Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Oversight Review of Quality of Care and Other Issues Grand Junction VA Medical Center Grand Junction, Colorado

Report No. 12-00206-180

May 14, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an oversight review to assess actions taken by Veterans Integrated Service Network (VISN) 19 and Grand Junction VA Medical Center (facility) leadership regarding the facility's surgical program.

Three VHA healthcare teams conducted site visits and reviewed the facility's surgical program between May and September 2011. Teams included a VISN 19 Quality Management Officer review team; a VISN 19 Surgical Consult team (Chief of Surgery, VA Eastern Colorado Healthcare System, General Surgeon, Cheyenne VA Medical Center); and a National Surgery Office team (surgeons from the Surgical Critical Care Advisory Board, the General Surgery Advisory Board, and the Deputy National Director of Surgery, Washington, DC). The three teams identified concerns and recommended action plans.

OIG received allegations from facility staff between October and November 2011, which reiterated concerns identified by the VHA healthcare teams. Because most of the allegations had been previously reviewed, we conducted an oversight review to determine if the facility and VISN adequately addressed the concerns and allegations.

The allegations are as follows:

- Surgical infections, complications, and perforations increased during the 2nd and 3rd quarters of fiscal year 2011.
- Surgery personnel and facility leadership issues
- Inadequate and missing surgical electronic health record documentation
- Inadequate emergency department triage and surgical referral
- Inadequate emergency, surgical, and intensive care resources
- Inadequate quality management and performance improvement programs
- Delayed endoscopy scheduling and unsafe endoscope practices
- Nonfunctional paging system

This oversight review report describes action plans taken by the VISN and the facility to address the allegations and review teams' findings and recommendations.

We recommended that the VISN Director continues to monitor facility action plans to ensure effective and complete follow up.

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

TO: Director, VA Rocky Mountain Network (10N19)

SUBJECT: Healthcare Inspection – Oversight Review of Quality of Care and Other Issues, Grand Junction VA Medical Center, Grand Junction, Colorado

Purpose

VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an oversight review to assess actions taken by Veterans Integrated Service Network (VISN) 19 and Grand Junction VA Medical Center (facility) leadership regarding the facility's surgical program.

Three VHA healthcare teams conducted site visits and reviewed the facility's surgical program between May and September 2011. These teams included a VISN 19 Quality Management Officer review team, a VISN 19 Surgical Consult team (Chief of Surgery, VA Eastern Colorado Healthcare System, General Surgeon, Cheyenne VA Medical Center), and a National Surgery Office team (surgeons from the Surgical Critical Care Advisory Board, the General Surgery Advisory Board, and the Deputy National Director of Surgery, Washington, DC). The three teams identified concerns and recommended action plans.

OIG received allegations from facility staff between October and November 2011, which reiterated concerns identified by the three VHA healthcare teams. Because most of the allegations had been previously reviewed by the three teams, we conducted an oversight review to determine if the facility and VISN adequately addressed the identified concerns and facility allegations.

The allegations are as follows:

- Surgical infections, complications, and perforations increased during the 2nd and 3rd quarters of fiscal year 2011.
- Surgery personnel and facility leadership issues
- Inadequate and missing surgical electronic health record (EHR) documentation
- Inadequate emergency department (ED) triage and surgical referral

- Inadequate emergency, surgical, and intensive care resources
- Inadequate quality management (QM) and performance improvement (PI) programs
- Delayed endoscopy scheduling and unsafe endoscope practices
- Nonfunctional paging system

This oversight review report describes actions taken by VISN 19 and the facility to address and respond to the allegations.

Background

The facility is a Level 2 Primary Care medical center that provides a broad range of inpatient and outpatient medical, surgical, mental health, geriatric, rehabilitation, and emergency services. A community based outpatient clinic, located in Montrose, CO, also provides outpatient care. The facility is part of VISN 19 and serves a veteran population of approximately 38,523 in a primary service area that includes 17 counties in western Colorado and southeastern Utah. It has 31 patient care beds and 30 community living center beds.

On June 30, 2011, during a surgical data review, the facility noted surgical infection rates had increased during the 2nd and 3rd quarters of fiscal year 2011. The facility conducted a quality review of the surgical program and, although the review found no causative commonalities in the patients who developed post-operative infections, it found opportunities for surgical program improvement.

The facility's Chief of Staff also requested an independent review of the General Surgery Program. Three VHA healthcare teams conducted site visits and reviewed the facility's surgical program between May and September 2011: a VISN 19 Quality Management Officer (QMO) review team, a VISN 19 Surgical Consult team (Chief of Surgery, VA Eastern Colorado Healthcare System, General Surgeon, Cheyenne VA Medical Center), and a National Surgery Office team (surgeons from the Surgical Critical Care Advisory Board, the General Surgery Advisory Board, and the Deputy National Director of Surgery, Washington, DC). The teams substantiated allegations found in this report and made recommendations for improvement. On September 30, in response to VHA review team findings, VISN 19 reduced the facility's surgical complexity designation[1] from intermediate to standard, but allowed select orthopedic surgeries.

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

During the week of October 17, OHI conducted a scheduled Combined Assessment Program Review.[2] One element of the review was an Employee Assessment Review (EAR) survey, a short confidential survey that invites all facility employees to share general observations about the quality of care and safety provided at the facility. The most serious concerns for patient care and safety found in the EAR survey results are included in this report's allegations. The OIG Hotline Division received additional allegations in the weeks following the Combined Assessment Program Review and the most serious of those are also included in this report.

On October 17, we reviewed the EAR survey results with the facility Director and we learned of the facility's and VHA's reviews. The Director provided us with pertinent information and actions plans. In the following weeks, we reviewed all EAR and Hotline Division allegations with the VISN 19 Quality Management Officer (QMO) who provided additional VHA review reports and recommendations, and evidence of both ongoing action plans and the monitoring of results of completed action plans.

Because the facility and VISN were aware of the EAR and Hotline allegations, and were already working towards action plans to affect changes in processes, we performed an oversight review to ensure that the quality of care and patient safety issues were being addressed appropriately and timely.

Scope and Methodology

We interviewed facility staff the week of October 17. We reviewed VHA policies, EHRs, pertinent facility documents, surgical peer reviews and root cause analyses, and the VHA review teams' findings and recommendations. We reviewed ongoing actions plans and the monitoring results of completed action plans. We conducted frequent meetings with VISN 19's QMO and monitored the progress the facility and VISN 19 made in response to the allegations and deficiencies identified by facility staff and in facility and VHA review team reports.

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.

Results

Surgical Infections, Complications, and Perforations

Surgical data revealed post-operative infection rates increased during the 2nd and 3rd quarters of fiscal year 2011. During this time, there were five reported post-operative infections: three organ space infections and two surgical wound infections. The facility conducted a quality review of the surgical program and, although the review found no

[2] *Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado*, Report No. 11-03657-62, January 12, 2012.

causative commonalities in the patients who developed post-operative infections, it found opportunities for surgical program improvement. Consequently, the facility developed action plans that addressed pre-operative skin preparation, antibiotic prophylaxis, hypothermia, and extended operating room times. The facility also sent surgical complication and perforation cases to Lumetra© and Maximus Peer Review (peer review contractors) and other VA facilities for independent peer reviews.

In addition to agreeing with the facility's surgical program review, the VISN and VHA review teams identified system dysfunctions within the facility's surgical program and made recommendations. On September 30, as a result of the review teams' findings, VISN 19 reduced the facility's surgical complexity designation to standard, but did allow for selected orthopedic surgeries. Surgical provider privileges now include only procedures allowed within the guidelines of the facility's current surgical complexity designation.[3] The facility developed and implemented plans to address the review teams' findings, which are enumerated below.

Personnel Issues and Facility Leadership

Hostile Work Environment. Nurses and physician assistants (PAs) were exposed to profane language, experienced hostile and angry reactions from surgeons, and feared retribution. As recommended, disciplinary processes occurred for general surgeons who violated accepted VA behavior standards.[4] Currently, an Administrative Investigative Board is reviewing one surgeon's 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 surgical coverage. The facility and VISN 19 now monitor the timeliness 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 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 facility revised the PA scope of practice and a facility surgeon now oversees PA activities.

Surgeon Competence, Privileges, and Professionalism. On September 30, VISN 19 reduced the facility's surgical complexity designation to standard, but did allow for

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[4] Under Secretary For Health's Information Letter, *Intimidating And Disruptive Behaviors That Undermine a Culture of Safety*, IL 10-2010-002, January 13, 2010.

selected orthopedic surgeries. The facility addressed surgical competency issues and all surgical cases are currently externally peer reviewed.

In November, 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. The facility mailed apology letters to all affected patients. The facility Director met with each professional staff member to clarify their conduct and professional responsibilities. Each professional staff member was required to sign a memorandum of understanding.

Leadership. We did not substantiate allegations related to the facility Director's leadership ability; however, VISN 19 is currently providing the Director with role development assistance. In December, the facility Chief of Staff retired and a replacement was hired. The interim Chief of Staff began work at the facility in January 2012.

EHR Documentation

Orders. Surgeons often gave staff verbal orders and did not always place orders in the patient's EHR. With the exception of emergent situations, physicians now enter orders directly in the EHR per VHA policy.[5]

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

Anesthesiologists did not scan paper anesthesia records into the EHR in a timely manner. The facility developed a procedure and timeline for placing anesthesia records in the patient EHR. Anesthesia staff now complete a preoperative paper template, which is scanned into the patient's EHR the same day.

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 and evaluations. The facility revised a nursing preoperative checklist and 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. An additional certified registered nurse anesthetist was hired to perform preoperative assessments for complicated cases.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Inadequate Triage and Treatment of Surgical Diagnoses in the ED

Surgeons did not adequately respond to surgical concerns in the ED. As recommended, 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 (a 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.

QM/PI

In May 2011, VISN 19 found the facility did not have a comprehensive, effective QM/PI program in place. As a result, the facility published a PI plan and OIG confirmed completion of the plan during our October 2011 Combined Assessment Program review. Issues related to the QM program, contractor EHR documentation and order entry, final peer reviews, critical test results, copy/paste, coding, and reimbursement have been addressed. The facility hired a new QM Director and VISN QM oversight is ongoing.

Endoscopy Scheduling

We received complaints that the facility lacked an efficient and timely endoscopy scheduling process[6], which we confirmed through select record reviews. During fiscal year 2011, approximately 100 patients received endoscopy procedures under fee basis care due to backlog. The facility identified the delay in 2011 and revised the endoscopy scheduling procedures. Additionally, the facility hired a dedicated endoscopy nurse to assist patients through the entire process and a surgeon assumed clinical oversight and coordination of care for the colonoscopy program.

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. VISN 19 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 to their return to service.

[6] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007.

Paging System

In November 2011, the 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.

Conclusions

The facility, VISN 19, and VHA review teams conducted site visits and made recommendations prior to our receiving the complainants' allegations. We concurred with the teams' recommendations. We reviewed facility action plans and found they addressed identified quality of care and safety concerns. We found VISN 19 is maintaining close oversight of the facility to monitor completed action plans and to ensure action plans in progress are completed. We will continue to monitor the facility until all action plans are completed.

Recommendation

Recommendation. We recommended that the VISN Director continues to monitor facility action plans to ensure effective and complete follow up.

Comments

The VISN Director concurred with our recommendation and provided an acceptable action plan. (See Appendix A, pages 8–9, for the Director's 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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 18, 2012

From: Director, VA Rocky Mountain Network (10N19)

Subject: **Healthcare Inspection – Oversight Review of Quality of Care and Other Issues, Grand Junction VA Medical Center, Grand Junction, Colorado**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

I have reviewed the attached draft report "OIG – Healthcare Inspection – Oversight Review of Quality of Care and Other Issues, Grand Junction VA Medical Center", Project Number: 2012-00206-HI-0384.

If you have any further questions, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.

for Ralph T. Gigliotti, FACHE

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

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

OIG Recommendation

We recommended that the VISN Director continues to monitor facility action plans to ensure effective and complete follow up.

Concur -Yes **Target Completion Date:** In progress

VISN 19 will continue to track the action plans of the Grand Junction VAMC to ensure the high quality of care and other issues are resolved or improved as appropriate.

Appendix B

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	Stephanie Hensel, RN, JD, Project Leader Ann Ver Linden, RN, MBA, Team Leader Jerome Herbers, MD, Physician Consultant

Appendix C

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