



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Clinical Privileges and Airway
Management
Marion VA Medical Center
Marion, Illinois**

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding quality of care at the Marion VA Medical Center, Marion, IL. Four complaints were received between October 2011 and January 2012 regarding the clinical practice of two physicians. In February 2012, Senator Richard J. Durbin forwarded additional allegations concerning one of the physicians.

This report addresses allegations regarding quality of care provided for the three patients named by complainants, and describes findings from our site visit. Not addressed in this report are allegations regarding quality of care for additional patients not specifically identified, and allegations regarding a second physician.

In the care of one patient, the risk of complications requiring urgent intervention should have been discussed with the patient as part of the informed consent process prior to a procedure, at which time the patient's therapeutic preferences could have been clarified. We identified no deficiencies in quality of care for the other two patients.

We also found that a physician who was hired after not being in clinical practice for many years was granted clinical privileges with the understanding that his competence would be confirmed by direct observation. However, competence was never documented for invasive procedures that he subsequently performed.

Additional findings include:

- Following deaths and Intensive Care Unit (ICU) readmissions, the Peer Review Committee did not consistently recommend actions for improving care when reviews found deficiencies.
- Even though the facility often had a patient in the ICU on a ventilator, it did not have staff with demonstrated competence in airway management on-site at night or on weekends.
- The ICU had no appointed Director and there was a lack of clarity about physician roles in the ICU. In addition, ICU beds were inappropriately used for patients when general medical-surgical beds were unavailable.

We recommended that the facility Director ensure that VHA and local policies are followed when initial clinical privileges are granted, peer review processes comply with VHA policy, staff with demonstrated competence in airway management are always available on-site, an ICU Director is appointed, and the facility adheres to local policy regarding the use of ICU beds. The Acting VISN Director and facility Director agreed with our findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.



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

TO: Acting Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Quality of Care and Management Issues,
Marion VA Medical Center, Marion, Illinois

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding quality of care at the Marion VA Medical Center (facility), Marion, IL. Four anonymous complaints were filed through the Hotline Division between October 2011 and January 2012, regarding the clinical practice of two physicians. In February 2012, Senator Richard J. Durbin received additional detailed allegations concerning one of the physicians.

Background

The facility provides services to approximately 43,000 veterans residing in southern Illinois, southwestern Indiana, and northwestern Kentucky. It is a general medical and surgical facility providing a full range of patient care services. Comprehensive healthcare is provided through primary care, specialty care, and long-term care, with services in medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. Additional specialty care is available by referral to other VA facilities or to contracted facilities. Part of Veterans Integrated Service Network (VISN) 15, the facility has 30 active acute care beds, an 8 bed intensive care unit (ICU), and a community living center (CLC) with 60 beds.

The facility ICU is categorized as Level 4,¹ indicating that dedicated ICU attending staff are not required and any physician may provide ICU care without specialty consultation.

¹ Almenoff P, Sales A, Sharon Rounds S, et al. Intensive care services in the Veterans Health Administration. *Chest* 2007;132:1455–62.

Complex airway management, including the use of ventilators, is one component of services provided in all ICUs, and the facility routinely has patients on ventilators. In fiscal year 2011, there were 233 ventilator days for 39 patients.

OIG received complaints in October and December 2011, and in January and February 2012, about the clinical care provided by two physicians at the facility.

- An anonymous complainant alleged that there were two patient deaths associated with poor care provided by a physician (Physician A). Physician A placed a central venous catheter that another physician felt was unnecessary and the procedure caused the patient's death. Physician A also allegedly performed bronchoscopy on a patient despite the fact that the patient was too unstable to undergo the procedure.
- Another complainant alleged that poor care by Physician A resulted in the deaths of 4–6 patients. This complainant also alleged that the facility Chief of Medicine encouraged health care practitioners to tamper with patients' charts and has created an environment in which substandard care is never recorded on charts to ensure that the facility passes inspections.
- Extensive further allegations concerning Physician A's clinical practice were received from the office of Senator Richard J. Durbin.
- An anonymous complainant alleged that another physician (Physician B) provided questionable specialty care. Allegations included not addressing abnormal laboratory values, incorrect ordering of medications, delays in patient treatment, and not seeing scheduled clinic patients in a timely manner.

Scope and Methodology

We visited the facility February 29–March 1, 2012, interviewed 33 managers and providers of care; and reviewed medical records, VHA and local policies, and quality management and credentialing and privileging documents. We obtained electronic progress notes that had been made not viewable. We also conducted telephone interviews with two physicians previously employed at the facility.

This report addresses allegations regarding quality of care provided by Physician A for the three patients named by complainants and describes findings from our site visit. Not addressed in this report are allegations regarding quality of care for additional patients not specifically identified and allegations regarding Physician B. These allegations will be addressed in the future by OIG.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

Patient 1

The patient was a man in his sixties who had been treated at the facility or one of its community-based outpatient clinics for approximately 14 years. He had diabetes, hypertension, dyspepsia, and chronic foot pain attributed to gout and osteoarthritis. He also had a history of intermittent migraine headache, and eight years prior to admission experienced a severe headache that led to admission to a local hospital. He was found to have a pituitary tumor and underwent surgery to remove the tumor. He was subsequently prescribed hormone replacement therapy and returned to the facility for continuing care.

During the ensuing nine years, the patient had regular follow-up appointments and was treated with opioid medications for hip pain and headache. Approximately ten days prior to his only admission to the facility, he suffered a fall at home, had worsening hip pain, and was admitted to a local hospital. After transfer to the facility, he underwent diagnostic testing and plans were made for transfer to the facility's CLC for rehabilitation. However, transfer to the CLC was delayed to clarify the cause of persistent right hip pain. A urinary catheter, which was placed prior to transfer to the facility, remained in place.

Early on the sixth hospital day, the patient continued to complain of hip pain and became less responsive. He was found to have decreased oxygen saturation and a rapid heart rate, and was transferred to the intensive care unit (ICU). At the time of transfer, he was drowsy and disoriented. His heart rate returned to normal after treatment with medication, but he became progressively short-of-breath and had low blood pressure requiring continuous intravenous (IV) medication. He was also treated with antibiotics for possible urinary tract or pulmonary infection. Blood cultures grew no organisms; no other body fluids were obtained for culture. Corticosteroid medication, which the patient had been taking as an outpatient, was added to his regimen. Physician A ordered an additional antibiotic later that day. Ultrasonography of the lower extremities revealed no evidence of deep vein thrombosis. The attending physician requested consultation with Physician A, who provided diagnostic and therapeutic recommendations and indicated that "hospitalist will manage the patient medically."

The attending physician discussed with the patient the possibility of endotracheal intubation and mechanical ventilation. The patient expressed his wish that cardiopulmonary resuscitation not be undertaken if his condition should worsen, and he repeatedly declined intubation. A psychiatric consultant wrote that the patient "does appear to possess the mental capacity to make decisions about his medical care," and a "do not resuscitate" (DNR) order was entered.

On the seventh hospital day, medication was no longer required to maintain a normal blood pressure and the patient experienced less shortness of breath. A ventilation-

perfusion scan revealed no evidence of pulmonary embolism and renal ultrasonography showed no obstruction or other abnormality. Computed tomography of the thorax was interpreted as revealing “bilateral pneumonia. Bilateral pleuritis/pleural effusion.” Later on the seventh hospital day, the patient’s breathing became labored and nursing notes indicated that Physician A suspected bowel obstruction.² Attempts at placement of a nasogastric tube were unsuccessful.

At the beginning of the eighth hospital day, the patient was described as having non-labored respirations. His blood pressure was normal and he had four peripheral IV catheters functioning normally. Later in the morning on that day, however, three of the IV sites were no longer functional. An order was entered by Physician A for patient-controlled anesthesia (PCA) for hip pain, which required use of the remaining IV access site. Physician A obtained written informed consent from the patient for placement of an arterial catheter and a central venous catheter. No physician notes were entered on the eighth hospital day prior to these procedures. An arterial catheter was ultimately not placed. During the procedure for placement of the central venous catheter, the patient’s condition suddenly deteriorated. The patient’s nurse wrote

After insertion of guide wire patient raised right arm straight up to ceiling, relaxed and raised again several times. He also arched back a few times. Eyes open and rolled back in head. Monitor showing Vfib.³ Staff present in room discussed code status, patient is DNR. After few seconds patient lying still. Not responding to verbal or tactile stimuli. Respiratory entered room and ambu bag applied with attempt at increased ventilation. Patient remained in V-fib. [Physician A] remained at bedside until asystole [no cardiac activity] at 1145.

No resuscitative efforts were made and the patient was pronounced dead at 11:45 a.m. Attempts to contact next of kin were initially unsuccessful. No autopsy was performed.

Patient 2

The patient had acute myelogenous leukemia and was admitted to the CLC for inpatient hospice care. On admission to the CLC, his nurse practitioner recorded that “Veteran understands that he has a terminal illness but at this time he DOES [emphasis in record] want to receive resuscitation in the event of cardiopulmonary arrest...but states, ‘I don't want to be kept alive on machines if that is all that is keeping me alive.’”

An oral antibiotic that had been prescribed by his private hematologist was continued for right foot and ankle cellulitis. Initial laboratory testing revealed marked

² No physician notes were entered near this time and no physician notes mentioned bowel obstruction prior to the patient’s death.

³ Ventricular fibrillation, a life-threatening cardiac rhythm disturbance.

thrombocytopenia and he was transferred to the facility medical-surgical acute care ward for transfusions.

The patient received transfusions of platelets and red blood cells and his foot and ankle pain resolved. However, he developed fever and chills, was noted to have low blood pressure, and was transferred to the ICU. He was treated with broad-spectrum antibiotics and IV medications for maintenance of a normal blood pressure, but after one day these were considered to be no longer necessary and were discontinued.

On the patient's second day in the ICU a nurse wrote that "he does not feel well this a.m. harder time breathing..." Because of hypoxemia⁴ and impending respiratory failure, an endotracheal tube was placed by a nurse anesthetist and the patient received ventilator support. Chest x-rays revealed pneumonia and antibiotics were adjusted based on the advice of an Infectious Disease consultant. However, the patient's respiratory status worsened and he had recurrent low blood pressure. After discussion with the patient's wife on the following day, the patient was extubated and ventilator support discontinued. He died five hours later.

While hospitalized this patient was under the care of hospitalist physicians, one of whom consulted with Physician A. Physician A entered one progress note in this patient's record.

Patient 3

The patient had a longstanding history of chronic obstructive pulmonary disease (COPD). For more than 3 years he had been prescribed an anticoagulant medication for stroke prevention following the diagnosis of atrial fibrillation.⁵ He had also been treated with medication for dementia and depression. Approximately two months prior to his final hospitalization, he was admitted for treatment of pneumonia. His last admission was because of weight loss, dizziness, sore throat, and difficulty swallowing. He was felt to have oral candidiasis⁶ and was treated with nystatin suspension. Computed tomography of the head showed cerebral atrophy and chronic vascular disease. On the second hospital day, he had respiratory failure, was intubated by an anesthetist, and was placed on mechanical ventilation. He also underwent placement of a central venous catheter (right internal jugular) and an arterial catheter, and was treated with IV medications for maintenance of normal blood pressure. Chest x-rays were indicative of pneumonia and he was treated with broad-spectrum antibiotics. On the fifth hospital day, bronchoscopy was performed through the endotracheal tube. On that day, the patient was evaluated for hospice; his prognosis was considered to be poor because of chronic lung disease. A "do

⁴ Decreased oxygenation of the arterial blood.

⁵ Rapid, irregular contractions of the upper chambers of the heart. With atrial fibrillation, abnormal blood flow can lead to formation of a blood clot, which can travel out of the heart to the brain, causing a stroke.

⁶ Candidiasis is also called thrush and referred to as a yeast infection.

not attempt resuscitation” order was entered after discussion with the family. On the seventh hospital day, the patient improved sufficiently to be extubated. Bronchoscopy through the endotracheal tube at the time of extubation revealed no evidence of tracheal obstruction, but there was “erythema⁷ of the vocal cords and larynx.” Approximately three hours after extubation, the patient described respiratory distress and developed stridor.⁸ Re-intubation was attempted without success and an abnormality considered to be a possible polyp was observed on the left vocal cord. An emergency tracheostomy tube was placed, but the patient died soon thereafter.

During his stay in the ICU, this patient was co-managed by a hospitalist physician and Physician A.

Inspection Results

Issue 1: Quality of Care for Three Patients

Patient 1

This patient was transferred to the facility from a local hospital following a fall. After five days, he had continued hip pain and plans were initiated for rehabilitation at the CLC. However, he developed decreased responsiveness and required transfer to the facility’s ICU. While in the ICU, management orders were entered by both the attending physician and Physician A, even though Physician A had written that “hospitalist [the attending] will manage the patient medically.” Corticosteroid medication, which the patient had been taking as an outpatient, should have been ordered at the time of hospital admission, but was not added to his regimen until after transfer to the ICU.

Medical record documentation and interviews with the physicians and nurses who provided care for the patient revealed no evidence of coordination between the physicians. Further, nursing staff reported that the attending physician and Physician A disagreed about whether a central line should be placed, and the attending physician told us that he did not learn that the procedure had been attempted until after the patient’s death. His final progress note stated, “patient is now off pressors⁹ and has remained hemodynamically stable for more than 48 hours, central line not indicated at this time.”

Physician A and ICU nurses gave conflicting accounts of events during the time of attempted central line placement. Physician A stated that when an abnormal cardiac rhythm was observed, nurses urged him to take no action because of the patient’s DNR status. However, nursing staff described that Physician A declined to take any action and that the nurses were prepared to treat the abnormal rhythm. The situation was further

⁷ Redness, usually indicative of a pathologic process.

⁸ A harsh, high-pitched respiratory sound that suggests upper airway obstruction.

⁹ Medications used to maintain normal blood pressure.

confused by a nurse's description that "Respiratory [a respiratory therapist] entered room and ambu bag applied with attempt at increased ventilation."

Physician A initiated an invasive procedure about which the attending physician was unaware. During the procedure, the patient developed an abnormal cardiac rhythm. Because of the patient's DNR status, Physician A was unsure about how to proceed and ultimately declined to treat the abnormal rhythm.

The risk of complications requiring urgent intervention should have been discussed with the patient as part of the informed consent process prior to the procedure, at which time the patient's therapeutic preferences could have been clarified.

Patient 2

This hospice patient was admitted for blood transfusions and his condition worsened during hospitalization. We identified no deficiencies in quality of care. At the request of the patient's attending physician, Physician A evaluated the patient but entered no orders.

Patient 3

This patient with chronic lung disease had initial improvement following intensive treatment for pneumonia. He died with an upper airway obstruction which became apparent only after extubation. We identified no quality of care deficiencies. This patient was co-managed by Physician A and a hospitalist. Medical records documentation indicates that management was well-coordinated between these physicians.

Issue 2: Hiring and Approval of Clinical Privileges for Physician A

Physician A had been out of active clinical practice for many years before applying for a facility position. According to Professional Standards Board (PSB) minutes, his state medical license had been reactivated. Physician A's resume stated that he held various positions at a private medical center.

Physician A requested clinical privileges at the facility in early 2011. According to facility PSB minutes, Physician A was "selected for a full-time position" and the PSB forwarded his file to the VISN Chief Medical Officer (CMO) for review. The facility Chief of Medicine recommended the requested clinical privileges, with the notation that "proctoring for consultations and procedures will be performed."¹⁰ Subsequent PSB minutes state that the VISN CMO approved Physician A's credentials and that a proctoring plan would be developed. June PSB minutes document that Physician A's

¹⁰ Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations. VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

proctoring plan was presented and approved, and the facility Director approved his clinical privileges.

During the next two months, a physician from another VA facility reviewed progress notes entered by Physician A and rated them satisfactory. The physician also directly observed Physician A performing three specialty-related procedures.

PSB minutes from September state that “board members requested that the Focused Professional Practice Evaluation (FPPE)¹¹ paperwork” be presented before approving privileges for Physician A. Members commented that there were many procedures on the privilege list that had not been proctored, and the Chief of Medicine requested that Physician A be approved only for the three procedures that were proctored.

September PSB minutes also state that during the evaluation period more than 40 encounters were reviewed and 54 procedures were proctored. The PSB minutes indicated that all procedures listed had been proctored and PSB members approved the FPPE. However, our interviews and document review revealed that, in fact, with the exception of the three procedures, none of Physician A’s procedures were directly observed by the assigned proctor.

In July, when Physician A performed a procedure, a nursing note identified a staff surgeon as one of the “staff/team members in room.” In August, Physician A performed another procedure; progress notes do not indicate the presence of another physician during the procedure. In September, Physician A performed a third procedure; a “supervisor practitioner” was identified in an informed consent document entered by a nurse, but there is no indication that another physician was present during the procedure.

The Chief of Medicine was unable to provide documentation of Physician A’s FPPE when we were onsite. However, in March 2012, the Chief of Medicine recreated the FPPE proctoring plan that included a list of patients’ records that were reviewed during the evaluation period.

Issue 3: Practice Evaluation for Physician A

VHA defines peer review as an organized process carried out by an individual health care professional or select committee of professionals to evaluate the performance of other professionals.¹² Specific circumstances requiring review are listed in VHA and facility policy. Physician A had eight cases referred for peer review during December 2011–March 2012:

- Two ICU readmissions within 24 hours

¹¹ FPPE is a process whereby the facility evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competence for the requested privileges. VHA Handbook 1100.19.

¹² VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

- One hospital readmission within 30 days
- Five deaths

At the time of this report, the Peer Review Committee (PRC) had completed reviews on five of the eight cases. According to VHA Directive 2010-025, service chiefs are responsible for initiating appropriate action and follow-up with staff for peer reviews that result in certain ratings. We requested documentation that the Chief of Medicine had discussed peer review results with Physician A. No documentation was available while we were onsite; however, we were provided documentation after our visit of one case discussed with Physician A on March 1.

PRC minutes reveal that the action taken in response to one of the reviews was a letter sent to the provider with the results of the peer review. The letter did not include any actions for improving care. The PRC is required to provide recommendations for non-punitive, non-disciplinary actions to improve the quality of health care delivered or the utilization of health care resources.¹³ The supervisor of the individual reviewed is then responsible for initiating appropriate action and follow-up and reporting back to the PRC upon completion of the action. We found that the PRC was not making appropriate recommendations to service chiefs and service chiefs were not reporting to the committee that actions had been completed. The Chief of Staff informed us that in February 2012, the PRC modified its processes to include documentation of service chief communication with the provider and notification through the Risk Management Department that the communication had occurred.

Issue 4: Out-of-Operating Room Airway Management

VHA policy requires that facilities provide inpatient physician coverage 24 hours a day, 7 days a week, in acute care patient facilities.¹⁴ In addition, VHA policy requires that each inpatient facility have a written policy regarding out-of-operating room airway management.¹⁵ VHA policy states that it is critical that trained and qualified individuals are available for urgent and emergent airway management outside of the operating room (OR).¹⁶ The policy states that:

Competence in airway management must be demonstrated and cannot be assumed based on job title, even for physicians. The requirements for competency include: cognitive skills associated with intubation; procedural skills with bag and mask ventilation; maintenance of airway; and endotracheal intubation. Appropriately mentored clinical experience is required and successful intubations must be performed on an actual patient, not on a mannequin.

¹³ VHA Directive 2010-025.

¹⁴ VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

¹⁵ VHA Directive 2005-031, *Out-of-Operating Room Airway Management*, August 8, 2005.

¹⁶ VHA Directive 2005-031.

The facility had eight physicians working as Medical Officers of the Day (MODs).¹⁷ The MODs work from 7 p.m. to 7 a.m. and provide medical coverage for the Emergency Department (ED) and inpatient units, including the ICU. Facility policy states that the MOD is responsible for responding to emergent situations and providing emergency airway management. Although facility policy was compliant with VHA requirements, none of the MODs had documentation of the required competence in airway management.

Issue 5: After-Hours Physician Coverage

Hospitalist physicians are on-duty from 8 a.m. to 8 p.m. daily. Nighttime coverage of the inpatient units, including the ICU, is the responsibility of MODs working in the ED. At the time of our site visit, the facility was unable to provide documentation that MODs had clinical privileges to work outside of the ED.

Approximately 10 days after our site visit, the facility provided documentation indicating that all ED physicians have privileges to provide care for inpatients.

Issue 6: ICU Management and Patient Care Coordination

Facility policy requires the Chief of Staff to appoint an ICU Director, who will be a physician qualified by interest, experience, availability, and training. The ICU Director will assume responsibility for professionally coordinating, supervising, and directing ICU activities. This individual will have the authority and responsibility to supervise and direct daily operations in the ICU, make emergency decisions on matters not covered by written policies, adjudicate differences among staff in the operation of the unit, and make decisions on patient admissions, transfers, and discharges when the unit is at full capacity. Staff reported that there was confusion about whether any physician had been designated as ICU Director. At the time of our site visit, there was no ICU Director.

Staff also reported there had been confusion about which physician has responsibility for a patient's care in the ICU, the attending hospitalist or Physician A. In December 2011, following a meeting of the Chief of Staff with hospitalist physicians, the Chief of Medicine issued a memorandum clarifying physicians' roles in the ICU. The memorandum prescribed that the attending hospitalist is responsible for all aspects of care of patients admitted to the ICU and that requests for consultation with Physician A should specify whether ongoing patient care management is expected.

¹⁷ The Medical Officer of the Day is a designated responsible physician who is physically present in an inpatient facility during periods when the regular medical staff is not on duty. These periods generally include evenings, nights, weekends, and holidays, but may be required in other circumstances.

Local policy requires that “the ICU will not be used as an alternative bed resource for patients not requiring intensive care when regular facility beds are unavailable...” However, staff reported that patients are admitted to the ICU when there is no available bed on the facility’s medical/surgical unit. The practice of admitting patients to the ICU who do not meet ICU admission criteria may result in erroneous Inpatient Evaluation Center (IPEC), utilization management, and nurse staffing reports.

Issue 7: Alleged Inappropriate Direction from a Supervisor

A complainant alleged that the facility Chief of Medicine encouraged health care practitioners to tamper with patients’ charts and created an environment in which substandard care is never recorded on charts to ensure that the facility passes inspections. We found no evidence to support this allegation.

Conclusions

In the care of Patient 1, the risk of complications requiring urgent intervention should have been discussed with the patient as part of the informed consent process prior to the procedure, at which time the patient’s therapeutic preferences could have been clarified. We identified no deficiencies in quality of care for Patients 2 and 3.

A physician who had not been in clinical practice for many years was hired by the facility. His clinical privileges were granted with the understanding that his competence would be confirmed by direct observation. However, competence was never documented for invasive procedures that he subsequently performed.

Following deaths and ICU readmissions, the Peer Review Committee did not consistently recommend actions for improving care when reviews found deficiencies.

Even though the facility often had a patient in the ICU on a ventilator, it did not have staff with demonstrated competence in airway management on-site at night or on weekends.

The ICU had no appointed Director and there was a lack of clarity about physician roles in the ICU. In addition, ICU beds were inappropriately used for patients when general medical-surgical beds were unavailable.

We found no evidence to support the allegation that a supervisor encouraged health care practitioners to tamper with patient records.

Recommendation 1. We recommended that the facility Director ensure that VHA and local policies are followed when initial clinical privileges are granted.

Recommendation 2. We recommended that the facility Director ensure that peer review processes comply with VHA policy.

Recommendation 3. We recommended that the facility Director ensure that staff with demonstrated competence in airway management are available at night or on weekends.

Recommendation 4. We recommended that the facility Director designate an ICU Director.

Recommendation 5. We recommended that the facility Director ensure that the facility adheres to local policy regarding the use of ICU beds.

Comments

The Acting VISN Director and facility Director concurred with the findings and recommendations and provided acceptable action plans (see Appendixes A and B, pages 14–18, for the full text of their comments and actions). We will follow up on the planned actions for recommendations 1–3 until they are completed, and we consider recommendations 4 and 5 closed.



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

Acting VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 2, 2012
From: Acting Director, VA Heartland Network (10N15)
Subject: **Healthcare Inspection – Quality of Care and Management Issues, Marion VA Medical Center, Marion, IL**
To: Director, Kansas City Office of Healthcare Inspections (54KC)
Thru: Director, VHA Management Review Service (10A4A4)

I have reviewed and concur with the OIG Quality of Care and Management Issues report and the Marion VA Medical Center, Marion, IL response. Thank you for this opportunity of review as a process to ensure that we continue to provide exceptional care to our Veterans.

If you have any questions regarding the information provided, please contact Jimmie Bates, VISN 15 Quality Management Officer at 816-701-3043.



William P. Patterson, MD, MSS
Acting Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 2, 2012

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

Subject: **Healthcare Inspection – Quality of Care and Management
Issues, Marion VA Medical Center, Marion, IL**

To: Acting Director, VA Heartland Network (10N15)

Please find attached the medical center response to the Office of Inspector General report.



Paul Bockelman, FACHE
Director, Marion VA Medical Center, (657A5/00)

describe timeliness expectations. The VISN will monitor compliance for the next 180 days to ensure compliance is maintained.

Status: In Progress

Recommendation 3. We recommended that the Acting VISN Director ensure that the facility Director ensure that staff with demonstrated competence in airway management is available 24/7.

Concur

Target Completion Date: Completed

Facility's Response:

The Acting VISN Director has confirmed that the facility has been in compliance since March 1, 2012, with competent staff providing 24/7 in-house coverage. Airway management has been added to the Ongoing Professional Practice Evaluation (OPPE) process to ensure competency is maintained and documented. Weekly monitoring by VISN via the schedule of out-of-operating room airway coverage has been in effect since March 1, 2012, and will continue until it is determined that this strong process is firmly and solidly entrenched.

Status: Closure to be requested.

Recommendation 4. We recommended that the Acting VISN Director ensure that the facility director designates an ICU Director.

Concur

Target Completion Date: Completed

Facility's Response:

A critical care trained Physician was designated as the Intensive Care Unit (ICU) Director effective May 2, 2012.

Status: Closure to be requested.

Recommendation 5. We recommended that the Acting VISN Director ensure that the facility director ensures that the facility adheres to local policy regarding the use of ICU beds.

Concur

Target Completion Date: Completed

Facility's Response:

The Acting VISN Director has confirmed that the facility is adhering to the policy of not using ICU beds for medical-surgical overflow since March 1, 2012. A critical care criteria plan is in place to ensure appropriate patient placements. Additionally, daily monitoring of ICU census by the VISN has been in effect since March 1, 2012, and will continue until it is determined that this strong process is firmly entrenched.

Status: Closure to be requested.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Dorothy Duncan, RN, MHA Regional Director Kansas City, Project Leader James Seitz, RN, MBA Team Leader Larry Selzler, MSPT Jerome Herbers, MD Medical Consultant

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