Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Surgical Quality of Care Review
Southern Arizona VA Health Care System
Tucson, Arizona

Report No. 09-02307-220 **September 18, 2009**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

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Executive Summary

The purpose of this review was to determine the validity of allegations that a surgical technician performed tasks beyond the standards of practice of the Association of Surgical Technologists which placed patients at risk for severe injuries. The complainant further alleged the operating room (OR) managers at the Southern Arizona VA Health Care System (the system), Tucson, AZ, failed to take corrective actions.

We substantiated that a surgical technician placed two sutures to close a patient's incision, a procedure that exceeded the standards of practice. However, there was no evidence that the incident resulted in patient harm. We did not substantiate that the technician attempted another procedure outside the standards of practice 2 weeks later or that managers failed to take corrective actions when they became aware of the incident. We discovered that during the time of the incident the surgical technician had not received a copy of the technician's job description which would have included a list of VA authorized procedures within the standards of practice. In addition, there were no standard operating procedures (SOPs) in the OR for non-physician surgical team members defining VA roles and responsibilities. During our onsite visit, managers were in the process of finalizing SOPs for all non-physician surgery staff that would also address surgical technician standards of practice.

The VISN and Management agreed with our findings. They also confirmed the SOPs were finalized and presented to all non-physician surgery staff on August 19, 2009; therefore, we made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Southwest Health Care Network (10N18)

SUBJECT: Healthcare Inspection – Surgical Quality of Care Review, Southern Arizona VA Health Care System, Tucson, Arizona

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations that a surgical technician performed tasks beyond the standards of practice of the Association of Surgical Technologists (AST)[1] which placed patients at risk for severe injuries. The complainant further alleged the operating room (OR) managers at the Southern Arizona VA Health Care System (the system), Tucson, AZ, failed to take corrective actions.

Background

The system provides tertiary medical, surgical, cardiovascular, orthopedic, neurological, psychiatric, geropsychiatric, long term care, and blind rehabilitative care for veterans in Tucson and the surrounding areas. It is a specialty referral center for Veterans Integrated Service Network (VISN) 18 and is affiliated with the University of Arizona School of Medicine.

The OIG Hotline Division received allegations from a complainant on May 12, 2009, that:

- On December 2008, a surgical technician (hereafter referred to as the technician) sutured a patient's incision, which exceeded the technician's standards of practice. Approximately 2 weeks later, the same technician was interrupted attempting another procedure outside the standards of practice.
- The technician's unauthorized actions placed patients at risk for injury.
- Managers failed to take corrective actions in regard to the surgical technician's improper actions.

[1] The Association of Surgical Technologists (AST) is the professional organization for surgical technologists and surgical assistants.

According to the AST, "Standards of practice are statements of the minimum expectation of the profession, designed to be references in establishing safe practice guidelines in individual health care facilities that employ Surgical Technologists."

Scope and Methodology

We interviewed the complainant via telephone in June 2009. We conducted a site visit July 6–10, 2009, and a detailed review of patient medical records, OR reports, policies, incident reports, AST standards of practice guidelines, National Surgical Quality Improvement Program data, functional (job) statements, and other related documents. During the site visit, we interviewed the system Director, Chief of Surgery, surgeons, OR managers, OR nurses, surgical technicians, and the Patient Safety Manager.

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

Inspection Results

Issue 1: Standards of Practice

We substantiated that a surgical technician placed two sutures to close a patient's incision, a procedure that exceeded the technician's standards of practice. In December 2008, the surgical team was completing a left axillo-bifemoral bypass[2] when the surgeon asked the surgical technician to suture the thigh incision. The surgical technician had placed two sutures before the circulating nurse realized this procedure was outside the technician's scope of practice and stopped the procedure. We did not substantiate the allegation that, 2 weeks later, the same surgical technician attempted another procedure beyond the standards of practice.

The OR manager was unable to show documentation that the surgery team member had received a job description prior to this incident as a part of the technician's orientation. The job description includes a list of procedures that surgical technicians are expected to perform in the OR at the VA. The OR manager did present evidence of a draft OR standard operating procedure (SOP) which will define basic OR duties and scope of practice for all non-physician surgical team members. The OR manager reported that once approved, the SOP will be distributed to OR staff including nurses, surgical technicians, and surgeons.

Issue 2: Patient Risk

The patient was not harmed by the surgical technician's placement of the sutures. The technician worked under a contract at the system from September 2008 to January 2009, when the technician was hired full-time by the system. The technician had received

[2] Left axillo-bifemoral bypass surgery is performed to restore circulation to both legs.

formal training at an Army Medical Center and had worked as a surgical technician in military and private sector healthcare facilities for several years. The technician had several years of experience and had performed this procedure in both military and private-sector healthcare settings. Nevertheless, the surgical technician's standards of practice as established by the AST did not include this procedure.

Issue 3: Corrective Actions

We did not substantiate the allegation that managers failed to take corrective action related to the surgical technician's performance of tasks outside the standards of practice. We found documentation that the technician was counseled by OR managers.

We discovered that during the time of the incident the surgical technician had not received a copy of a job description which would have included a list of VA authorized procedures within the technician's standards of practice. In addition, there were no SOPs in the OR for non-physician surgical team members defining VA roles and responsibilities. While onsite, surgery management provided evidence of the development of SOPs for all non-physician surgical team members designed to clarify duties and roles and to ensure they adhered to the standards of practice of their professional organizations.

Conclusions

We concluded that the technician performed a procedure that was not included in the technician's standards of practice. However, there was no evidence that the incident resulted in patient harm. We did not substantiate that the technician attempted another procedure outside the standards of practice 2 weeks later or that managers failed to take corrective actions when they became aware of the incident.

Because managers are in the process of finalizing SOPs for all non-physician surgery staff that will address surgical technician standards of practice, we made no recommendations.

Comments

We made no recommendations and plan no further actions. The VISN and system Directors concurred with the review findings.

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

Appendix A

OIG Contact and Staff Acknowledgments

OIG Contact	Stephanie Hills Dallas Office of Healthcare Inspections (214) 253-3369
Acknowledgments	Linda DeLong, Director, Dallas Office Ann Ver Linden Michael Shepherd, M.D.

Appendix B

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