Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00992-210

Healthcare Inspection

Alleged Surgical Care Issues
Malcom Randall VA Medical Center
Gainesville, Florida

July 14, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations concerning the Surgical Service at the Malcom Randall VA Medical Center (the facility), Gainesville, FL. The facility is part of the North Florida/South Georgia VA Healthcare System and Veterans Integrated Service Network 8.

We did not substantiate that a cardiopulmonary resuscitation event in the operating room was not handled appropriately. We did not substantiate that surgeons were not allowed to perform a certain procedure in the operating room so that surgical mortality data would be lower. We also did not substantiate that patients deemed at high risk of mortality were sent to a local hospital so that if these patients died, the deaths would not count against the facility's surgical mortality data.

We noted that a team from Veterans Integrated Service Network 8 completed a site visit at the facility in 2013 and made recommendations to strengthen the facility's surgical program. The facility developed and completed action plans based on these recommendations.

We made no recommendations.

Comments

The Veterans Integrated Service Network and System Directors concurred with the report. (See Appendixes A and B, pages 6–7, for the Directors' comments.) No further action is required.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to allegations made by an anonymous complainant regarding surgical care issues at the Malcom Randall VA Medical Center, Gainesville, FL (the facility). The purpose of the review was to determine if the allegations had merit.

Background

The facility is part of the North Florida/South Georgia VA Healthcare System within Veterans Integrated Service Network (VISN) 8. The facility has acute medical, surgical, and specialty services, with 240 inpatient beds, and is affiliated with Shands Hospital, a local institution that is part of the University of Florida health care system.

Surgical Data

VA's measures of surgical mortality include patient deaths within 30-days of a major surgical procedure completed in the facility. The 30-day measure does not include bedside procedures or VA-funded surgeries done in a private sector hospital.

Surgical mortality data is monitored at the national, VISN, and facility levels. VA's National Surgery Office[1] (NSO) publishes a quarterly report to provide VISNs and facilities with data to evaluate surgical care. The NSO report includes data analysis results for patient outcomes, surgical mortality, safety, access, productivity, and operating room (OR) efficiency.

VISN Surgical Quality Visit

In June 2013, the VISN 8 Surgical Quality Improvement Team conducted a review of the facility's surgical program. The review included interviews with physician staff, an organizational structure assessment, and reviews of relevant documents and electronic health records (EHRs). The review resulted in several recommendations to strengthen the facility's surgical program. NSO data and resulting reviews are confidential and privileged under the provisions of Title 38, U.S. Code section 5705.

Allegations

The complainant alleged that the Chiefs of Surgery and Anesthesia took inappropriate actions to improve the facility's surgical mortality data. Specifically:

- A patient was inappropriately transferred to the surgical intensive care unit (SICU) during a cardiopulmonary resuscitation event in the OR.
- Surgeons were not permitted to perform a procedure in the OR so that surgical mortality data would be lower.

[1] VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.

- High-risk patients were sent to Shands Hospital so that if these patients died, the deaths would not count against the facility's surgical mortality data.

Scope and Methodology

The allegations did not include patient names or dates of incidents, nor could we identify any through document review. Therefore, we designed and administered a brief survey through a confidential and secure website available to all staff in Surgery Service, Anesthesia Service, and the OR setting. We asked staff if they had concerns about surgical quality, instances of patient harm, unnecessary increases in Non-VA Care Coordination (NVCC)[2] referrals, and/or examples of inappropriate actions taken to manipulate surgical mortality data. We conducted telephone interviews with staff who indicated on the survey tool that they would like to speak with us.

We reviewed EHRs, quality management documents, committee minutes, NSO reports (including surgical mortality data), and specific surgical case peer reviews from October 1, 2013 through March 31, 2014. We also reviewed administrative investigation board findings and aggregate data relevant to surgical cases completed both at the facility and those sent to the community through NVCC. In addition, we reviewed relevant facility and VHA policies.

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.

[2] Non VA Care Coordination, formerly known as "fee basis," is the VA system for referring patients to community providers for care under VA pay.

Inspection Results

Issue 1: Inappropriate Care

We did not substantiate the allegation that a patient was inappropriately transferred to the SICU during a cardiopulmonary resuscitation[3] event in the OR.

We interviewed staff who reportedly witnessed this event but who did not provide a patient name. We were told that a patient experienced a cardiac arrest before a surgical procedure was started, resuscitation was begun, and the patient was transferred to the SICU for stabilization. We reviewed 6 months of the facility's Emergency Effectiveness Committee minutes in an attempt to identify the specific patient but did not find a reference to such an event. Based on the information available, we considered that moving the patient from the OR to the SICU would have been reasonable under such circumstances since the patient would no longer have been a candidate for surgical intervention and would have required close monitoring.

Issue 2: Surgical Procedures

We did not substantiate the allegation that surgeons were not allowed to perform a certain procedure in the OR on SICU patients due to the potential for increased mortality rates.

We interviewed surgeons who performed the procedure in the SICU and OR. No one we interviewed indicated that they were told to perform the procedure in the SICU, rather than the OR, to avoid negatively impacting surgical mortality data. The procedure is commonly performed in the SICU setting and, at this facility, providers are granted privileges by the Professional Standards Board to perform this procedure in that setting. We were told that maximizing OR resources was a factor in determining where procedures were done. Furthermore, we were told by multiple staff that no procedures were withheld because of concerns about impacting the facility's 30-day mortality data.

Issue 3: Increase in Non-VA Complex Surgical Care

We did not substantiate the allegation that an increased number of high-risk surgical patients were referred to Shands Hospital under NVCC to avoid affecting the facility's surgical performance data should a patient die.

We reviewed facility NVCC surgical referral data and found no pattern of inappropriate referrals. A defined process was in place for clinical review, justification, and approval prior to an authorization for services outside of the facility in a private sector hospital. Review of data of patients referred to Shands Hospital did not reflect an increased referral trend for surgical procedures.

[3] A procedure designed to restore normal breathing after cardiac arrest that includes the clearance of air passages to the lungs, artificial respiration, heart massage by the exertion of pressure on the chest, and advanced procedures with medications to promote survival of the patient.

In some instances, complex patients must be referred to non-VA providers. One of the surgeons told us that patients requiring complex procedures that involved reconstruction[4] were referred to NVCC providers because the reconstructive part of the surgery is not performed at the facility.

Survey Results

The confidential website survey was made available to physicians, surgeons, and other clinical staff during February 4–10, 2014. Of the 155 staff that were offered the opportunity to provide us with feedback, we received 32 responses. Survey results were as follows.

Table 1. Surgical Care Issues Survey

Answer Choices:	Q1. Are you aware of any actions taken to manipulate surgical outcomes data?	Q2. Do you have any specific quality of care or patient safety concerns affecting surgical patients?	Q3. Have your concerns already been addressed by Service or Medical Center Leadership?	Q4. Has there been a recent change in the number of surgeries sent out for Non-VA care (fee basis)?
YES	3 (9 percent)	11 (34 percent)	6 (19 percent)	1 (3 percent)
NO or NOT TO MY KNOWLEGE	29 (91 percent)	21 (66 percent)	6 (19 percent)	31 (97 percent)
NOT APPLICABLE			18 (56 percent)	
HAVE NOT BROUGHT CONCERNS FORWARD			2 (6 percent)	

Source: VAOIG

We shared the survey results with the Facility Director. Survey comments that reflected new allegations (unrelated to those within the scope of this report) were reviewed. Several procedures were identified in the survey comments as having poor outcomes. OIG physicians reviewed EHR documentation for all patients who had the identified procedures performed within the last 2 years and did not find poor outcomes subsequent to the procedures.

Conclusions

We did not substantiate that a patient was inappropriately transferred to the SICU during a cardiopulmonary resuscitation event in the OR. We did not substantiate that surgeons were not permitted to perform certain procedures in the OR in order to ensure that surgical mortality data would be lower. We did not substantiate that high-risk patients were sent to a local hospital to ensure the deaths would not count against the facility's surgical mortality data should the patients die. We noted that the VISN sent a

[4] This is a surgical procedure to restore function or normal appearance by remaking defective organs or parts.

team to inspect the facility's surgical program during 2013, and the facility has taken action based on the team's recommendations.

Based on results of staff comments from our survey, EHRs were reviewed to determine if there were poor outcomes from certain types of procedures. We did not substantiate that the outcomes of certain procedures were poor.

We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 16, 2014

From: Director, VA Sunshine Healthcare Network (10N08)

Subject: **Draft Report**—Healthcare Inspection – Surgical Care Issues, Malcom Randall VA Medical Center, Gainesville, Florida

To: Director, Region Office of Healthcare Inspections (54SP)

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

I have reviewed and concur with the conclusion of no findings or recommendations based on this report.

Thank you for the opportunity to add comments however no additional comments are requested.

Joleen Clark

Joleen Clark, MBA, FACHE

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 30, 2014

From: Director, North Florida/South Georgia Veterans Health System (573/00)

Subject: **Draft Report -** Healthcare Inspection – Surgical Care Issues, Malcom Randall VA Medical Center, Gainesville, Florida

To: Director, VA Sunshine Healthcare Network (10N8)

1. The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by an anonymous complainant regarding Surgical Services at the Malcom Randall, VA Medical Center, Gainesville, FL, a component of the North Florida /South Georgia VA Healthcare System.

2. I concur with the conclusions of the OIG who following their review had no findings to substantiate the allegations.

Thomas Wisnieski, MPA, FACHE

Director

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix D

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