Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care and Communication Issues VA Medical Center Louisville, Kentucky

Report No. 07-01749-169

July 17, 2007

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted an evaluation to determine the validity of allegations regarding quality of care and communication issues at the VA Medical Center in Louisville, Kentucky. At the request of Congressman Harry Mitchell, we evaluated allegations that: (1) the veteran was subjected to inappropriate and excessive testing with contrast dye; (2) providers did not diagnose a dissecting aortic aneurysm; (3) the veteran was not provided appropriate or adequate skin care; and (4) providers inappropriately excluded the designated surrogate decision maker who held a Durable Power of Attorney for Health Care from patient care decisions.

We visited the facility the week of April 9, 2007, and interviewed staff involved in the veteran's care. We examined relevant policies and procedures and quality management documents, and reviewed the veteran's medical record. We followed up on an Office of Medical Inspector review conducted in June 2006 about this same veteran's bed assignment and skin care. We interviewed the complainant by telephone and visited the veteran at the Jefferson Barracks spinal cord injury unit in Saint Louis, Missouri.

We did not substantiate the allegations that the veteran was subjected to inappropriate and excessive testing with contrast dye. We found that testing with contrast dye was necessary for his other medical conditions and providers took precautions to prevent complications. We did not find evidence that providers failed to diagnose a dissecting aneurysm, which caused the veteran's paralysis. According to an independent radiologist, imaging reports before and after the onset of paralysis did not reflect a dissecting aneurysm. We found that the veteran received adequate and appropriate skin care and that the designated surrogate decision maker was included in patient care decisions when appropriate. We made no recommendations.

Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid South Healthcare Network (10N9)

SUBJECT: Quality of Care and Communication Issues, VA Medical Center, Louisville, KY

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an evaluation to determine the validity of allegations regarding quality of care and communication issues at the VA Medical Center (the facility), Louisville, Kentucky.

Background

The facility is a tertiary care medical center that provides medicine, surgery, psychiatry, rehabilitation, and geriatrics and extended care services. The facility has 114 authorized beds and is part of Veterans Integrated Service Network (VISN) 9.

In response to a complaint, Congressman Harry Mitchell wrote to the OIG on March 15, 2007, requesting an immediate medical review of a veteran's care. The complainant, the veteran's sister, alleged that her brother received inadequate care at the facility. She alleged that vital tests were overlooked and many of her brother's present medical problems resulted from inappropriate care or delay in treatment. The complainant specifically alleged that facility providers:

- Subjected the veteran to inappropriate and excessive testing with contrast dye,[1] which caused his kidney failure.
- Did not diagnose a dissecting[2] aortic aneurysm, which resulted in the veteran's paraplegia.

[1] A radiopaque substance used in radiological procedures to better visualize tissue, organs, or blockages.
[2] A dissection is a tear in the inner portion of an artery allowing blood flow to create a second channel, thereby decreasing blood flow in the true channel and the amount of oxygenated blood available to organs beyond the dissection.

- Did not provide appropriate or adequate skin care, which resulted in the veteran developing a large sacral[3] decubitus ulcer.[4]

- Inappropriately excluded the designated surrogate[5] decision maker (the person who held a Durable Power of Attorney for Health Care (DPAHC)) for patient care decisions.

During our interviews with the complainant, she also alleged that documentation in the patient's medical record did not accurately reflect information provided to the family.

Although the complainant did not make allegations to the OIG about her brother's disability benefits, she provided us with copies of letters she sent to Congressmen Mike Sodrel and Steven Buyer requesting congressional assistance in resolving two Veterans Benefits Administration (VBA) issues. One issue involved collection of overpayments and the second involved her brother's application for service-connected benefits. We reviewed the current status of the issues and determined that VBA staff were following established procedures to appropriately address the complainant's concerns in this area. We did not investigate these issues further.

Scope and Methodology

We visited the facility April 10–12, 2007. We visited the Jefferson Barracks spinal cord injury unit (SCIU) in Saint Louis, MO, on April 13, 2007. In performing this review, we examined the Louisville facility's policies and procedures, nursing standards of practice and competency records, patient advocate reports, and other relevant documents pertaining to the veteran and the allegations. We interviewed facility managers and other employees knowledgeable about the issues and observed and interviewed the veteran at the Jefferson Barracks SCIU. We interviewed the complainant twice by telephone. We toured the facility's medical/surgical unit and inspected lift equipment used for the veteran. We examined the facility's documentation related to interactions and communications with this veteran and his family. We reviewed the veteran's medical records from his admissions to the Louisville, Nashville, Houston, and Saint Louis VA medical centers. We also followed up on an Office of the Medical Inspector (OMI) review conducted in June 2006, which evaluated a complainant's allegations that the facility did not provide this veteran with an appropriate pressure relief bed or provide proper wound care for his decubitus ulcer.

[3] Lowest portion of the back just above the buttocks.
[4] Skin and tissue damage caused by poor circulation or continuous pressure to an area. Stage IV decubitus ulcers involve full thickness skin loss with extensive destruction, or damage to muscle, bone, or supporting structures.
[5] A surrogate is an adult, other than the patient's agent or conservator, authorized under State law to make health care decisions for the patient; in this case, authorized when the patient lacked capacity to make his own health care decisions.

The inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case Summary

The patient is a 61-year-old male veteran who had been hospitalized 48 times at the facility between November 1995 and June 2006. His complex medical history includes coronary artery disease (CAD), multiple heart attacks, severe high blood pressure, hyperlipidemia (high fat level in the blood), peripheral vascular disease[6] (PVD), aortic aneurysms, pancreatitis (inflammation of the pancreas), hyperparathyroidism,[7] chronic renal insufficiency (CRI),[8] end stage renal disease,[9] adenocarcinoma of the colon, gastric (stomach) ulcers with five episodes of upper gastrointestinal (GI) bleeding, sleep apnea, and chronic generalized pain. The veteran used alcohol and smoked for more than 40 years.

The veteran was first diagnosed with CRI during a December 1996 admission. In 1997 facility clinicians diagnosed the veteran with an abdominal aortic aneurysm[10] (AAA), which he chose to have repaired at a private hospital. During the next 9 years, he required coronary angioplasty[11] or stent[12] placement five times, the surgical removal of a non-cancerous parathyroid tumor, and carotid endarterectomy[13] due to atherosclerosis. The veteran was admitted multiple times for severe high blood pressure, heart attacks, GI bleeding, PVD, and pancreatitis during the 6 years between his 1996 CRI diagnosis and 2002, when his kidneys completely failed and he started receiving hemodialysis.[14]

In November 2005, facility clinicians referred the veteran to the Houston VA medical center for surgical repair of his thoracic (chest)-abdominal aneurysm. After discovering a colon tumor, Houston VA surgeons aborted the aneurysm repair and transferred the veteran back to the facility for recuperation and treatment of his cancer. This veteran was high-risk both because of his complex medical history and because his blood type was difficult to match for the transfusions required for major vascular surgery. Since only certain VA medical centers are prepared to manage aortic aneurysm surgery in high-risk patients and the complainant did not want the veteran to return to the Houston VA

[6] The blood vessels in the arms and legs have poor circulation, often due to arthrosclerosis.
[7] Excessive amounts of parathyroid hormone causing elevated calcium levels and increasing the potential for kidney stones and pancreatitis.
[8] Progressive kidney function deterioration that does not yet require dialysis treatment or kidney transplantation.
[9] Kidney function is at 10 percent or less of normal function, requiring the patient to have either dialysis or a transplant in order to live (also called renal failure).
[10] An aneurysm beneath the diaphragm in the abdominal cavity.
[11] A technique using a balloon placed inside one of the heart's blood vessels to flatten plaque against the blood vessel wall, thereby allowing increased blood flow to the heart muscle.
[12] A spring that is inserted into a blood vessel to open and prevent the collapse of the vessel walls.
[13] The surgical removal of plaque in a carotid artery.
[14] The patient is connected to a machine that filters the blood, then returns it to the body.

medical center for aneurysm repair, facility managers continued to investigate other suitable facilities.

The veteran was discharged to his sister's home in January 2006. He was readmitted in February and facility surgeons successfully removed the colon tumor. The veteran was discharged on March 8 but returned on March 20 with pancreatitis. He was discharged again to his sister's home on March 27.

On March 30, the veteran was readmitted to the facility with complaints of low back pain and right leg weakness. He remained alert and ambulatory until April 3 when he became disoriented and experienced increased heart and breathing rates, low oxygen levels, and bluish legs. His potassium level[15] was dangerously high at 6.1 mmol/L[16] (normal is 4.0 – 5.0). He was transferred to the medical intensive care unit (MICU). The veteran remained in the MICU for 42 days and was transferred to the medicine floor on May 10.

During his 89-day hospitalization (March 30 – June 26, 2006), the veteran's medical problems included septicemia,[17] lower body paralysis secondary to spinal cord ischemia[18] and infarct,[19] heart attack, respiratory arrest requiring a breathing machine, pancreatitis, continuous chest pains, seizures, bleeding ulcers, a clotted dialysis fistula,[20] and anemia. He also developed a Stage IV sacral decubitus ulcer. On June 16, providers documented a dispute with the family regarding the veteran's decubitus ulcer and his restriction to the unit. On June 18, the veteran was discharged against medical advice after he left without notifying caregivers. However, he was readmitted the same afternoon. On June 26, the veteran was transferred to the Jefferson Barracks SCIU, a division of the Saint Louis VA medical center.

When we visited the veteran at Jefferson Barracks, we found that the he had undergone a colostomy,[21] which diverted stool away from the decubitus ulcer. The wound had improved significantly.

Results

In the complainant's letters to the Congressmen, as well as during her interviews with us, we noted her overall displeasure with care and clinicians at the facility. Although we interviewed the complainant twice to clarify her concerns, she was unable to provide us

[15] Potassium is necessary for normal heart function; if levels are too high, the heart rhythm can become erratic and cause the heart to stop pumping. Patients with kidney failure are at constant risk for elevated potassium levels.
[16] Millimoles per liter.
[17] A severe illness caused by overwhelming infection of the bloodstream by toxin-producing bacteria.
[18] A local and temporary blood supply deficiency due to circulatory obstruction.
[19] Destruction of the spinal cord caused by interruption of its blood supply.
[20] A surgical joining of an artery to a vein that causes both vessels to enlarge, creating an access to be used for hemodialysis.
[21] A surgical procedure that brings an end of the large intestine through the abdominal wall. Stool drains into a bag, thus preventing stool from contaminating a sacral decubitus ulcer.

with specific information (such as names, dates, and times) that would allow us to fully evaluate all her concerns.

Issue 1: Contrast Dye and Kidney Failure

We did not substantiate the allegation that inappropriate or excessive exposure to contrast dye caused the veteran's CRI and subsequent kidney failure. The veteran was first diagnosed with CRI in 1996. Many illnesses contributed to the veteran's CRI including CAD, high blood pressure, atherosclerosis, hyperparathyroidism, and long-term smoking. The veteran had three angioplasties as well as cardiac and renal artery stents between 1998 and 2003. In April 2001, a magnetic resonance imaging (MRI) exam confirmed renal artery stenosis (narrowing of a renal artery), which is a cause of high blood pressure and kidney failure.

The veteran's medical record reflects that from 1999 to 2002 (when the veteran began hemodialysis), he received intravenous contrast dye three times for heart catheterizations at the facility. In each of those instances, there was a clear clinical indication for the procedure and appropriate steps were taken to minimize contrast nephrotoxicity (a sudden increase in serum creatinine levels by more than 25 percent).

The foremost gauge of renal function is the serum creatinine level, which measures the kidneys' ability to filter impurities from the blood. Levels above 1.5 mg/dl indicate that kidney function is compromised. If contrast dye had caused nephrotoxicity, a creatinine level increase would have occurred within 3 days after contrast administration. From 1994–2002, the veteran received contrast dye 10 times; however, we found no evidence that serum creatinine values spiked after the procedures. The veteran's creatinine steadily increased from 1994 until he required hemodialysis in 2002.

It is our opinion that the veteran's kidney failure was primarily the result of his multiple illnesses and medical conditions. The use of contrast dye may have been contributory to his renal failure, but nephrotoxicity is a recognized complication of dye. The use of dye was warranted in the management of the patient's medical problems, and appropriate steps were taken to minimize renal damage from dye use.

Issue 2: Aortic Aneurysm

We did not substantiate the allegation that clinicians missed an aneurysm that dissected and resulted in the veteran's paralysis on or about April 3, 2006. The veteran had a history of multiple aortic aneurysms dating back to 1997. Records showed that clinicians appropriately evaluated and monitored the veteran's various aneurysms[22] every 6 months,[23] and emphasized risk reduction opportunities such as smoking cessation.

[22] The veteran had aneurysms in his chest and in his abdomen.
[23] Surgeons often choose to monitor the size and stability of aortic aneurysms rather than attempt high risk surgery.

Imaging reports also showed that AAA repairs completed in 1997 and 1998 remained intact and that his other aneurysms remained unchanged.

We reviewed all imaging reports prior to and following the veteran's onset of paralysis to determine whether (a) radiologists failed to identify a dissecting aneurysm or (b) radiologists did identify a dissection, but the veteran's providers failed to follow up. We found that:

- A May 18, 2005, computed tomography (CT) of the abdomen with contrast reported, "S/P *[after an operation]* endovascular stent for AAA unchanged." There was no mention of a dissection.

- A March 21, 2006, CT report documented "no evidence of dissection."

- A March 30 MRI (of the spine) report stated, "Not mentioned in the body of the report is that of an approximate 7 cm [*centimeter*] abdominal aortic aneurysm." No dissection was mentioned.

- An April 3 CT with contrast dye, completed on the day paralysis began, showed that aneurysms in the ascending aorta, descending aorta, and abdominal aorta were stable, and noted, "No evidence of dissection is seen."

- An April 7 MRI (thoracic spine) report, completed by the same radiologist who interpreted the March 30 MRI, annotated in the history, "a known dissecting aortic aneurysm." Surgeons reviewed the MRI report and films, documented that the MRI interpretation was not definitive, and ordered another CT with contrast dye to rule out dissection.

- An April 13 CT with contrast dye reflected, "CT of the thorax, abdomen, and pelvis demonstrate post-surgical change of the aortic root, with endovascular *[within a vessel]* graft repair of an abdominal aortic aneurysm, findings are stable from the most recent evaluation of 04/03/06, without evidence to suggest acute aortic dissection."

- A July 6 CT of the spine (thorax, lumbar, and pelvis) completed at the Saint Louis VA medical center reported, "No evidence of dissections or leaks."

An independent radiologist reviewed the veteran's April 2004 – April 2006 CT and MRI films and agreed with the interpretations and reports as written, with the exception of the April 7, 2006, MRI. In this case, he wrote, "No definitive evidence for an aortic dissection…." Further, imaging studies in April and July 2006 specifically state that there is no evidence of dissection. Since dissections do not resolve spontaneously, we believe that the interpreting radiologist who documented the presence of "a large abdominal aortic aneurysm" on March 30 inadvertently documented it as a "known

dissecting aneurysm" in the April 7 MRI report. That radiologist is now in private practice and was not available for comment.

While the complainant alleged that a dissecting aneurysm caused the veteran's paralysis, we found no consistent evidence of aortic dissection, and we believe that the patient's extensive atherosclerosis was most likely responsible for his spinal cord ischemia and paralysis.

Issue 3: Decubitus Ulcer Wound Care

We did not substantiate the allegation that nursing staff provided inappropriate and inadequate wound care, resulting in the development of a large decubitus ulcer. On April 5, 2006, 2 days after the onset of paralysis, the certified wound care nurse described a "butterfly shaped purple discoloration" over his sacral area. There was no skin breakdown at that time, but the wound care nurse told us that the discoloration indicated a severe lack of blood flow to that area, that the tissue was dead and would slough off, and that a decubitus ulcer would become evident in a short time.

While we found that the veteran developed a Stage IV sacral decubitus ulcer, facility staff addressed the potential for decubitus ulcer development in this new paraplegic patient and appropriately treated the decubitus ulcer, as follows:

Wound Care. Physicians wrote wound care orders that included decubitus ulcer dressing changes twice a day and as otherwise needed. We found documentation supporting the dressing changes at least twice a day, and in some cases, more frequently due to the veteran's inability to control his bowels. We also found that the wound care nurse monitored this veteran's decubitus ulcer between three and six times per week, which far exceeded the facility's requirement for weekly observation.

Competency of Wound Care Providers. Nursing staff, including registered nurses (RNs), licensed practical nurses, or nursing assistants (NAs) completed all ordered dressing changes. We reviewed competency records and position descriptions for all nursing staff on the medical/surgical unit and found documentation that all staff had demonstrated wound care competency. We found one instance where an RN (observing an NA for technique) reported an altercation between the NA and a family member regarding the dressing change. The RN confirmed that the NA's dressing change was inadequate, and the RN performed an appropriate dressing change.

Beds and Mattresses. While in the MICU, the veteran was placed on a Total Care Treatment Surface® bed designed to reduce the potential for further decubitus ulcer formation and to promote healing. He was turned from side to side every 2 hours in an attempt to reduce pressure on the sacral area. Documentation by MICU nurses showed that the veteran resisted attempts to have him lie on his side, and he would often roll to his back soon after turning. Upon transfer to the medical/surgical unit, he was placed on

a different support surface bed without a trapeze attachment (allowing a patient with upper body strength to move himself). When the patient asked, managers immediately obtained a bed with a trapeze. The wound care nurse told us that she had ordered five different beds for the veteran in an attempt to please the family, and emphasized that all beds, frames, or mattresses she obtained for the veteran were appropriate for his skin care.

Decubitus Ulcer Status. The veteran's provider initiated some procedures and restrictions to limit the veteran's tendency to sit in a wheelchair for long periods of time. Blood flow and increased oxygenation of the tissue surrounding the decubitus ulcer are necessary to promote healing. When the veteran sat in a wheelchair, his body weight was concentrated on the sacral area, so that it did not receive adequate oxygenation and blood flow. The veteran would frequently sit in a wheelchair in the smoking shelter for extended periods. We found several documented instances when the veteran left the unit for 2 hours or more. Staff also documented instances of the family taking the veteran outside for long periods of time. The attending physician told us he was concerned about the damage being done to the decubitus ulcer while the patient was sitting for extended periods; he was also concerned that the veteran was not always available for treatments or tests because of his trips off the unit. Because of his clinical concerns, he told the veteran and his family that the veteran should not sit in a wheelchair or leave the unit for more than 30 minutes at a time. He also initiated a sign-out sheet so nursing and medical staff could locate the veteran for treatments or tests.

Decubitus ulcers are not always preventable, particularly when blood supply to an area is impaired by ischemia. We found that clinicians provided appropriate wound care for this veteran.

Issue 4: Poor Communication

The complainant reported that staff made communication difficult for the family. Specifically, she alleged that staff (a) presented a threatening letter during a family meeting on June 19, 2006, and (b) did not recognize her as the veteran's surrogate (who held a DPAHC), as they refused to discuss the veteran's condition and treatment with her, and they ignored her concern that the veteran was allergic to morphine.

Letter(s) to the Veteran's Family. We found that staff members provided two letters to the veteran's family during meetings held on May 18 and June 19, 2006, and we determined that management's decision to issue the letters was understandable and in the veteran's best interest. Due to increasing family demands, staff requested an Ethics consultation on April 21 seeking guidance on managing interactions between the clinical staff and the family. As recommended by the Ethics team, the letters stated that the veteran's medical status would only be discussed with family members in the veteran's presence, listed the steps the family should take to discuss issues with the clinical staff, and discussed the availability of staff to address family concerns. The letters stated that

family members could be escorted from the premises if their actions were disruptive to the veteran's care.

We concluded that facility managers took these unusual actions to protect the rights of the veteran (as well as the rights of other patients on the ward), to minimize disruptions in his care, and to improve the effectiveness of communications.

Rights of Surrogate Decision Maker. We did not substantiate that staff disregarded the complainant's rights as surrogate decision maker who held a DPAHC. The complainant provided specific examples of her perception that staff refused to acknowledge her as the veteran's surrogate decision maker. In one example, the complainant alleged that the veteran signed a consent authorizing staff to pursue nursing home placement when, as the holder of the DPAHC, she should have been the authorizing signer. We found, however, that when the veteran gave consent, his medical record reflected that he was competent to make his own health care decisions. Thus, the surrogate's approval was not needed.

In another example, the complainant alleged that clinical staff refused to discuss the veteran's condition except in his room, took too long to come to the veteran's room to discuss his condition with the family, and refused to consider a change in his medication. We found that, to preserve the veteran's rights and privacy, clinical staff only discussed the veteran's medical status with his family when he was present and they were in the privacy of his room. We could not confirm or refute the allegation that staff took too long to come to the veteran's room to discuss his condition with the family.

While the complainant reported that staff did not listen to her when she advised them that the veteran was allergic to morphine (which was prescribed by the medical officer of the day on June 18), we found that the veteran has periodically received morphine dating back to 1998 with no documented or apparent allergic reactions. During our interview, the veteran, who was alert and oriented, insisted that he was not allergic to morphine. He continues to receive morphine occasionally at Jefferson Barracks for pain management and has not shown any signs of a morphine allergy.

Overall, we found that during times when the veteran was able to make his own health care decisions, staff appropriately discussed his care and treatment with him, and would include family at his request. When the veteran lacked the ability to make his own health care decisions, staff appropriately discussed and obtained consent from the surrogate who held the DPAHC to provide care and treatment. For example, the surrogate signed informed consents whenever the veteran lacked decision-making capacity from January 24 – June 26, 2006. During our interview with the veteran, he told us that he had temporarily removed the complainant as the holder of a DPAHC during periods when he felt she was interfering with the provision of his health care. Documentation confirmed his statement.

Accuracy of Documentation. We were unable to confirm or refute the complainant's verbal allegations that documentation did not accurately reflect information provided to the family. We found information documented in the veteran's medical record to be consistent with test results and treatment activities.

Follow-Up to 2006 OMI Review

On June 14, 2006, a complainant contacted Veterans Health Administration's (VHA's) Office of the Medical Inspector[24] (OMI) alleging that the same veteran was not assigned an appropriate bed for his decubitus ulcer and that his decubitus ulcer dressing changes did not meet professional standards of care because they were being completed by NAs. OMI staff reviewed medical records and interviewed facility staff; however, they did not substantiate the allegations. OMI staff reported these findings to the complainant by telephone and closed the case on June 15, 2006.

We spoke with the Medical Inspector, reviewed OMI summary findings, and investigated the appropriateness of the veteran's bed and decubitus ulcer dressing changes by NAs. We found that prior to May 10, 2006, the veteran was in the MICU on a Total Care Treatment Surface® bed that offered total weight distribution, full sitting position, and lateral rotation. Beginning with the veteran's transfer to the general medical/surgical unit on May 10, until his transfer to Jefferson Barracks on June 26, facility staff changed his support surface (bed or mattress) five times at the request of the veteran or his family. We found documentation that all support surfaces were appropriate for his decubitus ulcer care. We also found that nursing staff who provided decubitus ulcer care for this veteran met professional requirements to provide wound care dressing changes.

Conclusion

We determined that radiological testing with contrast dye was appropriate and that facility clinicians took actions to minimize its toxic effects.

We found that facility clinicians were aware of and properly followed the veteran's multiple aneurysms for 9 years. We also found that clinicians correctly ordered follow-up CT exams after the MRI report of April 7, 2006, to ascertain if, in fact, the aorta had dissected. Later films completed at the Saint Louis VA medical center did not show a dissection or aortic leak. The facility's CT and MRI films read for us by an independent radiologist confirmed there was no aortic dissection.

Although the veteran developed a decubitus ulcer after his paralysis began, we found care was satisfactory and appropriate. Managers and clinicians provided the best equipment available to prevent decubitus ulcer formation and promote healing, and nursing staff met

[24] The OMI is an internal office within VHA, providing the Under Secretary for Health with oversight on the quality of VHA medical care.

standards of care for providing wound care. Although caregivers were diligent in their efforts, the continuous pressure on the wound when the veteran sat for long periods, along with his co-morbidities, resulted in further skin breakdown and delayed healing. The decubitus ulcer was significantly improved at the time we observed it at Jefferson Barracks.

While communications were difficult between the family and clinical staff, we did not find that facility communications were inappropriate or that family rights were disregarded. Facility staff honored the surrogate decision maker who held a DPAHC, and all written communications with the family were professional. Managers ensured they met the veteran's wishes to be involved in his healthcare discussions and decisions.

The VISN and Medical Center Directors concurred with our findings. We did not make any recommendations and consider the issues closed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Bertha Clarke, RN Jerome Herbers, MD Toni Woodard

Appendix B

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