Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00084-370

Healthcare Inspection

Surgical Service Concerns
Fayetteville VA Medical Center
Fayetteville, North Carolina

September 30, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations received from an anonymous complainant in September 2014 regarding Surgical Service at the Fayetteville VA Medical Center (facility), Fayetteville, NC. The complainant alleged the following:

- Medicine and anesthesia providers did not perform adequate preoperative evaluations of some patients, causing unnecessary delays, occasional cancellations, and increased complications.
- Only one of four surgical deaths in the last 6 months was presented in a Morbidity and Mortality meeting.
- A patient was anesthetized for over an hour before a gynecological surgery was stopped because of a lack of necessary instruments.
- A surgical technician was placed in charge of the operating room schedule, bypassing input from both anesthesia and nursing services, and general surgeons now have to do their cases without adequate assistance.
- The organizational chart for Surgical Service shows at least four more surgical technician positions, but management has not approved any additional new hiring.
- Some surgical residents' complication rates exceeded 30 percent but have not been reported to surgical quality improvement.
- The Chief of Surgery awarded a contract to the Steris Corporation for thousands of dollars for new operating room lights and television monitors. The contract was not offered to other bidders, and all the equipment will have to be removed next year when the surgical suites are renovated.

We substantiated that some patients were not properly evaluated prior to surgery, causing surgical delays and cancellations. However, we could not substantiate that inadequate preoperative evaluations caused an increase in surgical complications.

We substantiated that patient deaths that occurred within 30 days of surgery were not reviewed as required. We also found that peer reviews were not conducted as required by Veterans Health Administration and facility policy.

We substantiated that a gynecological procedure was stopped after surgery had begun because of a lack of instruments. The patient subsequently underwent the surgical procedure at a non-VA hospital. Additionally, we learned of other occurrences that demonstrated ongoing problems with the operating room and Supply, Processing, and Distribution Service in obtaining and maintaining surgical supplies and instruments.

We substantiated that a surgical technician was placed in charge of the surgery schedule; however, this action was appropriate. We did not substantiate that Anesthesia and Nursing Services staff were bypassed in the scheduling process. We did not substantiate that general surgeons had to perform their cases without adequate assistance.

We substantiated that Surgical Service had approval for four more surgical technician positions that were not being actively recruited. We noted that having different service alignments for the surgical technician positions led to confusion within Surgical Service, Human Resources, and Nursing Service.

We did not substantiate that complication rates of some surgical residents exceeded 30 percent. We did not substantiate that the Chief of Surgery awarded a contract for new operating room lights and television monitors or that the contract was not offered to other bidders. While not an allegation, we found during our review that the facility's surgical post-operative clinic did not have the same nurse staffing pattern as other outpatient clinics.

We recommended that recommendations from previous reviews, if any, be implemented; that preoperative patients are adequately evaluated; that peer reviews are completed; that processes are implemented to ensure necessary surgical supplies, equipment, and instruments are available; that the organizational structure for surgical technicians be evaluated; and that the surgical post-operative clinic uses the same nurse staffing methodology as other outpatient clinics.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 14–18 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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 to assess the merit of allegations received from an anonymous complainant regarding Surgical Service at the Fayetteville VA Medical Center (facility), Fayetteville, NC.

Background

The facility is part of Veterans Integrated Service Network (VISN) 6 and has 58 general medical, surgical, and mental health inpatient beds. The facility has a "standard" surgical complexity designation[1] and completed 3,439 surgical procedures in fiscal year (FY) 2014.

Quality of Care Reviews

Veterans Health Administration (VHA) policy requires that facilities participate in activities intended to improve quality of care.[2] These activities include reviews of patients who died within 30 days of surgical procedures, unexpected deaths, and other clinical events that trigger the need for review.[3] Reviews should be performed by qualified personnel and reported to the appropriate clinical oversight committees, such as Peer Review, Morbidity and Mortality (M&M), and Surgical Work Group (SWG) for further action.[4] Quality of care reviews are confidential and privileged under the provisions of Title 38, U.S. Code, section 5705 (38 U.S.C. §5705).

Surgical Data

Surgical mortality data is monitored at the national, VISN, and facility levels. VA's National Surgery Office[5] (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. NSO data and resulting reviews are confidential and privileged under the provisions of 38 U.S.C. §5705.

VISN Surgical Quality Visit

In March 2014, a Surgical Quality Improvement Team from VISN 6 conducted a review of the facility's surgical program for quality improvement purposes; the results of the review are protected from disclosure pursuant to 38 U.S.C. §5705.

[1] VA assigned each of its inpatient medical centers a "surgical complexity" level of standard, intermediate, or complex. The designations are based on facility equipment, workload, and staffing.
[2] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This VHA Directive expired June 30, 2015, and has not yet been updated.
[3].VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[4] Ibid.
[5] VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.

Prior OIG Report

OIG report No. 14-02067-253, *Combined Assessment Program Review of the Fayetteville VA Medical Center*, Fayetteville, NC, published August 19, 2014, recommended that the Surgical Work Group (SWG) continue to meet monthly and document reviews of all surgical deaths and opportunities for improvement.

Allegations

In September, 2014, the anonymous complainant reported the following:

- Medicine and anesthesia providers did not perform adequate preoperative evaluations of some patients, causing unnecessary delays, occasional cancellations, and increased complications.
- Only one of four surgical deaths in the last 6 months was presented in an M&M meeting.
- A patient was anesthetized for over an hour before a gynecological surgery was stopped because of a lack of necessary instruments.
- A surgical technician was placed in charge of the OR schedule, bypassing input from both anesthesia and nursing services, and general surgeons now have to do their cases without adequate assistance.
- The organizational chart for Surgical Service shows at least four more surgical technician positions, but management has not approved any additional new hiring.
- Some surgical residents' complication rates exceeded 30 percent but have not been reported to surgical quality improvement.
- The Chief of Surgery awarded a contract to the Steris Corporation for thousands of dollars for new OR lights and television (TV) monitors. The contract was not offered to other bidders, and all the equipment will have to be removed next year when the surgical suites are renovated.

Scope and Methodology

We conducted our review from October 1, 2014, through April 14, 2015. We made a site visit from February 9, 2015, through February 12, 2015. We interviewed the Chief of Staff; the Chiefs of Surgery and Anesthesiology; the Chief of Supply, Processing, and Sterilization (SPS); the Acting Chief of Supply, Processing, and Distribution (SPD); Risk Manager; Patient Safety Manager; Surgical Quality Nurse; general surgeons; OR Manager and staff; Quality Management Manager; and VISN staff knowledgeable about the allegations.

We reviewed committee minutes, documents, and relevant VHA and facility policies related to the allegations. We reviewed the electronic health records (EHRs) of five patients. We inspected the physical layout of the OR and toured the SPS area and the post-operative clinic area.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

Inspection Results

Allegation 1: Surgical Delays, Cancellations, and Increased Complications because of Inadequate Preoperative Evaluations

We substantiated that medicine and anesthesia providers did not perform adequate preoperative evaluations of some patients, causing unnecessary surgical delays and at least two surgery cancellations. Facility leadership acknowledged problems with preoperative evaluations, and facility documents confirmed surgical delays because of inadequate preoperative evaluations and/or lack of history and physical examination documentation. However, we could not substantiate that inadequate preoperative evaluations caused an increase in surgical complications.

VHA policy requires that a standard surgical complexity facility have a preoperative diagnostic evaluation that includes required preoperative labs, X-rays and electrocardiograms.[6] Facility policy[7] addresses these requirements, and Medical Staff bylaws[8] require that providers perform preoperative histories and physicals.

Surgical Delays

The Chief of Staff and the Chief of Anesthesiology told us surgical delays had occurred but did not cite specific incidents. Some contributory factors for surgical delays identified by the Chief of Anesthesiology included surgical referral methods were inconsistent, patients were not pre-screened by their primary care providers before surgical consults were submitted, and Anesthesia staff used old practices calling for unnecessary tests prior to surgical procedures.

To further assess causes of delays in operations, we reviewed the facility Cancellation Rate Report[9] and Report of Delayed Operations. The facility Cancellation Rate Report showed that 5,227 surgical cases and gastrointestinal (GI) procedures were performed from October 1, 2013, through February 11, 2015. The facility Report of Delayed Operations showed that during this same time frame, 901 surgical and GI cases were delayed. According to details provided in the Report of Delayed Operations, 71 (8 percent) of the delays occurred because of the need for additional lab work, inadequate workups, and incomplete histories and physicals and/or anesthesia evaluations.

[6] VHA Directive 2010-018, *Facility Infrastructure Requirements To Perform Standard, Intermediate, Or Complex Surgical Procedures.* May 6, 2010. This Directive expired May 31, 2015 and has not been updated.
[7] Surgical Service Policy 112-14, *Preoperative Diagnostic Evaluation.* February 19, 2010.
[8] *Bylaws and Rules of the Medical Staff of Veterans Health Administration Department of Veterans Affairs Medical Center Fayetteville, NC.*
[9] This report provided data for all procedures performed.

Surgery Cancellations

The Chief of Anesthesiology could cite only one case that was cancelled because of an incomplete preoperative evaluation. The patient with a cardiac history had a recent changing chest pain pattern that was not elicited during the preoperative evaluation process. Nursing staff identified the change in the patient's condition just prior to surgery, so the surgery was cancelled.

We identified two cancellations due to inadequate preoperative evaluations from the Report of Delayed Operations. The first case was cancelled because it was discovered the patient had intermittent episodes of chest pain, but no cardiac studies were completed.[10] The second surgery case was cancelled when it was found that the patient had an "unacceptable medical status" and required further evaluation.

Surgical Complications

We could not substantiate that inadequate preoperative evaluations caused an increase in surgical complications. The complainant did not provide patient names, physicians, services, or other specific details supporting an increase in surgical complications. We identified only one instance in which an inadequate preoperative evaluation contributed to a surgical complication. In this case, the patient had a cardiac arrest during a procedure, and an internal review concluded that the patient should have undergone a more thorough preoperative examination.

Allegation 2: Surgical Mortality Reviews Not Conducted

We substantiated that prior to September 2014, surgical deaths were not reviewed or reported as required. The Chief of Surgery told us that for 8 years prior to his arrival in June 2014, surgical mortality reviews had not been done for unknown reasons.[11] However, since September 2014, surgical mortality reviews have been conducted as required.

M&M Reviews

VHA policy[12] requires that facilities have a SWG[13] that meets at least monthly and is chaired by the Chief of Surgery. The SWG is required to review all surgical deaths monthly and oversee surgical M&M meetings.

According to the Chief of Surgery, prior to his arrival in June 2014, the Chief position was in flux for at least a year. SWG meetings were not occurring, and formal M&M reviews of surgical deaths had not occurred for 8 years. He further stated that upon his

[10] In all likelihood, this is the same case cited by the Chief of Anesthesiology.
[11] OIG Report #14-02067-253, *Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, NC,* August 19, 2014, also identified that surgical deaths were not being reviewed as required.
[12] VHA Handbook 1102.01, *National Surgery Office.* January 30, 2013.
[13] Ibid. SWG functions to integrate surgical quality improvement data, improve practice and patient safety, and ensure communication to the NSO when appropriate.

arrival, he "set in place things that needed to be done," including starting monthly SWG meetings and incorporating monthly M&M reviews into the SWG minutes template.

Peer Review for Quality Management

While evaluating facility processes for review of surgical complications and deaths, we found that the facility's peer review process of surgical cases did not comply with VHA policy.[14]

VHA directive and facility policy require peer reviews of surgical cases when the following criterion is met, "Death during or within 30 days of a surgical procedure or (if after 30 days) death is suspected to be related to the original procedure."[15,16,17] We looked at facility internal review documents for the five deaths that occurred within 30 days of surgery in FY 2014. We found only one had a peer review done, which was not completed within the required time frame.

We found the facility processes used to determine if a case should be peer reviewed conflicted with the VHA peer review directive. At the time of our visit in February 2015, the Risk Manager reviewed cases independently and decided which cases to forward to peer review instead of following the established criteria.

Allegation 3: Surgery Procedure Affected by Insufficient Instruments

We substantiated that a gynecological procedure was stopped after a patient was anesthetized because of a lack of necessary instruments. This event occurred despite the fact that a pre-procedure time out checklist[18] was completed prior to surgery. Furthermore, based on discussions with SPS, SPD, and OR staff and information obtained from internal documents, and our tour of the OR and SPS areas, we concluded that a consistent, coordinated interdisciplinary process for the provision of supplies, equipment, and instruments necessary for scheduled cases on a daily basis was not in place.

Gynecological Procedure Stopped

VHA policy requires that a time-out be completed prior to every surgical procedure.[19] Included in the 12-point time-out checklist is availability of special equipment, if applicable.[20]

[14] VHA Directive 2010-025, *Peer Review For Quality Management.* June 3, 2010. This Directive expired June 30, 2015 and has not yet been updated.
[15] Ibid. Peer Review for Quality Management is a protected process to respond to adverse events that involve individual providers designed to contribute to improving quality of care in a non-punitive context.
[16] Center Memorandum No. 00-177, *Peer Review for Quality Management.* March 17, 2014.
[17] Center Memorandum No. 00-177, *Peer Review for Quality Management.* February 28, 2011.
[18] Surgical time out is a pre-procedure verification process to ensure that the correct surgery is being done, all necessary equipment is available, and that all surgical staff has an opportunity to express any concerns prior to the procedure.
[19] VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedure.* July 26, 2013.

For this particular case, a rarely used fluid management system was needed for the surgical procedure. Prior to surgery, a time-out checklist was completed and marked "yes" that the special equipment was available. Although the time-out process was completed, the fluid management system could not be located after surgery had begun, so the procedure had to be stopped. The patient had to have another surgery at a community hospital later to complete the procedure.

This incident is one example of what we found to be ongoing problems with provision of necessary surgical supplies and instruments.

Problems with Surgical Supplies, Equipment, and Instruments

The Association of periOperative Registered Nurses (AORN) states, "Teamwork between OR and SPD personnel is critical for the outcome of every surgical procedure. The staff members in these two departments must coordinate their activities so the right instruments and supplies are available for every surgical procedure."[21]

At this facility, SPS had the responsibility for cleaning, decontaminating, disinfecting, and sterilizing and packaging instruments, equipment, and supplies. The OR had the responsibility for letting SPD know what was needed for surgical cases, and SPD was responsible for making sure that the correct instruments, equipment and supplies were sent to the OR.

SPD and SPS management and OR staff voiced concerns to us about how surgical instruments and supplies for the OR were obtained and maintained.

We were told by SPS and SPD staff that SPD received a copy of the next day's surgery schedule and a pick list[22] from OR staff. Although not required, the pick list was not automated, and according to SPD staff, approximately 25 percent of the time the list did not get to SPD in time for case carts to be assembled before SPD staff shifts ended, leading to last minute efforts with getting case carts assembled the next day. The lack of automation made it difficult to keep inventory needs and surgeon/case preference lists current in both OR and SPD. We also learned that the responsibility for making sure that surgical trays and case carts contained the right instruments and equipment was fragmented. Some OR staff assigned to specialty services, such as Orthopedics and Urology, assembled their own trays and carts, but others did not, relying on SPD.

During our tour of the OR and SPD, we noted that some surgical supplies and instruments were stored in the OR and some in SPD. Staff reported that there were no set guidelines for what was kept where. Further, we were told by SPS and SPD staff that Surgical Service did not provide input during the budgetary process so SPD would know what instruments to purchase.

[20] VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedures.* July 26, 2013.
[21] *Table Talk,* AORN Journal, January 2012, Vol 95 No 1.
[22] A pick list is a list of items to be placed in a case cart for each surgical case.

We interviewed staff and reviewed facility documents to determine if the issues with obtaining and maintaining surgical supplies, equipment, and instruments caused potential or actual patient harm. Following are incidents we identified that, while frequently isolated occurrences that did not trigger formal reviews, were of concern because of the potential for patient harm. The number of incidents also demonstrated a pattern of problems between the OR, SPS, and SPD in obtaining and maintaining needed supplies, equipment, and instruments.

- Extra trays had to be opened over the course of "a few weeks" because trays were processed and sent for use with speculums that had rust on them.

- Extra forceps were ordered to avoid having to open another tray because the forceps in the trays were damaged.

- Hysteroscopes were provided but could not be used because it took 9 months to get the needed instrument trays that went with the scopes.

- The package wrap of sterile orthopedic screws had pinholes, which could mean the contents were unsterile, and the screws were not properly resterilized prior to use.

- An instrument tray and the "back-up" tray did not have the equipment assembled properly, resulting in a short delay prior to use.

- An emergency laparoscopic appendectomy was delayed 1½ hours due to instruments not being cleaned and sterilized timely.

- The pharmacy was informed that a solution needed for a surgery early the next day was expired. The pharmacy could not ensure its availability until late the next day. The surgeon involved in the case located the solution on his own.

- The equipment used for electrocautery for a tubal ligation malfunctioned. Attempts to troubleshoot the system were not successful, and back-up equipment was not available.

Approximately 1 month prior to our visit, OR and SPS managers implemented measures to improve communication and processes between the OR and SPD so that appropriate supplies, equipment, and instruments were available for surgical cases. These measures included:

- Morning huddles with surgical staff to check availability of supplies for scheduled cases

- Afternoon huddles with OR and SPD staff to ensure instruments availability for surgeries scheduled the following day

- Efforts to achieve adequate par levels[23] in both SPD and the OR
- Reorganization of the OR clean core area and identified areas for storage of supplies, equipment, and instruments for each specialty[24]

While these measures address systems improvement processes between the OR and SPD, their effectiveness was not yet apparent as of our February 2015 site visit.

Allegation 4: Surgical Technician in OR Scheduler Role

We substantiated that a surgical technician was placed in charge of the OR schedule; however, this was an appropriate action that improved the efficiency of scheduling surgeries.

At the direction of the Chief of Surgery, a surgical technician assumed the role as primary OR scheduler in February 2014. Prior to this, scheduling of surgeries was a fragmented process done by at least three different individuals. Staff told us that Surgical Service had a 30 percent increase in cases, improved efficiency, and increased patient satisfaction after the surgical technician assumed the scheduler role.

We did not substantiate that anesthesia and nursing services no longer had input into the scheduling process because a surgical technician was now the OR scheduler. Anesthesia and nursing supervisors denied problems with the surgical technician who was placed in the OR scheduler position and reported that having a single person familiar with OR processes scheduling patients for surgery had an immediate positive effect on the service.

We did not substantiate that since a surgical technician was placed in charge of the OR schedule general surgeons had to do their cases without adequate assistance. During our site visit in February 2015, two ORs were staffed with six surgical technicians.

VHA policy[25] states that a standard surgical complexity program must have, at a minimum, staffing that includes a circulating registered nurse[26] (RN) and a "scrub technician"[27] or second RN.

The OR Nurse Manager, a surgeon, and other surgical staff confirmed that all cases had the minimum number and type of staff as required by VHA policy. Based on VHA

[23] Par levels are set for an item for physical and inventory purposes. When an item falls below "par" it is replenished.
[24] Operating rooms are grouped around a clean core area that only authorized personnel with appropriate garb can enter. The clean core is used for sterile supply storage.
[25] VHA Directive 2010-018, *Facility Infrastructure Requirements To Perform Standard, Intermediate, Or Complex Surgical Procedures.* May 6, 2010. This Directive expired May 31, 2015, and has not yet been updated.
[26] A circulating RN monitors the procedures in the operating room during surgery.
[27] A scrub technician is an operating room employee who performs multiple job duties including providing the surgeon with the instruments needed to perform a surgery.

staffing requirements and the facility's staffing ratio policy, we found that recommended OR staffing ratios were maintained.

Allegation 5: Surgical Technician Positions

We substantiated that the organizational chart for Surgical Service showed at least four unfilled surgical technician positions but did not substantiate that management had not approved additional hiring. The organizational chart dated July 1, 2013, reflected three unfilled surgical technician vacancies. Human Resources had two approved surgical technician positions to be filled, but the positions were not identified as "top priority" for hiring efforts.

We found that the surgical technician staffing structure lead to confusion within management about open positions. Some of the surgical technicians were aligned under Nursing Service and some under Surgical Service, with different job titles and pay grades. The surgical technicians under Surgical Service were assigned to surgeons and were not in the OR consistently, making it difficult to make assignments for perioperative care and ensure efficient use of the staff.

Allegation 6: Resident Complication Rates

We did not substantiate that complication rates of some surgical residents[28] exceeded 30 percent. The only surgical residents associated with the facility were with Ophthalmology Service. Facility data from April 2013 through January 2015 showed that residents' complication rates averaged less than 5 percent, which was less than national complication rates.[29] We substantiated that complication rates were not routinely reported to the SWG or any other quality improvement forum.

Allegation 7: Contract and Procurement Irregularities

We did not substantiate that the Chief of Surgery awarded a contract to the Steris Corporation for thousands of dollars to install new OR lights and TV monitors.

Replacement of the equipment in the OR was a VISN initiative. We reviewed the contract award documents and confirmed that the contract was authorized by a VISN 6 Contracting Officer prior to the arrival of the Chief of Surgery at the facility.

We did not substantiate that the OR lights and TV monitors installation contract was not open to other bidders. We reviewed documentation that the contract was extended through the General Service Administration competitive bidding process.

[28] The term "resident" refers to an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, and podiatrists, and who participates in patient care under the direction of supervising practitioners. VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
[29] Stein JD, Grossman DS, Mundy KM, Sugar A and Sload FA, *Severe adverse events after cataract surgery among Medicare beneficiaries*, PubMed Journal, June 2, 2011.

Further, we could not substantiate that all the installed equipment would have to be removed in FY 2015 or FY 2016 when the surgical suites are fully renovated because renovation plans were not complete in February 2015. As of August 2016, the surgical suites were still undergoing renovation.

Additional Finding – Nurse Staffing in Post-Operative Outpatient Clinic

During a tour of the facility's surgery post-operative clinic in February 2015, we found nursing personnel were not assigned to the clinic. We also spoke with clinic staff and concluded that patients could be at potential risk because the clinic did not have the same nurse staffing pattern as other outpatient clinics.

VHA policy requires facilities to have a methodology for relating nurse staffing levels and staff mix to patient and resident outcomes, clinical effectiveness, and efficiency.[30] Following an established methodology enables facilities to demonstrate that they provide appropriate, high-quality health care to veterans. The staffing requirements determined through this methodology support and maintain a standardized approach to ensuring adequate nursing personnel across the facility.

At the time of our visit in February 2015, the Post-Operative Surgical Clinic did not have assigned nursing staff. During our tour of the surgery post-operative clinic, staff reported that when physicians were seeing patients in the clinic and assistance was needed, they had to find nurses assigned to the preoperative clinic or get surgical technicians present in the area to assist them. The facility did not have a policy stating specific duties of nursing staff in outpatient clinics; however, since our visit, VHA has clarified expectations of staff in specialty clinics to include, at a minimum, screen patients, monitor vital signs, chaperone providers as appropriate, and track abnormal test results.[31]

Conclusions

We substantiated the allegations that:

- Medicine and anesthesia providers did not perform adequate preoperative evaluations of some patients, causing preventable surgical delays and cancellations.

- Prior to September 2014, patient deaths occurring within 30 days of surgery were not reported to and/or reviewed by the appropriate oversight groups as required.

[30] VHA Directive 2010-034, *Staffing Methodology For VHA Nursing Personnel.* July 19, 2010. This Directive expired July 31, 2015, and has not yet been updated.
[31] VHA Handbook 1065.01, *Productivity and Staffing Guidance for Specialty Provider Group Practice.* May 4, 2015.

- A gynecological procedure had to be stopped after surgery had begun because of a lack of instruments.

- A surgical technician was placed in charge of the OR schedule; however, this was an appropriate action that improved efficiency and productivity of the service.

- Surgical Service had approval for at least four additional surgical technician positions, but active recruitment was not being done at the time of our site visit in February 2015.

We did not substantiate the allegations that:

- After a surgical technician was placed in charge of the OR schedule, Nursing and Anesthesia Services were bypassed regarding surgery scheduling practices, and surgeons had to work without adequate assistance.

- Surgical residents' complication rates exceeded 30 percent.

- The Chief of Surgery awarded a contract for new operating room lights and TV monitors. This initiative was completed through the VISN prior to the arrival of the Chief of Surgery.

We could not substantiate the allegation that:

- Inadequate preoperative evaluations caused increased surgical complications.

We found pervasive problems and lack of processes between the OR and SPS to ensure that appropriate supplies, equipment, and instruments were available. A lack of cohesiveness and communication between Surgical, Nursing, Anesthesia, and SPS was evident. We also found that peer reviews were not conducted according to VHA requirements.

We concluded that having different service alignments of the surgical technicians led to confusion within Surgical Service, Human Resources, and Nursing Service.

We also found that the facility's surgery post-operative clinic did not have nursing personnel assigned to the clinic, and consequently the clinic did not have the same nurse staffing pattern as other outpatient clinics.

Recommendations

1. We recommended that the Facility Director ensure that recommendations, if any, from other reviews of the surgical program be implemented.

2. We recommended that the Facility Director implement procedures to ensure patients are adequately evaluated by medicine and anesthesia providers prior to surgery.

3. We recommended that the Facility Director ensure that peer reviews are conducted as required when criteria are met.

4. We recommended that the Facility Director implement processes to ensure that necessary surgical supplies, equipment, and instruments are available, functional, and duplicated as needed.

5. We recommended that the Facility Director evaluate the organizational structure for parity concerning surgical technician positions.

6. We recommended that the Facility Director ensure that the surgical post-operative clinic uses the same nurse staffing methodology as other outpatient clinics.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 14, 2016

From: Director, VA Mid-Atlantic Health Care Network (10N06)

Subj: **Healthcare Inspection**—Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina

To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10E1D MRS Action)

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the Fayetteville VA Medical Center (VAMC), Fayetteville, North Carolina and concur with the facility's recommendations.

2. If you have further questions, please contact Elizabeth Goolsby, Director, Fayetteville VAMC, at (910) 822-7059.

(original signed by:)
Joseph Edger, Deputy Network Director, for
Daniel F. Hoffman, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 14, 2016

From: Director, Fayetteville VA Medical Center (565/00)

Subj: **Healthcare Inspection**—Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. Fayetteville VA Medical Center concurs with the findings brought forth in this report. Specific corrective actions have been provided for the recommendations.

2. Should you have any questions, please contact Damaris Reyes, Chief, Performance Improvement, at 910-822-7091.

(*original signed by:*)
ELIZABETH GOOLSBY

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 Facility Director ensure that recommendations, if any, from other reviews of the surgical program be implemented.

Concur

Target date for completion: November 30, 2016

Facility response:
[ ].[32]

Recommendation 2. We recommended that the Facility Director implement procedures to ensure patients are adequately evaluated by medicine and anesthesia providers prior to surgery.

Concur

Target date for completion: November 30, 2016

Facility response:
The preoperative evaluation function was transferred to the anesthesia section of the Surgical Service effective November 30, 2015. Risk factors for perioperative complications, including history of ischemic heart disease, history of compensated or prior heart failure, history of cerebrovascular disease, diabetes mellitus, or renal insufficiency are elicited from patients by interviewing and examining the patient, discussing the medical history, previous anesthetic experiences and drug therapy; and assessing those aspects of the physical condition that might affect decisions regarding management. Cardiac risk stratification for non-cardiac surgical procedures involves mostly low risk procedures (reported cardiac risk generally less than 1 percent) Examples: endoscopic procedures, superficial procedures, cataract surgery, breast surgery. When acute problems that should be addressed prior to elective surgery are identified, the appropriate contacts are made with the primary care physician (PCP) and surgeon. Depending upon the urgency, the patient may be referred immediately to his/her PCP on site or appointment made, laboratory testing or other studies ordered and follow up arranged in order to optimize the patient's condition prior to his or her is elective procedure. The Anesthesia Preop Screening Clinic is staffed with an RN and Anesthesia provider, with recruitment underway for a midlevel provider. Compliance

[32] This information has been redacted pursuant to 38 U.S.C §5705 which prohibits the unauthorized disclosure of VA medical quality assurance records.

with this process will be monitored and documented in the Surgical Work Group committee minutes with a target of 90 percent compliance.

Recommendation 3. We recommended that the Facility Director ensure that peer reviews are conducted as required when criteria are met.

Concur

Target date for completion: November 30, 2016

Facility response:

All surgical cases meeting criteria for peer review in accordance with the guidelines set forth in VHA Directive 2010-025, Peer Review for Quality Management will undergo first and second level reviews. To conduct peer review of those cases of veterans who died in the community within 30 days following a surgical procedure, close coordination with the Surgical Nurse Reviewer has been established so that those cases will be referred to the Peer Review Facilitator in a timely fashion. Surgical morbidity and mortality reviews of surgical cases, besides those resulting in death are considered initial first level reviews, however those cases rendered level 2 or level 3 are forwarded to the Peer Review Facilitator for an independent review also and will undergo second and final level review by the Peer Review Committee accordingly. The Surgical Clinical Reviewer and the Peer Review Facilitator now reconcile their information to ensure that all potential cases are being referred for review as appropriate. Compliance (with a goal of greater than 90 percent) with this process will be reported monthly by the Surgical Clinical Reviewer and documented in the Medical Executive Board committee minutes until closed by the OIG.

Recommendation 4. We recommended that the Facility Director implement processes to ensure that necessary surgical supplies, equipment, and instruments are available, functional, and duplicated as needed.

Concur

Target date for completion: November 30, 2016

The process to review provider preference cards was initiated immediately following this OIG review. To date, 100 percent of these have been reviewed and signed by each surgical specialty. This information is readily available to all services/department via a secure folder on the computer system's public drive. As of December 2, 2014 all staff has received instructions on how to locate and read provider preference cards. In order to discuss ongoing or potential concerns, collaborative meetings between Surgery, Sterile Processing Service (SPS), Supply Processing and Distribution (SPD), and Patient Care Services are held weekly. As of December 8, 2014, perioperative huddles were implemented. Disciplines involved include nursing, surgeons & anesthesia staff. These are completed each morning to discuss the scheduled surgeries for that day. The

use of a checklist to ensure case carts are checked and validated the day prior to surgery was incorporated into this process.

As of the end of Fiscal Year 2015, subsequent to the completion of an inventory, sufficient surgical trays were purchased to included quantities for back up. Compliance with this process will be monitored and documented in the Surgical Work Group committee minutes with a target of 90 percent compliance.

Recommendation 5. We recommended that the Facility Director evaluate the organizational structure for parity concerning surgical technician positions.

Concur

Target date for completion: November 30, 2016

Facility response:
Surgical technicians' functional statements are currently under review with revisions as appropriate. These positions will be realigned to report to the Associate Director for Patient Care Services. The completion of this realignment is expected to be completed NLT March 31, 2016. Compliance with this process will be monitored and documented in the Surgical Work Group committee minutes with a target of 90 percent compliance.

Recommendation 6. We recommended that the Facility Director ensure that the surgical post-operative clinic uses the same nurse staffing methodology as other outpatient clinics.

Concur

Target date for completion: November 30, 2016

Facility response:
Patient Care Services has hired additional staffing for support of the post-operative outpatient clinic area. Staffing consists of six nurses, two health technicians, two nursing assistants and three surgical technicians. All staff is on board with EOD as of November 2015. Compliance with this process will be monitored and documented in the Surgical Work Group committee minutes with a target of 90 percent compliance.

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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