Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Surgery Quality of Care Issues
VA Eastern Kansas
Health Care System
Leavenworth, Kansas

Report No. 07-02655-56 **January 10, 2008**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The purpose of this inspection was to determine the validity of allegations regarding surgery quality of care issues at the VA Eastern Kansas Health Care System (the system) in Leavenworth, Kansas. The complainant specifically alleged that a surgeon had a high patient mortality rate, left a surgical sponge in a patient's abdomen, and inappropriately accused a certified registered nurse anesthetist (anesthetist) of providing the wrong blood type to another surgical patient.

The Veterans Health Administration's Office of the Medical Inspector (OMI) and the system's management investigated the allegation of high patient mortality. We found that the OMI report thoroughly addressed the issue and did not substantiate the allegation. Therefore, we did not review this allegation further.

We did not substantiate the allegation that the surgeon left a surgical sponge inside an appendectomy patient's abdomen after surgery. The operating room (OR) nurses' documentation and the operative report validate that all surgical counts, including operative sponges, were correct during and after the procedure.

We did not substantiate the allegation that the surgeon inappropriately accused the anesthetist of providing the wrong blood type to another surgical patient. The OR staff validated that the communication between the surgeon and the anesthetist regarding fresh frozen plasma was appropriate and patient centered. The patient successfully received blood and blood products as ordered.

Because we did not substantiate any allegations, we made no recommendations.

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

TO: Director, Veterans Integrated Service Network (10N15)

SUBJECT: Healthcare Inspection ─ Surgery Quality of Care Issues, VA Eastern Kansas Health Care System, Leavenworth, Kansas

Purpose

The VA Office of Inspector General, Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding surgery quality of care issues at the VA Eastern Kansas Health Care System (the system), Leavenworth, Kansas.

Background

The system is part of VISN 15 and has two divisions located in Leavenworth and Topeka, Kansas. The system provides a broad range of inpatient and outpatient services to 104,000 veterans in 49 counties in Kansas and Missouri.

The system provides medical, surgical, mental health, geriatric, and rehabilitation services and has 213 hospital beds, 138 nursing home beds, and 202 domiciliary beds, and provides outpatient services at 13 community based outpatient clinics.

An anonymous complainant alleged that a surgeon had a high patient mortality rate, left a surgical sponge in a patient's abdomen, and inappropriately accused a certified registered nurse anesthetist (anesthetist) of providing the wrong blood type transfusion to another surgical patient.

The Veterans Health Administration's (VHA's) Office of the Medical Inspector (OMI) investigated the allegation of high patient mortality rates in a report dated December 2006. In addition, the system's management conducted an internal investigation regarding these allegations in a report dated August 2, 2007.

Scope and Methodology

We reviewed the system's August 2007 internal investigation, medical records, operating room (OR) reports, blood bank records, National Surgical Quality Improvement Program data, and surgery mortality data. We interviewed OR nurses, the anesthetist, and the Quality Manager. We reviewed the OMI's December 2006 report of their investigation of the allegation that a surgeon had a high patient mortality rate. We found that the OMI report thoroughly addressed the issue and did not substantiate the allegation. Therefore, we did not review this allegation further.

This review was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency**.**

Inspection Results

Clinical Case Reviews

Patient 1

On June 11, 2007, a 53-year-old male with a medical history of hypertension, diabetes, depression, low back pain, herpes zoster, and bronchitis presented to the Emergency Department with complaints of generalized abdominal pain. Physicians diagnosed the patient with acute appendicitis, and he underwent an emergency appendectomy following admission. The surgical procedure was uneventful, without complications. Nurses documented all surgical counts, including surgical sponges, as correct at the end of the procedure. The patient was taken to the Intensive Care Unit for recovery where he remained on a breathing tube and ventilator until his oxygen saturation levels and mental responsiveness were within normal limits. Physicians removed the breathing tube and ventilator the evening of June 11.

On June 13, the patient had a productive cough with thick yellow sputum and he required increased oxygen therapy. His oxygen saturation level dropped to 70 percent on room air. Consequently, he was placed on the breathing tube and ventilator again. A chest x-ray appeared to show worsening infiltrates at the lung base. His condition improved; on June 16, physicians removed the breathing tube and ventilator and then transferred him to the medical floor on June 19.

On June 22, the patient developed an increasingly abnormal white blood cell count, indicating an infection. A diagnostic computed tomography (CT) scan confirmed that the patient developed a pelvic abscess, with cause likely secondary to diverticulitis (inflammation of the colon).

On June 22, the patient was transferred to a community hospital for a guided CT procedure to drain the abscess. The procedure could not be done by that method so the patient was readmitted to the system for open drainage of the abscess.

On June 27, the patient underwent an exploratory laparoscopic procedure to drain the abscess. All surgical counts were correct at the end of the procedure. The patient tolerated the procedure well. The surgical report noted that x-ray results suggested that the patient might have had a possible diverticulitis episode. The patient was discharged to home on June 29.

Patient 2

In June 2007, a 46-year-old male with a complicated medical history including diabetes, chronic pancreatitis, intra-abdominal infections, ventral hernia, pancreatic tumor, and a liver lesion, developed a 2-week episode of abdominal pain and vomiting. The patient had multiple surgeries, from 1999 through June 2007, to treat his medical conditions.

On June 12, 2007, the patient had an esophagogastroduodenoscopy that revealed the presence of large amounts of fecal smelling material in his stomach. On June 13, a barium enema confirmed that the patient had an opening from the proximal descending colon to the greater curvature of the stomach. On June 15, the patient had an exploratory laparotomy, extensive lysis of adhesions (surgical process of cutting scar tissue), transverse colostomy, feeding tube placement, mobilization of hepatic and splenic flexures, and a liver biopsy.

During the surgical procedures, the patient received packed red blood cells (PRBCs) and fresh frozen plasma (FFP). The patient received all blood and blood products without adverse reactions.

Issue 1: Surgical Sponge Left in Patient's Abdomen

We did not substantiate the allegation that the surgeon left a surgical sponge inside Patient 1's abdomen after surgery. On June 11, 2007, the patient underwent an emergency appendectomy without incident. The OR nurses' documentation and the operative report validate that all surgical counts, including operative sponges, were correct. The patient's abscess was not related to the surgical procedure but was likely secondary to diverticulitis.

Issue 2: Surgeon Accused Anesthetist of Giving the Wrong Blood Type

We did not substantiate the allegation that the surgeon inappropriately accused the anesthetist of providing the wrong blood type to Patient 2. The PRBCs were typed and cross-matched appropriately. The OR nurses and the anesthetist told us that the surgeons

discussed concerns whether FFP required Rh[1] consideration. However, the blood bank staff validated that FFP is a cell free product that is typed for ABO compatibility but does not require Rh consideration. The OR nurses and the anesthetist reported that the surgeon's behavior and communication during the case were patient centered and appropriate.

Conclusion

We did not substantiate the allegation that a surgical sponge was left in an appendectomy patient's abdomen. National OR nursing standards require surgical counts before, during, and after procedures to ensure patient safety. All counted items, including surgical sponges, were correct at the end of the procedure. The patient later developed an abscess, most likely secondary to a diverticulitis episode.

We did not substantiate the allegation that the surgeon inappropriately accused the anesthetist of giving the wrong blood type. The communication between the surgeon and the anesthetist regarding FFP was appropriate. The patient successfully received blood and blood products as ordered.

Because we did not substantiate any allegations, we made no recommendations.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

[1] Rh factor is an antigen (molecule that stimulates an immune response) that was first found in the blood of rhesus (Rh) monkeys. Rh factor is present in red blood cells in most people and is capable of causing intense antigenic reactions.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 19, 2007

From: Director, Veterans Integrated Service Network (10N15)

Subject: **Surgery Quality of Care Issues**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Office (10B5)

I concur with the findings outlined in this report.

PETER L. ALMENOFF, MD., FCCP

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 21, 2007

From: Director, VA Eastern Kansas Health Care System (589A6/00)

Subject: **Surgery Quality of Care Issues**

To: Director, Veterans Integrated Service Network (10N15)

I concur with the report findings and conclusion. There are no recommendations.

(original signed by:)

MARIE L. WELDON, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 426-2016
Acknowledgments	Reba B. Ransom, Project Manager Dorothy Duncan, Associate Director Marilyn Stones, Program Assistant

Appendix D

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