Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03083-17

Combined Assessment Program Review of the Marion VA Medical Center Marion, Illinois

November 2, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of August 17–21, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Marion VA Medical Center (the medical center), Marion, IL. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to about 60 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

The CAP review covered five operational activities. We made recommendations in four of the activities reviewed. For these activities, medical center managers needed to ensure compliance with Veterans Health Administration (VHA) policies and other external standards related to:

- QM.
- Physician Credentialing and Privileging (C&P).
- Environment of Care (EOC).
- Medication Management.

The medical center complied with selected standards in the following activity:

- Coordination of Care.

This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations. While we disagree that the medical center had fully functioning programs and processes in place at the time of our review, the improvement plans provided are acceptable. (See Appendixes A and B, pages 19–28, for the full text of the Directors' comments.) We will follow up on the planned

actions until they are completed, and we will evaluate the effectiveness of those actions at periodic intervals to ensure that the identified conditions have been corrected.

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

Introduction

Profile

Organization. The medical center is located in Marion, IL, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at eight community based outpatient clinics in Effingham and Mt. Vernon, IL; Vincennes and Evansville, IN; and Owensboro, Hanson, Paducah, and Mayfield, KY. The medical center is part of VISN 15 and serves a veteran population of about 127,000 throughout 52 counties in southern Illinois, southeastern Indiana, and western Kentucky.

Programs. The medical center provides primary, specialty, and inpatient care; physical medicine and rehabilitation; neurology, oncology, cardiology, surgery, and urology services; pain management; behavioral health (BH); and geriatrics and extended care. It has 55 hospital beds and 60 community living center (CLC) beds.

Affiliations and Research. The medical center is affiliated with Saint Louis University and Southern Illinois University and provides training for six residents in cardiology and ophthalmology. The medical center does not have a research program.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled approximately $176.7 million. The FY 2009 medical care budget was about $188.4 million. FY 2008 staffing was 1,020 full-time employee equivalents (FTE), including 70 physician and 345 nursing FTE. FY 2009 staffing was approximately 1,310 FTE, including 111 physician and 455 nursing FTE.

Workload. In FY 2008, the medical center treated approximately 42,000 unique patients and provided about 13,000 hospital inpatient days of care. The hospital inpatient care workload totaled about 2,900 discharges, and the hospital average daily census was 37. The CLC provided about 21,000 inpatient days of care and had an average daily census of 58. Outpatient workload totaled about 352,000 visits. FY 2009 workload data was not yet available at the time of this report.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following five activities:

- Coordination of Care.
- EOC.
- Medication Management.
- Physician C&P.
- QM.

The review covered medical center operations for FY 2008 and FY 2009 through August 21, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from three previous reports:

- *Combined Assessment Program Review of the VA Medical Center, Marion, Illinois,* Report No. 05-03486-93, February 21, 2006. There were no health care related recommendations from our prior CAP review.

- *Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities*, Report No. 07-00029-151, June 20, 2007. We found that the medical center was in compliance with the recommendations.

- *Quality of Care Issues, VA Medical Center, Marion, Illinois,* Report No. 07-03386-65, January 28, 2008, (hereinafter referred to as the January 2008 Hotline report). We found that many of the previously identified issues had been corrected; however, several QM and C&P conditions still existed. Those repeat findings will be discussed further in the next section of this report. In addition, we noted that all of the medical center's senior leadership positions and many of the key service chief positions had experienced turnover in the past 2 years.

During this review, we also presented fraud and integrity awareness briefings for about 60 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective actions.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine whether (a) the medical center had a comprehensive and effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) senior managers actively supported QM efforts and appropriately responded to QM results. To evaluate QM processes, we interviewed senior managers, QM staff, and other knowledgeable personnel. In addition, we reviewed the self-assessment regarding compliance with QM requirements as well as committee minutes and other relevant QM documents.

We evaluated 13 QM areas and found that patient complaints and patient safety goals related to anticoagulation and medication reconciliation were monitored appropriately. However, we determined that the medical center did not fully comply with VHA guidelines, resulting in deficiencies in the remaining 10 QM areas we reviewed. We noted that several QM-specific corrective actions initiated in response to the January 2008 Hotline report had not been fully implemented and did not consistently correct the conditions identified. We also noted that conditions identified in the January 2008 Hotline report still existed in the areas of QM oversight structure, peer review, mortality assessment, patient safety, and adverse event disclosure.

The remainder of the QM section discusses those repeat findings from the January 2008 Hotline report, conditions newly identified during this CAP review, and the overall status of the medical center's QM Program.

Repeat Quality Management Findings

Committee Oversight Structure. The medical center's QM oversight and reporting structure was fragmented and inconsistent, making it difficult to determine the extent of oversight or the corrective actions taken to improve patient care. A functional and accountable QM oversight structure assures that oversight committees and their subordinate committees are monitoring, analyzing, and reporting according to guidelines and that recommendations and corrective actions are appropriately followed up. Also, the medical center's committee oversight structure was not fully integrated or functional, as evidenced by the span of deficiencies across multiple QM areas. See Table A on page 10 for further details.

Peer Review. The peer review program had a designated Peer Review Committee (PRC), and local policy was in compliance with VHA requirements. However, we found that the medical center had an inadequate peer review process, resulting in the following deficiencies:

- *Backlog of Cases.* Peer review cases were not completed within the required 45- or 120-day timeframes, as required by VHA policy.[1] Medical center staff provided us with the most recent available

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008. This is the reference for all peer review related findings in this section unless otherwise indicated.

data, a 1st quarter FY 2009 report showing that 13 (17 percent) of the 75 initial peer reviews were not completed within 45 days. In addition, the PRC had not finalized 18 (34 percent) of 53 final peer reviews within 120 days. The Peer Review Coordinator told us that the PRC had been meeting twice a week to decrease the case backlog and to improve timeliness of final peer reviews. However, we were not provided with documentation reflecting the current status of the backlog or the current timeliness of peer reviews.

- *Process and/or System Issues.* Communication was inadequate, and case referral systems were inefficient. For example, the PRC did not refer patient safety related process and/or system issues to the Patient Safety Manager (PSM). The PRC maintained a list of process and/or system issues identified during peer reviews. However, the list was not provided to the PSM, and the PSM was not included in discussions to determine the need for a root cause analysis (RCA) or other review. VHA policy requires that process and/or system issues identified through peer review be referred for appropriate evaluation.

  Also, we identified 27 cases listed in the February 2009 Operative and Other Invasive Procedure Review Committee minutes with events that occurred between May 2007 and January 2009. However, we could not validate whether the cases had actually been referred to the PRC. VHA policy requires that a peer review level be assigned to cases meeting screening criteria.

Mortality Assessment. Mortality screening criteria did not include all required elements, and mortality reports did not include trending by service or by provider, as required by VHA policy.[2] We also found that a critical analysis of deaths completed by QM staff was inadequate and that the number of reported deaths was inconsistent.

- *Inadequate Screening*. The medical center was using mortality screening criteria from an outdated VHA directive and, as a result, did not screen for deaths within 30 days of surgical procedures, as required by current VHA policy. Surgical Service staff were aware of two deaths occurring after surgical procedures, but it

[2] VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.

does not appear that the information was provided to QM staff. Thus, the deaths were not included in monthly mortality reports.

- *Critical Analysis.* Mortality data were not always critically analyzed when a specific concern was identified. For example, QM staff evaluated 16 deaths that occurred on a particular unit between January and July 2009. QM staff limited the review criteria to include: (a) change in patient's condition, (b) age, (c) terminal status, (d) hospice enrollment, and (e) do-not-resuscitate status. The report to medical center managers showed that these deaths were associated with a terminal illness and that no trends existed.

  QM staff noted in the margins or in the comments sections of their worksheets that 3 (19 percent) of the 16 patients had some type of infection prior to death. However, QM staff were unable to tell us whether these deaths were related to infections since they had not included that criterion in their review. In addition, they could not say whether the infections represented a pattern or cluster, signifying an infection control problem.

- *Validation.* The number of deaths at the medical center was inconsistently reported. For example, Clinical Executive Board (CEB) minutes documented that there were five deaths in April 2009. However, the Patient Movement Statistics Report listed six deaths, and the Gains and Losses sheets showed seven deaths. Staff were unable to describe the methods used to validate mortality data.

Patient Safety. The patient safety program was not integrated into all areas of the medical center, and tracking of completed actions and evaluation of outcomes were incomplete and inconsistent. We also found that a comprehensive report had not been presented to senior managers, as required by VHA policy.[3]

- *Integration.* Patient safety was not integrated throughout the medical center. We interviewed the PSM, the Risk Manager, the Peer Review Coordinator,

[3] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

and other staff. During these interviews, it became clear that there was no process in place for consistent sharing of information between the various entities. Risk management and patient safety staff confirmed that they were unaware of several significant patient safety events that would have warranted further review.

- *Tracking.* While staff told us that tracking had been documented in Patient Safety Council (PSC) minutes, we were unable to confirm this assertion. Our review of PSC minutes for the 12 months preceding our visit showed that reporting and tracking of RCA actions, evaluation of action effectiveness, and measurement of outcomes were sporadic.

- *Reporting.* Significant issues from RCAs were not reported to clinical staff, and a comprehensive patient safety report had not been presented to senior managers in the previous 12 months. Reporting is to include patterns and trends as well as process and/or systems issues. For example, we found no evidence that senior managers were aware of actions taken (or not taken) in response to an RCA involving clinic cancellations and a subsequent adverse patient outcome.

Adverse Events. The medical center was not in compliance with all elements of adverse event disclosure required by VHA policy.[4] From September 2008–May 2009, 15 peer reviews were assigned a Level 3 rating (indicating that peer reviewers would have handled patient care differently). We randomly selected four of these peer reviews and found that only one of them had been evaluated for disclosure. Again, risk management and patient safety staff informed us that they were unaware of the cases and therefore had not evaluated them for disclosure.

We also reviewed the three disclosure cases that the medical center did identify during FY 2009 through August 21, 2009. We found inconsistent decision criteria when determining the need for clinical versus institutional disclosure. In addition, we found delays in disclosure. In one case, disclosure occurred 2 months after discovery of the event; in another case, disclosure occurred 11 months after discovery of the event. As a result, we could not be

[4] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

assured that events were evaluated properly to determine the need for disclosure or that disclosure would be timely should it be indicated.

Newly Identified Quality Management Conditions

Medical Records. Service-level personnel did not conduct medical record reviews regularly, and the Medical Records Committee did not consistently receive data from clinical services. VHA policy[5] requires ongoing medical record reviews by staff who document in the record to assess quality, consistency, accuracy, completeness, and authentication.

In addition, the local computerized patient record system policy on the appropriate use of the copy and paste functions was just published in May 2009. Therefore, the medical center had not monitored the use of these functions in accordance with VHA policy.

Operative and Other Invasive Procedure Review. Conscious sedation (CS) data were not trended or analyzed in accordance with VHA policy[6] in all areas where moderate sedation was performed.

Resuscitation and Its Outcomes. Local policy did not identify which medical center staff needed to maintain basic life support (BLS) or advanced cardiac life support (ACLS) certification. In addition, 4 (40 percent) of the 10 police officers had not received the required cardiopulmonary resuscitation (CPR) training. VHA policy[7] requires that local policy designate staff who need to maintain BLS or ACLS certification and that all police officers receive CPR training.

System Redesign/Patient Flow. Data analysis was inconsistent, and actions taken had not consistently been evaluated for effectiveness.

Utilization Management. Data analysis was inconsistent, and actions taken had not consistently been evaluated for effectiveness.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[6] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[7] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

Overall Quality Management Program Status

We found that the medical center did not have a comprehensive and effective QM program that adequately monitored patient care activities and coordinated improvement efforts. The oversight reporting structure for QM reviews was fragmented and inconsistent, and accountability for quality monitoring and performance improvement activities appeared limited. These deficiencies, coupled with a lack of accurate data, seriously hindered senior managers' abilities to make reasonable, data-driven decisions and to respond to QM results.

Table A on the next page illustrates the extent to which the various types of deficiencies spanned multiple QM program areas. Repeat findings from the January 2008 Hotline report are denoted with an "R" in bold font.

Deficiencies generally fell into one of the following categories as defined by VHA policy, external accrediting body standards, or local policies:

- *Integration and Comprehensiveness of QM Program.* The QM program should include specific elements to monitor and evaluate QM activities across the organization.

- *Documentation of Conclusions, Recommendations, and Corrective Action Completion*. Identified QM improvement initiatives require documentation of conclusions, recommendations, and corrective actions.

- *Reporting to and/or Evaluation by an Oversight Committee*. Routine evaluation of important QM monitors by an oversight committee is required to ensure evaluation of improvement opportunities and implementation of appropriate actions.

- *Data Trending, Analysis, and Reporting.* To identify improvement opportunities, the QM program should evaluate trends, analyze data, and ensure reporting to appropriate medical center entities.

Table A. Matrix of QM-Wide Deficiencies

	QM REVIEW AREA									
	1	2	3	4	5	6	7	8	9	10
	Oversight Structure	Adverse Event Disclosure	Medical Record Review	Mortality Review	Operative and Other Invasive Procedures	Patient Safety	Peer Review	Resuscitation and Its Outcomes	System Redesign/ Patient Flow	Utilization Management
QM program not integrated or comprehensive (does not include all elements)	***Fragmented and Inconsistent***		X	**R**	X	**R**	**R**			
Inadequate documentation of conclusions, recommendations, and corrective action completion			X	X	X		X	X	X	X
Inadequate reporting to and/or evaluation by an oversight committee		**R**	X	**R**	X		X	X		
Inadequate data trending, analysis, and reporting			X	**R**			**R**	X	X	X

We determined that an overall evaluation and redesign of the QM program is needed to promote communication and collaboration and to comply with VHA and external accreditation standards. Prior to leaving site, managers confirmed that efforts were underway to secure an experienced QM consultant who would take a leadership role in this endeavor.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires an overall redesign of the QM oversight and reporting structure.

The VISN and Medical Center Directors agreed with our findings and recommendation. While we disagree that the medical center had a functioning QM structure in place at the time of our review, the improvement plans provided are acceptable. The medical center has established a new governance structure and revised the QM policy to comply with VHA guidelines. We will follow up until the planned

actions are completed and quarterly monitors reflect that the actions have been effective.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires the QM program to comply with VHA and local policies pertaining to:

- Adverse Event Disclosure.
- Medical Record Review.
- Mortality Review.
- Operative and Other Invasive Procedures.
- Patient Safety.
- Peer Review.
- Resuscitation and Its Outcomes.
- System Redesign/Patient Flow.
- Utilization Management.

The VISN and Medical Center Directors agreed with our findings and recommendation. While we disagree that the medical center had functioning processes in place at the time of our review, the improvement plans provided are acceptable. The medical center has revised policies to comply with VHA guidance, trained staff as indicated, and established a new committee oversight and accountability structure to monitor QM areas. We will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires full integration of the patient safety program throughout the medical center.

The VISN and Medical Center Directors agreed with our findings and recommendation. While we disagree that the medical center had an integrated patient safety program in place at the time of our review, the improvement plans provided are acceptable. The patient safety program has now been integrated into the governance structure and includes the required monthly and annual reporting. A SharePoint site has been established to facilitate integration and shared data between patient safety and QM staff. We will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires routine collection, trending, analysis, and reporting of QM data.

The VISN and Medical Center Directors agreed with our findings and recommendation. While we disagree that the medical center had a functioning QM structure in place at the time of our review, the improvement plans provided are acceptable. QM staff have received training in data analysis and data management tools, and a template has been implemented which standardizes meeting minutes and reporting to governing bodies. We will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that corrective actions relative to QM areas are evaluated for effectiveness and that outcomes are measured.

The VISN and Medical Center Directors agreed with our findings and recommendation. While we disagree that the medical center had a functioning QM program in place at the time of our review, the improvement plans provided are acceptable. Evaluation of effectiveness will become a standard agenda item for governing bodies. QM experts provided training to key staff on how to collect, review, and analyze data using statistical and analytic tools for effective decision making. These QM experts will continue as consultants to the QM program and medical center leadership. We will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the medical center complied with selected VHA[8] and local policy requirements for the C&P of physicians. We reviewed C&P files and provider profiles for 23 physicians who were newly hired or reprivileged in the past 12 months. We also reviewed CEB meeting minutes, which include discussions about physicians' privileges.

We found that licenses were current and that primary source verification had been obtained for all physicians

[8] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

included in our review. However, we identified the following areas that needed improvement.

Practitioner Professional Practice Evaluation. Privileging is the process by which a facility determines what procedures a provider may perform based on clinical competency and the needs of the organization. VHA regulations and external accrediting bodies require a written plan with specific competency criteria for all privileged physicians.

We found insufficient proctoring or monitoring information to confirm privilege-specific competency for 20 (87 percent) of the 23 physicians. In addition, we found that the CEB's Professional Standards Session meeting minutes did not reflect detailed discussion of physicians' performance data. This condition was also identified in the January 2008 Hotline report.

Physician Privileges. We found that two providers performed procedures for which they did not have privileges. One provider performed an arthroscopy (surgical procedure to view the inside of a joint through a viewing instrument); another provider administered CS to a patient on an inpatient medical unit. Local policy does not identify this unit as an area where CS can be administered. Neither patient suffered an adverse outcome as a result of their respective procedures.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that physician privileging processes comply with VHA requirements.

The VISN and Medical Center Directors agreed with our findings and recommendation. While we disagree that the medical center had a functioning privileging program in place at the time of our review, the improvement plans provided are acceptable. Appropriate staff will be trained on the requirements for provider privileging, and actions will be monitored through the CEB. We will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected infection control standards and maintained a clean and safe health care environment. VHA facilities are required to provide a comprehensive EOC program that fully meets VHA,

Occupational Safety and Health Administration (OSHA), Centers for Disease Control (CDC) and Prevention, and other external accrediting body standards.

We inspected inpatient medical wards 2A, 3A, and 3B, the intensive care unit, and the CLC. In addition, we inspected the emergency department and outpatient clinics.[9] We found that the medical center maintained a generally clean environment and promoted hand and respiratory hygiene programs. However, we identified the following conditions that needed improvement.

Safety. Medical center staff conducted EOC rounds; however, the system to document deficiencies and corrective actions was inadequate. Environmental Management Service (EMS) had responsibility for maintaining a list of the identified deficiencies, forwarding those deficiencies to appropriate staff or services for correction, and tracking those corrective actions through resolution. We found that EMS's tracking record did not consistently reflect that EOC deficiencies were referred, that responsible people or services responded, or that deficient conditions were addressed and resolved. In addition, EOC Committee minutes did not reflect discussion, trending, or analysis of the deficiencies over time. We were told that Engineering Service would be assuming responsibility for this function.

During our tour, we found the following conditions:

- Electrically operated lifts in bathrooms were not connected to ground-fault circuit-interrupter (GFCI) protected receptacles. The National Fire Protection Association's (NFPA's) National Electrical Code requires installation of GFCI protection devices in bathrooms. While we were onsite, program managers began installation of GFCI protected receptacles.

- Some storage areas in the medical center and the CLC did not meet NFPA standards. The standards require clearance of at least 18 inches between the ceiling and the top of stored items to allow sprinklers to work effectively in the event of a fire.

[9] Gastroenterology, nephrology, renal, BH (including the Rural King building), primary care (including the Primary Care Annex), dermatology, and surgery.

- Egress corridors were cluttered with equipment. NFPA standards require that corridors be clear of obstructions in the event that emergency evacuation is required.

Infection Control. Some practices and policies for infection control did not fully comply with VHA policy[10] and CDC guidelines. We found examination tables with torn covers in two outpatient clinic areas. In addition, we found that a patient with a history of Methicillin-resistant *Staphylococcus aureus (*MRSA)[11] and an order for contact precautions[12] was inappropriately placed in a room that shared a bathroom with two patients who did not require contact precautions.

Also, 7 (12 percent) of the 58 EMS employees did not receive training on cleaning and disinfection procedures, and 17 (29 percent) EMS employees did not receive annual training on the Bloodborne Pathogens Rule, as required by OSHA.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that deficiencies identified during EOC rounds are appropriately reported and that corrective actions are tracked through resolution.

The VISN and Medical Center Directors agreed with our findings and recommendation and provided acceptable improvement plans. An EOC rounds tracking tool has been implemented, and a process has been established to report EOC findings to the Joint Leadership Council through the EOC Committee. We will follow up until the planned actions are completed and quarterly monitors reflect that the actions have been effective.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that all bathroom receptacles, storage areas, and corridors comply with NFPA requirements.

The VISN and Medical Center Directors agreed with our findings and recommendation and provided acceptable improvement plans. The identified conditions have all been

[10] VHA Directive 2007-002, *Methicillin-Resistant Staphylococcus Aureus (MRSA) Initiative,* January 12, 2007.
[11] MRSA refers to a bacterium that causes infection and has become resistant to commonly used antibiotics.
[12] Contact precautions are steps taken, such as wearing gloves and gown, to reduce the risk of transmission of infection through direct and indirect contact.

corrected, and ongoing compliance will be monitored through EOC rounds. We will follow up until quarterly monitors reflect that the actions have been effective.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that infection control policies, practices, and training comply with current VHA policy and with CDC and OSHA guidelines.

The VISN and Medical Center Directors agreed with our findings and recommendation and provided acceptable improvement plans. EMS staff have completed the appropriate training, and infection control policies have been updated to comply with VHA policy and with CDC and OSHA guidelines. We will follow up until quarterly monitors reflect that the actions have been effective.

Medication Management

The purpose of this review was to evaluate whether the medical center had developed effective and safe medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed selected medication management processes on an inpatient medical ward (3B), on the intensive care unit, and in the CLC.

We found that the medical center had a designated Bar Code Medication Administration coordinator who appropriately identified and addressed problems. In general, pharmacy staff completed monthly medication reviews for CLC patients. However, we identified the following area that needed improvement.

Pain Medication Effectiveness Documentation. Local policy requires that nurses assess and document the effectiveness of PRN (as needed) pain medication within 240 minutes after administration. We reviewed the medical records of 10 patients who received a total of 49 doses of pain medications during the timeframe June 7–19, 2009. Only 33 (67 percent) of the 49 doses had effectiveness documented within the timeframe specified by local policy. Managers agreed that timely assessment and documentation of pain medication effectiveness are important.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently

assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

The VISN and Medical Center Directors agreed with our finding and recommendation and provided acceptable improvement plans. PRN pain medication effectiveness is now tracked and reported to the Nursing Service Committee, and continuous medical record reviews have been established to monitor compliance. We will follow up until quarterly monitors reflect that the actions have been effective.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and external accrediting body requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

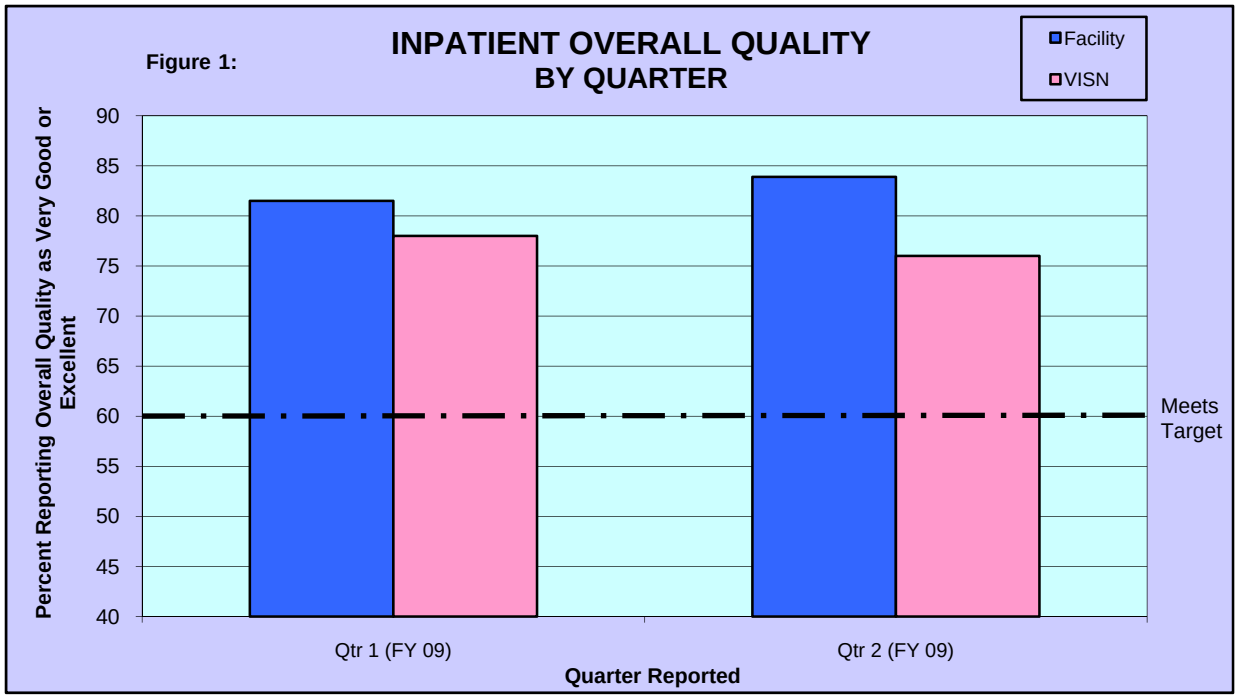
We reviewed the documentation for 10 intra-facility transfers that occurred during the timeframe May 20–31, 2009, and determined that all cases were managed appropriately. We found transfer notes from sending to receiving units and documentation that nursing assessments were performed by the receiving units within established timeframes.

We reviewed the medical records of 10 discharged patients and found that that all patients received appropriate written discharge instructions. We also found documentation that the patients understood those instructions. We made no recommendations.

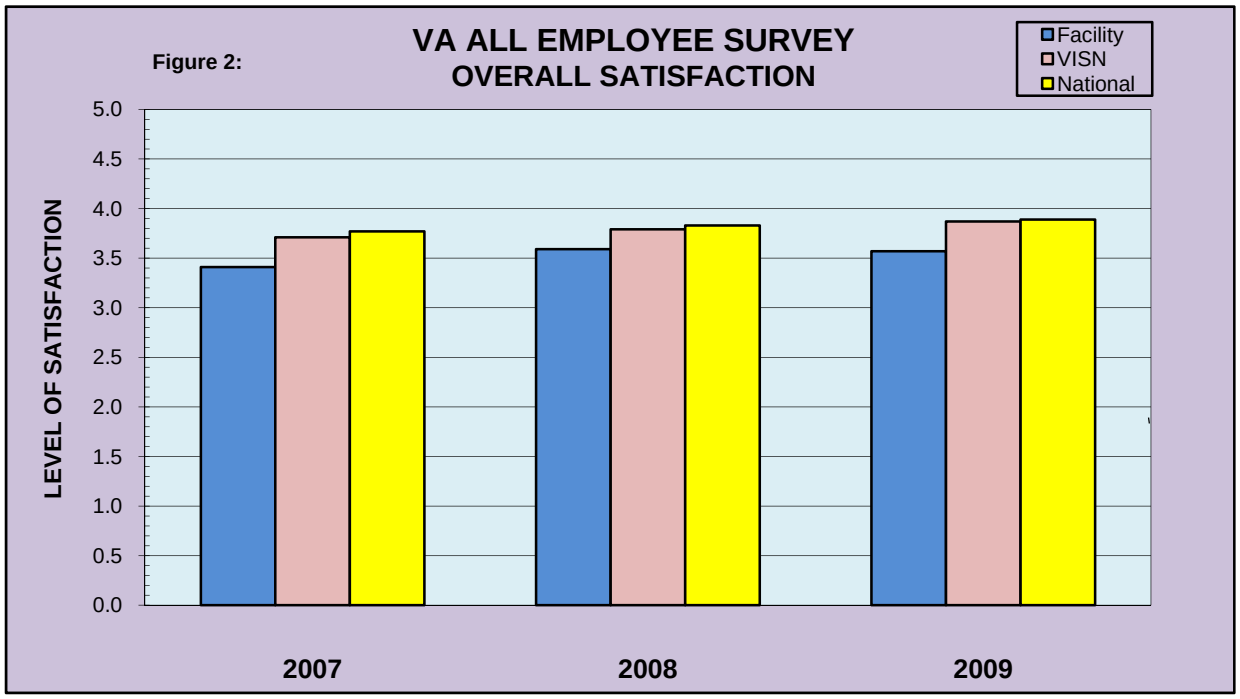
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1 and 2 of FY 2009.[13] The target score is noted on the graph.

[13] Due to technical difficulties with VHA's outpatient survey data, no outpatient satisfaction scores are available for quarters 1 and 2 of FY 2009.



Employees are surveyed annually. Figure 2 below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 27, 2009

From: Director, VA Heartland Network (10N15)

Subject: **Combined Assessment Program Review of the Marion VA Medical Center, Marion, Illinois**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (10B5)

Please accept the revised response to the Combined Assessment Program Review of the Marion VA Medical Center, Marion, Illinois, previously submitted to your office on October 15, 2009.

(original signed by:)
JAMES R. FLOYD, FACHE
Director, VA Heartland Network

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 26, 2009

From: Director, Marion VA Medical Center (657A5/00)

Subject: **Combined Assessment Program Review of the Marion VA Medical Center, Marion, Illinois**

To: Director, VA Heartland Network (10N15)

I concur with the findings from the OIG CAP visit conducted August 17–21, 2009. We recognize the progress that has been made, and both acknowledge and appreciate the opportunity to improve care for the nation's Veterans. The attached responses with action plans, as appropriate, for the recommendations are being resubmitted for your consideration.

At the time of this review, the VA Medical Center Marion, Illinois, had programs in all areas identified as needing improvement: Quality Management Oversight and Reporting; Adverse Event Disclosure; Medical Records Review; Mortality Review; Operative and Other Invasive Procedures; Patient Safety; Peer Review; Resuscitation and Its Outcomes; System Redesign/Patient Flow; Utilization Management; Physician Privileging; Environment of Care Rounds; NFPA Requirements; Infection Control Policies; Documentation of PRN Pain Medication Effectiveness.

VA Medical Center management had identified areas of improvement in most of these areas and was taking actions to strengthen these programs. We concur that these programs could be further enhanced through additional improvements.

(original signed by:)
WARREN E. HILL

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 report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires an overall redesign of the QM oversight and reporting structure.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, had a functioning quality management structure complete with reporting and oversight responsibilities in place at the time of this review. Opportunities for improvement in this structure had been identified by VA Medical Center management and were being implemented. We concur that these existing oversight and reporting structures could be strengthened through additional improvements. As a result of this review, the organization's governance structure has been redesigned, approved, and published with special attention to the four repeat areas. Committee data analysis and reporting have been intensified under this revised structure, and a new Quality Management (QM) organization chart is in place congruent with Veterans Health Administration (VHA) Directive 2009-043, Quality Management Systems.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires the QM program to comply with VHA and local policies pertaining to:

- Adverse Event Disclosure.

Concur Completion Date: 10/26/09

The VA Medical Center Marion, Illinois, had an adverse event disclosure process at the time of this review. Opportunities for improvement in this process had been identified by VA Medical Center management and were being implemented. We concur that this process could be strengthened through additional improvements. As a result of this review, the clinical and institutional disclosure processes and the Peer Review Committee Policy have been revised to be congruent with VHA Directive 2008-004. Trigger points are integrated into the clinical screen and peer review process to consider the need for disclosure. Clinical reviewers, committee members and medical staff have been trained. Peer review case load is

tracked through the Risk Management process. Outcome information is included in the monthly risk management report to the Clinical Executive Board.

- Medical Record Review.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, had a functioning medical records review process complete with committee reporting and oversight responsibilities in place at the time of this review. We concur that the existing medical records review processes could be strengthened through additional improvements. As a result of this review, the Medical Records Committee process has been modified so that data collection, analysis, and results tracking are reported through the governance structure to the Clinical Executive Board. Additional improvements include a physician appointed as chair of the Medical Records Committee, point of care record reviews, and reeducation of staff about these policy changes. The Copy and Paste Policy has also been updated and disseminated throughout the organization.

- Mortality Review.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, had a mortality review process in place at the time of this review, and no patients had been identified as being at risk. We concur that the mortality review processes could be strengthened through additional critical analysis of all mortality data. Additionally, the standard operating procedure (SOP) and screening tool for mortality assessment have been updated to include all criteria from VHA Directive 2005-056, and QM staff has been trained. An analysis of mortality records has been performed to verify facility data. Monthly reporting including analysis of mortality trends to the Clinical Executive Board is congruent with VHA Directive 2005-056.

- Operative and Other Invasive Procedures.

Concur Completion Date: 11/2/09

The VA Medical Center Marion, Illinois, had a functioning Operative and Invasive Procedures review process in place at the time of this review. We concur that the existing Operative and Invasive Procedures review process could be strengthened through additional improvements. As a result of this review, the Surgical Quality Assurance Committee (SQAC) will submit monthly moderate sedation trends and analyses to the Clinical

Executive Board. Use of a site-specific grid that identifies all areas for moderate sedation has been developed and is in use. Staff that is responsible for completing the grid has been educated on its use.

- Patient Safety.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, had a Patient Safety program in place at the time of this review. Although no patients were identified as being at risk, we concur that the existing patient safety program could be strengthened through additional improvements. As a result of this review, patient safety programs have been integrated into the governance structure with regular monthly and annual reporting. Root Cause Analyses are presented to executive leadership, discussed in the Patient Safety Committee, and tracked to completion. Issues related to patient safety, which are identified through the peer review process, are documented and sent to Patient Safety. The Patient Safety Manager is a member of the Peer Review Committee.

- Peer Review.

Concur Completion Date: 10/30/09

The VA Medical Center Marion, Illinois, had a functioning peer review process in place at the time of this review, and no patients were identified as being at risk. We concur that the peer review processes could be strengthened through additional improvements. As a result of this review, a plan for timely peer review and reducing the backlog of cases has been established and includes internal and external peer reviewers. A revised peer review tracking tool is being used to accurately track case load. Quarterly reports on timeliness will be reported through the governance structure to the Clinical Executive Board and Joint Leadership Council. Issues related to patient safety, which are identified through the peer review process, are documented and sent to Patient Safety. The Patient Safety Manager is a member of the Peer Review Committee. In addition, the process of integrating the cases from the Operative and Invasive Case Review Committee into the peer review process has been clarified. The 19 of the 27 cases from the February 2009 meeting have been closed. Eight cases are in process.

- Resuscitation and Its Outcomes.

Concur Completion Date: 10/30/09

The majority of Marion, Illinois, VA Medical Center employees who needed Advanced Cardiac Life Support (ACLS) and Basic Life Support

(BLS) training to perform their duties were trained on resuscitation and its outcomes even though the medical center's policy did not identify all those that were required to have this training. Employees identified as needing training were in the Police Service. We concur that the existing medical center policy and tracking tool could be strengthened through additional improvements. As a result of this review, the Cardio-Pulmonary Resuscitation Procedures policy has been revised and is in compliance with VHA Directives 2008-008 and 2008-063. Staff requiring Advanced Cardiac Life Support (ACLS) and Basic Life Support (BLS) is being trained and a tracking process established to assure certification currency for all applicable staff with reporting to the Critical Care Committee and Clinical Executive Board.

- System Redesign/Patient Flow.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, had a System Redesign Program at the time of this review. Opportunities for improvement in this program had been identified by VA Medical Center management and were being evaluated. We concur that the existing System Redesign program could be strengthened through additional improvements. As a result of this review, the System Redesign Program has been reviewed and incorporated into the Performance Improvement Program policy with quarterly reports to the Quality Executive Board to monitor effectiveness of actions taken.

- Utilization Management.

Concur Completion Date: 10/30/09

The VA Medical Center Marion, Illinois, had a functioning Utilization Management program at the time of this review. Opportunities for improvement in this program had been identified by VA Medical Center management and were being implemented. We concur that this program could be strengthened through additional improvements. As a result of this review, the Utilization Management Committee policy is being revised to provide oversight, reporting and tracking of the patient flow functions, patient flow processes and improvements, and analysis with reporting to the Quality Executive Board.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires full integration of the patient safety program throughout the medical center.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, had a Patient Safety program in place at the time of this review. Although no patients were identified as being at risk, we concur that the existing patient safety program could be strengthened through additional improvements. As a result of this review, the Patient Safety Program has been integrated into the governance structure, e.g., Quality Executive Board, Clinical Executive Board, and the Joint Leadership Council, with regular monthly and annual reporting. An electronic SharePoint site has been established to facilitate integration where Patient Safety and Quality Management staff have access to documented data, information, and analyses.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires routine collection, trending, analysis, and reporting of QM data.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, had a functioning quality management structure complete with reporting and oversight responsibilities in place at the time of this review. Opportunities for improvement in the data analysis and reporting structure had been identified by VA Medical Center management and were being implemented. We concur that the existing reporting structure could be strengthened through additional improvements. As a result of this review, the Quality Management reporting structure has been redefined and information has been disseminated to staff. Quality Management staff has received further training in data analysis and the use of data management tools to enhance their ability to analyze data and assist other departments. The "Council, Boards, and Committees" policy has been updated, which includes a standardized template for meeting minutes using the Conclusions, Recommendations, Actions, and Evaluation (CRAE) format.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that corrective actions relative to QM areas are evaluated for effectiveness and that outcomes are measured.

Concur Completion Date: 11/30/09

The VA Medical Center Marion, Illinois, had a quality management program in place at the time of this review. Opportunities for improvement in program had been identified by VA Medical Center management and were being implemented. We concur that the existing effectiveness and outcome measurements could be strengthened through additional improvements. As a result of this review, the medical center continues to strengthen the Quality Management program. Evaluation of effectiveness will be a standard agenda item for governance bodies such as the Quality

Executive Board, Clinical Executive Board, and the Joint Leadership Council. Quality Management experts provided training to key staff on how to collect, review, and analyze data using statistical and analytical tools for effective decision-making. Furthermore, the aforementioned collegial relationships with Quality Management experts will be sustained to evaluate and provide feedback to the Quality Executive Board, Clinical Executive Board, and the Joint Leadership Council on the effectiveness of the Quality Management program.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that physician privileging processes comply with VHA requirements.

Concur Completion Date: 10/30/09

The VA Medical Center Marion, Illinois, had a functioning privileging program complete with reporting and oversight responsibilities in place at the time of this review. Opportunities for improvement in these areas had been identified by VA Medical Center management and were being implemented. We concur that the existing privileging program could be strengthened through additional improvements. As a result of this review, Quality Management and Service Chiefs work collaboratively to develop sustainable improvements by providing current, reliable, specialty-specific monitoring information to confirm privilege competency in the Ongoing and Focused Professional Practice Evaluations. Regular recurring reports will be presented at the Professional Standards Board. The Professional Standards Board minutes will include detailed discussions of physicians' performance data.

A physician performance and provider profile library is used as a standardized process that provides clarity to the assessment of competency. A required training session on physician privileging processes for Professional Standards Board members, credentialing, and quality management staff is scheduled. An automated system is being pursued so that credentials and privileges are readily accessible to appropriate staff.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that deficiencies identified during EOC rounds are appropriately reported and that corrective actions are tracked through resolution.

Concur Completion Date: Complete

The VA Medical Center Marion, Illinois, performed environment of care rounds at the time of this review. Opportunities for improvement in this program and reporting process had been identified by VA Medical Center

management and were being implemented. We concur that environment of care rounds could be strengthened through additional improvements. As a result of this review, a process has been established to report environment of care findings through the Environment of Care Committee and governance structure to the Joint Leadership Council. A revised environment of care rounds tracking tool has been implemented. Implementation of an automated reporting tool is being pursued to facilitate tracking.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that all bathroom receptacles, storage areas, and corridors comply with NFPA requirements.

Concur Completion Date: Complete

Proper shelf height and items in hallways have been addressed and are monitored through environment of care rounds. Ground-fault circuit-interrupter (GFCI) protected receptacles have been installed in bathrooms according to the National Fire Protection Association's (NFPA) National Electric Code.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that infection control policies, practices, and training comply with current VHA policy and with CDC and OSHA guidelines.

Concur Completion Date: Complete

The majority of Marion, Illinois, VA Medical Center employees who needed infection control training to perform their duties were trained. The Medical Center's policies were not in compliance with VHA policies and CDC and OSHA guidelines. Employees identified as lacking training were in Environmental Management Service. We concur that the existing medical center policies could be strengthened through additional improvements. As a result of this review, Environmental Management Service (Housekeeping) staff have completed annual review of cleaning and disinfection procedures and OSHA Blood Borne Pathogen Rule. Infection Control policies have been updated and comply with VHA policy and CDC and OSHA guidelines.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

Concur Completion Date: Complete

VA Medical Center Marion, Illinois, was tracking PRN medication effectiveness at the time of this review. We concur that documentation of PRN pain medication effectiveness could be strengthened. As a result of this review, PRN pain medication effectiveness is now both being tracked and reported to the Nursing Service Committee. Medical record reviews have been established to monitor compliance.

OIG Contact and Staff Acknowledgments

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