



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection Oversight Review of Anesthesia and Management Issues Sacramento VA Medical Center Mather, California

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections reviewed actions taken to address a complainant's allegation that an anesthesiologist provided inadequate care to two named patients at the Sacramento VA Medical Center (the facility) in Mather, CA. The complainant also alleged that facility leadership did not take effective actions to address Anesthesia Service operational issues and that providers breached patient privacy policy through the inclusion of patient personal identifiable information in personal electronic mail messages (e-mails). Our review describes actions initially taken by the Veterans Integrated Service Network (VISN) 21 and the facility to address the allegations and makes further findings and recommendations relative to these actions.

We did not substantiate the allegation that the subject anesthesiologist provided inadequate anesthesia care to two specific patients. We concur with the facility's conclusions that the anesthesiologist provided reasonable care to one patient and was not involved in the care of the other patient.

We substantiated the allegation that facility leaders had not taken effective actions to resolve operational issues involving Anesthesia Service. We determined that facility leaders need to address VISN Team concerns related to lack of Anesthesia Service leadership, limited anesthesia staffing, lack of processes to formally monitor patient outcomes in the operating room (OR), and a dysfunctional OR work environment.

We substantiated the allegation that facility providers breached patient privacy policy through the use of unencrypted personal e-mails and also noted violation of VA information security policy. Although the facility providers have been counseled to encrypt e-mails when sending personally-identifiable information, Regional Counsel should be consulted to determine whether patient notification of the breach is required.

We recommended that the Facility Director:

- Comply with the Anesthesia Service's leadership and staffing requirements as detailed in the VISN Team report.
- Implement processes to formally monitor patient outcomes in the OR and promote a culture of patient safety in the OR, and address the concerns raised by the VISN team in its review of the Surgery and Anesthesia Services.
- Consult with Regional Counsel to determine whether patient notification of a breach in privacy is required.

The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Sierra Pacific Network (10N21)

SUBJECT: Healthcare Inspection – Oversight Review of Anesthesia and Management Issues, Sacramento VA Medical Center, Mather, California

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an oversight review to assess actions taken by Sacramento VA Medical Center (the facility) leadership to address a complainant's allegations that: an anesthesiologist provided inadequate care to two named patients, facility leaders' did not take effective actions to address Anesthesia Service's operational issues regarding this same anesthesiologist falling asleep in surgery and falsifying his charts (medical record documentation), and that providers breached patient privacy policy through the use of unencrypted personal electronic mail (e-mail) accounts.

This review describes actions initially taken by the Veterans Integrated Service Network (VISN) 21 and the facility to address and respond to the allegations and makes further findings and recommendations relative to these actions.

Background

The facility, which is part of the VA Northern California Health Care System within VISN 21, has 50 inpatient beds and offers a full range of services, including medical, surgical, primary, and mental health care. Prior to June 2011, the facility's anesthesia care was under the organizational responsibility of Surgical Services, which provides complex surgical care in its four-room operating suite. During fiscal year 2010, the facility performed 2,889 surgeries.

Facility anesthesiologists and nurse anesthetists approach anesthesia care in a team fashion, taking into account the education, training, and licensure of all practitioners. While ultimate responsibility for the patient's care in the operating room (OR) rests with the

surgeon performing the procedure, the treatment of physiologic changes during surgery rests with the anesthesia practitioner.¹ Types of anesthesia services include:

- Providing insensibility to pain during surgical procedures.
- Monitoring and restoring homeostasis during the perioperative period.
- Clinically managing cardiac and pulmonary resuscitation.
- Evaluating respiratory function and applying respiratory therapy in all its forms.

VHA infrastructure requirements for facilities performing complex surgical procedures include the management of anesthesia services by a board-certified or board-eligible anesthesiologist.² Key components of a healthy perioperative work environment to ensure the delivery of quality surgical patient care include collaborative practice, rich communication, accountability, adequate staffing systems, shared decision making, and encouragement of professional practice.³

In the perioperative setting, patient safety is a priority. Patient safety is defined as the process of ensuring freedom from accidental or inadvertent injury during health care procedures. The process of patient safety includes taking small steps in the way things are done so that a level of faith and trust is established and so that behaviors designed to prevent adverse events become a part of all employees' behavior.⁴

One important component of the patient safety process involves identifying and reporting adverse events (unexpected occurrences requiring medical interventions). During the review of these adverse events, the facility identifies underlying causes and implements changes to reduce the likelihood of recurrence. The determination of cause is aimed at systems issues and is not punitive. This is an ongoing process, and facility leadership is responsible for promoting a culture conducive to patient safety and continuous quality improvement.⁵

E-mail can only be used for authorized government purposes and must contain only non-sensitive information unless protected with a VA-approved encryption mechanism. For Outlook/Exchange mail, the Office of Cyber and Information Security issues Public Key Infrastructure (PKI) certificates to encrypt communications between a sender and receiver.⁶ VA staff are to refrain from conducting government business through personal e-mail accounts without PKI encryption.

¹ Veterans Health Administration (VHA) Handbook 1123, *Anesthesia Service*, March 7, 2007.

² VHA Directive 2010-0018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

³ Association of Peri-Operative Registered Nurses, *Position Statement on Key Components of a Healthy Perioperative Work Environment*, March 2009.

⁴ VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, May 23, 2008.

⁵ VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

⁶ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 26, 2006.

Scope and Methodology

On April 7, 2011, OHI contacted the facility and learned that facility and VISN 21 leadership were aware of these same allegations and had already initiated actions, including chartering a VISN Team, to evaluate clinical and administrative concerns with anesthesia services. The VISN team conducted a site visit May 2–4, 2011, and their report “Review Team Report – Northern California Health Care System Surgery and Anesthesia Services” was issued on May 16, 2011.

We reviewed VHA policies, medical records, and pertinent facility documents, including the VISN Team’s report. We monitored facility action plans and the progress that was made in response to the allegations and deficiencies identified in the VISN report. This review enumerates and comments on events subsequent to the case referral to the facility with VISN oversight.

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.

Inspection Results

Issue 1: Inadequate Care by an Anesthesiologist

We did not substantiate the allegation that the subject anesthesiologist provided inadequate anesthesia care to two specific patients. Facility leadership conducted reviews of the care provided to these patients and concluded that the subject anesthesiologist provided adequate care to one patient and was not a participant caregiver of the other. We reviewed these same two cases and concurred with the facility’s findings.

Issue 2: Ineffective Leadership Actions

We substantiated the allegation that facility leadership did not take effective actions to address operational issues within Anesthesia Service. In addition, we determined that facility leaders need to address significant concerns identified by the VISN Team.

Facility and VISN managers informed us that there were three reports of contact documented during September 2010 regarding the subject anesthesiologist sleeping in the OR. We noted the lack of timely actions taken to address this issue and prevent recurrence.

Regarding the alleged falsification of medical records, facility managers reported that the subject anesthesiologist initiated anesthesia notes prior to the actual start of the cases. This practice is not considered falsification of the medical record. Our review of the documentation of OR events for the one subject patient supported the facility’s findings.

The VISN Team identified other concerns related to lack of leadership actions, which included:

- Lack of anesthesia leadership.
- Limited anesthesia staffing and a dysfunctional work environment in the OR.
- Lack of processes to formally monitor patient outcomes in the OR.

The VISN Team found that the facility had no anesthesia chief or effective leadership for more than a year. The result has been a disorganized, dysfunctional, inefficient, and poorly staffed Anesthesia Service.

The facility was authorized for 6.0 full time employee equivalents (FTEs) in the Anesthesia Service. There were only 3.25 FTEs at the time of the VISN Team review, but the facility utilized supplemental fee-based anesthesiologists, as needed, to address workload demands. The VISN Team report also described a dysfunctional work environment in the OR and a lack of effort by management to ensure a safe patient care environment. Contributing factors may be the fact that the OR Committee has not included participation by anesthesia staff, and neither has the Anesthesia Chief Search Committee previously included anesthesia staff participation.

The VISN Team also noted a lack of processes to monitor patient outcomes in the OR. There has been no apparent effort to pursue quality improvement efforts, and there has been reluctance for anesthesia staff to participate in Morbidity and Mortality Conferences or peer review despite the facility's standard operating procedure for quality improvement in the OR.⁷

Issue 3: Breach of Patient Privacy Policy

We substantiated the allegation that facility providers breached patient privacy policy when personally-identifiable information (PII) was transmitted using unencrypted personal (non-VA) e-mail accounts.

The facility Privacy/Freedom of Information Act (FOIA) Officer reviewed this issue and took actions when it was noted that the e-mails in question contained PII. The facility FOIA Officer initiated a privacy violation tracking system (PVTS) ticket as required.⁸

The FOIA Officer concluded that staff violated established procedures for transmitting sensitive information without encryption but determined that the incident did not violate VA's privacy policy because the information was apparently shared among providers who had a need to know. All providers involved received counseling to use encrypted VA e-mail exclusively, and the PVTS ticket was closed out.

⁷ SOP 112-015, *Quality Improvement in the Operating Room*, February 16, 2010.

⁸ VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006.

We agree with the facility Privacy/FOIA Officer that the providers violated VA information security policy. However, we determined that the providers also violated VHA patient privacy policy. VA security and privacy policies are interdependent. The security policy exists to ensure that employees do not violate the privacy of VA patients and others.

The transmission of PII using unencrypted personal e-mail accounts allows sensitive information to be potentially viewed by unauthorized persons. Such an unauthorized disclosure violates VHA privacy policy and constitutes a security incident.⁹ We concluded that facility leaders should consult with Regional Counsel to determine whether patient notification regarding a breach in privacy is required.

Conclusions

We concluded that the subject anesthesiologist provided adequate care to one patient and was not involved in the care of the other patient.

We substantiated the allegation that facility leaders had not taken effective actions to resolve operational issues involving Anesthesia Service. We determined that facility leaders need to address significant concerns identified by the VISN Team related to Anesthesia Service's leadership, limited anesthesia staffing, lack of processes to formally monitor patient outcomes in the OR, and a dysfunctional work environment.

We substantiated the allegation that facility providers breached patient privacy policy through the use of unencrypted personal e-mail accounts. We noted that facility providers also violated VA information security policy. Although the facility providers involved have been counseled to encrypt VA e-mail messages when sending PII, facility leaders should consult with Regional Counsel to determine whether patient notification of the breach in patient privacy is required.

Recommendations

Recommendation 1. We recommended that the Facility Director comply with the required Anesthesia Service's leadership and staffing requirements as detailed in the VISN Team report.

Recommendation 2. We recommended that the Facility Director implement processes to formally monitor patient outcomes and promote a culture of patient safety in the OR, and address the concerns raised by the VISN in its review of the Surgery and Anesthesia Services.

Recommendation 3. We recommended that the Facility Director consult with Regional Counsel to determine whether patient notification of a breach in privacy is required.

⁹ VA Directive 6500, *Information Security Program*, August 4, 2006.

Comments

The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 7–12 for the full text of their comments.) We will follow up on the planned actions until they are completed.

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D." The signature is written in a cursive, flowing style.

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 16, 2011

From: Director, VA Sierra Pacific Network (10N21)

Subject: **Healthcare Inspection – Oversight Review of Anesthesia and Management Issues, Sacramento VA Medical Center, Mather, California**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Thru: Director, VHA Management Review Service (10A4A4)

1. I have reviewed the draft document in reference to the review that was conducted by your office regarding the Anesthesia and Management Issues at Sacramento VA Medical Center and concur with the report.
2. Attached is the action plan from the facility addressing the recommendations. I agree with their plan and the Network will continue to monitor their actions until resolution.
3. If you have any questions regarding this response please contact Terry Sanders, Associate Quality Manager at (707) 562-8370.

(original signed by:)
Sheila M. Cullen
Director, VA Sierra Pacific Network (10N21)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 16, 2011

From: Director, VA Northern California Health Care System
(612/00)

Subject: **Healthcare Inspection – Oversight Review of Anesthesia and Management Issues, Sacramento VA Medical Center, Mather, California**

To: Director, VA Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review the draft Oversight Review of Anesthesia and Management Issues. We concur with the recommendations and will ensure completion as described in the action plan.
2. Please find our responses to each recommendation in the attached action plan.
3. If you have any questions regarding the response to the recommendations in the report feel free to call me at (916) 843-9058.

(original signed by:)

Brian J. O'Neill, M.D.

Director, VA Northern California Health Care System (612/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendation

Recommendation 1. We recommended that the Facility Director comply with the required Anesthesia Service's leadership and staffing requirements as detailed in the VISN Team report.

Concur

Target Completion Date: 2/28/12

Facility's Response:

An Acting Anesthesia Chief (AAC) was appointed on June 20, 2011. Anesthesia was designated as a Service separate from Surgical Service on July 13, 2011 with the Service Chief as a direct report to the Chief of Staff. Recruitment for the Chief of Anesthesia Service has been ongoing since April 2010. The Chief of Staff designated a multidisciplinary Search committee comprised of Surgical Service, Nursing, and Anesthesia, which has recommended top candidates to the Chief of Staff for selection. A candidate has been selected by the Chief of Staff and Human Resources have made an offer of employment to the final candidate. The candidate has not yet made a final acceptance, but a confirmation of acceptance is expected by December 30, 2011 or sooner. The Acting Anesthesia Chief has been actively building the Service and additional, administrative support has been approved and will be hired to support the Anesthesia Service.

The Acting Anesthesia Chief has coordinated and facilitated efforts to recruit, train, and hire additional VA credentialed Anesthesiologists, thus reducing the need for use of contract Anesthesiologists and improving the staffing for the OR overall. At this time an additional 3.25 FTE have been added with 1.75 FTE selected and currently in the credentialing and privileging process with expected start dates of February 28, 2012 or sooner. The Anesthesia tours of duty have been reviewed to determine the most appropriate staffing schedule to meet the workload demands in the

OR. As new Anesthesiologists are hired they are assigned a tour of duty to fulfill the OR schedule needs.

Status: Open

Recommendation 2. We recommended that the Facility Director implement processes to formally monitor patient outcomes in the OR and promote a culture of patient safety in the OR.

Concur

Target Completion Date: 4/30/12

Facility's Response:

The Acting Anesthesia Chief (AAC) revised the Anesthesia orientation process and forms. An improved FPPE/proctoring program resulted from the redesign of the orientation process. The AAC is actively collaborating with other Anesthesia Service Chief colleagues at other VA sites to obtain tools and measures for building an Anesthesia Service Performance Plan to monitor OR outcomes.

Additionally, the pre-operative screening process has been reviewed and actions taken to improve opportunities related to the Anesthesia involvement and oversight. Anesthesia trained Pre-operative providers to better evaluate patient airways and risk. A process has been developed for high risk or complicated patients to be brought to the standing weekly Anesthesia staff meeting for case review prior to scheduling the case. This new process promotes improvements with case planning and reduced numbers of same day cancellations.

The AAC implemented an Anesthesia Morbidity and Mortality (M&M) review. M&M cases are brought forward either by providers and or quality management nurses. Cases are sent through Anesthesia peer review and forwarded to the VA Northern California Health Care System (VANCHCS) Peer Review Committee as required. AAC has planned to set up regular meetings between the Martinez and Mather sites and a standing agenda item would be devoted to review of M&M and challenging cases for staff learning opportunities. The AAC also participates in the OR Committee and Surgical Service Meetings to integrate and collaborate with Surgical Service.

VANCHCS Surgical Service has an ongoing participation in a joint M&M at the affiliate for all the major surgical sections, though not all sections doing non-complex procedures have been included. Discussions are underway about how best to provide this within our system without losing the benefits of the significant surgical expertise at the affiliate.

Education has been provided to the OR staff to include Surgery and Anesthesia staff regarding the definitions and process for incident reporting, adverse events, and the Tort Claim process. Education included the culture of safety and “no blame” role of employees to promote identification of opportunities for improvement.

The Chief of Staff (COS) established recurring open agenda OR Town Hall meetings to discuss topics such as administrative changes and transitions, external review recommendations, culture of safety, schedules, and workload. COS instituted weekly rounds to provide additional opportunity for communication, oversight and transition support for OR staff.

Regular recurring meetings between the Chief of Staff and the Chief of Surgery have been implemented to discuss opportunities for improvement in Surgical Service administration and employee relations. The Chief of Surgery has been assigned a VISN Surgical Chief mentor as a management coach to provide further learning opportunities and personal growth.

Medical Team Trainings (MTT) sessions were conducted at the Mather OR in 2006 and the Martinez OR in 2008. Future MTT sessions are planned for the OR Staff including all team members and disciplines when the permanent Anesthesia Chief and remaining Anesthesia staff are in place. In addition, the Chief of Surgical Service will implement TeamSTEPPS (Strategies & Tools to Enhance Performance and Patient Safety) training for OR staff in the spring of 2012.

Status: Open

Recommendation 3. We recommended that the Facility Director consider consulting with Regional Counsel to determine whether patient notification of a breach in privacy is required.

Concur

Target Completion Date: 12/30/11

Facility's Response:

On April 14, 2011 the VANCHCS Information Security Officer (ISO) initiated a privacy violation tracking system (PVTS) ticket, which was completed on May 5, 2011 concluding staff violated established procedures for transmitting sensitive information without encryption, but determined the incident did not violate VA's privacy policy. All providers involved received counseling to use encrypted VA e-mail exclusively, and the PVTS ticket was closed on May 5, 2011.

The conclusions and PVTS ticket information were sent to Regional Counsel for review on December 12, 2011. VANCHCS is awaiting response and guidance from Regional Counsel on what if any actions need to be taken to close out this item.

Status: Open

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Daisy Arugay, MT Thomas Jamieson, MD Mary Toy, RN George Wesley, MD

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