Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Surgeon Privileging and Resident Supervision Issues W. G. (Bill) Hefner VA Medical Center Salisbury, North Carolina

Report No. 11-01993-281

September 16, 2011

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 an inspection to determine the validity of allegations of surgeon privileging and resident supervision issues at the W. G. (Bill) Hefner VA Medical Center (the facility), Salisbury, North Carolina.

The complainant made the following allegations:

- Surgeons at the facility were performing operations that they did not have the clinical privileges to perform, which resulted in poor surgical outcomes.
- Residents were not supervised appropriately.

We substantiated the allegation that some surgeons performed certain operative procedures without the appropriate corresponding privileges; however, we did not find evidence that poor surgical outcomes resulted. We substantiated the allegation that residents in Surgical Service were not supervised as required by VHA policy. We found that there was no surgeon on site 2 days per week while residents were seeing patients in the Clinic. Local policy did not define timeframes for the documentation of resident supervision as required by VHA. We also found that resident authored progress notes were not consistently co-signed by a supervising surgeon in the timeframe verbalized as acceptable by clinical leadership.

VHA policy requires an "interval note" be entered into the medical record by a physician immediately prior to operative procedures. This note documents that the information in the previous progress notes was still accurate, an appropriate assessment was completed prior to surgery, the patient still required the procedure, and that the patient's condition had not changed. We found that interval notes were not consistently entered into the medical record by the attending surgeon.

We recommended that the Medical Center Director ensure that surgeons have current privileges for the procedures they perform and that Surgical Service residents have supervision onsite in accordance with VHA policy. We also recommended that the facility resident supervision policy define timeframes for the documentation of resident supervision and that pre-operative documentation be completed as required by VHA policy. The Veterans Integrated Service Network and Medical Center Directors concurred with our findings and recommendations and provided acceptable action plans.

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

TO: Director, VA Mid-Atlantic Health Care Network (10N6)

SUBJECT: Healthcare Inspection – Surgeon Privileging and Resident Supervision Issues, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of surgical privileging issues and inadequate resident supervision at the W. G. (Bill) Hefner VA Medical Center (the facility), Salisbury, NC.

Background

The facility is a level 2 tertiary care medical center within Veterans Integrated Service Network (VISN) 6, which offers inpatient and outpatient medical, surgical, and rehabilitative services. The facility has an academic affiliation with Wake Forest University and an active residency program in multiple specialties. The facility operating room (OR) is classified by Veterans Health Administration (VHA) as an Intermediate Complexity OR.

In February 2011, the OIG received an anonymous complaint alleging that:

- Surgeons at the facility were performing operations that they did not have clinical privileges to perform, which resulted in poor surgical outcomes.
- Surgical Service residents were not supervised appropriately

Scope and Methodology

We conducted a site visit May 9–11, 2011. We interviewed the facility Chief of Staff, as well as other clinical, administrative, and management staff with knowledge relevant to the allegations. We interviewed the VISN 6 Chief Medical Officer and Quality Management staff, as well as the VA Central Office Director of Credentialing and

Privileging, and the Senior Medical Officer, Office of Quality and Safety, regarding oversight of privileging processes. We reviewed VHA and local policies, electronic medical records, committee meeting minutes, credentialing and privileging folders, and reviews completed by the facility and VISN. We also reviewed staff and clinic schedules, OR reports, National Surgical Quality Improvement Project data, American Council for Graduate Medical Education Guidelines, and other related documents.

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: Surgeons Performing Procedures Without Privileges

We substantiated the allegation that surgeons were performing procedures in the OR without having the clinical privileges to do so. We identified four surgeons who did not have privileges for one or more procedures they performed.

VHA policy[1] addresses the privileging process for providers to practice at a VHA facility. Privileges are granted and approved by a facility Professional Standards Board (PSB) comprised of medical leaders who have reviewed and discussed the provider's training and practice information. After a provider is hired and approved for initial privileges, a Focused Professional Practice Evaluation is conducted, in which the Service Chief and PSB review practice patterns and confirm that the provider demonstrates clinical competence.

We reviewed all of the operative procedures performed at the facility between October 1, 2009 and March 31, 2011. We compared the procedures performed by each surgeon with his/her PSB approved privilege list. Where there were discrepancies, we reviewed the medical records of the patients involved.

A surgeon performed cholecystectomies[2] using a laparoscopic technique[3] without having privileges to do so. The surgeon also performed creation of arteriovenous fistulas[4] and lower extremity amputations without having clinical privileges to do so. We reviewed the medical records for these patients and did not find evidence of poor surgical outcomes

[1] VHA Directive 2006-067, *Credentialing of Healthcare Professionals*, December 22, 2006. Clinical privileges are specific skills and procedures a provider is allowed to perform at a facility, determined by a review of the provider's qualifications, education, experience, and practice history in order to determine competence to perform particular skills and techniques.
[2] A cholecystectomy is the surgical removal of the gallbladder.
[3] Laparoscopic technique is a minimally invasive surgery involving multiple small incisions and a camera in lieu of the traditional long open incision.
[4] Arteriovenous fistula is a surgical procedure in which an artery is connected to a vein in the forearm for the purpose of using this site for hemodialysis access.

from these procedures. The VISN identified this problem in November 2010, and by the time of our visit, the facility had addressed the issue and taken action.

Radical prostatectomies[5] may be performed in VHA designated Intermediate Complexity ORs when the attending surgeon has the clinical privileges for that procedure.[6] However, the facility had a statement on their privileging form that "facility constraints prevent privileges for radical prostatectomy." Clinical staff and leadership told us that radical prostatectomies had not been performed at the facility because nursing staff did not have the necessary training to provide post-operative care following this procedure. We found that a surgeon performed a radical prostatectomy at the facility in May 2010, despite this exclusionary statement. In September 2010, the facility provided radical prostatectomy post-operative care training to the nursing staff. Two weeks later, another surgeon performed a radical prostatectomy; however, the privilege lists were not updated to reflect approval for the surgeons to perform this procedure. In late December 2010, the facility's PSB approved the revised urology privilege list, which included radical prostatectomy. We reviewed the medical records for these patients and did not find poor surgical outcomes as a result of these procedures.

A surgeon had privileges to perform closed reduction internal fixation of fractures, but performed an open reduction internal fixation of a fracture[7], which was not on the surgeon's list of approved privileges. This surgeon was practicing at the time under a set of general surgeon privileges with additional orthopedic privileges handwritten in margins of the form. The orthopedic surgery privilege list has since been revised to be specific to that discipline. We reviewed the medical records for this patient and did not find a poor surgical outcome as a result of the procedure.

OR nurses were to validate and document prior to surgery that the procedures to be performed were on the surgeon's approved privilege list. This was not being done. The OR Nurse Manager told us that this process is now being enforced and closely monitored.

Clinical staff and leadership also told us that, to further improve the privileging process, privilege forms for each surgical specialty are being re-written by an interdisciplinary team. The forms will not go to the PSB for approval until there is agreement on content and clarity between the Chief of Surgery, section chiefs, surgeons, OR Nurse Manager, and the facility's Office of Performance and Quality.

[5] Radical prostatectomy is a surgery to remove all of the prostate gland and some of the tissue around it, to treat prostate cancer.
[6] VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.
[7] A closed reduction internal fixation of fractures is a technique where the fracture is set with physical manipulation, without an incision. An open reduction internal fixation of fractures involves an incision and the use of screws and/or plates to set the fracture.

To further evaluate the allegation of poor surgical outcomes, we reviewed National Surgical Quality Improvement Project data, internal reviews, and other documents, and found no adverse patient outcomes related to these procedures that were performed without approved privileges.

The facility had received recommendations from previous reviews regarding the privileging of physicians. OIG conducted a scheduled site visit in 2009 and recommended that ongoing professional practice evaluations, provider profiles, and privileges comply with VHA requirements.

As a result of their site visit in November 2010, the VISN required that surgeons not be allowed to perform procedures they had not been granted privileges for, and that action be taken to improve the privileging processes at the facility. The VISN also provided education regarding privileging processes to the facility. VISN staff conducted another site visit in July 2011, and recommended that surgical core privileges be reviewed and revised.

Issue 2: Resident Supervision

We substantiated the allegation that a specialty surgery service's residents were not supervised appropriately. We found that residents were seeing patients at the facility 2 days per week without a supervising attending physician (SA) with them in the clinic. We also found that the facility policy did not define the timeframe for documentation of resident supervision by the SA in the patients' medical records.

Onsite Supervision

In the outpatient setting, surgeons see patients in the clinic for consultation, follow-up, and invasive procedures. The facility currently employs one full-time and three part-time surgeons in the specialty service to meet patient care needs, including supervision of residents rotating through this specialty. While there are two residents at the facility during an academic year, the residents rotate monthly so there is only one resident assigned at a time.

VHA Policy[8] requires that when residents are working in an outpatient clinic, a supervising practitioner must be physically present during clinic hours. We reviewed the specialty service surgeons' work schedules for the last 24 months. The only full-time specialty surgeon on staff has been on extended leave for several months. One part-time surgeon works at a Community Based Outpatient Clinic and is onsite at the facility 1 half-day per month. The remaining two part-time surgeons work at the facility on Mondays, Tuesdays, and Thursdays. There is no SA present in the clinic when residents are seeing patients on Wednesdays and Fridays.

[8] VHA Handbook 1400.1, *Resident Supervision*, July 27, 2005.

The facility's attempts to recruit additional specialty service surgeons were unsuccessful. As a result, on the days in which a surgeon was not on site, procedure clinics were cancelled and the residents were only allowed to perform pre-operative assessments (history and physicals) and post-operative follow-up visits. Both of the specialty service residents currently assigned to the facility are 2nd year residents and clinical leadership told us they thought these arrangements would be commensurate with the residents' level of training and experience. Although changes were made in services offered on days in which no surgeon was onsite, the facility was not in compliance with the VHA resident supervision policy.

Documentation of Resident Supervision

VHA policy[9] permits four ways to document resident supervision in the medical record:

1. The SA writes a progress note of his own along with the resident's note.
2. The SA writes an addendum to the resident's note.
3. The SA co-signs the resident's note, which implies that the SA is in agreement with the content (absent an addendum to the contrary).
4. The resident includes specific verbiage in the note, such as, "I have seen and discussed the patient with my supervising practitioner Dr. [X], and Dr. [X] agrees with my assessment and plan."

Facilities are also required to determine acceptable timeframes for documentation of resident supervision and this should be included in local policy. We reviewed the facility's local policies and found that no such timeframes were defined. However, the Chief of Surgery told us that she expected documentation of resident supervision to occur within 24 hours. The Chief of Staff and Associate Chief of Staff for Education stated that they expected this documentation to occur within 48 hours, or 72 hours if over a weekend.

We found that, generally, the facility relied on SA co-signature of residents' entries into the medical record to document resident supervision. We randomly selected 50 patients seen in the Specialty Resident Clinic between October 1, 2010 and March 31, 2011. We reviewed the 50 progress notes associated with these clinic appointments. Only 25 of the 50 notes were co-signed within 48–72 hours; 5 of the 25 notes were not co-signed for over a week. These progress notes were not visible in the medical record until they were co-signed; therefore, other staff involved in the care of these patients could have experienced delays in accessing important clinical information.

[9] VHA Handbook 1400.1.

VHA policy[10] states that when pre-operative assessments are completed by residents, a co-signature by the SA is not sufficient. The SA must write his own note or addendum describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed. We found that the specialty SAs did not complete pre-operative documentation in the patients' medical records as required. Of the 50 medical records we reviewed, 31 had a pre-operative assessment (history and physical report) completed by a specialty resident. We found that none of the 31 records contained the required SA progress note or addendum.

Issue 3: Pre-Operative Documentation

Although not one of the complainant's allegations, we found deficiencies in required pre-operative documentation by the specialty surgeons.

Per VHA policy[11] and Joint Commission standards, an "interval note" must be completed immediately prior to any operative procedure by a physician indicating that the information in the previous notes is still accurate, an appropriate assessment was completed prior to surgery, the patient still requires the procedure, and that the patient's condition has not changed.

We reviewed the medical records of 31 patients who had surgery in the OR between October 1, 2010 and April 30, 2011. In 15 (48 percent) of the 31 records we reviewed, there was no interval note as required.

Conclusions

We substantiated the allegation that some surgeons performed operative procedures that were not on their PSB approved privilege list. We substantiated the allegation that residents were not supervised as required while they were seeing patients in the clinic. We found that facility policy did not define timeframes for documentation of resident supervision as required, and progress notes were not co-signed in a timely manner. We also found that required additional pre-operative assessment documentation was not completed by attending surgeons. We found that surgeons did not complete interval notes immediately prior to an operative procedure as required.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that privileges are appropriate for the procedures being done and that compliance with this be monitored.

[10] VHA Handbook 1400.1 and VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.
[11] VHA Handbook 1400.1 and VHA Handbook 1907.01

Recommendation 2. We recommended that the Medical Center Director ensure that residents have onsite supervision as required.

Recommendation 3. We recommended that the Medical Center Director ensure that the resident supervision policy defines timeframes for the documentation of supervision as required.

Recommendation 4. We recommended that the Medical Center Director ensure that pre-operative documentation is completed as required and that compliance with this be monitored.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with our findings and recommendations and provided acceptable action plans. See Appendixes A and B, pages 8–13, for the full text of the Directors' 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: August 17, 2011

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

Subject: **Healthcare Inspection – Surgeon Privileging and Resident Supervision Issues, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina**

To: Associate Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. The attached subject report is forwarded for your review and further action. I have reviewed the responses and concur with the facility's recommendations.

2. Please contact Paul Russo, Director, W. G. (Bill) Hefner VA Medical Center at (704) 638-3344 if you have any further questions.

DANIEL F. HOFFMAN, FACHE
Network Director, VISN 6

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 4, 2011

From: Director, W. G. (Bill) Hefner VA Medical Center (659/00)

Subject: **Healthcare Inspection – Surgeon Privileging and Resident Supervision Issues, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina**

To: Director, VA Mid-Atlantic Healthcare Network (10N6)

1. I have reviewed the draft report of the Office of Inspector General and I concur with the recommendations.

2. I have included my response in the attached Director's Comments.

3. Please contact me if you have any questions or comments.

Paul M. Russo

Paul M. Russo, MHSA, FACHE, RD
Director, W. G. (Bill) Hefner VA Medical Center (659/00)

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

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

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that privileges are appropriate for the procedures being done and that compliance with this be monitored.

Concur **Target Completion Date: August 19, 2011**

Facility's Response:

Based upon recommendations from the VISN review of Surgery Service that occurred in November 2010, and in consultation with the VHA Director of Quality Standards, privilege forms for general surgery, urology and orthopedics were revised. The two surgeons identified operating outside of approved privileges in this time frame were appropriately suspended until cases were reviewed and surgeons cleared to return to duty. All surgical section chiefs reviewed these revised privilege forms with the surgeons to ensure understanding and clarity.

Completed

Under the direction of the Chief of Staff, the Professional Standards Board (PSB) was restructured to include critical stakeholders and ensure a quorum. At the request of the Medical Center Director, all PSB members completed re-education on credentialing & privileging and the quality of the PSB minutes has been improved to accurately and comprehensively address actions and decisions made by the PSB.

Completed

In May 2011, the new Chief of Surgery arrived at Salisbury VAMC. To further improve the privilege form, the Medical Center Director directed the Chief of Surgery to re-write the privilege forms for each surgical specialty. To ensure accuracy, these forms will be reviewed and concurred upon by the Chief of Surgery, section chiefs, surgeons, the OR Nurse Manager, and the Office of Performance and Quality prior to being presented to the PSB for approval.

Target Date: August 19, 2011

To ensure compliance, each morning the Chief of Surgery reviews the surgery schedule with the OR Nurse Manager and signs the schedule to indicate concurrence. Prior to each surgery, the OR Nurse Manager validates that the procedure to be performed is on the surgeon's approved privilege list. This is then documented and maintained in the Surgery Clinic. In addition, the Medical Center Director instructed the Office of Performance and Quality staff to conduct random audits of this process to monitor compliance. Random audits have been completed since January 2011 and any questions are immediately discussed with the Chief of Surgery. To date, no outliers have been identified and all surgeons have been fully compliant.
Completed/Ongoing

The primary surgeon of concern with 17 instances of performing procedures outside of his privileges is currently under a 120-day Focused Professional Practice Evaluation (FPPE) that was established in consultation with the VHA Director of Quality Standards. The PSB is reviewing the FPPE documentation at 30 day intervals.
Target Date: September 30, 2011

The Medical Center Director has also instructed leadership to evaluate and strengthen staff performance standards related to credentialing and privileging requirements in order to maintain accountability for adherence to relevant policy and procedures.
Target Date: October 30, 2011

Recommendation 2. We recommended that the Medical Center Director ensure that surgical service residents have onsite supervision as required.
Concur **Target Completion Date: September 15, 2011**

Facility's Response:

On May 12, 2011, immediately following receipt of guidance from the OIG inspectors, clinical leadership assigned a supervising attending physician (SA) to provide onsite supervision of the residents in the clinic. The surgeon who had been on military leave returned to work and since July 6, 2011, has provided onsite supervision of the residents in the clinic.
Completed

Should a situation arise where the SA is unavailable, resident supervision will be halted and patients will be reassigned to another provider if possible and fee basis authorization will be considered based upon clinical urgency. If another provider is not available and there is no clinical urgency, clinics will be cancelled until such time that a SA is available to provide onsite

supervision. Staff from the Office of Performance and Quality will conduct weekly random audits in all areas with residents to determine the presence of an onsite supervisor with the residents. Any instance of non-compliance will immediately be reported to the Chief of Staff and the Medical Center Director. This will be monitored for 6 months at which time the process will be reassessed for continuation or modification.

The Medical Center Director has instructed the Chief of Staff and Associate Chief of Staff for Research and Education to review compliance with resident supervision requirements with all clinical department chiefs. All clinical department chiefs will review these requirements with their staff. **Target Date: September 15, 2011**

Recommendation 3. We recommended that the Medical Center Director ensure that the resident supervision policy defines timeframes for the documentation of supervision as required.

Concur **Target Completion Date: Completed**

Facility's Response:

The Medical Center Director has ensured that the documentation of supervision of residents is in compliance with VHA Handbook 1400.1, "Resident Supervision." According to Handbook 1400.1, the timeframe given to the supervising attending physician for co-signing the residents' progress notes, consultations, and reports is delineated in local facility policy or local medical staff bylaws. The timeframe for documentation of resident supervision has been added to the Salisbury VA Medical Center medical staff bylaws and these bylaws were approved on June 30, 2011.

To monitor compliance, Research and Education staff will perform fifteen monthly reviews of surgical residents' and thirty quarterly reviews of all non-surgical residents' documentation to determine timeliness of the SA physician's co-signature. Results of this monitoring will be reported to the Clinical Executive Board. This will be monitored for 6 months at which time the process will be reassessed for continuation or modification.

Recommendation 4. We recommended that the Medical Center Director ensure that pre-operative documentation is completed as required and that compliance with this be monitored.

Concur **Target Completion Date: Completed**

Facility's Response:

The Medical Center Director has directed the Chief of Surgery to instruct all surgeons to complete all pre-operative documentation for all cases. The Chief of Surgery sent an electronic memorandum to all surgeons on August 8, 2011, with a read receipt. The topic of completing pre-operative documentation was discussed at the May 19, 2011 surgery staff meeting and was also added to the agenda for the surgery staff meeting scheduled August 11, 2011.

Monitoring is completed by peers during the clinical pertinence reviews, of which 10 are completed each quarter. The results of these reviews are reported to the PSB every 6 months. In addition, the Chief of Surgery will complete medical record reviews for 50 percent of all surgical cases for the History and Physical update and 50 percent of all urology cases to validate compliance with weekly reports to the Chief of Staff and monthly reports to the Clinical Executive Board. This monitor will continue for 6 months to ensure compliance and will be reported to the Chief of Staff. At that time, the monitoring will be reassessed for continuation or modified if needed. Should there be a lack of compliance with pre-operative documentation, the Chief of Surgery will identify the outliers and meet with those individuals to review the importance of this documentation. The results of individual surgeons' pre-operative documentation will be reflected in their performance appraisals.

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	Carol Torczon, ACNP, Associate Director, Project Leader Karen McGoff-Yost, LCSW, Team Leader Robert Yang, MD

Appendix D

Report Distribution

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