Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00623-18

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

October 29, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CLC	community living center
CT	computed tomography
EAM	emergency airway management
ED	Emergency Department
EHR	electronic health record
EOC	environment of care
facility	Marion VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of August 24, 2015.

Review Results: The review covered eight activities. We made no recommendations in the following activity:

- Environment of Care

Recommendations: We made recommendations in the following seven activities:

Quality Management: Ensure licensed independent practitioners who perform emergency airway management have the appropriate skills and training. Require that the interdisciplinary committee includes a physician to review all episodes of care where resuscitation was attempted.

Medication Management: Complete monthly medication storage area inspections.

Coordination of Care: Ensure requestors consistently select the proper consult title.

Computed Tomography Radiation Monitoring: Develop a computed tomography policy that includes all required elements. Require a medical physicist to inspect computed tomography scanners that have repairs or modifications that affect dose or image quality before return to clinical service and to document the inspection.

Advance Directives: Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives. Hold advance directive discussions requested by inpatients, and document the discussions.

Surgical Complexity: Revise the electrocardiogram, blood bank, respiratory therapy, and radiology policies to clearly define appropriate availability for support services. Ensure Emergency Department and inpatient medical/surgical unit employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented. Require that post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the intensive care unit. Implement a defined plan or policy to have a qualified surgeon available 24/7 on call within 60 minutes.

Emergency Airway Management: Revise the emergency airway management policy to include a plan to manage a difficult airway. Ensure initial clinician emergency airway management competency assessment includes all required elements. Require that clinician reassessment for continued emergency airway management competency includes completion of all required elements at the time of renewal of privileges or

scope of practice. Ensure a qualified, non-Emergency Department clinician is assigned inpatient emergency airway management coverage.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–30, 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

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 quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2014 and FY 2015 through August 28, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Marion VA Medical Center, Marion, Illinois,* Report No. 13-00887-204, May 20, 2013).

During this review, we presented crime awareness briefings for 104 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 420 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 13 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Of the 13 licensed independent practitioners' folders reviewed, 12 practitioners' EAM privileges were not appropriate for their skills and training.	**1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.	Twelve months of Resuscitation Committee meeting minutes reviewed: • The committee's physician member was not in attendance from January 2015 to July 2015.	**2.** We recommended that the interdisciplinary committee include a physician to review all episodes of care where resuscitation was attempted.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.[b]

We inspected the ED, the CLC, inpatient units (medical/surgical and intensive care), and outpatient clinics (behavior health, primary care clinics at the main facility and the annex, and specialty clinics.) We also performed perimeter inspections of the Building 37 Remodel and ED Remodel construction sites. Additionally, we reviewed relevant documents, including 10 employee training and competency records, and conversed with key employees and managers. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met patient privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the ED, post-anesthesia care unit, CLC, and medical/surgical unit and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
X	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.	• The ED, operating room, CLC, and medical/surgical unit all had one or more missed monthly medication storage area inspection.	**3.** We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
	The facility employed practices to prevent wrong-route drug errors.		
NA	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 39 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		.
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Nineteen consult requests (49 percent) did not include "inpatient" in the title.	**4.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 15 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
X	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans	• The facility did not have a CT policy that addressed: o A CT quality control program o Monitoring CT protocols to ensure they are as low as reasonably achievable o A method for identifying and reporting excessive patient doses for CT to the Radiation Safety Officer o A process for managing/reviewing CT protocols, including how often the protocols are to be reviewed o Radiologist review of appropriateness of the CT order o Protocol specification by the radiologist before the patient is scanned	**5.** We recommended that the facility develop a computed tomography policy that includes all required elements.
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A medical physicist tested a sample of CT protocols at least annually.		
X	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.	• One CT scanner that had a repair or modification that affected dose or image quality did not receive an inspection by a medical physicist before return to clinical service.	**6.** We recommended that a medical physicist inspect computed tomography scanners that have repairs or modifications that affect dose or image quality before return to clinical service and document the inspection and that facility managers monitor compliance.
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Thirty-one of the 47 applicable EHRs (66 percent) did not contain documentation that employees asked patients whether they wished to discuss creating, changing, and/or revoking ADs. • Two of the six applicable EHRs did not contain documentation that employees held the discussions requested.	**7.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance. **8.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.	• Electrocardiogram, blood bank, respiratory therapy, and radiology policies did not clearly define appropriate availability for all support services.	**9.** We recommended that the facility revise the electrocardiogram, blood bank, respiratory therapy, and radiology policies to clearly define appropriate availability for support services.
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• None of the 10 employees in the ED and on the inpatient medical/surgical unit had 12-lead electrocardiogram competency assessment and validation included in their competency checklists or 12-lead electrocardiogram competency assessment and validation documentation completed. • None of the 10 employees on the intensive care unit had post-anesthesia care competency assessment and validation included in their competency checklists or post-anesthesia care competency assessment and validation documentation completed.	**10.** We recommended that facility managers ensure Emergency Department and inpatient medical/surgical unit employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented. **11.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the intensive care unit.
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy on surgical designation reviewed, which requires the facility to have a defined plan or policy for the availability of a qualified surgeon 24/7 on call within 60 minutes. • The facility did not have a defined plan or policy for the availability of a qualified surgeon.	**12.** We recommended that facility managers implement a defined plan or policy to have a qualified surgeon available 24/7 on call within 60 minutes.

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 13 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

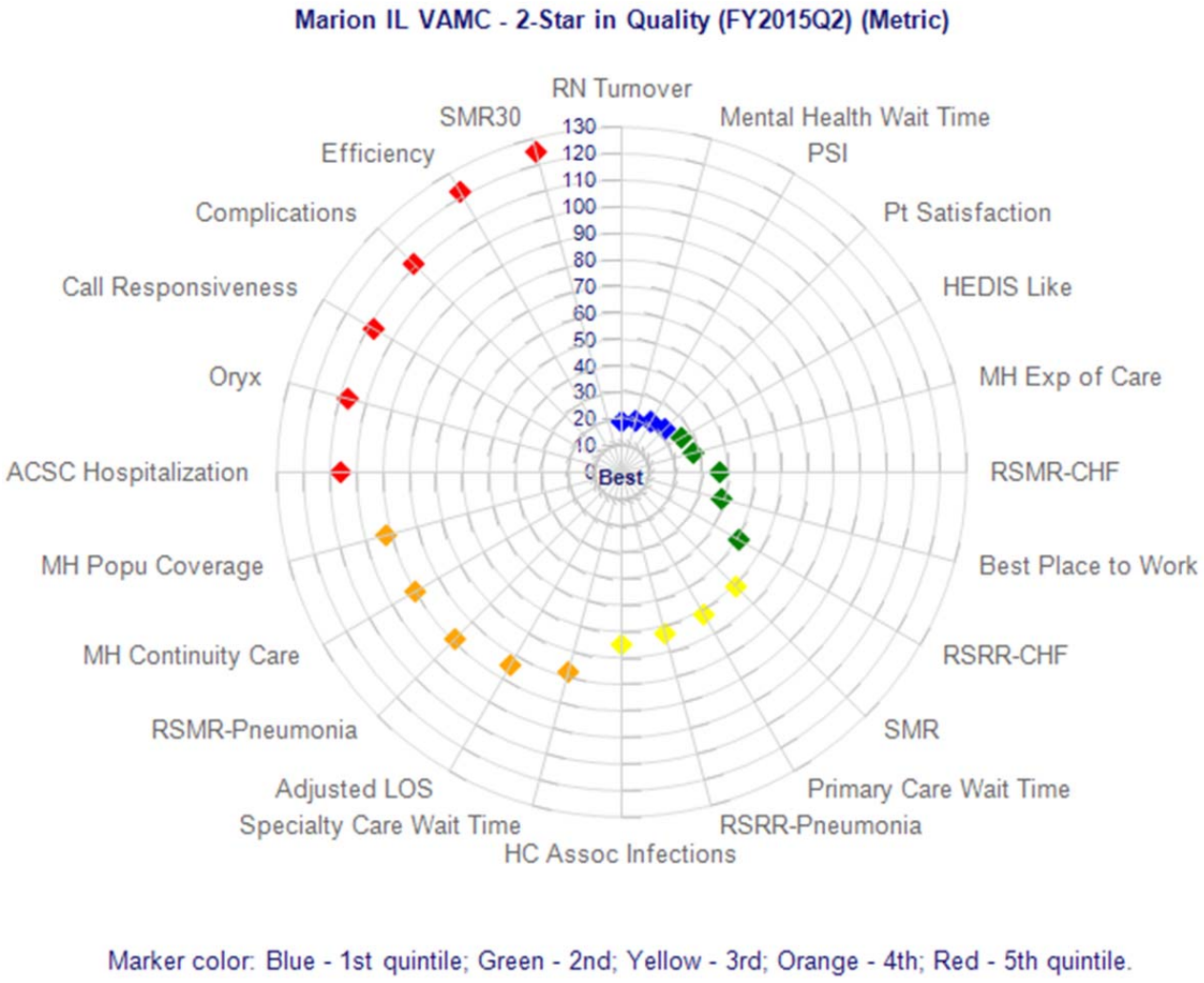
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
X	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway	• Facility policy did not address a plan for managing a difficult airway.	**13.** We recommended that the facility revise the emergency airway management policy to include a plan to manage a difficult airway.
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	• Eight of 11 clinicians with initial EAM competency assessment did not have documentation of all required elements.	**14.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• Neither of the two clinicians with reassessments for continued EAM competency had all required elements completed at the time of renewal of privileges or scope of practice.	**15.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes completion of all required elements at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy reviewed, which requires a qualified physician to be present in the ED at all times unless the facility has a waiver: • Seven of the 13 assigned EAM providers were ED physicians. This required the sole ED physician to leave the ED, and the facility did not have a current waiver.	**16.** We recommended that the facility ensure that a qualified, non-Emergency Department clinician is assigned inpatient emergency airway management coverage and that facility managers monitor compliance.

Facility Profile (Marion/657A5) FY 2015 through July 2015[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$289.1
Number of:	
• **Unique Patients**	40,934
• **Outpatient Visits**	388,448
• **Unique Employees**[2]	1,452
Type and Number of Operating Beds:	
• **Hospital**	39
• **CLC**	54
• **MH**	14
Average Daily Census:	
• **Hospital**	21
• **CLC**	33
• **MH**	10
Number of Community Based Outpatient Clinics	10
Location(s)/Station Number(s)	Evansville/657GJ Mt. Vernon/657GK Paducah/657GL Effingham/657GM Hanson/657GO Owensboro/657GP Vincennes/657GQ Mayfield/657GR Carbondale/657GT Harrisburg/657GU
VISN Number	15

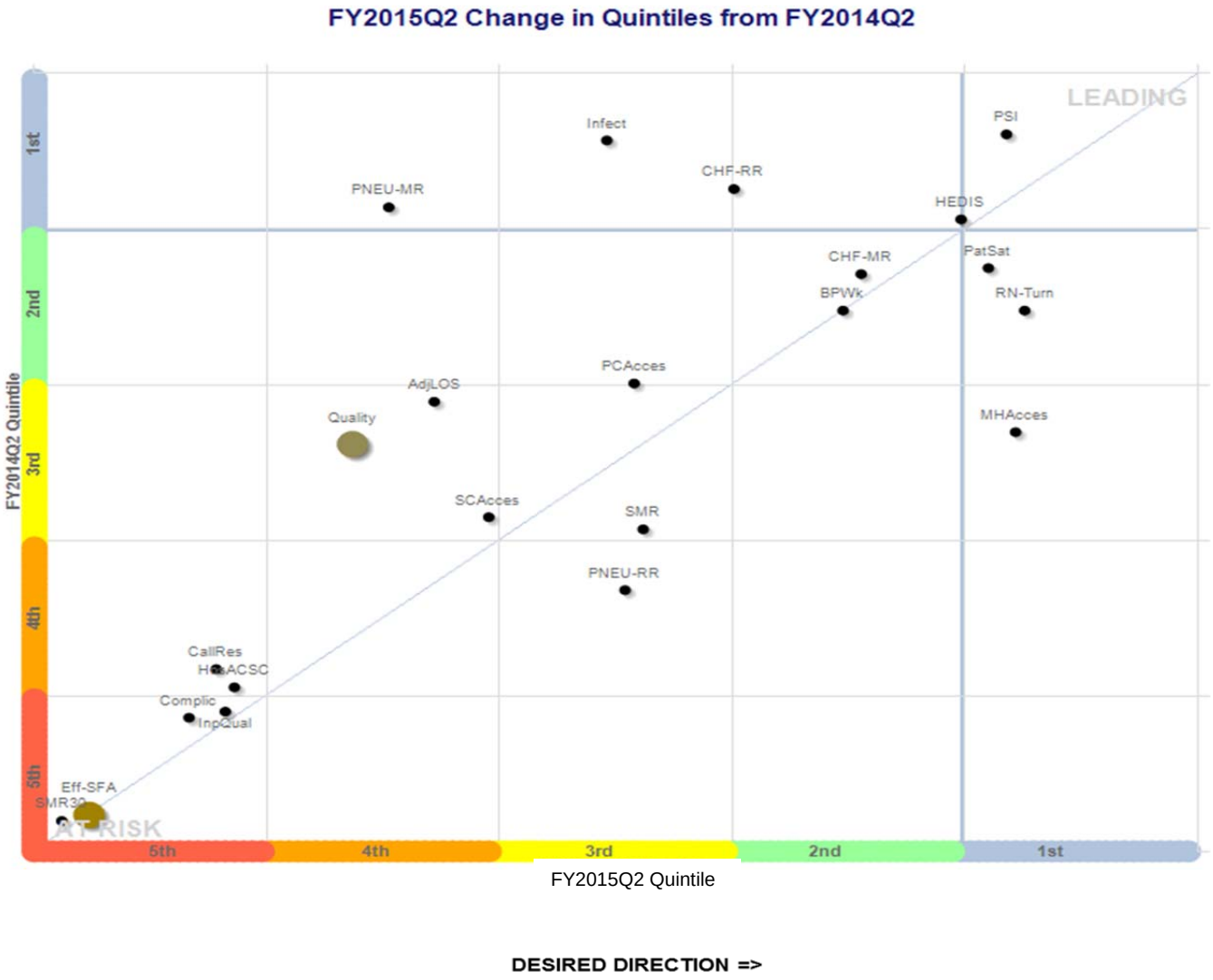
[1] All data is for FY 2015 through July 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: October 6, 2015

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the Marion VA Medical Center, Marion, IL**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

Attached is the response from Marion VA Medical Center, Marion, IL. I have reviewed and concur with the Medical Center Director responses. Thank you for the review and its focus on continuous improvement.

For additional questions, please feel free to contact Mary O'Shea VISN 15 Quality Management Officer.

(original signed by:)
William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 5, 2015

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

Subject: **CAP Review of the Marion VA Medical Center, Marion, IL**

To: Director, VA Heartland Network (10N15)

I have reviewed the report, we appreciate the feedback from the OIG CAP review conducted at the VA Marion, IL Health Care System. Please find the attached response for each recommendation. I am in agreement with the findings presented in this review.

Corrective action plans have been established with completion dates as outlined in this report.

(original signed by:)
Donald H. Hutson, FACHE
Medical Center Director
VA Marion, IL Health Care System

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.

Concur

Target date for completion: December 31, 2015

Facility response: Medical Center Memorandum 609 "Emergency Airway Management" with airway certification attachments have been revised to be congruent with the Directive and include all the required elements at the time of initial request and renewal of privileges. Professional Standards Board will continue to monitor initial and renewal certification to ensure the facility is 100% compliant.

Recommendation 2. We recommended that the interdisciplinary committee include a physician to review all episodes of care where resuscitation was attempted.

Concur

Target date for completion: October 1, 2015

Facility response: A Physician has been assigned to this interdisciplinary committee membership and will participate in the review of all resuscitation episodes. Attendance will be monitored and reported to Critical Care Committee at least quarterly.

Recommendation 3. We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: Workload shifting will occur to complete these inspections by December 31, 2015. Clinical Pharmacists will do inspections on the stations they are visiting for Academic Detailing. Pharmacists in addition to technicians will be assigned to complete inspections. The in-house inspections will be shifted to off tours in the areas that are open 24 hours per day. Quarterly reports will be provided to the Executive Leadership Council to ensure compliance.

Recommendation 4. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: Training to the medical staff was completed September 15, 2015 with service specific training dates to be scheduled. Menus will be developed for inpatient and outpatient use to facilitate appropriate selection. Review and monitoring of this process will be done by the Consult Management Committee on a monthly basis.

Recommendation 5. We recommended that the facility develop a computed tomography policy that includes all required elements.

Concur

Target date for completion: November 30, 2015

Facility response: The facility is in the process of developing a policy that includes all the required elements for computed tomography. Education will be provided to 90% of the imaging staff by November 30, 2015.

Recommendation 6. We recommended that a medical physicist inspect computed tomography scanners that have repairs or modifications that affect dose or image quality before return to clinical service and document the inspection and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: As of August 3, 2015, a medical physicist completed an inspection on the computed tomography scanner after repairs were made. The equipment was found to be functioning within guidelines. To ensure ongoing compliance, Marion, IL VAMC is engaged in discussion to establish a VISN process for availability of a medical physicist. This process will be monitored by the Chief of Imaging to ensure once equipment repair is completed; a medical physicist inspects the equipment.

Recommendation 7. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: The screening template for Veterans who have an Advance Directive has been changed to ask Veteran "Would you like to speak with someone about your Advance Directive to review, update or make a change?" The screening template for Veterans who have no Advance Directive has been changed to ask Veteran "Would you like to speak with someone for more information about or to complete an Advance Directive?" Compliance will be monitored by Social Work Services and reported to Executive Leadership Council quarterly.

Recommendation 8. We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: Social Work Service will hold advance directive discussions as requested by inpatients and document the discussions in the medical record. Chief of Social Work Service will monitor compliance and report results to the Executive Leadership Council quarterly.

Recommendation 9. We recommended that the facility revise the electrocardiogram, blood bank, respiratory therapy, and radiology policies to clearly define appropriate availability for support services.

Concur

Target date for completion: November 30, 2015

Facility response: Policies for electrocardiogram, laboratory, respiratory therapy, and radiology have been revised to clearly define the appropriate timeframe.

Recommendation 10. We recommended that facility managers ensure Emergency Department and inpatient medical/surgical unit employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented.

Concur

Target date for completion: September 25, 2015

Facility response: These skills have been added to the FY 15 annual competency checklists with oversight by the Nurse Managers to ensure annual completion. For FY 15, 100% of Emergency Department and inpatient medical/surgical unit employees have 12-lead electrocardiogram competencies documented.

Recommendation 11. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the intensive care unit.

Concur

Target date for completion: September 25, 2015

Facility response: These skills have been added to the FY 15 annual competency checklist with oversight by the Intensive Care Unit Nurse Manager to ensure annual completion. For FY 15, 100% of intensive care unit employees have post-anesthesia care unit competencies documented.

Recommendation 12. We recommended that facility managers implement a defined plan or policy to have a qualified surgeon available 24/7 on call within 60 minutes.

Concur

Target date for completion: October 3, 2015

Facility response: Facility Medical Center Memorandum 170 "Guidelines for Performing Surgery" has been revised to state that a qualified surgeon will be available 24/7 on call within 60 minutes.

Recommendation 13. We recommended that the facility revise the emergency airway management policy to include a plan to manage a difficult airway.

Concur

Target date for completion: December 31, 2015

Facility response: Medical Center Memorandum 609 "Emergency Airway Management" has been revised to be congruent with the Directive. Included is a plan to manage a difficult airway and a process for alert notification in the clinical record. Professional Standards Board will monitor difficult airway management certification to ensure the facility is 100% compliant.

Recommendation 14. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Medical Center Memorandum 609 "Emergency Airway Management" has been revised to be congruent with the Directive and include all the required

elements at the time of initial privileges. Professional Standards Board will monitor initial certification to ensure the facility is 100% compliant.

Recommendation 15. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes completion of all required elements at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Medical Center Memorandum 609 "Emergency Airway Management" has been revised to be congruent with the Directive and include all the required elements at the time of renewal of privileges. Professional Standards Board will monitor renewal certification to ensure the facility is 100% compliant.

Recommendation 16. We recommended that the facility ensure that a qualified, non-Emergency Department clinician is assigned inpatient emergency airway management coverage and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: 100% of all hospitalists have completed Emergency Airway management certification. A new process has been implemented and will provide that a hospitalist must have completed the Emergency Airway Management training prior to assuming care of patients. Professional Standards Board will monitor initial and renewal certification to ensure the facility is 100% compliant.

Office of Inspector General
Contact and Staff Acknowledgments

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This report is available at **www.va.gov/oig**.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.