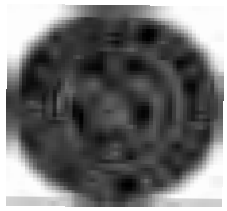

Administrative Closure
Alleged Quality of Care Issues
Grand Junction VA Medical Center (575/00)
Grand Junction, Colorado
MCI # 2012-00206-HI-0348

On November 9, 2011, the OIG Hotline Division received multiple allegations from multiple confidential complainants via FAX. The complainants were Grand Junction VA Medical Center (the facility) health care providers. The complainants alleged:

- surgery personnel issues and suboptimal facility leadership
- inadequate and missing medical record documentation by surgeons
- inadequate emergency department (ED) triage and surgical referral
- inadequate emergency, surgical, and intensive care resources
- nonfunctional overhead paging system
- inadequate quality management and performance improvement (QM/PI) programs
- delayed endoscopy scheduling and unsafe endoscope practices

We learned the facility and VISN 19 had already reviewed the allegations, conducted site visits, and developed action plans. With our Medical Consultant, we determined we would proceed with an oversight review of their actions to determine if the complainants' allegations were adequately addressed.

Three VHA healthcare teams conducted site visits and reviewed the facility's surgical program between May and September 2011: the VISN 19 Quality Management Officer (QMO) review team, the VISN 19 Surgical Consult team ((b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705), and the National Surgery Office team ((b)(3):38 U.S.C. 5705 and the (b)(3):38 U.S.C. 5705). These groups substantiated many of the allegations. Their findings and the facility responses follow.

Personnel Issues and Facility Leadership

Hostile Work Environment. Nurses and physician assistants (PA's) were exposed to profane language, and experienced hostile and angry reactions from surgeons and feared retribution. It was recommended that a disciplinary process occur for general surgeons who violated the VA Code of Conduct. Currently, an Administrative Investigative Board is reviewing one surgeon's possible unprofessional behavior.

Surgeon Response. Surgeons did not respond to phone calls or overhead pages in a timely manner, did not provide adequate patient coverage, and did not maintain a call schedule. As recommended, the facility updated the on-call schedule policy and developed a plan for surgery coverage and a call schedule. The facility and VISN now monitor the timelines of surgeons' return calls and surgical staff attendance to outpatient clinics.

Surgical Rounds. Surgeons did not conduct daily rounds as required. As recommended, facility surgeons developed an intra-disciplinary team, which includes the patient and family. Surgical rounds now occur at least daily during regular hours and additionally as needed. The facility monitors and reports to the VISN inter-disciplinary round attendance.

PA Scope of Practice. The VISN team recommended that the facility modify the PA scope of practice and that there be appropriate PA oversight. The PA scope of practice has been revised and a facility surgeon now oversees PA activities.

Surgeon Competence, Privileges, and Professionalism. On September 30, 2011, VISN 19 reduced the facility's surgical complexity level from intermediate to standard, but did allow for selected orthopedic surgeries. Competency issues have been addressed and external peer review of all general surgery cases continues.[1]

In November 2011, surgeons cancelled clinic appointments and scheduled procedures without consideration of patient needs after learning the facility was reducing their surgical privileges to reflect only those privileges required for standard surgical procedures.[2] The facility mailed apology letters to all affected patients. The Director met with each professional staff member to clarify their conduct and professional responsibilities. Each professional staff member was required to sign a memo of understanding.

Leadership. Allegations related to the facility (b)(3):38 U.S.C. 5705 were not substantiated; however, VISN 19 now provides the (b)(3):38 with role development assistance. In December 2011, the COS retired. The acting COS (from the Togus VAMC) began at the facility in January 2012.

In light of the reduction of surgical complexity from intermediate to standard; reassignment of one surgeon, identified by the facility as deficient, to a non-surgical role; and the ongoing surgical peer review process, we are satisfied VISN 19 is assuring surgeons provide safe patient care.

Medical Record Documentation

Orders. Surgeons often gave staff verbal orders and did not always place orders in the patient's electronic medical record. With the exception of emergent situations, physicians now enter orders directly in the electronic medical record per VHA policy.

Incomplete/Absent Surgical Medical Record Documentation. There was incomplete or absent surgical medical record documentation. Surgeons now complete a brief operative before patients leave the recovery room and dictate a full operative note within 48 hours. Documentation completion is now a performance standard for surgical physician ongoing professional practice evaluations.

Anesthesiologists were not scanning paper anesthesia records into the medical record in a timely manner. The facility developed a procedure and timeline for placing anesthesia records in the patient electronic medical record. Anesthesia now completes a preoperative paper template, which is scanned into the patient's electronic medical record the same day.

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[1] Healthcare Inspection Administrative Closure – *Quality of Care Issues, Grand Junction VA Medical Center, Grand Junction, CO*, Report No. 2012-00206-HI-0336, January 2012.

[2] VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

Discharge instructions were not always available to staff. PAs now complete a discharge instruction template when an inpatient leaves the ward and post anesthesia care unit nurses complete a discharge instruction template for outpatients.

Perioperative and anesthesia staff did not complete required assessments/evaluations. The facility revised a nursing preoperative checklist, a perioperative assessment form, and anesthesia staff developed a pre-operative evaluation form. Assessments now allow for a full review of necessary testing and system review prior to surgical procedures. The medical center also hired an additional certified registered nurse anesthetist to perform preoperative assessments for complicated cases.

Inadequate Triage and Treatment of Surgical Diagnoses in the ED

Surgeons did not respond to surgical concerns within the ED, which is staffed by primary care practitioners. The Medical Officer of the Day managed all ED emergencies as well as inpatient emergencies. There was no onsite cardiology or pulmonary physician support.

VISN 19 downgraded the facility's surgical complexity from intermediate to standard. Additionally, the facility has established clear lines of responsibility for all physicians (surgeons and primary care) related to the triage and treatment of surgical diagnoses in the ED.

Resources

There were inadequate resources for intermediate levels of care provided in the intensive care unit (ICU), ED, and surgical department. The ICU did not have a dedicated intensivist, hospitalist formally trained in critical care, adequate monitoring capability, or expertise to manage ventilators or hemodynamic monitors. There was no onsite cardiology or pulmonary physician support. VISN 19 reduced the facility to a standard complexity level, which resulted in a lower acuity of patients. If the facility is returned to intermediate status, VISN 19 has identified the required resources.

Overhead Paging System

In November 2011, the overhead paging system stopped working. Complainants alleged measures to correct the problem were ineffective. Installation of a new system is scheduled to begin in February 2012, and VISN 19 is providing oversight of interim measures until that time, which include two-way radios, cell phones, and interfacing the fire alarm paging system to the code blue enunciator panel. Dedicated staff monitor the enunciator panel 24/7 and VA police also perform radio checks every 4 hours. The facility conducts mock code blue drills twice daily, on all shifts in different areas; and monitors drill results, response times, and other pertinent information daily.

QM/PI

During a May 2011 VISN QM review, they found the facility did not have a comprehensive, effective QM/PI program in place. As a result, the facility published a PI plan and we confirmed completion of the plan during our October 2011CAP review. Issues related to the QM program, contractor electronic medical record documentation and order entry, final peer reviews, critical test results, copy/paste, coding, and reimbursement have been addressed. A new QM Director has been hired and VISN QM oversight is ongoing.

Endoscopy Scheduling

The facility lacked an efficient and timely scheduling endoscopy scheduling process. During FY 2011, approximately 100 patients received endoscopy procedures under fee basis care due to backlog. One complaint alleged that a patient may have experienced metastatic disease due to a delayed colonoscopy and esophagogastroduodenoscopy in 2011. It was found that (b)(3):38 U.S.C. (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 5705,(b)(6)

Reusable Medical Equipment

A complainant alleged an unsafe endoscope, removed from service in 2010, was placed back into service in 2011 at the insistence of a surgeon. The VISN was not able to confirm this incident, but the facility has a process to identify broken endoscopes, which are then removed from service and repaired. The Biomedical shop inspects all repaired endoscopes prior their return to service.

Conclusion

We conducted bi-weekly meetings with the VISN 19 quality management officer between October 2011 and January 2012. We conducted several meetings with our Medical Consultant to discuss our findings. We found VISN 19 is maintaining close oversight of the facility and we concur with the actions that were taken. We plan to conduct an onsite review of the surgical program in August 2012.

Approved by: John D. Daigh, Jr., M.D.
3/12/12 Assistant Inspector General
for Healthcare Inspections

(b)(5)