**Department of Veterans Affairs**
**Office of Inspector General**

Report No. 13-00872-71

# Healthcare Inspection

# Quality of Care, Management Controls, and Administrative Operations
# William Jennings Bryan Dorn VA Medical Center
# Columbia, South Carolina

**February 6, 2014**

# Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations concerning quality of care, clinical oversight, management controls, and administrative operations in the Surgery Service at the William Jennings Bryan (WJB) Dorn VA Medical Center (the facility) in Columbia, SC.

We could not substantiate high general and vascular surgery complication rates or that contaminated surgical equipment, contributed to surgical site infections. We substantiated improper use of hard-copy logbooks, insufficient staffing in surgery clinic, and several vacancies in Anesthesia Service. We did not substantiate patients being placed under extended anesthesia so residents could be trained in laparoscopic techniques; or that a power outage negatively impacted surgical patients. We determined that deficient surgical scheduling processes had a direct impact on operating room scheduling and caused case delays resulting in overtime.

We found that the facility's Infection Control program was fragmented and inconsistent, surveillance data was rarely analyzed or trended, and Infection Control Sub-Council minutes lacked evidence of preventive and corrective measures. Reusable Medical Equipment Oversight Committee minutes did not reflect discussion and reporting of required elements. We confirmed that in the past, back-up surgical instruments and surgical mesh were not always available.

We confirmed that the University affiliate had removed general and orthopedic surgery residents from the VA training rotation at different times. After some improvement initiatives, general surgery residents returned to VA training rotations. Most recently, however, the general surgery residency program is again in jeopardy.

We found that the Quality Management program did not provide the necessary monitoring and oversight to assure that some patient care processes were safe and effective. High-level oversight committees did not consistently receive required reports, act on identified conditions, or follow-up to resolution. We found similar deficits in subordinate committee documentation and reporting, including Operative and Other Invasive Procedure Monitoring, Infection Control, and Peer Review.

The facility's Patient Safety and Peer Review Programs did not comply with VHA requirements. We noted that many of the facility's key leaders were functioning in "acting" capacities.

We made 12 recommendations.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 19–29 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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## Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations concerning quality of care, clinical oversight, management controls, and administrative operations in the Surgery Service at the William Jennings Bryan (WJB) Dorn VA Medical Center (the facility) in Columbia, SC. During this review, OIG assessed the merit of the allegations and evaluated the facility's status and performance in other select areas.

## Background

The facility provides a broad range of inpatient and outpatient medical, surgical, mental health, and long-term care services. It has 95 operating hospital beds and 75 community living center beds. Outpatient care is also provided at seven community based outpatient clinics located in Anderson, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg, and Sumter, SC. The facility serves a veteran population of about 410,000 throughout South Carolina and is part of Veterans Integrated Service Network (VISN) 7.

Surgery Service is comprised of approximately 15 specialties including general and vascular surgery, ophthalmology, and orthopedics. According to National Surgery Office data, facility surgeons completed about 3,500 cases in FY 2012.

### Senior Leadership

Since 2010, senior leadership has been in flux, with many leaders serving in acting or interim capacities while simultaneously performing significant collateral duties within the facility or VISN. In the past 3 years, there have been five Medical Center Directors, three Associate Medical Center Directors, eight Chiefs of Medicine (COMs), nine Chiefs of Mental Health, and five Quality Managers. The long-term Chief of Staff (COS) retired in December 2012, and the long-term Chief of Surgery retired in February 2013. Currently, the Medical Center Director, COS, COM, and Chief of Surgery are assigned to those positions temporarily until permanent replacements are hired. The Chief Nurse Executive (CNE) has filled that position for more than 10 years.

### Quality and Performance Measure Data

VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain in comparison to other VHA medical centers. The Strategic Analytics for Improvement and Learning (SAIL) model reflects the facility's performance over a rolling 12-month period ending as of the $2^{nd}$ quarter FY 2013. Based on these measures, the facility has achieved an overall "3-star in quality; 3-star in efficiency" ranking amongst all VHA medical facilities. VHA facilities with 3-star rankings are in the middle 30–70 percent of all VHA facilities.

**Previous Reviews and Reports**

From February 2008 to June 2013, the facility underwent multiple oversight surveys/inspections. We noted repeated concerns in the areas of facility leadership, patient care, and quality management (QM) across multiple surveys and over time.[1]

Allegations

On November 16, 2012, a confidential complainant contacted the OIG hotline and alleged:

1) Poor surgical quality of care including: (a) high general and vascular surgery complication rates, and (b) patients being kept under general anesthesia longer than needed because of the teaching of laparoscopic techniques.

2) Violation of VA policies related to patient privacy and security involving the use of logbooks containing patients' protected health information (PHI).

3) Contaminated surgical trays received from Supply Processing Service (SPS) that contained blood, hair, and other debris. The use of these instruments contributed to a higher infection rate when compared with other hospitals.

4) Weak surgical oversight and administrative controls including: (a) inadequate general surgery resident supervision, especially at nights and on weekends; (b) orthopedic residents being removed from the facility by the affiliate institution; (c) an inadequate number of Advanced Cardiac Life Support (ACLS)-certified surgeons; (d) surgical cases that are improperly booked by attending physicians, resulting in the high use of overtime (OT); and (e) surgeries that continued during a power-outage.

The complaint included 12 case examples to support the allegations. When we contacted the individual listed as the complainant to get clarification about some of the cases, the individual denied submitting the complaint and allegations. This individual surmised that a former co-worker had initiated the complaint under his/her name. Because the complainant was therefore unknown to us, we were unable to clarify some allegations and/or secure details which would have allowed us to more thoroughly evaluate some of the concerns. The results of our reviews of the case examples included in the complaint are reported in selected sections of this report.

During the course of our initial site visit February 25–28, 2013, several supplemental allegations were brought to our attention and a significant event involving the general surgery residency program occurred. Given the seriousness of the allegations, we

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[1] For example, the Accreditation Council for Graduate Medical Education (ACGME) report in June 2013; the OIG Combined Assessment Program report dated April 2013; and the Joint Commission report dated March 2013.

expanded our review to include a larger evaluation of facility operations which revealed deficiencies in the Infection Control (IC), QM, and Peer Review programs.

To promote readability, we have addressed the allegations and deficiencies under the broader facility operations topics of Surgical Service, IC, Supply Processing Service (SPS), Affiliation and Resident Teaching, Quality Management, and Peer Review.

## Scope and Methodology

We conducted site visits February 25–28, April 22–25, May 6–9, May 22–24, May 28–31, and June 26–28, 2013. We interviewed the person listed as the complainant; former and current acting facility Directors; former and current acting COSs; CNE and Deputy CNE; associate facility director; former and current Chiefs of Surgery; acting COM; Chief of Anesthesia; operating room (OR), acute care, and outpatient nurse managers; SPS, Human Resource, Business Office, and Finance managers; Infection Control and VA Surgical Quality Improvement Program (VASQIP) Coordinators; QM staff; the Associate COS for Education; the Chairman of the USCSOM Department of Surgery; and other staff knowledgeable about the issues.

Prior to and during our site visits, we reviewed extensive system documentation, including VHA and local policies, meeting minutes, internal evaluations and external surveys, and performance data. We also reviewed electronic health records (EHRs), OR schedules and variance reports, on-call coverage schedules, employee training and competency files, Issue Briefs, staffing data, and relevant literature. Our review areas were based on the initial and supplemental allegations, and on information collected during interviews and from document reviews.

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

# Inspection Results

## Issue 1.  Surgical Service

**Allegation 1.**  There are high complication rates in general and vascular surgery.

We could not substantiate the allegation due to a lack of supporting data sources.  The VASQIP predicts an individual patient's expected outcome based on the patient's preoperative characteristics and the type and nature of the surgical procedure. The observed rates of mortality (deaths) and morbidity (complications) are compared to the expected rates for those patients undergoing the procedure and are expressed as the observed-to-expected (O/E) ratios.  Morbidity O/E encompasses a range of unexpected outcomes including wound, respiratory, urinary tract, central nervous system, cardiac, and other complications.

The VASQIP data that we reviewed for FY 2009 through the 1st quarter of FY 2013 reflected that the mortality for general and vascular surgeries was generally below what would be expected in all 4 years; however, the VASQIP morbidity data reflected that the observed morbidity for general and vascular surgery was higher than expected in all 4 years.  While VASQIP does track surgical complications, we could not use this data alone to determine whether the morbidity rate was "high".

We found that clinical managers did not adequately review morbidity data.  The VASQIP coordinator told us that she provides morbidity data to the appropriate clinical Service Line chiefs for review and action.  However, we found no evidence in the Surgical Service Morbidity and Mortality (M&M) reports that morbidity data was tracked and analyzed for patterns and trends, or that actions were discussed and considered, as needed, to address the outlier status for general and vascular surgery morbidities.

For example, the February 27, 2013, Medical Executive Board (MEB) minutes document that the expected morbidity data for vascular surgery was a high outlier, and the action plan was to be presented to the MEB in April 2013.  The April–July minutes, however, did not include discussion or follow-up relating to this issue.

**Allegation 2.** Surgeons prolonged anesthesia to accommodate student teaching during laparoscopic procedures.

We did not substantiate this allegation.  The complaint did not include specific case examples, so we reviewed a convenience sample of 25 patients who underwent laparoscopic procedures during the period January 2012–January 2013.  In 17 of these cases, the actual operative time exceeded the requested operative time by an average of 1 hour.  In a majority of these cases, additional time was needed to permit for lysis (cutting) of extensive adhesions which could not be identified pre-operatively and/or for complicating factors such as involvement of other organs.  The remaining 8 cases were completed in the expected amount of time or less.

**Allegation 3.** Surgical residents breached PHI privacy and security rules.

We substantiated the allegation that the general and vascular surgery chief residents maintained hard-copy logbooks that included patients' PHI. In April 2011, VA's Assistant Secretary for Information and Technology issued a memorandum banning logbooks, and the VA Privacy and Information Security Awareness and Rules of Behavior training completed annually by all VA employees reiterates this prohibition. Guidance does permit logbooks "for a compelling business reason as approved by the VHA facility," but that "Every effort must be made to make the log book electronic and secure on systems with appropriate IT [information technology] security controls."

We were told that all logbooks had been turned into the COS prior to our visit. However, during a tour of the surgery residents' reading room in April 2013, we found seven logbooks with patients' PHI. Several of the logbooks included surgical case information that was more than 5 years old. Facility leaders had not approved the use of these logbooks and were surprised to learn of our discovery.

After confirming that case information noted in several of the newer logbooks had been appropriately captured in the SharePoint scheduling and case management system, we turned the logbooks over to the facility's Privacy Officer for disposition.

**Allegation 4.** There are an inadequate number of ACLS-certified surgeons.

We did not substantiate the allegation. The complainant alleged that there were only four ACLS-certified attending surgeons at the facility and implied that this was an unacceptable condition given that it is a teaching hospital. The complainant also described a case where there were no surgical residents present during a Code Blue (cardiopulmonary arrest event) and implied that this was inappropriate.

Facility policy requires all physicians to maintain basic life support (BLS) certification but only specified providers to be ACLS-certified. ACLS requirements apply to emergency department physicians, Code Team providers, and anesthesiologists, as well as physicians performing or assisting in "…other invasive procedures and/or moderate sedation without an anesthesiologist." Attending surgeons who supervise surgery residents are not required by policy to be ACLS certified. Further, surgeons and surgery residents are not members of the Code Team and do not respond to cardiopulmonary arrest events unless otherwise notified.

All surgeons maintained active BLS certification as required, and five had ACLS certifications.

**Allegation 5.** Surgery Clinics and Anesthesia staffing was inadequate.

Clinic Staffing. We substantiated that the Pre-bed Surgery Clinic and other surgery clinics have not been adequately staffed by nursing and support personnel. Several staff we interviewed reported that physicians and residents have to call patients into the rooms, clean the rooms between patients, monitor and record vital signs, and order and follow-up on procedures.

VHA does not have a nurse staffing model for outpatient clinics other than primary care. The Deputy CNE told us that the facility has been trying to develop a staffing model for non-primary care outpatient clinics since February 2013; a draft staffing model was completed in July 2013. The acting outpatient clinic nurse manager compared facility staffing to two other facilities with similar volume which demonstrated staffing shortages in the outpatient surgery and Pre-bed Surgery Clinic. She requested additional staff to contact patients, take vital signs, and ensure that all pre-op evaluations are completed prior to surgery.

Anesthesia Service Staffing. We substantiated that Anesthesia Service has two full-time certified registered nurse anesthetist vacancies and one full-time and one part-time vacant anesthesiologist positions. In addition, a third anesthesiologist has been deployed on military duty since September 2012, further reducing available staff. The Chief of Anesthesia told us that "inefficiencies" in the Human Resources department have been a major inhibiting factor in his ability to fill positions. We confirmed delays approving specialty pay which resulted in at least one anesthesiologist accepting another position. In late July, the facility selected three additional anesthesia providers.

**Allegation 6.** In spite of a power failure on May 18, 2011, some surgeries continued.

While we confirmed that some surgeries continued during a power failure, we did not substantiate the implied inappropriateness of these actions.

The facility experienced a commercial power failure and the facility converted to emergency generator power. The complainant implied that the former Chief of Surgery erred by allowing some of the surgical cases to proceed under these circumstances. The complaint included the names of eight patients that were allegedly negatively impacted by the power-outage.

We reviewed the Engineering data from the event and found that the facility initiated their electrical failure contingency plan and that all emergency generators were on-line and functional at the onset of the failure. Four of the eight named cases were completed while the facility was on emergency power and the other four were rescheduled.

**Allegation 7.** Surgeons improperly "booked" surgical cases, resulting in excessive use of OT.

While we confirmed that OT was incurred because of delayed cases on a regular basis, we did not substantiate that this occurred because surgeons were improperly booking cases. The complainant alleged that attending surgeons improperly "booked" surgical cases, that cases routinely extended beyond the expected end time, and that the OR rarely finished the daily scheduled cases by 3:30 p.m. As a result, OT was incurred to compensate nursing staff for staying late.[2]

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[2] Surgeons and anesthesia staff would be exempt from receiving OT but would adjust their work hours accordingly, e.g. may come in late the following morning if they had no scheduled cases.

The complainant did not provide specific details of how the surgeons were allegedly "improperly booking" cases, so we reviewed the OR nursing staff OT report from August–December 2012 to determine the reasons for the OT. We found that in nearly half of the delayed cases, the justification for OT was either (a) unscheduled add-on cases, primarily for vascular and general surgery cases, or (b) incomplete paperwork, primarily related to outdated history and physical (H&P) notes. Also cited were 15 other "reason" categories including (c) no case cart; (d) complex case set-up; (e) housekeeping; and (f) attending/resident unavailable. There was no category code for improper booking, although the complainant could have been referring to the unscheduled add-on cases. Our review of the OR scheduling practices revealed communication deficits and dysfunctional surgical processes that contributed to surgical case delays.

Patients were not removed from the surgery schedule when staff were unable to contact them or it was known that medical clearances were incomplete. We were told by several knowledgeable witnesses that because OR time was so valuable, some surgeons would intentionally keep a case on the schedule that they knew would not be performed so that they could use the time for their unscheduled "add-on" cases. Add-on cases present challenges, however, as they can require last-minute preparations (such as surgical case carts or trays, informed consent or other paperwork updates, etc.) that disrupt the work flow and cause delays.

Patients were not always notified that they had been scheduled for surgery. On several occasions, the Pre-bed Surgery Clinic staff were unable to reach patients in time to notify them of their scheduled surgeries. These cases were not cancelled; rather, the time slots were often used for add-on cases.

Surgery was sometimes cancelled the day it was to be performed due to incomplete pre-operative medical work-ups. Staff we interviewed attributed this to staffing shortages in the Pre-bed Surgery Clinic.

When the OR schedule was running late, late-day cases would be cancelled in order to prevent OT at the end of the day. Elective surgeries are generally scheduled between 8:00 a.m. and 3:00 p.m. At 3:00 pm, all but one OR room is closed in order to prevent OT. The reduction to one OR room caused further delays for waiting patients.

Ambulatory surgery check-in procedures were inefficient. There was no consistent method for surgery outpatients to check in upon arrival in the surgery waiting area, and when a volunteer was not available, there was not an established method to inform the OR staff that the patient had arrived. This resulted in cancellations and delays of surgical procedures although the patients presented as scheduled.

Communication and scheduling processes were inefficient. For example, it was well established that surgery residents were in a required meeting on Friday mornings at the affiliate hospital, but their patients were still scheduled for surgery during those times. Also, OR staff did not always know which attending surgeon would arrive to perform a

procedure, which caused delays in obtaining and setting up instruments due to surgeon preferences.

<u>Needed equipment was not available.</u>  Add-on cases were delayed while staff looked for computers and iMed pads to complete the informed consent process.  This issue was addressed by the facility's process action team beginning in January 2013.  Four new computers on wheels were ordered for the OR and iMed consent pads were obtained for the outpatient clinics.

A process improvement team from another VISN 7 facility completed a review of SPS and OR operations in January 2013, and the facility implemented an action plan to improve communication, scheduling processes, and patient notification.

## Issue 2.  Infection Control

While not a specific allegation, during the course of our review we identified several deficiencies in the IC program.

The facility's IC program was fragmented and inconsistent, surveillance activities were superficial, and corrective actions were rarely discussed, implemented, or completed. The SAIL report reflected that as of the 3rd quarter FY 2013, the facility ranked poorly (127 of 128 VHA facilities) in relation to the healthcare-associated infection (HAI) and patient safety indicator.

The IC Sub-Council (ICSC) provides oversight for the facility's Infection Prevention and Control Program.  According to facility policy,

> …data will be collected and reviewed by the IC staff and [ICSC] Chairperson.  Comparative analysis will be done using CDC's National Healthcare Safety Network (NHSN) criteria, and against our past values as baseline data.  Any indicators found to be outside of the threshold will be evaluated by the IC department, and a plan of action determined. Patterns and trends will be determined, analyzed, and presented at the [ICSC] meeting monthly, and reported to managers and/or directors of departments as appropriate.

We reviewed ICSC meeting minutes for the period April 2012 through March 2013[3] and found the following:

<u>Required data elements were not consistently reported</u>.

- The 2012 and 2013 IC Risk Assessments and Plans were not presented to the ICSC for discussion and prioritization of high-risk areas as required by Joint Commission.
- Pathology Service did not submit required monthly reports on the numbers and identification of microorganisms found in cultures; diseases that are reportable to

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[3] The ICSC did not meet in November or December 2012.

local or State health departments; organisms requiring special isolation precautions; or reports of skin contaminants in blood cultures (required quarterly).
- Biomedical Engineering's dialysis-related report did not include results for endotoxins and dialysate.
- Required surgical site infection (SSI) surveillance was not presented.
- The only microbiology report submitted was the antibiogram report, which does not include the results of all IC.

<u>Surveillance data was rarely analyzed or trended, and ICSC minutes lacked evidence of preventive and corrective measures</u>.

- The HAIs included in the SAIL measure are catheter-associated urinary tract infection (CAUTI), central line associated blood infection (CLABSI), ventilator associated pneumonia (VAP), and methicillin-resistant *Staphylococcus aureus* (MRSA) infection. As noted above, the facility ranked poorly in the HAI measure. The ICSC minutes included data on the HAIs and reflected low compliance with the CAUTI bundle, with a plan to refer back to Medical Service. We found no evidence in the ICSC minutes that actions were taken by Medical Service or that the ICSC followed up to determine the status of proposed actions. In general, the actions documented for the HAIs was "continue to monitor."
- Several sets of ICSC minutes included graphs of MRSA and vancomycin-resistant *enterococcus* (VRE); however, there was no discussion of the significance of the increasing prevalence rate trend line over a period of months. Further, the action was "continue to monitor."
- Raw numbers of patients with VRE and ESBL were reflected in the ICSC minutes from April–August 2012; however, the rates of infection (which allows for benchmarking and comparison) were not reported until September 2012.
- ICSC minutes indicated that a cluster is defined as "three or more patients on a unit." Although clusters were identified, VRE and ESBL data did not include a unit breakdown until February 2013.
- Facility-wide MRSA transmission rates were reported beginning in August 2012 via graph displays, and unit-level MRSA transmission rates were reported beginning in February 2013. However, the reports did not include analysis of the findings or need for corrective actions.

## Issue 3.    SPS

SPS is responsible for assuring that the surgical case carts contain the appropriate instruments and items needed for the designated surgeries. Surgical equipment and instruments must be cleaned and sterilized to exacting standards to minimize the possibility of cross-contamination and infection in patients.

During our review of the allegations listed below, we observed an orthopedic case cart returned to SPS after completion of a surgical procedure. The instruments were supposed to have been precleaned but were still covered with blood and debris. Upon questioning, the OR technician responsible for pre-cleaning of the instruments in the OR

suite told us he did not "have time" to pre-clean. When pre-cleaning is not completed in accordance with manufacturers' instructions (MIs), bioburden and debris could adhere to the instruments, making it more difficult to remove during the next reprocessing steps. We also found inconsistencies between standard operating procedures, manufacturers' instructions, and competency forms. In addition, RME Oversight Committee minutes did not reflect discussion and reporting of required elements including results of compliance with established SOPs, results of infection prevention and control monitoring, and risk management activities.

**Allegation 1.** Contaminated surgical trays resulted in high infection rates.

According to multiple interviewees and supporting documents, contaminated surgical equipment was a known problem within the facility; however, we could not substantiate that this condition contributed to high SSI rates. The Centers for Disease Control and Prevention (CDC) categorizes surgical SSIs as superficial, deep, or organ/space infections.

The VASQIP M&M complications report for general and vascular surgery in FY 2011 through the 1st quarter FY 2013 showed that the facility's post-SSIs compared similarly to national averages for the procedures reviewed by VASQIP. However, the facility did not conduct surveillance to identify patterns or trends which might identify potential causes or other commonalities requiring further review.

**Allegation 2.** SPS lacked back-up surgical instruments.

We substantiated the allegation. Surgeons we interviewed reported that the primary reason cases were delayed while the patient was under anesthesia was because they were waiting for back-up instruments when the original trays appeared to be contaminated or had missing or broken instruments. The Chief of Logistics confirmed the problem and showed evidence of an April 2013 request for $246K worth of instruments that are now on order.

**Allegation 3.** Implantable devices, like surgical mesh, were not always available.

We substantiated the allegation. The Chief of Logistics told us that in the past, vendors had refused to restock supplies due to disputes over billing or payment. In February 2013, a team was initiated to perform daily bed huddles to discuss supply issues of the current day and supply needs for the following day. The billing issue has been resolved and needed supplies are routinely available.

## Issue 4.     Academic Affiliation and Resident Teaching

Education and training for health professions students and residents is one of VA's four statutory missions. Through its partnerships with affiliated academic institutions, VA conducts the largest education and training effort for health professionals in the nation.

The facility is affiliated with the USCSOM, the University of South Carolina College of Nursing, South Carolina College of Pharmacy, and Palmetto Health, and has sharing

agreements with Shaw Air Force Base and Fort Jackson Army Base. In FY 2012, the facility had a total of 737 trainees across the participating disciplines.

During the 2012–2013 academic year, the facility had a base allocation of 48.6 medical/surgical training positions. Surgery Service provided training opportunities to 17 surgical residents from USCSOM.[4]

**Allegation 1.** The general surgery residents were not adequately supervised, especially at night and on weekends.

We substantiated the allegation. During our initial site visit the week of February 25, several surgical residents expressed concern over the lack of general surgery attending coverage during non-administrative hours. To verify, we obtained a copy of the on-call schedule from the ED and contacted the listed attending surgeon who informed us that he was unaware he was on-call that night. We then contacted the on-call surgical resident who stated that there was not a general surgery attending available on-call that night.

We learned that in early February 2013, there were three general surgeons on staff, all of whom supervised residents. Within a matter of weeks, however, one general surgeon required use of extended sick leave and another general surgeon abruptly retired. The third general surgeon, who was working part-time, resigned. Further, a vascular surgeon and a cardiothoracic surgeon who had been performing limited general surgeries were unable to continue these procedures while their general surgery privileges were under review.[5] The USCSOM general surgery residency program recalled their residents from the VA rotation as there was no attending physician coverage available to them, which was in conflict with ACGME requirements.[6]

In response to the loss of the general surgery attendings and residents, the facility discontinued all general surgery cases and coordinated with its academic affiliate hospital to manage new general surgery consults and emergent situations. In mid-March, a general surgeon from Moncrief Army Community Hospital (MACH) began providing surgical coverage one day per week at the facility. In late March, the facility finalized two contracts with the academic affiliate hospital. As additional attending surgeons were available through MACH and the affiliate, limited general surgeries resumed in late March. Two general surgery residents returned to the facility after more general surgeons were hired. Most recently, however, the facility has been unable to maintain an adequate number of general surgery attending physicians which has put the general surgery residency program at the facility again in jeopardy.

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[4] Surgery residents are on monthly rotations.

[5] The cardiothoracic surgeon has since resumed providing on-call coverage for general surgery cases.

[6] The ACGME (Accreditation Council for Graduate Medical Education) is the accrediting body for graduate medical training programs.

**Allegation 2.** The orthopedic surgery residency program was discontinued.

We substantiated the allegation that orthopedic residents had been "pulled" from the facility. In January 2012, the Department of Orthopedics at USCSOM notified the facility that they "would not be seeking a renewal of the contract" when the current extension expired (in September 2012). Currently, there are no residents in an orthopedic surgery program being trained at the facility.

Because of the events involving the orthopedic and general surgery residency programs, we assessed the ACGME reports and the academic affiliate's trainee exit interview data to determine whether there were earlier indications of trainee dissatisfaction or other concerns. We concluded that there were no specific indications in the preceding months that the programs were about to collapse.

At the facility's request, VHA's National Director of Surgery and the Deputy Chief of the Office of Academic Affiliations (OAA) conducted a consultative site visit in November 2013 to assess the status of the general surgery program. They made multiple recommendations, and the facility has developed an action plan to correct the deficiencies.

## Issue 5.    QM Operations and Activities

While not an allegation, during the course of our review we identified multiple deficiencies in the QM program.

We found that the QM program, as well as other reporting systems, did not provide the necessary monitoring and oversight to assure that some patient care processes were safe and effective. As a result, opportunities for improvement may not have been identified and addressed. We identified the following areas that needed improvement.

QM Oversight and Reporting

The facility's QM oversight and reporting structure was not fully integrated, comprehensive, or functional as evidenced by the span of deficiencies across multiple QM areas.

The Executive Leadership Board (ELB) is responsible for oversight of critical quality and safety monitors. The ELB oversees the MEB, Nurse Executive Board (NEB), and Quality Executive Board (QEB).

We reviewed ELB, NEB, MEB, and QEB meeting minutes for the period October 2012–April 2013 and found a pattern of deficits; specifically, the Boards did not consistently receive required reports; and did not document corrective action tracking on identified issues. We also found inconsistencies between the ELB policy and the other Board policies related to oversight responsibilities, making it difficult to determine where responsibilities for oversight were expected. Facility leaders did not consistently have the information needed to identify and act upon performance, quality, or safety issues in a timely manner.

We found similar deficits in subordinate committee documentation and reporting.

Operative and Other Procedure Monitoring

The facility did not have a structure to evaluate the quality and appropriateness of surgical and anesthesia care. Joint Commission requires facilities to engage in performance improvement (PI) activities to enhance patient care, treatment, services, and safety. Also, the facility did not comply with the National Surgery Office's January 2013 guidance regarding Surgical Work Groups (SWGs). The SWG's function is to integrate surgical quality improvement data, improve practice and patient safety, analyze efficiency and utilize metrics, develop a strategic plan to improve surgical care, and to oversee compliance with VHA facility surgical complexity infrastructure requirements. We found that:

- The facility did not consistently collect data related to invasive or other procedures performed.
- The facility did not have a process or committee (i.e., SWG) responsible for collecting and analyzing important data to ensure quality and safety.
- M&M minutes did not provide specific case analysis or an aggregated approach to analyzing data, identifying PI opportunities, or taking and monitoring corrective actions. The facility revamped the M&M meeting minutes in January 2013 which more clearly reflected the meeting discussions and included individual case reviews. However, the revised minutes did not include review of the following required elements:
  - Operative or other procedures that place patients at risk for disability or death.
  - Significant discrepancies between pre-operative and post-operative diagnoses, including pathologic diagnosis.
  - Adverse events related to using moderate or deep sedation or anesthesia.

Non-OR Invasive Procedure Sub-council

The facility designated a Non-OR Invasive Procedure Sub-council to "…create and oversee procedures for the aggregation, analysis, and tracking of procedure and complication data for invasive procedures and moderate sedation performed outside of the OR." We reviewed the Sub-council's minutes for February 2012–April 2013 and found it did not comply with local policy, as follows:

- Data collection and reporting did not include all non-OR cases performed.
- Minutes did not include aggregate data review and evaluation.
- Minutes routinely reflected difficulty in obtaining the required self-reports from each Service.
- The annual evaluation was not completed in 2011 or 2012.

The facility continues to utilize the surgical M&M committee structure for PI and oversight activities. As noted above, however, the M&M structure and the Non-OR Sub-council were deficient in several basic requirements and did not take a broad and strategic view of surgical oversight and operations.

Patient Safety and Incident Reporting

The facility's Patient Safety Program did not comply with VHA requirements in several areas. VHA policy requires that adverse events and close calls be reported to the Patient Safety Manager (PSM) and facility policy requires this be done through an incident report system that includes hard-copy, electronic (available since August 2012), or anonymous telephone hotline reporting.

We found the following deficiencies:

- The Patient Safety Program policy did not clearly define what events would constitute a "close call" and how they should be reported.
- Patient safety events were not consistently reported to the PSM via approved channels. For example, there were approximately 62 incidents involving RME that occurred between October 2011 and April 2013, but at least 34 of those events were not reported to the PSM. The PSM served as the chair rather than facilitator, for all RCAs. Both practices are inconsistent with VHA policy.
- The 2011 and 2012 Patient Safety Program annual reports were not presented to the Health Systems Council as required by local policy.

Without consistent patient safety processes, facility leaders could not be assured that incidents were being properly identified, reported, and analyzed, and that vulnerabilities were being addressed.

## Issue 6. Peer Review

While not an allegation, during the course of our review we identified deficiencies in the Peer Review program.

Peer Review Processes

The facility did not have effective processes to identify cases for peer review, and cases that should have been peer reviewed were not. VHA Directive 2010-025, *Peer Review for Quality Management,* dated June 3, 2010, defines 16 different death review criteria. Certain cases must be screened against the death review criteria and referred for peer review.

VHA Directive 2010-025 also requires the use of the VISTA-based occurrence screen package to gather and track comparable data. The occurrence screen package, if programmed correctly, will automatically generate and print the specified occurrence screens and worksheets daily for specified admissions, readmissions, returns to the OR, and inpatient deaths.

A designated QM nurse is supposed to conduct an initial screening against the 16 death review criteria and refer cases for peer review as appropriate. We found, however, that the occurrence screen package was not programmed to print the specified occurrence screens and worksheets as required, and that the QM nurse had not received adequate

training on the occurrence screen package or the peer review screening process. Of note:

- In November 2012, the Risk Manager provided a report to the MEB reporting 36 inpatient deaths during the 3rd quarter FY 2012 and that none of the 36 were peer-reviewed. However, there were seven deaths within 30 days of surgery (and therefore met peer review criteria).
- From FY 2011 through April 24, 2013, 558 patients died during inpatient hospitalization. We identified several cases that met the death review criteria that were not referred for peer review.

Without adequate processes to identify and follow-up on potential peer-review cases, facility leaders could miss opportunities to improve patient care and organizational performance.

Peer Review Committee

The facility's Peer Review Committee (PRC) did not comply with certain oversight and documentation requirements, as follows:

- The PRC did not provide quarterly reports, including required reporting elements, to the MEB. As a result, the MEB was unable to determine whether further actions were needed in relation to: completed peer reviews and PRC level assignments; level changes and/or unusual patterns of level changes; systems issues requiring action(s); or establishment of peer review or professional activity triggers based on specific providers.
- Peer reviews were not tracked by provider, patient identifier, or level of care.
- Reports did not consistently include evidence that specific systems or process issues had been forwarded to the appropriate areas in a timely manner. For example, a compilation of issues from October–December 2011 was forwarded to the MEB via a memo dated August 2012 stating the issues were for "further discussion, follow-up, and responsibility."
- Action items from a report dated November 2012 were not resolved as of the subsequent report dated March 2013. We noted that the tracking system did not include specific responsibility for the actions.

# Conclusions

We substantiated many of the initial and supplemental allegations related to Surgery Service and its operations, and identified deficient conditions in IC, SPS, QM, and Peer Review. Our review of other performance measures and facility operations revealed inadequate processes, poor data analysis and reporting, and a weak oversight and accountability structure. We also noted that many of the facility's key leaders were functioning in "acting" capacities.

We could not substantiate high general and vascular surgery complication rates. While VASQIP data reflected the facility exceeded the expected morbidity rates in 4 consecutive years, other factors could have been contributory. We substantiated improper use of hard-copy logbooks containing PHI, and surgery clinic staffing levels and Anesthesia Service vacancies that contributed to OR scheduling and procedure delays. We did not substantiate that patients underwent extended anesthesia so residents could be trained in laparoscopic techniques or that a power outage negatively impacted surgical patients. We determined that deficient surgical scheduling processes had an impact on OR scheduling and case delays resulting in OT.

We found that the facility's IC program was fragmented and inconsistent, surveillance data was rarely analyzed or trended, and ICSC minutes lacked evidence of preventive and corrective measures.

We could not substantiate that contaminated surgical trays resulted in high infection rates. We found that RME Oversight Committee minutes did not reflect discussion and reporting of required elements including results of compliance with established SOPs, results of infection prevention and control monitoring, and risk management activities. We confirmed that in the past, back-up surgical instruments and surgical mesh were not always available.

We confirmed that the USCSOM had removed general and orthopedic surgery residents from the VA training rotation at different times. After some improvement initiatives, general surgery residents had returned to VA training rotations. Most recently, however, the general surgery residency program is again in jeopardy due to the lack of qualified general surgery attending physicians.

We found that the QM program, as well as other reporting systems, did not provide the necessary monitoring and oversight to assure that some patient care processes were safe and effective. PI processes and oversight structures that were in place often lacked depth and accountability. High-level oversight committees such as the MEB did not consistently receive required reports, act on identified conditions, or follow-up to resolution. We found similar deficits in subordinate committee documentation and reporting, including Operative and Other Invasive Procedure Monitoring, Infection Control, and Peer Review.

The facility's Patient Safety Program did not comply with VHA requirements. The Patient Safety Program policy did not clearly define what events would constitute a "close call" and how they should be reported.

The facility did not have effective processes to identify cases for peer review, and cases that should have been peer reviewed were not. The occurrence screen package was not programmed correctly and the designated QM nurse had not received adequate training on the occurrence screen package or the peer review screening process. The facility's PRC did not adequately evaluate, track, report, or follow-up on provider-related quality of care issues.

Overall, system and process weaknesses impacted providers' abilities to consistently deliver safe and efficient patient care. Further, a lack of stable leadership in critical positions over the past several years has contributed to delays in correcting some of the identified deficiencies.

## Recommendations

**1.** We recommended that the VISN Director take action to ensure more permanent, stable leadership in key positions.

**2.** We recommended that the Facility Director ensure that morbidity outliers are discussed and analyzed, and that corrective actions are taken as indicated.

**3.** We recommended that the Facility Director ensure that residents and staff discontinue use of logbooks and utilize approved electronic methods to track and schedule surgical cases.

**4.** We recommended that the Facility Director ensure adequate staffing and processes to minimize operating room delays and meet patient care needs.

**5.** We recommended that the Facility Director ensure that infection control surveillance data is analyzed and trended, and that Infection Control Sub-Council minutes include required elements and reflect preventive and corrective measures.

**6.** We recommended that the Facility Director ensure compliance with VHA guidance regarding identification, reporting, and follow-up of reusable medical equipment reprocessing issues, and that Reusable Medical Equipment committee minutes reflect these and other required elements.

**7.** We recommended that the Facility Director improve Supply Processing Services processes to ensure staff are trained and competent in relevant reusable medical equipment reprocessing activities, and that competencies, manufacturer instructions, and standard operating procedures are consistent.

**8.** We recommended that the Facility Director ensure that Quality Management oversight and reporting structures are fully integrated, comprehensive, and functional.

**9.** We recommended that the Facility Director ensure oversight and subordinate committee minutes include required elements; and reflect data analysis, conclusions, action tracking and follow-up, and outcome measurement.

**10.** We recommended that the Facility Director ensure compliance with patient safety program reporting and evaluation policies, and ensure that reportable close calls are clearly defined in local policy.

**11.** We recommended that the Facility Director ensure compliance with VHA policies on identification and reporting of cases for peer review, including use of the Occurrence Screening package.

**12.** We recommended that the Facility Director ensure the Peer Review Committee complies in a timely manner with VHA guidelines regarding discussion, analysis, tracking, and follow-up of final Peer Review Committee decisions.

# VISN Director Comments

**Department of
Veterans Affairs**                                    **Memorandum**

**Date:**     January 13, 2014

**From:**     Director, VA Southeast Network (10N7)

**Subject:**  Healthcare Inspection – Quality of Care, Management Controls, and Administrative Operations, WJB Dorn VA Medical Center, Columbia, SC

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

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

1. I have reviewed the findings and recommendations contained with the subject OIG Draft Report and support the medical center's action plans and customized strategies.

2. VISN 7 will provide full support and oversight to ensure that all actions and improvements are implemented and sustained. If there are further questions please contact Dr. Robin Hindsman, VISN 7 Quality Management Officer at 678-924-5723.

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

# VISN Director Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

## OIG Recommendations

**Recommendation 1.** We recommended that the VISN Director take action to ensure more permanent, stable leadership in key positions.

Concur

Target date for completion: February 28, 2014

VISN response:

VISN leadership has placed a high priority on finding permanent, stable leadership at the William Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina. VISN leadership has been working closely with the medical center to identify individuals for the senior leadership positions of Medical Center Director and Chief of Staff, as well as the key leadership positions of Chief of Surgery and Chief of Medicine.

VISN leadership has completed the final phases of the selection process for the Medical Center Director, having identified a top candidate for the position. The candidate is currently being vetted through VA and Office of Personnel Management approval procedures. The selection process for the Chief of Staff has been underway and the Performance Based Interview (PBI) process to identify the best qualified candidate was completed on December 12, 2013. We anticipated that the final selection process will be completed by February 28, 2014.

The medical center leadership have completed the final phases of the selection process for the Chief of Surgery, having identified a top candidate for the position. Final vetting of the top candidate is underway and we anticipate completion before February 28, 2014. The selection process for the Chief of Medicine has been underway and is currently in the PBI process to identify the best qualified candidate. Dependent on the results of the PBI process and subsequent steps, it is anticipated that this process will be completed before February 28, 2014.

# Facility Director Comments

**Department of
Veterans Affairs**                                        **Memorandum**

**Date:** December 13, 2013

**From:** Director, WJB Dorn VA Medical, Columbia, SC

**Subject:** Healthcare Inspection – Quality of Care, Management Controls, and Administrative Operations, WJB Dorn VA Medical Center, Columbia, SC

**To:** Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review and provide comments to this report.

2. I concur with the conclusions and recommendations presented by the Office of Healthcare Inspections and present you with corrective actions as noted in the comments section.

3. If you have any questions or need further information, please contact Bridget Schausten (803) 776-4000, x7731.

*(original signed by:)*
John S. Goldman
Interim Director

# Facility Director Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

## OIG Recommendations

**Recommendation 2.** We recommended that the Facility Director ensure that morbidity outliers are discussed and analyzed, and that corrective actions are taken as indicated.

Concur

Target date for completion: All actions have been completed

Facility response:

Beginning in March 2013, a 100% review of all cases involving VASQIP morbidity and mortality was performed at the monthly Morbidity and Mortality (M&M) Conference. In July 2013, M&M reviews were strengthened by structuring discussion to include the elements of findings, conclusions, and corrective actions when indicated.

The medical center's Surgical Workgroup (SWG) was initiated and the first meeting was held on August 28, 2013. In the September 18, 2013 SWG meeting, the 3rd quarter FY13 VASQIP Data Report quarter was discussed and this has been added as a recurring agenda item with discussion elements required as previously noted.

**Recommendation 3.** We recommended that the Facility Director ensure that residents and staff discontinue use of logbooks and utilize approved electronic methods to track and schedule surgical cases.

Concur

Target date for completion: All actions have been completed

Facility response:

Log books were removed and disposed of properly with provider/resident education on the policy and restrictions regarding log books at the facility; completed April 22, 2013. To prevent the recurrence of log books and to strengthen the Surgical Service scheduling process, Systems Redesign worked with Surgery and created an approved electronic surgical tracking system via SharePoint. The Surgical Service Master Implementation/Control Plan form was used to communicate the status of deploying the Surgical OR Share Point schedule, standard operating procedures, and associated tools within Surgical Service. This multi-purpose template was used as a reporting and certification mechanism for the medical facility to track and evaluate the success of the implementation. SharePoint tracking for all surgical services and conversion to an electronic protected document was fully implemented by July 24, 2013.

Effective April 22, 2013, the Privacy Officer added monitoring for logbooks as a routine and recurring component of rounds.

**Recommendation 4.** We recommended that the Facility Director ensure adequate staffing and processes to minimize operating room delays and meet patient care needs.

Concur

Target date for completion:  February 1, 2014

Facility response:

A staffing plan for surgery clinics was developed and approved by Nursing Leadership. The plan identified a need for 3 additional nursing staff and they are expected to be on board before February 1, 2014.

Human Resources conducted training for supervisors and administrative officers regarding improving packet preparation for review by recommending compensation and pay panels on November 21, 2013.  On December 4, 2013 Human Resources began an improvement initiative to address the hiring process, by sending queries to selected providers regarding desired/expected salaries.  During October 2013, the frequency of compensation panel meetings was increased to two week increments.  As of December 2013, selectees are being presented for review of recommended pay, prior to completion of VetPro, to ensure timely tentative salary offers to selected providers.

An Operating Room SOP was updated, approved and implemented, to define and control the processes for surgical scheduling, in June 13, 2013.

To improve communication issues found in regards to surgical team staff, clinical team training was completed on October 10, 2013 with 90 participants.  The Operating Room and surgical management team instituted the use of a communication white board on October 15, 2013.  Pre-operative briefings are currently being instituted.  The creation of a Registered Nurse Operating Room scheduling position is currently in the selection process.

The institution of Pre-operative briefings, clinical team training, and creation of Registered Nurse Operating Room Scheduler position have been completed.

**Recommendation 5.** We recommended that the Facility Director ensure that infection control surveillance data is analyzed and trended, and that Infection Control Sub-Council minutes include required elements and reflect preventive and corrective measures.

Concur

Target date for completion: March 31, 2014

Facility response:

The Infection Control Committee minutes are being revised to include standardized formatted data elements, consistency in reporting, surveillance data that will be analyzed and trended, with corrective and preventive measures documented with a target date for implementation of January 1, 2014. To strengthen processes and ensure documentation reveals data analysis and trending, action plans for identified areas of improvement, and follow-up evaluation, the minutes template for the Infection Control Committee will be modified to reflect these components for ongoing follow through of identified issues. Review of the committee's prior minutes will be conducted when developing the next meeting's agenda for old business items. Committee minutes will be completed within 10 business days of the committee meeting. The next Infection Control Committee meeting in January will include a twelve month retrospective data review with analysis and a complete review of the past 6 months' minutes to ensure all items requiring follow-up have been addressed or remain active as an open agenda item. Audit for completion of actions, evaluation, and closure will be conducted to ensure compliance is sustained over the next quarter. The Infection Control Committee reports directly to the Medical Executive Board (MEB). In 2013, the Infection Control (IC) Committee Charter was updated to require all minutes (with attached data) be reported within twenty working days, by the recorder. Once minutes have been completed, they are delivered to the IC Committee Chair and Facility Director for review and signature. All signed minutes are posted in the Quality Management SharePoint.

The updated IC Committee continues to meet monthly and on-call by the Chairperson. According to the IC Committee Charter, the Chairperson has the authority to call emergency meetings of an Ad Hoc Committee when deemed necessary. During such meetings, the minutes and unit specific review data must be prepared within ten working days, and presented to the MEB. Each unit manager is notified of findings accordingly.

**Recommendation 6.** We recommended that the Facility Director ensure compliance with VHA guidance regarding identification, reporting, and follow-up of reusable medical equipment reprocessing issues, and that Reusable Medical Equipment committee minutes reflect these and other required elements.

Concur

Target date for completion: March 31, 2014

Facility response:

As of May 3, 2013, the facility has instituted the VISN7-HSC-015 Loaner Instrument Policy. The policy requires that back-up instruments are provided by vendors. All back-up instruments are currently available. In January 2013, instrument 544-13-2-069-1885 was received. Instrument 544-13-3-069-4150 was received in May 2013. In August 2013, instrument 544-13-4-069-6360 was received.

In July 2013, Logistics IMS and Prosthetics implemented a collaborative plan to ensure availability of surgical mesh: Logistics IMS orders the initial supply and Prosthetics is responsible for replenishing.

To ensure minutes include documentation of RME reprocessing issues, analysis of problems, interventions, and evaluation for resolution the minutes template will be modified to reflect these components for ongoing follow through of identified issues. Review of the committee's prior minutes will be conducted when developing the next meeting's agenda for old business items. RME Committee minutes are required to be completed within 10 business days of the meeting. RME minutes are then reviewed by the Associate Director, Patient Care and Nursing Services, and a Quality Management representative prior to publishing. The RME Committee Chairperson will complete a review of the past 6 months minutes to ensure all items requiring follow-up have been addressed or remain active as an open agenda item. The RME Committee reports directly to the MEB and the Nurse Executive Board (NEB). By December 20, 2013, the Chief, Quality Management will provide a minutes training class for appropriate staff in the medical center.

**Recommendation 7.** We recommended that the Facility Director improve Supply Processing Services processes to ensure staff are trained and competent in relevant reusable medical equipment reprocessing activities, and that competencies, manufacturer instructions, and standard operating procedures are consistent.

Concur

Target date for completion: March, 1 2014

Facility response:

On January 18, 2013, training was completed with staff, regarding proper procedure for pre-cleaning of reusable medical equipment (RME). The Operating Room staff was also trained on pre-cleaning techniques of ortho vendor instruments on the above noted date. Corrective actions were taken as appropriate from the training date forward. The Operating Room management staff implemented monthly monitoring and audits of ten case carts, and results were reported to the Infection Control and Reusable Medical Equipment Committees. Specific competencies for pre-cleaning of instruments by staff was completed May 31, 2013. A second training for staff was completed, for reinforcement of technique, on June 7, 2013. As defined in Medical Center Memorandum (MCM) 544-816, Use and Reprocessing of Reusable Medical Equipment, all personnel involved in the use and reprocessing of RME have documented training on the set-up, reprocessing, and maintenance of the specific equipment leading to initial competency and validation of competency on an annual basis. Reporting required to the MEB includes: validation of initial and on-going competency of staff, results of compliance with established SOPs, results of infection prevention and control monitoring, and risk management related activities.

A process has been implemented to increase Operating Room use of nationally approved OneSource database for manufacturers' Instructions for Use (IFUs) of Critical and Semi-critical RME when available. By March 1, 2014, the facility will conduct a systematic review of all OR RME policies to ensure they comply with manufacturer's instructions.

**Recommendation 8.** We recommended that the Facility Director ensure that Quality Management oversight and reporting structures are fully integrated, comprehensive, and functional.

Concur

Target date for completion: December 30, 2013

Facility response:

An external review completed May 2013, identified gaps in the overall Quality Management (QM) Program. The review concluded that basic program elements were either not in place or lacked depth. To strengthen the QM Service, overall facility QM Program, and ensure accountability for quality and safety at all levels of the organization a restructuring and implementation plan was submitted to executive leadership and approved on June 28, 2013. This plan focuses on the QM Service commitment to leading the changes needed to resolve open actions from external review and accreditation findings and build processes to assist supervisors and service chiefs in demonstrating accountability for quality and safety processes in their services. Fully supported by the organization, the restructuring and realignment within the QM Service adds significant value and support to program functions and integration of a facility wide culture of safety. Staff reassignments integral to the success of the restructuring plan were completed September 30, 2013. Specific programmatic improvements are included in the responses to the following recommendations: Recommendation 2, morbidity reviews, M&M Conference, and SWG implementation; Recommendation 10, Patient Safety Program; Recommendation 11 and 12, Peer Review Program and processes. Please refer to these responses for specific actions.

In addition to the improvements noted in response to Recommendation 2 regarding overall quality management of morbidity outliers, representatives from Quality Management and Anesthesia were assigned as members to the Surgical Morbidity and Mortality Conference and the Surgical Workgroup, effective November 2013. The increase in membership assists in identifying and tracking trends, ensures that reviews of care by other services are performed, and ensures the monitoring of corrective actions.

**Recommendation 9.** We recommended that the Facility Director ensure oversight and subordinate committee minutes include required elements; and reflect data analysis, conclusions, action tracking and follow-up, and outcome measurement.

Concur

Target date for completion: January 21, 2014

Facility response:

The medical center will develop a Medical Center Memorandum (MCM) to establish the reporting structures for committees strengthening communication within the medical

center governance structure. All medical center committees will have a corresponding center policy or charter which serves to outline the committee's, scope, function, and membership. Each committee will report to Leadership by way of a Leadership Board or a direct report to the medical center Director. The MCM will delegate authority and responsibilities of the Executive Leadership Board (ELB) as the governing body. The ELB will ensure compliance with VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value.*

The medical center will develop an MCM to establish structure of committee minutes and include a mandatory template that clearly identifies required elements and establishes a specific time frame for minute completion (10 business days). The medical center will provide education related to the new requirements and minute taking by providing training for all appropriate staff, by the Chief, Quality Management.

**Recommendation 10.** We recommended that the Facility Director ensure compliance with patient safety program reporting and evaluation policies, and ensure that reportable close calls are clearly defined in local policy.

Concur

Target date for completion: January 21, 2014

Facility response:

The local policy MCM 544-312 Incident Reporting Patient Safety Program will be revised to clearly define close calls as required in VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook.* In addition, the local policy was reviewed for congruence with the handbook and was found to have all components present. In August 2012, desktop access to Electronic Patient Event Reporting (ePER) System was implemented. Facility wide *Stop the Line* training was initiated in October 2013 and has resulted in two successful occurrences of front line staff stopping the line for patient safety.

**Recommendation 11.** We recommended that the Facility Director ensure compliance with VHA policies on identification and reporting of cases for peer review, including use of the Occurrence Screening package.

Concur

Target date for completion: December 15, 2013

Facility response:

Immediately upon recognition of ineffective peer review processes, an employee was detailed to the Acting Risk Manager position (June 10, 2013). On September 23, 2013, a peer review nurse was hired and entered into the position. Peer Review functions have been taken over by this position with oversight by the Acting Risk Manager. A

selection for the Risk Manager position was submitted to Human Resources on December 6, 2013.

Beginning on October 10, 2013, the VISTA occurrence screen package was reprogrammed and is now automatically generating and printing specified occurrence screens (to include all inpatient deaths) as required via VHA Directive 2010-025. Both the Acting Risk Manager and Peer Review nurse have read all user manuals for the program and developed a standardized completion process within the RM Program, ensuring coverage for screen completion and follow-up.

As of October 10, 2013, the VASQIP mortality report is now being submitted monthly to QM for review and the Chief of QM has obtained the VISTA access to print the surgical mortality reports at any time necessary. All surgical deaths within 30 days of a procedure from January 2011 thru fiscal year (FY) 2013 were reviewed according to VHA Peer Review Directive and Death Screening criteria. Peer Reviews were initiated on all occurrences appropriate for review which excludes deaths that were within 30 days of clearly identified palliative care procedures. A QM representative is attending M&M meetings to monitor cases that meet criteria for peer review. Effective November 19, 2013, the Risk Management and Peer Review nurses have access to M&M meeting minutes via SharePoint.

**Recommendation 12.** We recommended that the Facility Director ensure the Peer Review Committee complies in a timely manner with VHA guidelines regarding discussion, analysis, tracking, and follow-up of final Peer Review Committee decisions.

Concur

Target date for completion: January 31, 2014

Facility response:

The Peer Review (PR) Committee has been presenting Quarterly reports to MEB effective since July 2013. Peer Review process utilizes the "Peer Review Tracker", which is an access data base that houses all peer review information, supports agenda and minute development, queries, data tracking and analysis to include recommended actions and systems issue actions. The PR tracker, fully implemented June 10, 2013, incorporates timeframes from PR initiation to PRC final decision. Changes to the PR Tracker access data base are ongoing as potential improvements are identified, i.e., additional space for discussion, separation of action items, minute/agenda formatting, etc. Since June 10, 2013, system and process issues including actions recommended by the PRC have been sent to the specific Service Chiefs and documented and tracked within the Peer Review Tracker to completion. Outstanding and completed action items are a permanent agenda item presented to the PRC for appropriate follow up. By January 31, 2014, a 12-month look-back at all actions and systems issues will be completed to ensure all issues were addressed with tracking mechanisms and verified.

Local QM Peer Review Policy was closely reviewed on June 10, 2013, for congruence with the VHA Directive 2010-025 and was found to have all components present.

Development of PRC member training and ongoing PR training programs are scheduled to begin January 1, 2014 with a target completion date of January 31, 2014. The training is intended as a refresher for existing members and orientation for new members to strengthen existing processes and build a solid foundation.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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