Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Clinical and Administrative Allegations Involving Surgical Service Carl Vinson VA Medical Center Dublin, Georgia

Report No. 12-02277-49 **November 28, 2012**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation related to inadequate communication and delayed inter-facility patient transfers between the Carl Vinson VA Medical Center (the facility) in Dublin, GA, and the Charlie Norwood VA Medical Center (Augusta VAMC) located in Augusta, GA.

We did not substantiate the allegation that facility providers gave inaccurate patient information to the Augusta VAMC prior to a patient's transfer for neurosurgical evaluation. We found documentation in the patient's electronic health record to support that appropriate information was communicated to the Augusta VAMC.

We did not substantiate the implication that a patient's colon perforation was the result of the physician's non Board-certified status. We could not confirm or refute that delay and transfer issues resulted in a patient's death. We determined that the perforation was promptly identified after onset of abdominal symptoms and that appropriate actions were taken to transfer the patient to a suitable facility for surgical repair. Once the patient was transferred to the Augusta VAMC, his surgery commenced as soon as it was reasonable and practicable for the on-call surgery team. The patient's condition was relatively stable for almost 36 hours after the perforation repair. It is unknown whether his outcome would have been different had a more timely transfer occurred.

During the course of our review, we identified opportunities to improve the facility's provider reprivileging processes, as well as the collection and analysis of aggregated surgical complication data. We recommended that provider reprivileging processes be conducted in accordance with VHA guidelines. We also recommended that the Operative and Other Procedures Review Committee collect and analyze aggregate surgical complication data to identify trends and patterns, and take appropriate corrective action when indicated.

The Veterans Integrated Service Network (VISN) and facility Directors concurred with the findings and recommendations and provided acceptable action plans. We will follow up on actions to ensure completion.

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

TO: Director, Veterans Integrated Service Network (10N7)

SUBJECT: Healthcare Inspection – Clinical and Administrative Allegations Involving Surgical Service, Carl Vinson VA Medical Center, Dublin, Georgia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation to address allegations of inadequate communication and delayed inter-facility patient transfers between the Carl Vinson VA Medical Center (the facility) in Dublin, GA, and the Charlie Norwood VA Medical Center (Augusta VAMC) located in Augusta, GA. The purpose of the review was to determine whether the allegations had merit.

Background

The facility is designated as a Veterans Rural Access Hospital. It is located in Dublin, GA, and operates 34 acute care beds, 161 community living center beds, and 145 domiciliary beds. The facility provides inpatient and outpatient services including outpatient care provided at four community based outpatient clinics in Albany, Macon, Brunswick, and Perry, GA. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of approximately 125,000 throughout 52 counties in Georgia.

In March 2012, OIG received allegations that inadequate communication and delayed inter-facility patient transfers resulted in negative patient outcomes for two patients. Specifically, it was alleged that:

- A patient with a brain tumor was urgently transferred to the Augusta VAMC for neurosurgical intervention after facility providers told Augusta VAMC that the patient's "lungs were clear and the tumor was confined to the brain." However, Augusta VAMC clinicians noted a large tumor mass in the patient's lungs and he was therefore not a candidate for neurosurgical intervention.

- A non-Board-certified physician perforated a patient's colon during a routine colonoscopy. A delay in identifying the perforation, compounded by a delay transferring the patient to Augusta VAMC, resulted in the patient's death.

There were additional complaints regarding personnel-related allegations involving hiring practices, supervision, and management decisions.

Scope and Methodology

We conducted a site visit at the facility on May 9–10, 2012. We interviewed the facility's Chief of Staff, Quality Manager, Chief of Surgical Service, Risk Manager, and the VISN 7 Quality Manager. We reviewed patient electronic health records (EHRs), quality management records, provider privileging files, reports related to the subject cases, pertinent committee meeting minutes, and Veterans Health Administration (VHA) policies and directives. We also reviewed inter-facility transfer records for the facility and Augusta VAMC. We did not address the personnel-related allegations as they did not fall under the purview of OIG.

We performed this review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summaries

Patient A

Patient A presented to the facility's emergency room (ER) in April 2011, complaining of left-sided weakness and the inability to walk for 3 days. A computed tomography (CT) scan of the chest revealed a left upper lobe mass, and a head CT revealed a mass in the right temporal area with surrounding edema (swelling). The ER physician consulted with the Augusta VAMC Neurosurgical Service and the patient was transferred for a neurosurgery evaluation the same day. The neurosurgery consult request included the findings from the chest and head CT scans. The Augusta VAMC neurosurgeon determined that the patient was a poor surgical candidate due to multiple metastases (cancer that had spread to distant sites in the body) from a primary cancer in the brain. The patient underwent 10 days of palliative x-ray therapy to his head while at the Augusta VAMC and was transferred back to the facility in May for hospice care.

Patient B

Patient B underwent a diagnostic colonoscopy in March 2011. The procedure began at 2:04 p.m. and was discontinued when the patient's oxygen saturation dropped to 88 percent (normal range 95-100 percent). The patient was stabilized and Cardiology

Service was consulted to determine the appropriate course of treatment. The cardiologist recommended placing the patient in observation due to possible mild heart failure. The patient was transferred to the intensive care unit at 3:55 p.m. The following table provides the timeline of events from the date of the colonoscopy until the patient's death two days later.

	Day 1
6:00 p.m.	Patient began complaining of abdominal pain.
6:30 p.m.	Abdomen and chest x-rays were ordered. The x-rays revealed a large amount of free intra-peritoneal air consistent with a perforation of the colon.
9:00 p.m.	The patient was initially accepted for transfer to a private-sector hospital.
9:15 p.m.	The transfer was cancelled because the private-sector facility was at capacity and could not accept additional patients for care. The on-call surgeon contacted two additional private-sector hospitals in Macon, GA, but they were also unable to accept the patient.
10:00 p.m.	The on-call surgeon contacted the VISN 7 Chief of Surgery who arranged for the patient's transfer to the Augusta VAMC. The facility also conducted an institutional disclosure and informed the patient of the impending transfer for perforation repair.
	Day 2
12:25 a.m.	The patient was transferred to the Augusta VAMC.
2:35 a.m.	The initial nursing assessment was completed.
3:03 a.m.	The surgical resident evaluated the patient.
3:50 a.m.	The surgical resident confirmed a diagnosis of colon perforation.
6:02 a.m.	Surgeons began an exploratory laparotomy followed by a colostomy after identifying an 8-centimeter tear.
8:15 a.m.	The operation ended.
8:30 a.m.	The patient was admitted to the cardiac care unit and remained on post-operative mechanical ventilation. His post-surgical course was uncomplicated; he was without fever and his surgical wound was clean.
	Day 3
6:55 p.m.	The patient became hypoxic (low oxygen supply) and hypotensive (low blood pressure). He was successfully resuscitated.
9:39 p.m.	After another episode of clinical deterioration, a second resuscitation effort was unsuccessful and the patient expired. The family declined an autopsy to determine the cause of death.

Inspection Results

Issue 1: Inadequate Inter-facility Communication

We did not substantiate the allegation that facility providers gave false information to Augusta VAMC providers regarding Patient A's clinical findings and condition. Patient

A's EHR, including the transfer summary available to Augusta VAMC clinical staff, included the CT results showing the left upper lobe mass. The EHR does not reflect any concerns by Augusta VAMC providers regarding the quality and accuracy of information provided about this patient.

Issue 2: Inter-facility Transfer Delays

We substantiated that the patient's colon was perforated during the course of a diagnostic colonoscopy. We do not relate this perforation to the physician's Board certification status.

We could neither confirm nor refute the allegation that inter-facility transfer delays resulted in Patient B's death. We found that the colonoscopy was discontinued due to symptoms suspected to be cardiac in nature. Approximately 4 hours later, the patient complained of abdominal pain and a CT scan confirmed the presence of a colon perforation. The facility attempted to transfer the patient for surgical repair to three private-sector hospitals over the next 3 hours without success. The patient was transferred to Augusta VAMC within 3 1/2 hours after exhausting the private-sector options, arrived at Augusta approximately 2 hours later, and had surgery at 6:00 a.m. The surgery delay was partly due to the availability of surgical staff whom had been involved in a complicated 10-hour surgery and needed time to rest before starting another surgery. The surgical repair occurred approximately 12 hours after the CT scan initially confirmed the perforation.

We found that the perforation was promptly identified after onset of abdominal symptoms and that appropriate actions were taken to transfer the patient to a suitable facility for surgical repair. The facility's on-call surgeon could not have predicted that the local private-sector facilities would not be able to accept the patient and, unfortunately, these efforts took time. Once the patient was transferred to Augusta VAMC, his surgery commenced as soon as it was reasonable and practicable for the on-call surgery team. The patient's condition was relatively stable for almost 36 hours after the perforation repair. It is unknown whether his outcome would have been different had a more timely transfer occurred.

We reviewed root cause analyses (RCAs), a joint VISN and VHA independent review, and issue briefs concerning these events. We determined that the facility, the Augusta VAMC, and VISN leaders made appropriate efforts to improve processes and minimize delays.

Conclusions

We did not substantiate the allegation that facility providers gave inaccurate patient information to the Augusta VAMC prior to a patient's transfer for neurosurgical evaluation. We found documentation in Patient A's EHR to support that appropriate information was communicated to Augusta VAMC.

We substantiated that the patient's colon was perforated during the course of a diagnostic colonoscopy; however, we did not relate this perforation to the physician's Board certification status. We could neither confirm nor refute the allegation that delay and transfer issues resulted in Patient B's death. We determined that the perforation was promptly identified after onset of abdominal symptoms and that appropriate actions were taken to transfer the patient to a suitable facility for surgical repair. Once the patient was transferred to Augusta VAMC, his surgery commenced as soon as it was reasonable and practicable for the on-call surgery team. The patient's condition was relatively stable for almost 36 hours after the perforation repair. It is unknown whether his outcome would have been different had a more timely transfer occurred.

During the course of our review, we identified opportunities to improve the facility's provider reprivileging processes and the collection and analysis of aggregated surgical complication data.

Recommendations

Recommendation 1. We recommended that the facility Director ensure that provider reprivileging processes be conducted in accordance with VHA guidelines.

Recommendation 2. We recommended that the facility Director ensure the OOPRC collects and analyzes aggregated surgical complication data to identify trends and patterns, and takes appropriate corrective actions when indicated.

Comments

The VISN and facility Directors concurred with the findings and recommendations (see Appendixes A and B, pages 6–10, for the full text of their comments) and provided acceptable action plans. We will follow up on actions to ensure completion.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 30, 2012

From: Director, VA Southeast Network, VISN 7 (10N7)

Subject: **Healthcare Inspection –** Clinical and Administrative Allegations Involving Surgical Service, Carl Vinson VA Medical Center, Dublin, GA

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Service (VHA 10AR MRS)

1. I have reviewed and concur with the recommendations in the report regarding the above referenced Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, GA.

2. Appropriate action has been completed as detailed in the attached report.

(original signed by:)
Charles E. Sepich, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 30, 2012

From: Director, Carl Vinson VA Medical Center, Dublin, GA

Subject: **Healthcare Inspection –** Clinical and Administrative Allegations Involving Surgical Service, Carl Vinson VA Medical Center, Dublin, GA

To: Director, VA Southeast Network, VISN 7 (10N7)

1. Thank you for your consultation and review conducted of the Carl Vinson VA Medical Center, Dublin, GA.

2. We concur with all the recommendations and appreciate the time and expertise of the OIG team. This review provides us with the opportunity to continue improving care to our Veterans.

(original signed by:)
John S. Goldman
Director

Facility Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the facility Director ensure that provider reprivileging processes be conducted in accordance with VHA guidelines.

Concur **Completion Date:** March 2012

Facility Response: Providers are privileged/re-privileged in accordance with VHA Handbook 1100.19 "Credentialing and Privileging." There has been an increase in awareness of the opportunity to improve the re-privileging process. The facility is compliant, and will remain in compliance with VHA Credentialing and Privileging guidelines.

Actions taken to improve the re-privileging process include the following:

- During the past year, the facility has worked closely with program officials at the VHA Credentialing and Privileging Program. The National Director of Credentialing & Privileging assigned a staff member to conduct a site visit and to provide training to the staff. The Credentialing and Privileging (C&P) Coordinator attended training at the "VHA LIP Credentialing Boot Camp" in September 2011. An additional C&P Coordinator was hired. The facility has two Credentialing & Privileging Coordinators assigned to process independent practitioners.

- New software was installed to improve tracking and internal controls. The "Priv Plus" software was purchased and installed in October 2011. The software is used to run monthly reports
  .
- The Credentialing & Privileging (C&P) staff has developed a C&P Checklist used to validate the completion and inclusion of all required components of the privileging and re-privileging process. This tool is used to process candidates submitted to the Medical Executive Committee for C&P.

- The Risk Manager provided training to the Medical Staff in October 2011. Members of the Medical Executive Committee (MEC) reviewed the requirements of the re-privileging process. Each provider received a copy of the Medical Staff Bylaws. It is the policy of the medical staff to specifically consider, on an ongoing basis, the abilities, competencies and health status of each practitioner who has privileges in accordance with the bylaws, policies, and procedures related to clinical privileging.

Recommendation 2. We recommended that the facility Director ensure the OOPRC collects and analyzes aggregated surgical complication data to identify trends and patterns, and take appropriate corrective actions when indicated.

Concur: **Completion Date:** September 2012

Facility Response: The Operative and Other Procedures Review Committee (OOPRC) is in compliance and will continue to comply with guidelines to collect and analyze aggregated surgical complication data to identify trends and patterns, and take appropriate corrective actions when indicated.

An opportunity to improve the collecting, reporting, and utilization of data was identified in May 2012, during a conversation with the OIG Project Leader. The facility immediately took action to enhance the tools and quality of the Operative and Other Procedures Review Committee (OOPRC) documents and ensure continuous compliance.

The Chief of Staff met with the Chief of Surgery, VA Surgical Quality Improvement Program (VASQIP), Surgical Clinical Nurse Reviewer (SCNR), and administrative support to review and identify the indicators in providing the surgical mortality report.

The team has revised data tools to improve the identification of trends and patterns. The revised format enables the committee to provide continuous, comprehensive monitoring of important patient care and safety processes and ensure performance improvement (PI) activities are consistently initiated when deficiencies are identified.

The Gastroenterologist nurse works closely with the surgical staff. GI data is aggregated and analyzed by the GI Nurse. The collection of data begins with a consult, and is tracked throughout treatment and follow-up.

The Operative and Other Procedures Review Committee (OOPRC) at the Carl Vinson VA Medical Center, Dublin, Georgia evaluates and measures the performance of operative, other invasive and non-invasive procedures performed on inpatients and outpatients in accordance with medical staff approved criteria governing these interventions.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Toni Woodard, BS, Project Leader Victoria Coates, LICSW, MBA Michael Shepherd, MD

Appendix D

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