Administrative Closure
Alleged Quality of Care Issues
Grand Junction VA Medical Center (575/00)
Grand Junction, Colorado
MCI # 2012-00206-HI-0336

The OIG Hotline Division received a complaint on October 14, 2011, alleging that the Grand Junction VA Medical Center's rate of surgical infections, complications, and perforations had doubled during the 2nd and 3rd quarters of FY 2011. Because we learned the facility and VISN 19 had already reviewed these same allegations and developed action plans related to the allegations, we conducted an oversight review of their responses to determine if the complainant's allegations were adequately addressed.

The facility noted an increase in the surgical infection rate on June 30, 2011. This information was identified through review of the VA Surgical Improvement Program data for 2nd and 3rd quarters of FY 2011. The facility conducted a quality review of the surgical program and found no causative commonalities in the patients who developed infections post surgery. The facility developed an action plan for all 3rd quarter Surgical Site Infection (SSI) cases and addressed preoperative skin preparation, antibiotic prophylaxis, hypothermia, and extended operating room times. Recent peer review cases that addressed surgical complications and perforations were sent outside of the facility, utilizing the national Lumetra contract, Maximus Peer Review and/or other VA facilities, for review.

The Chief of Staff also requested a VISN 19 site visit to review the General Surgery Program. During July, 2011, a VISN 19 team (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705 conducted an onsite visit and reviewed five operative cases. Although the VISN team concurred with the facility's review and did not find any causative commonalities for post surgical infections, the team did identify multiple system dysfunctions within the facility's surgical program and made recommendations. On September 30, 2011, VISN 19 reduced the facility's surgical complexity level from intermediate to standard, but did allow for selected orthopedic surgeries.

We conducted numerous meetings with the VISN 19 Quality Management Officer between October 2011 and January 2012, and discovered that VISN 19 continues to provide oversight of the surgical program and monitors facility leadership's corrective actions.

We concur with the facility's response and make no recommendations.

Approved by: _____
for John D. Daigh, JR., M.D.
Assistant Inspector General
for Healthcare Inspections