Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Follow-Up Review of Quality of Care and Other Issues Grand Junction VA Medical Center, Grand Junction, Colorado

Report No. 12-00206-23 October 26, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review in follow-up of a report published May 14, 2012, *Oversight Review of Quality of Care and Other Issues, Grand Junction VA Medical Center, Grand Junction, Colorado* (OIG Report number 12-00206-180). The purpose was to determine whether adverse conditions have been resolved and whether OIG's recommendations were implemented.

We conducted a site visit to the Grand Junction VA Medical Center (facility) during the week of August 6–9, 2012, interviewed key staff members, and evaluated current processes and documentation. We found appropriate oversight by Veterans Integrated Service Network 19. The facility was providing surgical care in accordance with its standard complexity designation and had implemented plans to address deficiencies in perioperative care. The facility had also taken appropriate action to address the inconsistent availability of surgeons for consultations, deficiencies in quality management procedures, and incomplete medical record documentation.

We made no recommendations.

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

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

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to follow-up on our report, *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).[1] The purpose was to determine whether quality of care and other issues have been resolved.

Background

The Grand Junction VA Medical Center (facility) provides a broad range of inpatient and outpatient medical, surgical, mental health, geriatric, rehabilitation, and emergency services. The facility is part of Veterans Integrated Service Network (VISN) 19 and serves more than 38,000 veterans in a primary service area that includes 17 counties in western Colorado and eastern Utah. It has 31 patient care beds and 30 community living center beds.

The OIG received allegations from facility staff in October and November 2011 regarding surgical complications; staff interactions, availability, communication, and professionalism; electronic health record (EHR) documentation; Quality Management (QM) effectiveness; and colonoscopy scheduling.

Because three Veterans Health Administration (VHA) teams had recently conducted site visits and reviewed the facility's surgical program, we conducted an oversight review to assess actions taken. We found allegations from staff were in the process of being addressed by facility and VISN leadership.

[1] http://www.va.gov/oig/pubs/VAOIG-12-00206-180.pdf

Scope and Methodology

We visited the facility August 6–9, 2012. Our primary purpose was to determine if actions taken since October 2011 were effective, to evaluate whether the quality of surgical care had improved, and if other identified issues had been resolved. We interviewed VISN and facility leadership, service chiefs, physicians, physician assistants, and nurses. We also interviewed the medical records manager, facility management engineer, and the union president. We reviewed credentialing and privileging records, ongoing professional practice evaluations, meeting minutes, and EHR and other relevant documents. We reviewed the current process for fee-based colonoscopy cases. We toured the operating room and intensive care unit. We reviewed quality management documents, including medical executive board meeting minutes, the peer review process, VA Surgery Quality Improvement Program (VASQIP), and VA Inpatient Evaluation Center reports. We reviewed results from an administrative investigation board.[2]

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: Surgical Infections, Complications, and Perforations

VASQIP data indicated post-operative infection rates had increased during the 2nd and 3rd quarters of fiscal year 2011. The facility requested an independent review of the general surgery program. This was performed by a National Surgery Office team and a VISN 19 surgical consult team. Although the review found no causative commonalities in the patients who developed post-operative infections, it found opportunities for surgical program improvement. VASQIP data for the 1st and 2nd quarters of fiscal year 2012 does not indicate any further concerns regarding post-operative infection rates. The facility has implemented action plans to address pre-operative skin preparation, antibiotic prophylaxis, hypothermia, and extended operating room times. The facility also sends surgical peer reviews to an outside source.

In the spring of 2012, VISN leadership identified two colonoscopy complications and one possible misdiagnosis. During the same period, there was a reduction in the number of general surgeons. The VISN and facility leadership made the determination to suspend colonoscopies at the facility pending review and provision of adequate surgical staffing. Colonoscopy procedures are sent to VA facilities and fee-based to community facilities. Facility leadership has contracted with a community gastrointestinal specialist to provide care and perform procedures at the facility.

[2] An Administrative Investigation is a procedure designed to ensure timely, objective, complete, and thoroughly documented investigations regarding issues or matters of significant interest to the VA.

Issue 2: Personnel

Hostile Work Environment. Surgeons, anesthesiologists, and Operating Room (OR) staff expressed satisfaction with the increased level of communication. There are no reported concerns regarding the surgeons' behavior.

Surgeon Response. Results of monitoring indicate surgeons are responding timely to phone calls and to overhead paging system announcements.

Surgeon Competence, Privileges, and Professionalism. The National Surgery Office conducted a site visit on June 19, 2012, and approved the facility to perform procedures within the standard surgical complexity designation.[3] An intermediate complexity designation for orthopedic surgery is pending the hiring of an in-house vascular surgeon. A contract is in progress to allow facility surgeons to perform intermediate surgical procedures on VA patients at a community hospital. This arrangement will result in maintenance of competencies for facility surgeons, continuity of pre-and post-operative VA care, and the provision of local care for patients.

Issue 3: EHR Documentation

VHA requires facilities to conduct EHR reviews that include specific elements and to monitor the documentation, implementation, and evaluation of action items[4]. The medical records department is monitoring completion of post surgical notes, discharge instructions, signed orders, and preoperative nursing documentation. We found that perioperative staff, including anesthesia, have developed templates to adequately assess and document the preoperative status of surgical patients. We also found that a process is in place to scan anesthesia documents into the EHR daily.

Issue 4: Resources

Internal medicine/hospitalist physicians remain the primary coverage for the emergency department. A service agreement between internal medicine and surgery outlines the appropriate responsibilities for care and admission of surgical patients. During our physician interviews we found that due to the prolonged personal leave of a general surgeon, there was a gap in emergency department surgery coverage. While we were onsite, the facility contracted with community general surgeons to assist with surgery coverage until additional surgeons are hired.

Issue 5: QM/PI

The QM/PI department has reorganized assigned duties. We interviewed the new QM Director and reviewed the redesigned QM plan and QM meeting minutes. We found that

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[3] VHA Directive 2010-018 *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures,* May 6, 2010.
[4] VHA Handbook 1907.01 *Health Information Management and Health Records,* August 25, 2006.

appropriate data is gathered and critically analyzed for relevance to quality and safety. We found that opportunities for improvement are identified and actions are implemented and evaluated until resolved or improvements are made.

Issue 6: Endoscopy Scheduling

Endoscopy (colonoscopy) services were suspended May 11, 2012, pending facility review and provision of adequate surgical staffing. We reviewed a sample of previously scheduled colonoscopy cases and positive fecal occult blood tests. We found that VA staff made appropriate, timely arrangements to reschedule patients requiring colonoscopy procedures within the community or at another VA facility.

Issue 7: Paging System

In February 2012, the paging terminal was replaced. The facility engineer stated the paging system has some reliability issues. Funding for a separate public address system has been awarded. Funding should be available in the fall of 2012; however, it will take approximately 4–6 months for purchase and installation.

Interim measures include a code blue button on the wall of each patient's room, a paging system that is activated by phone, and two-way radios. In addition, an engineer will be responsible for proactive monitoring and development of a new public address system.

We found the interim measures are adequate until the public address system is funded, purchased, and installed.

Conclusions

We found that the VISN was providing appropriate oversight and that the facility has implemented corrective actions to address deficiencies in perioperative care. The facility was providing surgical care in accordance with its standard complexity designation and has implemented plans to address the inconsistent availability of surgeons for consultations, deficiencies in quality management procedures, and incomplete medical record documentation. We made no recommendations.

Comments

The VISN and facility Directors concurred with our report. No further action is required.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 4, 2012

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

Subject: **Healthcare Inspection – Follow-Up Review of Quality of Care and Other Issues, Grand Junction VA Medical Center, Grand Junction, CO**

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

The VA Rocky Mountain Network (10N19) concurs with the conclusions of this VA Office of Inspector General Follow-Up Review. No recommendations were made.

(original signed by:)
Ralph Gigliotti
Network Director

Appendix B

System or Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 4, 2012

From: Terry Atienza, Director, Grand Junction VA Medical Center (575/00)

Subject: **Healthcare Inspection – Follow-up Review of Quality of Care and Other Issues, Grand Junction VA Medical Center, Grand Junction, CO**

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

The Grand Junction VA Medical Center 575 concurs with the conclusions of this VA Office of Inspector General Follow-Up Review. No recommendations were made.

(original signed by Patricia A. Hitt for:)
Terry S. Atienza
Medical Center Director

Appendix C

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	Ann Ver Linden, RN, MBA, Project Leader Virginia Solana, RN, MA Jerome Herbers, MD, Physician Consultant

Appendix D

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