DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

HEALTHCARE INSPECTION | REPORT #19-09377-192 | JULY 2, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection in response to anesthesia provider (provider) practice concerns, including unsafe practices alleged to have affected patient care at the W.G. (Bill) Hefner VA Medical Center (facility) in Salisbury, North Carolina.

The OIG did not substantiate unsafe practices within the context of the nine patient electronic health records that were reviewed. The alleged unsafe practices focused on the provider's anesthesia technique and choice of medications. The OIG did not identify issues related to the quality of anesthesia care.

When reviewing the provider's credentialing and privileging process, the OIG identified initial hiring process deficiencies related to the provider's reporting and the facility's verification of previous employment.

The OIG determined that the provider did not accurately document a prior discharge from a work position with a locum tenens contracting company (contracting company).[1] The OIG also noted that current Veterans Health Administration (VHA) policy does not specifically require a physician applicant to include both the contracting company and the hospitals where a physician worked as a locum tenens when listing prior employment history during the initial hiring process.[2] This vulnerability in VHA guidance lends itself to potential omissions in employment history used during consideration for hiring and could place facilities at risk for selecting unsuitable providers. The provider at issue worked with a contracting company and was assigned as a locum tenens at various hospitals. When completing forms for the initial hiring process, the provider listed hospitals where the provider worked as a locum tenens, but not the contracting company.

Facility credentialing and privileging staff, who should complete primary source verifications of the provider's employment history during the hiring process, did not timely complete the verifications as required. Facility staff were unable to explain why primary source verifications

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. VetPro is an internet enabled database that facility credentialing and privileging staff must use to track and verify information submitted by the provider. The provider inaccurately documented a prior discharge on the three forms: (1) Application for Physicians, Dentists, Podiatrists, Optometrists, and Chiropractors, (2) Declaration for Federal Employment, and (3) Supplemental Attestation Questions. Merriam Webster, *Definition of locum tenens.* The term, locum tenens, describes a healthcare provider who is temporarily taking a position (not on a permanent basis) or filling in for another provider for a short period of time. https://www.merriam-webster.com/dictionary/locum%20tenens. (The website was accessed on December 9, 2019.)

[2] VHA Handbook 1100.19.

were not completed until two years after the provider was hired.[3] As a result, facility leaders did not have complete and accurate information when hiring the provider in November 2011.

The OIG determined that, at the time of reprivileging in October 2013, the provider's supervisor completed a document entitled "Addendum for Probationary Period Evaluation" noting practice concerns and recommending termination and revocation of privileges. The OIG confirmed that the supervisor's comments and termination recommendation were not presented to the Professional Standards Board during the provider's reappraisal that year. When interviewed by the OIG, the former Chief of Surgery could not recall the reason why this information was not elevated to the Professional Standards Board but did recall the document and admitted failure to appropriately elevate supervisory recommendation of termination to the facility's Professional Standards Board. The OIG also found gaps in the provider's personnel file. The proficiency reports for fiscal years 2013 and 2014 were missing, and when asked, facility staff were unable to locate them.

Clinical leaders identified concerns with the provider's practice and initiated two "for cause" focused professional practice evaluations.[4] The first occurred in early 2018 and was related to the timely completion of clinical notes in patient electronic health records. In the first, the provider successfully met the expectations outlined in the for cause focused professional practice evaluation. The second was initiated in August 2019 due to a variety of concerns related to the provider's clinical practice and professionalism. It was successfully completed on February 20, 2020.

The OIG determined that facility staff did not consistently follow VHA policy to report patient safety events and quality of care concerns, which affects facility leaders' ability to respond and take action. Staff utilized reports of contact to communicate safety concerns to facility supervisors who failed to elevate the concerns to the Patient Safety Manager in accordance with VHA policy for tracking, monitoring, and analysis.

The OIG made five recommendations including one to the Under Secretary for Health to review the VHA credentialing policy to determine the need for requirement clarification related to applicants listing prior positions with locum tenens contracting companies.[5] The other four recommendations to the Facility Director related to ensuring (1) timely credentialing and

[3] VHA Handbook 1100.19.

[4] Office of Safety and Risk Awareness, Office of Quality and Performance, "*Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*," July 2016 (Revision 2). The FPPE for cause is a prospective oversight activity that allows providers to demonstrate competence and ability to perform as expected and should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The review is limited to a specific timeframe and the clinical concerns related to the specified provider.

[5] The recommendation directed to the Under Secretary for Health was submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

privileging of applicants; (2) completion and maintenance of annual proficiency reports; (3) provision of performance and competency information to the Professional Standards Board for consideration during probationary and reprivileging reviews; and (4) patient safety reporting training is provided to facility staff.

Comments

The Executive in Charge and the Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B, C, and D). The OIG considers recommendation 1 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until completed.

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Contents

Abbreviations

CRNA	certified registered nurse anesthetist
EHR	electronic health record
ePER	electronic patient event reporting
FPPE	focused professional practice evaluation
JPSR	Joint Patient Safety Reporting
LMA	laryngeal mask airway
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
PSB	Professional Standards Board
ROC	report of contact
TAP	transverse abdominis plane
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection in response to anesthesia provider (provider) practice concerns, including unsafe practices alleged to have affected patient care at the W.G. (Bill) Hefner VA Medical Center (facility) in Salisbury, North Carolina.

Background

The facility, part of Veterans Integrated Service Network (VISN) 6, offers primary and specialized outpatient services and inpatient services for acute medicine, cardiology, surgery, psychiatry, physical rehabilitation, subacute and extended care, neuropsychiatry, psychiatric intensive care, and geropsychiatry. The facility supports community-based outpatient clinics in Charlotte and Winston-Salem, North Carolina. Contractual extended care is provided through an extensive residential care treatment program and a community nursing home program. VA classifies the facility as a Level 1c–mid-high complexity facility.[1] Between October 1, 2017, and September 30, 2018, the facility served 90,009 patients and had a total of 272 hospital operating beds, including 84 inpatient beds, 56 domiciliary beds, 124 community living center beds, and eight compensated work therapy/transitional rehabilitation beds.

Allegations and Related Concerns

The OIG received allegations on January 28, 2019, outlining an anesthesia provider's generalized unsafe practices, mental instability, ineffective communication, and unprofessional conduct and interdepartmental interactions and facility leaders' failure to act, which placed patients at risk. The Office of Healthcare Inspections (OHI) Hotline Working Group reviewed the complaint and considered the allegations of mental instability, ineffective communication, and unprofessional conduct and interdepartmental interactions to be personnel issues and declined further work in those areas. The Veterans Health Administration (VHA) was tasked to provide information and comments regarding the generalized unsafe practices.[2] While awaiting VHA's response, a similar allegation related to clinical competence was submitted by a second complainant prompting the acceptance and bundling of the two complaints for evaluation. The

[1] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing. (The website was accessed on August 19, 2019, and is an internal VA website not publicly accessible.)

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. VHA responded on August 27, 2019, that the provider was placed on a "for cause" focused professional practice evaluation, a type of evaluation that may be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care.

OIG team focused on the patients identified by the complainants to evaluate unsafe practices within the context of quality of care concerns.

During a preliminary review of documents received from the complainants, which included email communications and specific patient records, OHI staff identified common concerns related to quality of care and facility leaders' response to ongoing anesthesiology service issues including

1. Quality of care for identified patients;
2. Facility leaders' response to provider performance or competency concerns;
3. Effectiveness of processes and policies used by staff to report quality of care concerns and facility leaders' actions taken in response to reports; and
4. Impact to patient scheduling, care delivery, satisfaction, or experience.

The OIG did not identify patient complaints in the Patient Advocate Tracking System submitted between October 2017 and September 2019 related to scheduling, care delivery, satisfaction, or experience involving anesthesia service, or the provider. Therefore, the OIG does not address these issues further in this report.[3]

[3] Facility staff stated that the reporting system provides department-level patient satisfaction data and did not have the capability to pull provider-specific information.

Scope and Methodology

The OIG initiated the inspection in August 2019 and conducted a site visit October 7–11, 2019.

The OIG team interviewed the Facility Director, former Chief of Staff, former and current Chiefs of Anesthesia, former and current Chiefs of Surgery, Chief of Office of Performance and Quality, and Chief of Human Resources; and staff from surgery, anesthesia, and nursing service; the Risk Manager; the Patient Safety Manager, and other staff knowledgeable about the concerns under review.

The OIG reviewed the electronic health records (EHRs) of patients identified through interviews, documents provided by facility staff, and the named provider's personnel file from initial hiring in October 2011 to December 2019. The OIG conducted an in-depth review of the provider's focused professional practice evaluations (FPPEs), ongoing professional practice evaluations (OPPEs), and proficiency reports completed between November 2011 and December 2019. Also reviewed were VHA directives, handbooks, facility policies and procedures, facility communications, and staff scopes of practice.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG 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

1. Quality of Patient Care

The OIG did not substantiate unsafe practices within the context of the nine patients reviewed. The alleged unsafe practices focused on the provider's anesthesia technique and choice of medications. The OIG reviewed patient records and did not identify issues related to quality of anesthesia care. See appendix A for further information on patient case review results.

2. Provider Performance and Competency

To evaluate the provider's performance and competency, the OIG team reviewed aspects of the credentialing and privileging process, including the initial hiring documentation, and identified deficiencies in the provider's reporting and the facility's verification of previous employment. The OIG team also reviewed facility leaders' response when issues were identified.

Initial Hiring Deficiencies

The OIG identified deficiencies with the provider's initial hiring and employment application documentation and the facility's processes for prior employment verification. The OIG determined that the provider did not accurately document a prior discharge from a work position with a locum tenens contracting company (contracting company) during the initial hiring process.[9] Facility staff did not follow VHA requirements to verify the provider's prior employment history.[10] As a result, facility leaders did not have complete and accurate information when hiring the provider in November 2011.

VHA requires potential staff, including providers, to complete an application and submit necessary documents for consideration. Upon accepting a job offer, a provider must enroll in VetPro and submit several hiring documents to the Human Resources Management Office.[11] Credentialing, which is part of the hiring process, involves a review of the provider's background including education, training, and prior work experiences by facility credentialing and

[9] VHA Handbook 1100.19. VetPro is an internet enabled database that facility credentialing and privileging staff must use to track and verify information submitted by the provider. The provider inaccurately documented a prior discharge on the three forms: (1) Application for Physicians, Dentists, Podiatrists, Optometrists and Chiropractors, (2) Declaration for Federal Employment, and (3) Supplemental Attestation Questions. Merriam Webster, *Definition of locum tenens.* The term, locum tenens, describes a healthcare provider who is temporarily taking a position (not on a permanent basis) or filling in for another provider for a short period of time. https://www.merriam-webster.com/dictionary/locum%20tenens. (The website was accessed on December 9, 2019.)

[10] VHA Handbook 1100.19.

[11] VHA Handbook 1100.19.

privileging staff.[12] VHA policy requires facility credentialing and privileging staff to verify the provider's prior work history by reviewing documentation from the original source (employer) to validate the accuracy of the information supplied by the provider.[13] Providers are expected to supply accurate and complete information during this process.[14] The documents include language that certifies information provided is "true, correct, complete, and made in good faith" and that "a false or fraudulent answer to any question" may be grounds for "firing" after hiring.[15] Verification of the provider's qualifications through the credentialing process must be completed prior to the provider's appointment to the medical staff and granting of provider-specific clinical privileges.[16]

The OIG identified public court records indicating the provider was discharged in 2007 from a locum tenens position following concerns related to a patient's care at a private hospital. However, the provider failed to disclose this discharge on three separate documents during the 2011 application process. Each document included a similarly phrased question regarding discharge from a prior position for any reason in the last five years; the provider responded that there were no prior discharges.

The OIG reviewed the provider's VetPro file to determine verification of prior employment history. The provider previously held a position with a contracting company and worked under the contract at a private hospital. While the VetPro file included the private hospital as a previous place of employment, it did not list the contracting company. A facility credentialing and privileging staff member reported being unaware of the contracting company. Further, facility credentialing and privileging staff failed to complete primary source verifications of the provider's employment history at the listed locum tenens contracted private hospitals until 2013.[17] A facility credentialing and privileging staff member stated being unsure why there was a two-year delay in verifying all the provider's prior employment and admitted this was an error in the initial 2011 credentialing process.

The facility credentialing and privileging staff member further stated that a provider would usually include contracting companies as well as the hospitals where the provider worked under contract when listing prior employment history during the initial hiring process. However, VHA

[12] VHA Handbook 1100.19.

[13] VHA Handbook 1100.19.

[14] VHA Handbook 1100.19.

[15] U.S Office of Personnel Management, Optional Form 306, *Declaration for Federal Employment*, Revised January 2001; Department of Veterans Affairs, Standard Form 171, *Application for Physicians, Dentists, Podiatrists, Optometrists and Chiropractors.*

[16] VHA Handbook 1100.19.

[17] VHA Handbook 1100.19. Verifying a provider's status from a prior work position accesses if there were any performance or competency concerns such as the "loss of medical staff membership or a loss or reduction of clinical privileges."

policy language does not specifically require listing contracting companies.[18] Further, the credentialing and privileging staff member indicated that the private hospital "typically will inform you that the provider is locums [*sic*]" which would then lead facility credentialing and privileging staff to contact the contracting company for employment verification. The private hospital did not indicate the provider worked as a locum tenens during the verification process and the provider did not list the contracting company on application documents or in VetPro. As a result, the OIG determined that facility credentialing and privileging staff were unaware of, and did not verify employment history with, either the contracting company or all private hospitals where the provider worked while under contract.

Deficient Performance and Competency Evaluation Practices

During the inspection, the OIG identified that the former Chief of Surgery failed to provide the facility's Professional Standards Board (PSB) pertinent documentation related to the provider's performance and competency for consideration at the conclusion of the two-year probationary period and at the time of the reprivileging review. The provider's 2012 OPPE and the Addendum for Probationary Period Evaluation identified practice concerns. In addition, the facility did not complete the 2013 and 2014 annual proficiency reports as required. These failures affected PSB decisions related to continued employment and reprivileging.

Background

VHA policy requires facilities to monitor and evaluate a provider's performance and competency through a combination of FPPEs, OPPEs, and annual proficiency reports.[19] Once clinical privileges are granted, the provider's service chief documents the provider's professional performance, judgment, and clinical skills to support reprivileging every two years.[20]

FPPEs and OPPEs assess a provider's patient care, procedural skills, and professionalism while proficiency reports evaluate a provider's clinical competence, personal qualities, and overall job performance.[21] An initial FPPE allows a provider to independently practice during performance evaluation of newly granted privileges.[22] In addition, FPPE occurs when an existing provider requests a new privilege, or for cause when there is concern regarding competence and patient

[18] VHA Handbook 1100.19.

[19] VHA Handbook 1100.19; VA Directive 5013, *Performance Management Systems*, April 15, 2002.

[20] Privileges are the specific treatments and services a healthcare provider can utilize while taking care of patients based on their training, experience, licenses and resources available at the facility.

[21] VHA Handbook 1100.19; VA Directive 5013.

[22] VHA Handbook 1100.19. Credentials include a combination of the provider's licensure, education, training, experience, competence, and health status.

care.[23] FPPE results must be documented and reported to an oversight body in order to inform recommendations on privileges and other considerations.[24]

An OPPE is initiated upon the successful completion of an FPPE. In order to determine a provider's level of competence and evaluate the outcomes of care, service chiefs must collect and maintain relevant provider-specific data. The reappraisal (reprivileging) "process includes consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in a provider's clinical practice."

Annual proficiency reports are to be maintained in employees' personnel folders.[25] While a provider is still in a probationary period, the facility's PSB reviews the provider's performance and makes a recommendation to the Medical Executive Committee to either maintain or change clinical privileges.[26] The provider's supervisor rates performance via the proficiency report.[27] Separation from employment can occur if a provider is determined not "fully qualified and satisfactory."[28]

Initial FPPE and OPPEs

After the provider successfully completed the initial FPPE in 2012, the OPPE process was initiated and was continued every six months as required by VHA policy.[29] Concerns with the provider's practice were identified during OPPEs in fiscal year 2012 as noted by the former Chief of Anesthesia, who documented concerns with clinical care as well as a "lack of professional inter-personal skills." From 2014 through 2019, the provider's OPPEs were reviewed with recommendations to continue clinical privileges.[30]

[23] Salisbury VA Health Care System, Bylaws and Rules of the Medical Staff, September 21, 2017. Office of Safety and Risk Awareness, Office of Quality and Performance, "*Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*," July 2016 (Revision 2). The FPPE for cause is a prospective oversight activity that allows providers to demonstrate competence and ability to perform as expected, and should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The review is limited to a specific timeframe and the clinical concerns related to the specified provider.

[24] VHA Handbook 1100.19. The facility's oversight body is known as the Medical Executive Committee.

[25] VA Directive 5013.

[26] Salisbury VA Health Care System, *Bylaws and Rules of the Medical Staff*, September 21, 2017.

[27] VA Directive 5013.

[28] VA Directive 5005.

[29] VHA Handbook 1100.19.

[30] The Addendum for Probationary Period Evaluation was not added to any documentation despite the title.

Probationary Period Evaluation

At the time of reprivileging in 2013, the provider's supervisor completed an Addendum for Probationary Period Evaluation noting practice concerns and recommending termination and revocation of privileges. When interviewed by the OIG, the provider's supervisor relayed concern that documentation provided was not being used appropriately or forwarded for consideration by the PSB. The former Chief of Surgery stated during an interview a recollection of the document and admitted having failed to appropriately elevate supervisory recommendation of termination to the facility's PSB. When asked by the OIG, the former Chief of Surgery could not recall the reason why this information was not elevated to the PSB. The OIG confirmed that the supervisor's comments and termination recommendation were not presented to the PSB during the provider's reappraisal that year.

Provider Proficiencies

The provider's proficiency report for fiscal year 2012 was completed by the former Chief of Surgery, who rated the provider as satisfactory. When interviewed, the former Chief of Surgery did not recall why the provider's supervisor did not sign the proficiency report adding that at times it was practice for the Chief of Surgery to do so. The proficiency reports for fiscal year 2013 and 2014 were requested; however, facility staff stated they were unable to locate the missing documents. The provider's proficiency reports for fiscal year 2015 through fiscal year 2017 documented the provider's performance as "high satisfactory." The former Chiefs of Surgery and Anesthesia left their positions in 2016 and 2017 respectively. The provider's evaluations declined to "satisfactory" in fiscal year 2018, and "low satisfactory" in fiscal year 2019.

For Cause FPPEs

Clinical leaders identified concerns with the provider's practice and initiated two for cause FPPEs. The first occurred in early 2018 and was related to the timely completion of clinical notes in patient EHRs; the provider successfully met the expectations outlined in the FPPE. The second for cause FPPE was initiated in summer 2019 secondary to a variety of concerns related to the provider's clinical practice and professionalism. The OIG noted that the initiation of the for cause FPPE was not annotated in the section of the OPPE designated for this purpose. The 2019 for cause FPPE was extended beyond the initial 90 days and was successfully completed in early 2020.

The OIG concluded there were instances throughout the provider's employment when informed decision-making may have changed the course of employment, beginning with the initial hiring and continuing with professional performance and other evaluations. Facility leaders did not have complete and accurate information when hiring the provider and the PSB was not provided

documentation to inform decision-making regarding the provider's practice and supervisory concerns.

3. Effectiveness of Patient Safety and Quality of Care Concern Reporting and Facility Leaders' Actions

The OIG determined that facility staff did not consistently follow VHA policy to report patient safety events and quality of care concerns, which affected facility leaders' ability to respond and take action.[31] Facility staff began submitting patient safety events, quality of care concerns, and reports of disruptive behavior regarding the provider within six months of employment through reports of contact (ROCs), emails, and verbal communication to facility leaders rather than through the patient safety reporting system.[32]

VHA policy establishes procedures for reporting, analyzing, and addressing patient safety events, which include quality of care concerns, and instructs facility staff to report any unsafe conditions to the patient safety manager.[33] VHA requires staff reporting of patient safety events to the patient safety manager. According to facility policy, the executive leadership team reviews patient safety events daily and forwards to appropriate staff for additional follow-up when warranted. The facility utilized the Electronic Patient Event Reporting (ePER) system for reporting patient safety events prior to January 2018, at which time the facility began using the Joint Patient Safety Reporting (JPSR) system. A staff member indicated that the facility did not have a local policy to support the use of ROCs to document or report staff concerns related to potential patient safety events.

Through interviews and document reviews, the OIG found 40 unique concerns reported to facility leaders including the Chiefs of Staff, Anesthesia, and Surgery between January 1, 2017, and October 9, 2019, from staff with direct involvement in patient care. Of the reported concerns, there were 29 related to patient care and an additional five instances where disruptive behavior potentially affected patient care. The remaining six concerns contained instances involving both patient care and disruptive behavior. The OIG found documentation showing the current Chief of Anesthesiology addressed some, but not all the staff's concerns with the

[31] Patient safety events in this report encompass actual patient safety events, close calls, and near misses.

[32] VHA Handbook, 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. The American Medical Association defines physician disruptive behavior as speech or action "that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician." https://www.ama-assn.org/delivering-care/ethics/physicians-disruptive-behavior. (The website was accessed on February 4, 2020.)

[33] Medical Center Memorandum 659-00B-1, *Patient Safety Improvement (PSI) Program*, Salisbury VA Health Care System, January 17, 2017. The Electronic Patient Event Reporting System is an electronic system that allows staff to report anonymously "events impacting patient safety, general concern for patient safety and/or close calls/near misses," and tracks and monitors reported patient safety events. Joint Patient Reporting System is an electronic system that standardizes data management on medical errors and near misses for Department of Defense and Veterans Health Systems. February 2018.

provider. When asked, the OIG was told that as a new supervisor, the Chief of Anesthesiology determined that some early issues could be addressed with verbal discussions and email communications. As patterns evolved over time, additional actions were taken including documentation labeled as a "write up" in some cases and reflected that the provider was informed of the concerns and the expectations of improvements in patient care and behavior or both. The OIG was told by the current Chief of Surgery that the concerns noted did not rise to a higher level of action by facility leaders.

When asked to describe the appropriate mechanism for reporting these concerns, some of the interviewed staff were unaware of national patient safety reporting procedures. Virtually all staff interviewed described an informal process of alerting supervisors to patient safety concerns via verbal or written communication rather than utilizing the official patient reporting systems. Staff reported, and the OIG confirmed, that concerns were submitted using the ROC format to the former and current Chiefs of Anesthesia. The OIG did not find evidence that facility leaders redirected staff to the appropriate reporting process upon receipt of the concerns or ensured concerns were forwarded to the Patient Safety Manager. During interviews, staff noted frustration with the lack of follow-up on the submitted concerns, and an interviewee reported having "given up" on reporting further provider-related concerns. The concerns were not included in the daily JPSR reports presented to the executive leadership team for review since they were inappropriately reported via ROCs.

When interviewed by the OIG, the Patient Safety Manager reported that facility staff were trained in 2018 on the current patient safety event reporting process upon transition to JPSR from ePER, and described the JPSR training as a "blitz," noting that several sessions were held. Prior to JPSR, the Patient Safety Manager stated that the only training was through new employee orientation. Further, the Patient Safety Manager stated that ongoing discussions regarding patient safety occurred in staff meetings and while "out and about." The Patient Safety Manager was unable to provide evidence of staff education during either formal training sessions or informal conversations.

The OIG concluded that opportunities to identify trends and patterns in reported concerns were missed as facility staff did not use the proper reporting systems and facility leaders' failed to redirect the identified concerns to the Patient Safety Manager.

Conclusion

The OIG did not substantiate unsafe practices within the context of the nine patients reviewed. The alleged unsafe practices focused on the provider's anesthesia technique and choice of medications. The OIG reviewed patient records and did not identify issues related to quality of anesthesia care.

When reviewing the credentialing and privileging process, the OIG identified deficiencies in the provider's initial hiring and employment application documentation and the facility's processes for prior employment verification. The provider failed to disclose a discharge on three separate documents during the 2011 application process. Each document included a similarly phrased question regarding discharge from a prior position for any reason in the last five years; the provider responded that there were no prior discharges. The OIG determined that current VHA policy does not specifically require a physician applicant to include both the contracting company and the hospitals where a physician worked as a locum tenens when listing prior employment history during the initial hiring process.[34].[35] This vulnerability in VHA guidance lends itself to potential omissions in employment history used in consideration for hiring and could place facilities at risk for selecting unsuitable providers.

Additionally, facility staff did not follow VHA requirements to verify the provider's prior employment history during the initial hiring process. Verification was not completed until two years later.[36] As a result, facility leaders did not have complete and accurate information when hiring the provider in November 2011.

The former Chief of Surgery failed to provide the facility's PSB pertinent documentation related to the provider's performance and competency for consideration at the conclusion of the two-year probationary period and at the time of reprivileging review. The 2012 OPPE and the Addendum for Probationary Period Evaluation identified provider-related practice concerns. In addition, the facility did not complete the 2013 and 2014 annual proficiency reports as required. These failures affected PSB decisions related to continued employment and reprivileging.

Clinical leaders identified concerns with the provider's practice and initiated two for cause FPPEs. The first occurred in early 2018 and was related to the timely completion of clinical notes in patient EHRs; the provider successfully met the expectations outlined in the FPPE. The second was initiated in summer 2019 secondary to a variety of concerns related to the provider's clinical practice and professionalism; the FPPE was successfully completed in early 2020.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

The OIG determined that facility staff did not consistently follow VHA policy to report patient safety events and quality of care concerns, which affected the facility leaders' ability to respond and take action.[37] Facility staff began submitting patient safety events, quality of care concerns, and reports of disruptive behavior potentially affecting patient care regarding the provider within six months of employment through ROCs, emails, and verbal communication to facility leaders rather than through the patient safety reporting system. The OIG found documentation showing the current Chief of Anesthesiology addressed some, but not all the staff's concerns with the provider. As patterns evolved over time, additional actions were taken including documentation labeled as a "write up" in some cases and reflected that the provider was informed of the concerns and the expectations of improvements in patient care and behavior or both. The OIG was told by the current Chief of Surgery that the concerns noted did not rise to a higher level of action by facility leaders.

Recommendations 1–5

1. The Under Secretary for Health initiates review of the Veterans Health Administration's credentialing policy to determine the need for requirement clarification related to prior employment history to include applicant listing of locum tenens contracting companies.[38]

2. The W. G. (Bill) Hefner VA Medical Center Director ensures credentialing and privileging staff verify applicants' information within the required timeframe outlined by Veterans Health Administration policy and monitors for compliance.

3. The W. G. (Bill) Hefner VA Medical Center Director ensures annual proficiency reports are completed and maintained consistent with Veterans Health Administration requirements and monitors for compliance.

4. The W. G. (Bill) Hefner VA Medical Center Director ensures all available performance and competency information is provided to the Professional Standards Board for consideration during provider probationary and reprivileging reviews and monitors for compliance.

5. The W. G. (Bill) Hefner VA Medical Center Director ensures that all staff are trained on reporting patient safety events using the correct reporting system and monitors for compliance.

[37] Patient safety events in this report encompass actual patient safety events, close calls, and near misses.

[38] The recommendation directed to the Under Secretary for Health was submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Appendix A: Patient Case Reviews

Patient	Complainant Concern	OIG Decision
1	After undergoing a regional block for a rotator cuff surgery, a patient developed a blank stare and difficulty communicating. The provider prepared to give Versed, which, according to the complainant, was not indicated. The provider changed course and instead gave intralipids. The patient improved after about two minutes.	Versed is a benzodiazepine used to treat seizures. Preparing a versed injection was reasonable if the provider suspected onset of a toxin-induced seizure. The provider decided instead to administer intravenous lipids (an antidote for possible neuro-toxic reaction). Prior to receiving the intralipids, the patient appeared to be recovering. After consultation with the Chief of Anesthesia, it was determined that the patient could proceed with surgery, which was uneventful.
2	A patient with cocaine use disorder was scheduled for a prostatectomy. Upon arrival in the operating room, the blood pressure was higher than normal limits. The provider recommended labetalol; per the complainant, this was contraindicated due to the cocaine use disorder. The labetalol was not given. After induction of anesthesia, the blood pressure was not detectable from either arm although the carotid pulse was palpable. The provider gave ephedrine and phenylephrine, became excited, gave corticosteroid medication, and canceled the surgery.[39] A low blood pressure was not confirmed; other data did not support low blood pressure. The provider overreacted.	After receiving anesthesia, the patient had low blood pressure that did not respond to phenylephrine and ephedrine. The blood pressure improved after administration of large doses of corticosteroids (stress steroids). Stress steroids are used for patients who have acute episodes of adrenal insufficiency, the inability to secrete appropriate amounts of steroids in response to stress (adrenal crisis). The patient's improved blood pressure after receiving the steroids supports the actions taken. If the provider suspected that this patient was experiencing an adrenal crisis, the actions were reasonable. Not treating an adrenal crisis can result in death, which overrides other concerns.
3	The patient was being readied for a cystoscopy when a pause in heartbeat (about 5–10 seconds) occurred. The provider was notified. When the provider arrived, the patient was noted to have high blood pressure. The provider recommended labetalol to treat the blood pressure. According to the complainant, labetalol was not indicated for patients with such pauses. The labetalol was not given, anesthesia was completed, and the patient's blood pressure decreased with the anesthetic medication.	The patient, who underwent a cardiac monitoring test a few months prior to the cystoscopy, was noted to have a conduction delay with a missed heartbeat. While labetalol is a beta-blocker medication that may slow the electrical conduction in the heart, the literature does not contain specific contraindications for patients where slowed heart conduction is present with an occasional missed beat. The patient did not receive the labetalol; the procedure was successfully completed.

[39] Ephedrine and phenylephrine are medications that are used to treat low blood pressure by stimulating the sympathetic nervous system.

4	The provider wants to do interscalene and transverse abdominis plane (TAP) blocks under general anesthesia when the patient does not like needles.[40] The provider did an interscalene block while a patient was under general anesthesia which, according to the complainant, risked cardiac arrest.	The patient at issue had a history of a gunshot wound to the left neck and face. A consequence of the injury was frequent aspiration of food into the lungs related to facial and left vocal cord paralysis. Due to the patient's higher risk of aspiration than the usual population, general anesthesia prior to the block was a reasonable option. It allowed improved protection of the airway when positioning the patient for the regional block thereby decreasing the possibility of aspiration.
5	A patient underwent a robotically assisted laparoscopic inguinal hernia repair. The provider did not agree with a TAP regional blocks. According to the complainant, the blocks eliminated the need for narcotics. The patient received general and local anesthesia.	An incision is the main source of immediate post-operative pain. Laparoscopic procedures involve minimal incisions, typically one-half to one centimeter in length. Incisional pain may also be lessened with infiltration of long-acting anesthesia medication at the sites of the laparoscopic instrument placement. It was therefore reasonable to not use TAP for the purposes of minimizing incisional pain in this patient.
6	Per the surgeon's request, a laryngeal mask airway (LMA) was attempted but unsuccessful.[41] The patient was intubated without difficulty after a second LMA attempt was unsuccessful. The provider returned to the room and stated an LMA should not have been attempted due to obesity. The patient's body mass index was 27 (not obese). The provider told a colleague about returning to the operating room due to an airway emergency. The anesthesiologist entered the room just after the certified registered nurse anesthetist (CRNA) successfully intubated the patient.	The patient underwent an open repair of an inguinal hernia. The case was done under general anesthesia, oral endotracheal tube intubation. Induction and intubation was done without the attending anesthesiologist present. The patient was adequately oxygenated during the LMA attempts.
7	An elderly patient underwent a lipoma excision. The provider requested that the patient receive "lots" of versed and fentanyl as the patient had reported a panic attack in a dentist's office. The CRNA indicated a preference for propofol to avoid side effects of versed/fentanyl. Propofol was used. The CRNA suggested using propofol for sedation rather than a	The patient underwent excision of subcutaneous left shoulder lipoma under local, monitored anesthesia care. The patient gave a history of lidocaine allergy, that occurred while having a dental procedure; the patient became anxious and short of breath but required no treatment.

[40] TAP is a type of regional anesthesia used for abdominal procedures.

[41] The patient's ventilation must be supported during general anesthesia. A tube may be placed into the lungs (endotracheal intubation) or a laryngeal mask airway may be inserted into the upper airway.

	combination anxiolytic and narcotic. The provider agreed.	
8	A patient was in the post-anesthesia care unit after surgery. The provider ordered a full dose of "reversal" for the muscle relaxant. According to the complainant, this action was unnecessary and not communicated to the CRNA in charge of the patient.	The patient underwent a robotic-assisted laparoscopic mesh repair of a recurrent umbilical hernia. Bilateral TAPs were done to anesthetize the nerves supplying the anterior abdominal wall prior to the procedure. During the procedure, a muscle relaxant agent was administered for general anesthesia. The anesthesiologist gave a muscle relaxant reversing agent. Administration of the muscle relaxant and dose was appropriate.
9	A surgeon prefers patients undergo TAP. The TAP involves injections into the abdomen that can be done with or without sedation in the preoperative area. The provider does not agree with TAPs and, to avoid them, does not give the patient complete information including the option of sedation in the preoperative area. The provider did not tell a patient that the TAP could be done after receiving sedation. After more discussion with the CRNA, the TAP was uneventfully performed in the preoperative area under sedation. The provider untruthfully told the surgeon that the patient had been over-sedated in the preoperative area.	The patient underwent a laparoscopic repair of a symptomatic left inguinal hernia. A TAP block, a peripheral nerve block designed to anesthetize the nerves supplying the anterior abdominal wall, was done in the preoperative holding area under intravenous sedation.

Source: VA OIG

Appendix B: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 28, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, VETERANS HEALTH ADMINISTRATION: Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina (VIEWS 02748676)

To: Director, Office of Healthcare Inspections (54HL03)

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report, VETERANS HEALTH ADMNISTRATION: Anesthesia Provider Concerns at the W.G. (Bill) Hefner VA Medical Center, Salisbury North Carolina.

2. I concur with OIG's recommendation to the Under Secretary for Health. The Veterans Health Administration has fully implemented the action plan for this recommendation and has provided OIG with documentation to support its request for closure.

3. Comments and action plans for recommendations 2-5 are provided by the Medical Center Director for W.G. (Bill) Heffner VA Medical Center.

4. If you have any questions, please contact Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10EGGOALAction@va.gov.

(*Original signed by*:)

Richard A. Stone, M.D.
Executive in Charge, Office of the Under Secretary for Health

Executive in Charge Response

Recommendation 1

The Under Secretary for Health initiates review of the Veterans Health Administration's credentialing policy to determine the need for requirement clarification related to prior employment history to include applicant listing of locum tenens contracting companies.

Concur.

Target date for completion: May 2020

Executive in Charge Comments

The policy was reviewed, and it was determined this recommendation would be best addressed through clarification in guidance to the providers on the Personal History Screen in VetPro. The following statement has been added to the VetPro Personal History screen for future applicants who have performed clinical care at a facility through a contractual arrangement:

"*If you have provided clinical services through a contractual arrangement, please list the name of your contract employer as well as each facility where you provided clinical care as a contractor*".

VHA requests OIG consider closure of this recommendation based on completion of needed actions.

OIG Comment

Based on information received with the Executive in Charge response, the OIG considers this recommendation closed.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 14, 2020

From: Network Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subj: Draft Report: Healthcare Inspection—Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

To: Director, Office of Healthcare Inspections (54HL03)

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the W. G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina, and concur with the facility's recommendations.

2. If you have further questions, please contact Dana Ballard, QMO, VISN 6.

(Original signed by:)

DEANNE M. SEEKINS, MBA, VHA-CM
VA Mid-Atlantic Health Care Network Director, VISN 6

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 13, 2020

From: Director, W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina (659)

Subj: Healthcare Inspection— Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

To: Director, Mid-Atlantic Health Care Network (VISN 6)

1. I have reviewed the draft report of the Office of Inspector General. I concur with the recommendations. I have included my response in the attached Director's Comments. Please contact me if you have any questions or comments.

(Original signed by:)

Joseph P. Vaughn, MBA, FACHE
Executive Director

Facility Director Response

Recommendation 2

The W. G. (Bill) Hefner VA Medical Center Director ensures credentialing and privileging staff verify applicants' information within the required timeframe outlined by Veterans Health Administration policy and monitors for compliance.

Concur.

Target date for completion: August 15, 2020

Director Comments

The Salisbury VA Healthcare Center uses the VetPro program to enter all provider credentialing and privileging information. The facility will ensure that Credentialing and Privileging staff complete primary source verification as required on all applicants. The verified required information is entered into the VetPro system. The Executive Assistant to the Chief of Staff will audit the VetPro system to ensure that verified information is entered into VetPro in compliance with VHA timeframes prior to the applicant being presented to the Professional Standards Board (PSB) for privileging. Results will be presented to the Medical Executive Council for oversight until 90% compliance is maintained for 3 consecutive months.

Recommendation 3

The W. G. (Bill) Hefner VA Medical Center Director ensures annual proficiency reports are completed and maintained consistent with Veterans Health Administration requirements and monitors for compliance.

Concur.

Target date for completion: August 15, 2020

Director Comments

Annual proficiency reports are completed by the supervisor and forwarded to the Human Resources Department for uploading in the Electronic Official Personnel Folder (eOPF). Moving forward, the Director will require all Service Line Chiefs to certify to the Human Resources Department that all required proficiencies have been completed. Service Line Chiefs will complete the certification quarterly. Human Resources will complete a random audit of employee records in the eOPF (electronic official personnel file) system each month to ensure that 90% of employee records audited have an annual proficiency report. Audits will continue until 90% compliance is maintained for three consecutive months. Auditors will ensure that the

record contains annual proficiency reports for the previous 2 years. Results will be reported to the Executive Leadership Board for oversight.

Recommendation 4

The W. G. (Bill) Hefner VA Medical Center Director ensures all available performance and competency information is provided to the Professional Standards Board for consideration during provider probationary and reprivileging reviews and monitors for compliance.

Concur.

Target date for completion: August 15, 2020

Director Comments

Beginning February 2020, all FPPE and OPPE information is uploaded to a secure SharePoint prior to the Professional Standards Board meeting. The FPPE and OPPE information is reviewed during the Professional Standards Board meeting as members make a determination for approval of privileges. Discussion that occurs in the meeting is included in the minutes. Minutes for the meeting will be reviewed by the Office of Performance & Quality to ensure the FPPE & OPPE information was discussed and is included in the meeting minutes. Results will be presented to the Medical Executive Council for oversight. The minutes will reflect 90% compliance for three consecutive months.

Recommendation 5

The W. G. (Bill) Hefner VA Medical Center Director ensures that all staff are trained on reporting patient safety events using the correct reporting system and monitors for compliance.

Concur.

Target date for completion: August 15, 2020

Director Comments

Although staff completed a face to face training in December 2017 and January 2018 during the implementation of the JPSR system, training attendance records were not collected. To ensure staff are familiar with the JPSR system for reporting safety events, all staff will be required to complete the Talent Management Solutions online training, “Joint Patient Safety Reporting System – Reporting a Safety Event.” In addition, all new staff will be required to complete the training during New Employee Orientation. Rates of completion will be presented monthly to the Quality, Safety, Value Council for oversight until at least 90% of all staff have completed the training.

OIG Contact and Staff Acknowledgments

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