Administrative Closure

Review of Selected Surgical Services
Phoenix VA Health Care System
Phoenix, Arizona (10N18)
MCI Number: 2010-03276-HI-0347

Purpose

The VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of surgical care provided to patients during and after surgery at the Phoenix VA Health Care System, (facility) Phoenix, AZ. Specifically, the complainant alleged the following:

- The surgical mortality rate had risen to more than three times the national average.
- The longer than average surgery times caused excessive intraoperative blood loss and post surgical complications.
- The staff surgeons did not have adequate training.
- There was no staff physician responsible for the surgical intensive care unit (SICU) and there was poor resident supervision in the SICU after hours.
- Colon perforations during surgical colonoscopies were occurring at a high rate.
- Inadequate anesthesia staffing resulted in delayed or missed preoperative and postoperative anesthesia assessments.
- Excessive after hour coverage for on-call cases caused anesthesia staff to be overworked and exhausted.
- Requests for assistance from management and human resources to address concerns resulted in no changes.
- Employee satisfaction scores decreased.

Background

The facility is in Veterans Integrated Service Network 18. It is a tertiary care facility providing medical, surgical, mental health, geriatric, rehabilitation, and diagnostic services. The facility has 7 operating suites and performed over 3,000 major surgical procedures during fiscal year (FY) 2009 and over 3,600 major surgical procedures during FY 2010. The facility's surgical service provides anesthesia and general, and specialty surgical services. The facility is affiliated with the University of Arizona's College of Medicine. It provides training for residents in medicine, surgery, and psychiatry. The services of both anesthesiologists and certified registered nurse anesthetists (CRNAs) are utilized in the provision of anesthesia care.

Scope and Methodology

During our interviews and review. we looked at staff surgeon credentialing and privileging folders, FY 2009 and 2010 VA Surgical Quality Improvement Program (VASQIP) data, anesthesia department schedules, colonoscopies performed over a one year period, 12 specific patients sited for the various concerns; as well as, employee satisfaction data and committee meeting minutes for the last year.

Conclusions

Issue 1: Surgical Mortality Rates

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The facility monitors quality of surgical care through ongoing processes that include surgical morbidity and mortality conferences, review of surgical cases prior to surgery, clinical review of surgical deaths and unplanned returns to the operating room, peer review, and VASQIP program participation. Based on the complainant and onsite interviews, a medical record review of 12 identified surgical patients was completed. The review showed that patients were appropriately assessed by surgery and anesthesia prior to and following surgery. In all cases, there was documentation of appropriate attending physician involvement and actions taken in response to changes in patients' conditions. All patients were peer reviewed by the facility.

Issue 2: Surgery Times, Blood Loss, and Post Operative Complications

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Issue 3: Expertise of Surgeons

VHA policy[5] requires credentialing of physicians prior to appointment. We reviewed the credentialing and privileging records for 15 surgeons. The facility performed primary source verification of professional education, professional training, and licensure for all surgeons reviewed, as required. All service-level provider profile folders had adequate data to meet current requirements.

Issue 4: Physician Coverage and Supervision in the SICU

For SICU patients, local policy states that the Intensive Care Unit (ICU) attending is the attending surgeon or medical intensivist by consult. VHA policy[6] requires that attending physicians be involved in and supervise ICU patient care. A medical records review of 12 identified surgical patients was completed. Daily documentation of supervision by the attending physician was evident in all cases.

Issue 5: Colonoscopy Complications

The facility's Invasive Procedure Committee minutes were reviewed from May 2009 to May 2010.

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Issue 6: Surgery Cancellations and Anesthesia Assessments

We reviewed the facility list of surgeries performed and surgeries canceled for FY 2009 and FY 2010 through July 30, 2010.

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[5] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[6] VHA Handbook 1400.1, *Resident Supervision*, July 27, 2005.

The facility's overall surgical cancellation rate for FY 2009 was 351 (9.72 percent) of 3,611 cases. The overall surgical cancellation rate for FY 2010 through July 30, 2010, was 344 (11.34 percent) of 3,034 cases. The facility surgical cancellation rate attributed to anesthesiology staffing issues in FY 2009 was 3 (0.08 percent) of 3,611 cases. The surgical cancellation rate attributed to anesthesiology staffing issues at the facility for FY 2010 through July 30, 2010 was 7 (0.23 percent) of 3,034 cases.

The allegation of delayed or cancelled anesthesia assessments was not substantiated. VHA policy[7] requires that a member of the anesthesia care team determine the status of the patient prior to surgery. Specific time requirements beyond "prior to surgery" are not provided. Local facility policy states that a preoperative assessment will be performed within 30 days prior to a surgery or procedure. Interviews of staff and medical records reviewed validated that anesthesia assessments were completed preoperatively.

Issue 7: Anesthesia Staffing

At the time of the review, four anesthesiologists and five CRNAs were on staff. The facility's approved staffing plan listed seven full-time CRNA positions. However, Executive Review Board minutes for FY 2009 through June 2010 documented that only one request for one additional full-time CRNA was submitted. The request was approved. When interviewed, surgical service staff stated there had been no formal requests for additional staff beyond the approved sixth CRNA.

A sampling of surgery staff was interviewed. The facility practice is for a CRNA and an anesthesiologist to be on call. Both staff report for any surgical case after hours. A total of 130 after hours surgical cases occurred between July 1, 2009, and June 30, 2010. The number of after hour's surgical cases in a day never exceeded two cases. Thirty one (23.8 percent) of the 130 after hours surgical cases were completed between 10:00 p.m. and 5:00 a.m.

Issue 8: Management Response to Staff Concerns

Onsite interviews revealed that management and human resource staff did address concerns expressed by staff. However, feedback was not always provided to staff. During our review, current leadership identified several actions to respond to ongoing staff concerns and increase communication including the implementation of regular leadership rounding, leadership attendance at general staff meetings, and enhancement of the employee assistance program to include the opportunity for staff to discuss difficult clinical cases.

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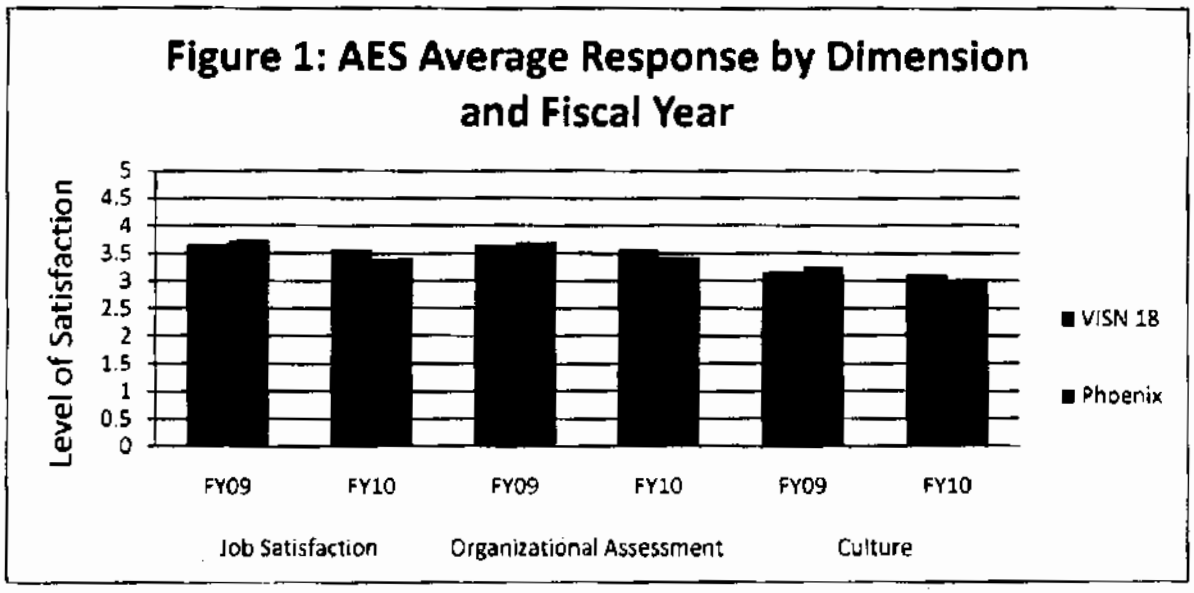
[7] VHA Handbook 1123, *Anesthesia Service*, March 7, 2007.

Issue 9: Employee Satisfaction

Staff completes the All Employee Survey (AES) annually. AES response scores for the facility were reviewed using data cubes developed by the National Center for Organizational Development, VHA Management Support Office, and VHA Support Service Center.

The average responses for the facility decreased across all dimensions of the AES for FY 2010 (Figure 1).



Facility action plans for responding to the AES scores had been discussed by senior management prior to our arrival. The facility had identified opportunities for improvement and had developed action plans targeting specific services and departments. Leadership is implementing a strategic approach that includes increased leadership communication, staff training and development, monitoring progress toward goals, and regular communication of progress to staff. We made no recommendations.

The allegation that FY 2010 employee satisfaction decreased compared to FY 2009 was substantiated. Facility action plans for responding to the AES scores had been discussed by senior management prior to our arrival and an action plan is in place. We did not substantiate any of the other allegations and recommend administrative closure of this case.

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