privileges. Together, the Department of Medicine and Department of Surgery ICU Admission Standards, ICU-stroke escalation workflows, and Medical ICU coverage expectations ensure that all patients admitted to the ICU have clearly defined access to continuous critical care, including after-hours support.

Quality Management will monitor applicable ICU admissions by non-intensivist providers until 90% or more reflect required documented intensivist consultation for six consecutive months. The numerator is the number of ICU admissions by non-intensivist providers with documentation in the Electronic Health Record (EHR) of consultation of intensivist and warm handoff after hours. The denominator is the number of ICU admissions by non-intensivist providers that include required documented intensivist consultation. Compliance monitoring will be reported monthly to the Quality and Patient Safety Board (QPSB).

Recommendation 2

The Wm. Jennings Bryan Dorn VA Medical Center Director ensures that in the absence of patient-specific orders for vital sign parameters that warrant provider notification, intensive care unit nurses adhere to facility policy for provider notification parameters.

_X_ Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

The facility has strengthened nursing expectations for notification of providers when patient-specific parameters are not present. SOP 118-45, Vital Sign Assessment and Documentation Including Pulse Oximetry and ECG Monitoring in Acute Care Units, remains the governing policy and requires provider notification when blood pressure deviates by 20 mmHg or more from baseline in the absence of patient-specific parameters. To strengthen implementation at the point of care, ICU nursing leadership developed and distributed an ICU Vital Sign Assessment

Frequency Quick Guide that outlines required assessment frequency and notification thresholds for blood pressure, heart rate, respiratory rate, and oxygen saturation.

Nursing leadership has also initiated focused staff education on the quick guide, provider notification requirements, documentation expectations, and reassessment standards. The current ICU Nurse Manager identified ambiguous language in SOP 118-45 that could allow individual nursing judgment to reduce vital-sign frequency in the ICU and initiated revision of that SOP to eliminate inconsistency. In addition, charge nurses are entering Essentris vital signs into the Computerized Patient Record System (CPRS) at 8 a.m., 4 p.m., 8 p.m., and 4 a.m. to improve review visibility, and Assistant Nurse Managers are conducting daily mid-shift review with planned monthly audits.

These actions demonstrate that the facility has moved beyond policy reaffirmation and implemented operational tools, education, documentation review, and leadership oversight to drive compliance. The facility will continue auditing ICU records to confirm that abnormal vital signs are recognized, documented, and communicated in accordance with policy.

The Associate Nurse Executive (ANE) for Inpatient will monitor until 90% compliance with provider notification and documentation requirements for abnormal vital signs is sustained for six consecutive months, using daily review and monthly audits of at least 20 ICU charts per month. The numerator is the number of provider notifications of abnormal vital signs and the denominator is the number of abnormal vital signs documented. Compliance monitoring will be reported monthly to QPSB.

Recommendation 3

The Wm. Jennings Bryan Dorn VA Medical Center Director reviews VHA Directive 1155(1), *Treatment of Acute Ischemic Stroke*, August 22, 2025, and ensures the facility is in full compliance with current stroke center designation requirements, including protocols for inpatient stroke response, diagnostic imaging, consultation, and transfer processes.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Director Comments

The facility completed a comprehensive redesign of its acute ischemic stroke (AIS) program to align with Veterans Health Administration (VHA) Directive 1155(1), American Heart Association (AHA) and American Stroke Association (ASA) Guidelines, and current stroke center designation requirements. Effective October 14, 2025, the facility issued Medical Center Policy (MCP) 544-111-1, Acute Ischemic Stroke Care Plan, which established an updated AIS management plan with defined responsibilities for leaders and clinical services, target process

times, 24/7 use of the National Telestroke Program (NTSP), required imaging and laboratory timelines, stroke education requirements, transfer pathways, and monthly reporting to the Department of Veterans Affairs (VA) Inpatient Evaluation Center acute stroke data module.

To operationalize the care plan, the facility issued the Inpatient Stroke SOP effective September 2, 2025, the ED Telestroke SOP effective August 11, 2025, and supporting Telestroke checklists, flow maps, thrombolytic administration guidelines, and transfer workflows. These documents establish a standardized process for code stroke activation, direct computed tomography (CT) access, Telestroke consultation, National Institutes of Health (NIH) Stroke Scale completion, thrombolytic readiness, and transfer to Lexington Medical Center or Prisma Health Richland for higher-level stroke intervention when indicated. To support NTSP inpatient expansion requirements and test the stroke pathways in practice, Columbia completed ED mock stroke code and GoLive inpatient Telestroke mock stroke code simulations on October 3, 2025, in collaboration with the VA NTSP. These simulations are documented in ED and inpatient simulation summaries, Telestroke mock stroke code assignment sheets, Talent Management System (TMS) rosters for ED and inpatient medicine unit and Telestroke Simulation Time Sheets for ED and inpatient units.

Following the simulations, leadership conducted a formal debriefing focused on process flow issues, communication, and opportunities for improvement, captured in the Columbia SC Leadership Debriefing document. The VA NTSP subsequently confirmed Columbia's successful completion of the GoLive activation simulations and authorized the facility to GoLive for inpatient Telestroke on October 14, 2025.

Stroke governance and education are overseen by the Stroke Committee Charter 544-111-2-C, which establishes a standing stroke committee reporting monthly to the Medical Executive Board, and by ICU stroke curricula for fiscal year (FY) 2024 and FY 2025 that define recurring stroke education for ICU staff. In addition, an "Office Hours for New Inpatient Stroke SOP" Microsoft Teams session on September 4, 2025, with 69 participants, and subsequent education stand-down activities are documented in attendance reports and rosters, demonstrating broad frontline engagement in the updated inpatient stroke process.

Columbia's participation in the VA NTSP is governed by the VA NTSP Nationally Designed Telehealth Hub (NDTH) Terms of Service (Revision 4, September 2023), which defines Telestroke Acute Care services for ED and inpatient units, technology and space requirements, telepresenter training and role expectations, emergency handoff procedures, and quality-oversight obligations. This framework, combined with local stroke policies, education, simulations, and governance, ensures alignment with VHA Directive 1155(1) and current stroke center designation requirements.

In addition to policy and workflow revision, the facility implemented a sustained stroke education and simulation program during FY 2026 to hardwire the updated processes into practice. The FY 2026 stroke education curriculum identified code stroke response, NTSP

activation, NIH Stroke Scale training, stroke swallowing screening, thrombolytic treatment education, unit-based stroke posters, quarterly code stroke training, in-situ mock code stroke drills, and annual NTSP mock code participation as required competencies for ICU/Step-Down Unit (SDU) and inpatient nursing staff. Training records also show repeated mock stroke code drill simulations conducted across December 2025 and January through May 2026 involving ICU, SDU, inpatient medicine and surgery units, ED, Post Anesthesia Care Unit (PACU), and other inpatient staff, with participation by nurses, nursing assistants, educators, and some providers.

The facility supplemented the mock drills with focused practice labs in April 2026 on the ASA's B.E. F.A.S.T. stroke-recognition mnemonic, which stands for balance loss, eye (vision) changes, face drooping, arm weakness, speech difficulty, and time to call 911. The facility also supplemented mock drills with Stroke Mimics Board training during the May 2026 spring skills fair, and Telestroke packet update sessions in March 2026 to reinforce stroke recognition, differentiate stroke from common mimics, and improve staff familiarity with Telestroke tools and workflows. Simulation materials describe mock stroke code training that includes recognition of stroke symptoms, activation of local and NTSP services, stroke scale assessment, and simulated thrombolytic medication preparation and administration. In addition, the facility conducted timed Telestroke mock stroke code drill simulations in both the ED and inpatient setting on October 3, 2025, using standardized simulation tools and TMS-supported training. These simulations documented key response intervals including symptom recognition, provider notification, NTSP consultation, CT workflow, NIH Stroke Scale completion, laboratory turnaround, and thrombolytic preparation and administration timing. The simulation records demonstrated door-to-thrombolytic intervals of 33 minutes and 40 minutes, further showing that the facility operationalized stroke response expectations through measurable interdisciplinary drills rather than policy revision alone.

Additional supporting documentation further demonstrates that the facility translated its revised stroke program requirements into role-specific staff education. Attendance rosters document completion of an "Acute Rapid Assessment Stroke" course in March 2026, with participation from ED and ICU/SDU nursing staff. Separate attendance records also document a thrombolytic reconstitution and administration for nursing supervisors, ED, and ICU class in September 2025, with participation from ED, ICU, acute-care staff, and nursing leadership roles including flow coordination and nurse operations management.

In addition to policy revision and simulation-based education, the facility implemented mandatory stroke training requirements across the workforce to reinforce timely stroke recognition and response. All employees were assigned TMS course 131006314, Keep the Brain Alive in 45 Game, and all clinical staff were required to complete TMS course 4685556, CMS Acute Ischemic Stroke and the OIG Stroke Advisory Training and Review. Leadership directed Service Chiefs and supervisors to provide immediate follow-up for staff available for duty, allow

duty time for course completion as needed, and actively monitor deficiencies because stroke training was identified as a patient safety requirement. As of July 3, 2026, compliance for TMS course 4685556 was 97.49%, with 1,672 of 1,715 assigned clinical staff complete, and compliance for TMS course 131006314 was 97.82%, with 2,912 of 2,977 assigned employees complete.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 4

The Wm. Jennings Bryan Dorn VA Medical Center Director clarifies the qualifications for provider coverage in the intensive care unit and ensures all intensive care unit providers are appropriately privileged to deliver care in the intensive care unit prior to providing care.

_X_ Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

The facility clarified its ICU provider qualification requirements through the Department of Medicine ICU Admission Standards effective January 6, 2026. Under this standard, providers without intensivist privileges may admit patients to the ICU only if they possess internal medicine admission privileges and obtain mandatory documented intensivist consultation through local intensivist coverage or telehealth/Tele-ICU. The standard further clarifies that pulmonary and cardiology fellowship completion may be treated as intensive care fellowship equivalents within the Department of Medicine, while any other training equivalency is reviewed by the Chief of Medicine.

This action established a defined operational standard for the participation of non-intensivist providers in ICU care and clarified the requirement for intensivist involvement and documentation. The facility is also using leadership review of ICU schedules, admission documentation, and privileging alignment to ensure this standard is applied consistently before and during participation in ICU care.

The facility further strengthened this work through Chief of Surgery ICU Admission Standards. The standard establishes that surgical providers may admit patients to the ICU only when they hold ICU admission privileges through the standard credentialing and privileging process and obtain mandatory documented consultation with an intensivist/critical care physician. The standard also defines Department of Surgery fellowship equivalencies for intensive care qualifications, including pulmonary, cardiology, and trauma surgery fellowship training, with

other training considered at the discretion of the Chief of Surgery. These requirements reinforce that ICU participation is limited to appropriately qualified and privileged providers and that intensivist oversight is required when the admitting provider does not independently hold critical care privileges.

The Medical Staff Office will monitor 100% of providers participating in ICU admissions to verify that the required privileges and documented intensivist consultation are in place, when applicable, for 6 consecutive months. Compliance monitoring will be reported monthly to QPSB.

Recommendation 5

The Wm. Jennings Bryan Dorn VA Medical Center Director determines whether providers delivered patient care in the intensive care unit without approved, current, facility-specific privileges and, if so, completes required reviews and assessments in accordance with VHA requirements.

_X_ Concur

____Nonconcur

Target date for completion: September 2026

Director Comments

Following the OIG review, the facility evaluated the historical ICU coverage model and aligned current practice expectations through January 6, 2026, Department of Medicine ICU Admission Standards. That standard now defines the conditions under which non-intensivist providers may participate in ICU admissions and requires internal medicine admission privileges together with documented intensivist consultation.

In addition to clarifying current practice, the facility recognizes that this recommendation requires retrospective review and any required follow-up action for identified cases.

The Chief of Quality Management and Chief of Staff reviewed privileges of providers covering the intensive care unit to determine whether they had approved, current, facility-specific critical care privileges. While all providers had current privileges, two providers were identified as not having critical care privileges and provided coverage in the intensive care unit. Chief of Quality Management in collaboration with the Chief of Staff, Chief of Medicine, and Credentialing and Privileging Office will ensure the necessary reviews of prior ICU care, provider privilege status, and professional practice concerns are completed in accordance with VHA requirements. This includes documenting determinations, completing indicated reviews, and maintaining records of resulting actions.

The facility will complete a review of 100% of identified cases and any required follow-up actions in accordance with VHA requirements. Review results will be reported to the QPSB.

Recommendation 6

The Wm. Jennings Bryan Dorn VA Medical Center Director creates a process ensuring contract ICU physicians covering in the intensive care unit have access to the electronic health record for documentation and order writing from the start of their tour.

_X_ Concur

____Nonconcur

Target date for completion: November 2026

Director Comments

The facility established an operational process to ensure contract ICU physicians have active EHR access at the beginning of scheduled ICU coverage. Service line leadership now actively monitor Office of Information and Technology (OIT) Upcoming Dis-users reports to identify and remediate accounts at risk of being disabled due to inactivity before a scheduled shift begins. Service line leadership partnered with OIT and scheduling staff to verify access prior to shifts and to prevent providers from starting ICU coverage without active documentation and order-entry capability. ICU and Medicine leadership also reinforced expectations that contract physicians are not to rely on another clinician for routine order entry due to access delays. These local processes are aligned with the VA NTSP NDTH Terms of Service (Revision 4, September 2023), which require participating sites to ensure appropriate technology, EHR access, and documentation workflows for telehealth acute stroke consultations in ED and inpatient units. By pairing enterprise account-management procedures with NDTH terms of service expectations, the facility ensures that contract ICU physicians covering the ICU have full EHR access, including documentation and order-entry capability, from the start of their tour.

To further strengthen this process, the facility aligned its local workflow with current OIT enterprise account-management procedures for urgent access issues. Current OIT guidance defines a structured after-hours process for disabled network accounts, including Health Administrative Specialist on Duty (HOD) coverage during weekdays from 5:01 p.m. to 6:59 a.m. and all hours on weekends and federal holidays, Enterprise Service Desk intake, and ServiceNow ticket initiation for urgent access concerns. These procedures also permit supervisor, Contracting Officer Representative (COR), delegate, or HOD involvement in escalating urgent disabled-account issues to the Enterprise Service Desk when the affected user cannot independently resolve the issue.

In addition, the OIT Account Management Playbook establishes contingency workflows for emergency account recovery and re-enablement outside routine business hours. For returning

users whose accounts are disabled in Active Directory, Local OIT may follow the account re-enablement process and update expiration settings as needed. For accounts deleted but still recoverable, a priority ticket may be opened and callback procedures initiated for Domain Infrastructure support to restore the account. The playbook also provides for creation of emergency access accounts, when necessary, with defined time-limited expiration controls not to exceed 72 hours.

The VA Account Provisioning/Deprovisioning System further supports this control environment by documenting standardized provisioning, deprovisioning, delegation, and account reactivation processes, reinforcing that access management is governed through formal workflow rather than ad hoc intervention. Together, the local pre-shift verification process and the OIT enterprise escalation pathway provide both preventive control and a defined backup process to reduce the risk that a contract ICU physician begins coverage without required access for documentation and order entry.

The Chief of Medicine will monitor ICU physicians' access to EHR prior to start of shift until compliance is at or above 90% for 6 consecutive months. Compliance monitoring will be reported monthly to QPSB.

Recommendation 7

The Wm. Jennings Bryan Dorn VA Medical Center Director reviews this patient's case and any associated quality management reviews, and if gaps are identified, develops an action plan to ensure quality management processes are completed in accordance with relevant VHA quality management directives.

_X_ Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

The facility re-reviewed the index case and evaluated the associated quality management processes after OIG identified that system issues recognized during peer review were not clearly escalated.

Quality Management leadership strengthened the Peer Review Committee process so systems issues are now a mandatory topic for every peer review case. The Peer Review Committee agenda includes a dedicated systems issues section, and documentation is required for each case to reflect whether a systems issue was identified, what action is needed, who is assigned responsibility for follow-up, and how the issue will be tracked moving forward. The discussion will be captured in the peer review tracker and meeting minutes to ensure reliable documentation of systems issues and educational opportunities.

The facility also strengthened coordination between Risk Management and Patient Safety through a formal weekly Patient Safety-Risk Management Huddle agenda implemented June 30, 2026. This written agenda captures review and discussion of institutional disclosures, Joint Patient Safety Reports (JPSRs), and active root cause analyses, and prompts case-based decisions regarding whether peer review, disclosure review, additional JPSR action, or root cause analysis (RCA) consideration is warranted. The process also requires cases to remain on the tracking list until required actions are completed, including disclosure review and completion when warranted, peer reviews, JPSR entry, RCA chartering, and RCA completion, as applicable.

The facility will address the concern related to JPSR Safety Assessment Code (SAC) scoring and RCA consideration. The Patient Safety Program will complete the initial JPSR review with appropriate clinical subject-matter expertise. Events involving death, potential catastrophic harm, major permanent loss of function, stroke response delays, unplanned transfer for higher-level care, or other high-risk concerns identified through JPSR will be flagged for second-level review. Cases meeting the established review criteria will be referred to the VISN Patient Safety Officer for secondary review of SAC scoring and RCA consideration. This review will be completed within seven business days and will document whether the original SAC score was appropriate and whether reconsideration of RCA is warranted. Findings identified through this process will be discussed with Patient Safety and documented in the audit log. The Chief of Quality Management will monitor completion, timeliness, trends, identified process gaps, and implementation of required corrective actions. Monthly summary review by the Chief of Quality Management will be used to identify trends, education needs, and process gaps requiring broader corrective action.

The Quality Management Deputy Chief will review Peer Review Committee minutes for documented discussion of identified systems issues, assigned follow-up responsibility, and tracking until compliance is at or above 90% for 6 consecutive months. The numerator is the number of minutes with documented systems section complete and when indicated systems review is forwarded for appropriate referral through quality process. The denominator is the number of Peer Review Committee minutes reviewed.

The Quality Management Chief will conduct a focused secondary review of 10% of JPSRs with an identified triggering event and a SAC score less than three until compliance is at or above 90% for 6 consecutive months. The review will include reassessment of RCA consideration and documentation of any required follow-up actions. The numerator is the number of JPSRs with scoring consistent with National Center for Patient Safety criteria. The denominator is the number of JPSRs submitted for a second level review.

Glossary

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

acute. A rapid, sudden, and sometimes unexpected change in patient condition. "It is the opposite of chronic."[86]

adverse event. "Untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers."[87]

average daily census. A calculation of the cumulative bed days of care for a selected time period divided by the number of calendar days.[88]

carotid artery. There is a carotid artery on each side of the neck and together they supply blood and oxygen to the head, neck, and brain. The main ("common") carotid artery on each side of the neck divides, giving one branch (external carotid artery) to the face and other tissues outside of the skull, and the other branch (internal carotid artery) that supplies blood to brain and eyes, internal to the skull. The internal carotid itself branches many times after it enters the skull.[89]

carotid artery stenosis (or alternatively, carotid stenosis). The buildup of atherosclerotic plaque, fatty cholesterol deposits, inside the carotid artery, blocking normal flow of blood to the brain. Pieces of plaque can break free and travel to the brain, blocking blood supply to a portion of the brain, which may cause brain cells to die, a condition called ischemic stroke.[90]

carotid duplex study. Or alternatively, carotid duplex scan, is a noninvasive exam of the neck where a provider uses a handheld "probe" or "transducer" that sends and receives sound waves to evaluate the carotid arteries in the neck. It is called "duplex" because there are two categories of results that come from the exam: pictures of the structure of the carotid arteries and an assessment of the blood flow (see *doppler ultrasound*) in the carotid arteries.[91]

carotid endarterectomy. A surgical procedure on the neck intended to reduce the risk of stroke by removing atherosclerotic plaque that has developed in a carotid artery, affecting blood flow to

[86] "Acute," Medline Plus, accessed December 18, 2025, https://medlineplus.gov/ency/article/002215.htm.

[87] VHA Directive 1050.01(1).

[88] VHA Support Service Center, "Operating Beds, Average Daily Census, and Occupancy Rate Using Actual Beds," November 17, 2025.

[89] "Carotid Artery," Cleveland Clinic, accessed November 19, 2025, https://my.clevelandclinic.org/health/body/21492-carotid-artery.

[90] "Carotid Artery Disease (Carotid Artery Stenosis)," Cleveland Clinic, accessed November 18, 2025, https://my.clevelandclinic.org/health/diseases/16845-carotid-artery-disease-carotid-artery-stenosis.

[91] "Carotid Artery Duplex Scan," Johns Hopkins Medicine, accessed November 19, 2025, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/carotid-artery-duplex-scan.

the brain. There is a carotid artery on each side of the neck, and they are important sources of blood flow to the brain.[92]

code stroke. An "emergency team-based response" protocol like a cardiac arrest response protocol, or code blue.[93]

computed tomography angiogram. Or alternatively, CT angiogram. During a computed tomography scan- a radiologic study that uses x-rays to create detailed images of specific parts of the body, dye is injected into the bloodstream to enhance and emphasize blood vessels on the images. This test may be used to make detailed images of the carotid arteries, including any blockages within them.[94]

computerized patient record system. An electronic application that enables staff to enter, review, and continuously update patient information.[95]

consult. A request for service or a referral on behalf of a patient.[96]

doppler ultrasound. A noninvasive test used to measure the flow of blood through blood vessels using sound. It can be used to diagnose blood clots, narrowing of an artery, or a blocked artery, among other uses. It may be used by a surgeon near the completion of carotid endarterectomy surgery to ensure normal blood flow in the carotid artery prior to finishing the operation.[97]

Essentris. Also known as Clinicomp**.** A web-based commercial inpatient EHR used in acute and critical care areas. This system interfaces with VA's CPRS and Veterans Health Information Systems and Technology Architecture (VistA).[98]

focal neurologic deficit. A physical exam finding that suggests a problem with a nerve, the spinal cord or the brain. It affects a specific part of the body such as "the left side of the face or the right arm" or specific functions such as speech, vision, or hearing. In contrast, a non-focal

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[92] "Carotid endarterectomy," Mayo Clinic, accessed November 18, 2025, https://www.mayoclinic.org/tests-procedures/carotid-endarterectomy/about/pac-20393379.

[93] Andrea M. Kuczynski, et al., "The In-Hospital Code Stroke: A Look Back and the Road Ahead."

[94] "Computed tomography angiography," within "Carotid Artery Stenosis," Cleveland Clinic, accessed November 18, 2025, https://my.clevelandclinic.org/health/diseases/16845-carotid-artery-disease-carotid-artery-stenosis.

[95] VA, "Computerized Patient Record System (CPRS), User Guide: GUI Version," August 2025.

[96] VHA Directive 1232.

[97] "Doppler ultrasound: What is it used for?," Mayo Clinic, accessed November 18, 2025, https://www.mayoclinic.org/tests-procedures/ultrasound/expert-answers/doppler-ultrasound/faq-20058452?cjdata=MXxOfDB8WXww&cjevent=0b0762afc47d11f08009026d0a1cb828&cm_mmc=CJ-_-100357191-_-5250933-_-Evergreen+Link+for+Mayo+Clinic+Diet&utm_source=cj&utm_content=100357191&utm_capaign=3-months.

[98] "CliniComp," VA, accessed January 27, 2026, https://www.oit.va.gov/services/trm/ToolPage.aspx?tid=7764.

neurological deficit is not specific to an area of body and may include findings such as a decreased level of consciousness, being weak "all over," or mental health changes.[99]

Focused Professional Practice Evaluation. An "oversight process within a defined period of evaluation whereby the respective clinical service chief and the [Executive Committee of the Medical Staff] evaluates the privilege-specific competence of a [licensed independent provider] who does not yet have documented evidence of competently performing the requested privileges at the VA medical facility."[100]

hemiparesis. When one side of the body does not have the same strength as the opposite side. This can be caused by a problem in the brain, the spinal cord or peripheral nerves. Ischemic stroke in the brain is one cause of hemiparesis.[101]

hypotension. Low blood pressure. Veterans Affairs Post Anesthesia Score (VA-PAS) individualizes the determination of post-procedural hypotension to a specific patient by comparing the patient's current blood pressure to their pre-procedural "baseline" blood pressure. According to the criteria used in VA-PAS, a blood pressure decrease of either 20 mmHg or 20 percent from baseline values indicates hypotension, and a decrease of 40 mmHg or 40 percent from baseline indicates significant hypotension.[102]

institutional disclosure. "A formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[103]

intensive care unit. A location within a facility that provides 24-hour a day specialized care for patients with life-threatening illnesses or injuries. ICU care may be provided by a team of clinicians including intensivists, surgeons, advanced practice providers, and nurses.[104]

[99] "Focal neurologic deficits," University of Florida Health, accessed December 1, 2025, https://ufhealth.org/conditions-and-treatments/focal-neurologic-deficits.

[100] VHA Directive 1100.21(1).

[101] "Hemiparesis," Cleveland Clinic, accessed November 19, 2025, https://my.clevelandclinic.org/health/symptoms/24952-hemiparesis.

[102] VHA Directive 1073(2), *Moderate Sedation by Non-Anesthesia Providers*, December 20, 2022.

[103] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[104] "Intensive Care Unit (ICU)," Cleveland Clinic, accessed September 30, 2025, https://my.clevelandclinic.org/health/articles/icu-intensive-care-unit.

intensivist. A physician who has successfully completed an accredited critical care/intensive care medicine program (or equivalent training) and whose professional work is dedicated to providing care to critically ill patients, in collaboration with an interprofessional team.[105]

internal carotid artery. The common carotid arteries are paired, right and left, and travel from the upper chest through their respective sides of the neck toward the skull. The common carotid artery on each side of the neck divides into two branches, the internal and external carotid artery. The internal carotid artery on each side of the neck enters the skull and supplies blood to the brain and eyes.[106]

interventional neuroradiology. A sub-specialty of radiology, a specialty of medicine, which uses diagnostic imaging and minimally invasive treatments to address a wide range of conditions involving the brain, head and neck, and spine and spinal cord.[107]

Joint Patient Safety Reporting system. A system for reporting patient safety events that is accessible to VHA employees through a web-based system.[108]

magnetic resonance imaging. An imaging technique to create images of human organs and tissues via the use of magnetic field and computer-generated radio waves.[109]

maximum assistance. Also known as total care; indicates the care needs of a person who has severe functional impairment in activities of daily living such as bathing, dressing, toileting, transferring from one location to another, continence, and feeding. The person is incapable of doing these basic tasks of life without being fully assisted in all aspects of these tasks. The Katz Index is one scale used to determine the extent of such impairment.[110]

mean arterial pressure. A value derived from the systolic blood pressure (the force produced when the heart pumps) and the diastolic blood pressure (when the heart is at rest) and is an

[105] Daniel Wu et al., "The Definition of the Intensivist in the Era of Global Healthcare: 2024 Consensus Statement From the Society of Critical Care Medicine Defining Intensivist Task Force," *Critical Care Medicine* 53, no. 3 (March 2025): e548-554, https://doi.org/10.1097/ccm.0000000000006580.

[106] "Carotid Artery," Cleveland Clinic.

[107] "Interventional Neuroradiology," Johns Hopkins Medicine, accessed December 1, 2025, https://www.hopkinsmedicine.org/interventional-neuroradiology.

[108] VHA Directive 1050.01(1).

[109] "MRI," Mayo Clinic, accessed December 31, 2025, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768?p=1.

[110] "Katz Index of Independence in Activities of Daily Living (ADL)," New York University Rory Meyers College of Nursing, accessed November 19, 2025, https://hign.org/consultgeri/try-this-series/katz-index-independence-activities-daily-living-adl.

estimate of the overall blood pressure during the complete cardiac cycle (beat to beat). For example, a blood pressure 120/80 mmHg has an estimated MAP of 93 mmHg.[111]

middle cerebral artery. As the right and left carotid arteries travel through the neck to reach their respective sides of the brain, they send blood to many branches, including their respective middle cerebral artery, a large blood vessel that supplies blood to the areas of that side of the brain that control the ability to use the senses, move, and use language. The middle cerebral artery is the blood vessel that ischemic strokes most commonly affect.[112]

neurological assessments. Or alternatively, neurological exam or neuro exam, is a physical exam used to check the function of the brain, spinal cord, and peripheral nerves. The components and length vary depending on the provider and context for use, but may include evaluation of mental status, speech, strength, sensation, and coordination. Frequent assessments in the acute care setting allow healthcare providers to recognize changes that may require further evaluation or intervention.[113]

neurologically intact. A patient status determined by a health care provider indicating the patient does not have evidence of neurological deficits, after performing a physical exam assessing the function of the brain, spinal cord and peripheral nerves.[114]

non-contrast head computed tomography scan (head CT scan). Or alternatively, non-contrast brain computed tomography scan, is a radiologic study that uses x-rays to create detailed images of the head and brain. It is an important early step in the evaluation of a patient who is suspected to be having a stroke, to determine if the cause of the stroke is hemorrhagic (bleeding in or around the brain), or ischemic (insufficient blood flow to the brain). Treatment of stroke takes very different paths depending on the result of the head CT.[115]

Ongoing Professional Performance Evaluation. "The ongoing monitoring of privileged [licensed independent providers] to identify clinical practice trends that may impact the quality and safety of care."[116]

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[111] Paul Munter et al., "Measurement of Blood Pressure in Humans," *Hypertension* 73, no. 5 (March 4, 2019): e35-e66, https://doi.org/10.1161/HYP.0000000000000087.

[112] "MCA (Middle Cerebral Artery) Stroke, Cleveland Clinic, accessed November 19, 2025, https://my.clevelandclinic.org/health/diseases/mca-stroke.

[113] "Neurological Exam," Cleveland Clinic, accessed November 18, 2025, https://my.clevelandclinic.org/health/diagnostics/22664-neurological-exam.

[114] "Neurological Exam," Cleveland Clinic.

[115] "CT head (protocol)," Radiopaedia.org, accessed November 19, 2025, https://radiopaedia.org/articles/ct-head-protocol?lang=gb; VHA Directive 1155(1); William J. Powers et al., "Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association."

[116] VHA Directive 1100.21(1).

peer review. A non-punitive assessment of whether an individual provider's decisions and actions met the standard of care.[117]

root cause analysis. A comprehensive study of systems-level concerns that is conducted by a team with the goal of reviewing close calls and adverse health events.[118]

routine (consult). A standard non-urgent consult or referral for care.[119]

safety assessment code. A score given to a patient safety event that, using a low to high matrix, takes the severity and probability of harm into account.[120]

stat. A consult that has an immediate need and is to be completed within 48 hours.[121]

stroke. A medical emergency that causes brain tissue to die. There are two types: *ischemic*, when the blood supplying a part of the brain is either blocked or reduced, and *hemorrhagic*, when a leaking or burst blood vessel in the brain causes bleeding and pressure on the brain. The term cerebrovascular accident is synonymous with stroke; however, stroke is used in this report.[122]

stroke team. A team available during facility operational hours and available to respond within 30 minutes either in person or via tele-medicine as part of the VHA facility management plan requirement for acute ischemic stroke response**.**[123]

telecritical care. Remote monitoring of critical care patients by critical care physicians and nurses 24 hours per day, seven days a week using audiovisual technology.[124]

thrombectomy. Directly removing a clot from a blood vessel through a conventional, "open" surgical incision to access the clot. Alternatively, a "minimally invasive" interventional technique to remove the clot may be used, reaching the clot from a more easily accessed blood vessel in a distant location on the patient, then passing instruments through the blood stream to reach the affected site.[125]

[117] VHA Directive 1190(1).
[118] VHA Directive 1050.01(1).
[119] VHA Directive 1232.
[120] VHA Directive 1050.01(1).
[121] VHA Directive 1232.
[122] "Stroke," Mayo Clinic.
[123] VHA Directive 1155(1).
[124] VA TeleCritical Care," About TeleCritical Care (Fact Sheet)," (no date).
[125] "Thrombectomy" in "Thrombosis," Cleveland Clinic, accessed November 11, 2025, https://my.clevelandclinic.org/health/diseases/22242-thrombosis.

thrombolytic therapy. The administration of medications that dissolve blood clots. These medications are especially useful for clots in critical areas such as those that cause heart attacks and ischemic strokes.[126]

thrombosis. A condition where one or more blood clots form in a blood vessel (artery or vein) or the heart. It can block blood flow where it has formed, or it can break loose and travel through the blood vessels to other areas of the body. For example, if a clot travels to the brain and blocks blood flow, it may cause a stroke. Atherosclerosis, smoking, and cancer are some of the risk factors for developing thrombosis. Depending on the location in the body where thrombosis develops, a CT scan, magnetic resonance imaging, or ultrasound may be used to precisely locate the clot.[127]

VA National TeleStroke Program. This service provides facilities with timely access to resources for stroke care, including connection with expert stroke specialists via interactive video conferencing.[128]

[126] "Thrombosis," Cleveland Clinic, accessed November 11, 2025, https://my.clevelandclinic.org/health/diseases/22242-thrombosis.

[127] "Thrombosis," Cleveland Clinic.

[128] "What We Do & How to Participate," VA National Telestroke Program, accessed January 1, 2025, https://dvagov.sharepoint.com/sites/vanationaltelestrokeprogram/SitePages/Welcome-to-the-VA-National-Telestroke-Program.aspx.

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