Administrative Closure
Alleged Quality of Care Issues
VA Black Hills Health Care System-Fort Meade, SD
MCI# 2011-01519-HI-0150

On February 8, 2011, the Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received allegations regarding the care of a patient at the VA Black Hills Health Care System, Fort Meade, SD.

An anonymous complainant alleged that:

- A patient died unexpectedly after transurethral resection of the prostate.
- As an unexpected death the case should have been reported through the incident report (IR) protocol within the facility and VISN.

The complainant contacted the OIG Hotline Division on February 3, 2011. The complaint was referred to the facility and the facility's response was received by OHI for review. The Black Hills Director provided the following documents to OHI: surgical peer review, minutes of the surgical Morbidity and Mortality Committee, minutes of the Peer Review Committee, and a root cause analysis.

The unexpected death had been immediately reported to the Organizational Improvement Department and VA Occurrence Screen. A surgical peer review was promptly initiated and the case was presented to the Morbidity and Mortality Committee and the Peer Review Committee.

Review of the medical record by an OHI physician indicated that the preoperative assessment was appropriate and consistent with the standard of care.

The facility did not enter an IR in this case, reasoning that the purpose of an IR is to assure communication to Organizational Improvement to facilitate thorough case review and appropriate follow-up actions, which had already been accomplished.

I concur with recommendation for administrative closure of this inspection.

Approved by: _____
for JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections