Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Review of Quality of Care, Management, and Operations

Iowa City VA Health Care System, Iowa City, Iowa

Report No. 12-02263-269 August 29, 2012

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Contents

Page

Executive Summary i

Purpose and Background 1

Scope and Methodology 3

Inspection Results 5

Quality of Care 5

Management Effectiveness 6

Staff Morale 10

System Operations 11

Conclusions 14

Appendixes

A. VISN Director Comments 15

B. System Director Comments 16

C. OIG Contact and Staff Acknowledgments 19

D. Report Distribution 20

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a comprehensive review of the Iowa City VA Health Care System in response to a request from Senator Charles E. Grassley. OIG assessed the merit of allegations about quality of care and that concerns expressed by staff "have been largely ignored."

All system employees were invited to respond anonymously to a survey about patient care and working conditions through a dedicated OIG internet portal. Individuals responding to the survey could, if they wished, provide specific details and contact information. Analysis of responses to the survey afforded an opportunity to focus on issues that might otherwise receive less attention.

During two site visits, OIG staff inspected the parent facility and two Community Based Outpatient Clinics, and conducted scheduled and unscheduled interviews with approximately 125 individuals, including senior leaders, mid-level managers, front line employees, patients, and volunteers.

We found that high quality medical care has been maintained. However, we also found that a pervasive lack of support for staff problem-solving is a potential threat to patient safety, and that several process deficiencies were identified. During a prolonged period when key leadership positions were held by individuals on a temporary basis, decisions were delayed or never made, and a highly competent professional staff was frustrated by the persistent ineffectiveness of senior leadership.

We recommended that the Veterans Integrated Service Network Director ensure that system leaders take appropriate action in response to identified problems and communicate action plans to staff. We also recommended that system leaders clarify organizational lines of authority and responsibility and improve components of Environment of Care and Pharmacy management.

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

TO: Director, VA Midwest Health Care Network (10N23)

SUBJECT: Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, IA

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted a comprehensive review in response to a letter sent March 7, 2012, from Senator Charles E. Grassley, ranking member of the Committee on the Judiciary, to the VA Inspector General regarding "reports of a variety of serious allegations" about the Iowa City VA Health Care System (system). Individuals who had contacted the Senator expressed concern about "the direction of the facility and its impact on patient care" and that "their concerns have been largely ignored by the leadership at the Iowa City VA facility." The Senator wrote that:

> These whistleblowers fear retaliation and characterize the working atmosphere as "vindictive," which prevents many employees from voicing concerns to superiors…Also, according to these individuals, there have been many complaints from patients and families regarding the quality of care and while these complaints are reported, the problems reoccur…Consequently, I am requesting your office conduct a thorough and comprehensive "top to bottom" review of this VA facility in Iowa City.

OIG assessed the merit of the allegations and evaluated overall quality of care, management, and system operations.

Background

The system includes a tertiary care university-affiliated teaching hospital with 83 acute medical, surgical, and psychiatric beds, and provides outpatient care at the parent facility and at nine Community Based Outpatient Clinics (CBOC), six in Iowa and three in Illinois. The system is part of the VA Midwest Health Care Network (Veterans Integrated Service Network [VISN] 23) and serves veterans in 33 counties in eastern Iowa, 16 counties in western Illinois, and one county in northern Missouri.

Prior Reports

OIG and The Joint Commission have conducted evaluations of the system since 2009. Findings have recurred in the areas of credentialing and privileging and environment of care (EOC). In OIG's Combined Assessment Program Review, 2009,[1] recommendations for improvement were made in the areas of quality management, credentialing and privileging, peer review, EOC, coordination of care, suicide prevention, and emergency/urgent care operations. Also, a repeat recommendation was made regarding follow-up for community nursing home patients, the original recommendation having been made in 2006.[2]

In OIG's Community Based Outpatient Clinic Review, 2009,[3] the Waterloo, IA, and Galesburg, IL, clinics were inspected. Deficiencies were identified in processes for granting clinical privileges to providers, information technology security, handicap accessibility, and panic alarm system effectiveness.

Following a routine survey by The Joint Commission in 2010,[4] the system received accreditation with five direct impact requirements of improvement within the following four areas: EOC, patient safety, equipment use, and infection control.

Transitions in Senior Leadership

Senior leadership is comprised of the following quadrad: Director, Associate Director for Operations, Chief of Staff (COS), and Associate Director for Patient Care Services. The Medical Center Director was appointed in July 2006. The Director, in addition to his system responsibilities, serves in two key VISN level positions. He co-chairs the VISN Finance and Capital Asset Council where he serves as the senior leadership representative on the VISN Council that advises the Network Director and VISN Executive Leadership team on allocation of appropriated funds across the system. The Council does not have authority for allocation of funds and serves as an advisory body. As Director of the Mental Health Service Line and working in concert with a full time Mental Health VISN Service Line Medical Director he serves as the VISN senior lead to provide program direction, monitoring and guidance for Mental Health services in VISN 23. He was Acting Director of the VISN July 13–August 28, 2010. In January 2012 he became Acting Director of the Minneapolis VA Health Care System and the system's Associate Director for Patient Care Services was appointed to the position of Acting Director.

[1] Combined Assessment Program Review of the Iowa City VA Medical Center, Iowa City, Iowa. Report No. 08-02604-214 (September 16, 2009).
[2] Combined Assessment Program Review of the Iowa City VA Medical Center, Iowa City, Iowa. Report No. 06-01602-219 (September 25, 2006).
[3] Community Based Outpatient Clinic Reviews. Macon and Albany, GA, Beaver Dam, WI, and Rockford, IL, Sioux City, IA, Aberdeen, SD, Waterloo, IA, and Galesburg, IL. Report No. 09-01446-37 (December 2, 2009).
[4] Joint Commission Award Letter, August 3, 2010.

The former Associate Director for Operations served from November 2006 through May 2011. There were two Acting Associate Directors of Operations from May 2010 until December 2011. The position was permanently filled in December 2011.

The former COS served from June 2004 through June 2011. An Acting COS, who is also the system Chief of Radiology and the VISN 23 Lead Radiologist, has been in that role since July 2011.

The Associate Director for Patient Care Services was appointed in March 2005. Following her assignment as Acting Director in January 2012, the role of Associate Director for Patient Care/Nurse Executive has been divided between two Specialty Care Nursing Administrators.

Directors of the Surgical/Specialty Care, Primary and Specialty Medicine, Mental Health, Imaging, and Pathology and Laboratory Service Lines have been in their positions for at least three years. The Extended Care and Rehabilitation Service Line has had an acting director since February 2012.

Scope and Methodology

To gather information from system employees, OHI conducted an Employee Assessment Review (EAR) survey regarding patient care and working conditions. All staff, paid (1650) and volunteer (1037), received an e-mail invitation on April 4, 2012, to respond anonymously through a dedicated OIG internet portal. Individuals responding to the survey could, if they wished, provide specific details and contact information.

The EAR survey received 943 responses through April 26; 361 included written comments. OIG staff attempted to contact all 180 persons who provided identifying information. Twelve persons provided additional information or requested an interview. We maintained the confidentiality of all EAR survey respondents.

Analysis of responses to the survey afforded an opportunity to focus on issues that might otherwise receive less attention. The following principal categories of concern were identified:

- Morale, with concerns about possible retribution for reporting problems.
- CBOCs, various issues.
- Specific functional areas, particularly medical and surgical units, radiology, pharmacy, specialty clinics, dialysis.
- Infection control, including incomplete use of isolation precautions and deficiencies in processing of reusable medical equipment.
- Staffing and workload.
- Personnel practices.
- Management structure and style.

- Patient access to specialty care.

Prior to site visits, we requested and reviewed extensive system documentation, including Veterans Health Administration (VHA) and local policies, meeting minutes, internal reviews, and performance data. We interviewed the Director, Chief Medical Officer, and Quality Manager of the VISN, as well as the System Director. As noted above, the System Director was also Acting Director for the Minneapolis VA Health Care System.

We conducted site visits May 22-24 and May 30-31, visiting the parent facility as well as two CBOCs. We interviewed the Acting Director, Acting COS, Acting Associate Directors for Patient Care Services, and Associate Director for Operations. Additional interviews were scheduled at the request of individuals who responded to the EAR survey or contacted OIG. We conducted scheduled and unscheduled interviews with approximately 125 individuals, including directors and acting directors of Pharmacy, Surgical/Specialty Care, Primary and Specialty Medicine, Mental Health, Imaging, Pathology and Laboratory Medicine, and Extended Care and Rehabilitation Service Lines; mid-level managers; caregivers and other front-line employees; patients; and volunteers.

We evaluated patient care areas, including inpatient, outpatient, primary care, and specialty care, and clinical and administrative support services, including nursing, social work, pathology and laboratory, imaging, respiratory therapy, pharmacy, logistics, health information management, and volunteer services.

We also assessed institutional structures, processes, and relationships pertaining to Quality Management, the EOC Committee, clinic staffing, and university relations, including training programs and trainee supervision.

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

Inspection Results

1. Quality of Care

a. Aggregate Measures of Quality

VHA routinely collects data from each of its facilities to allow comparisons of performance.[5] Measures of clinical performance include 28 related to quality and safety. During the period October-December 2011, the system excelled with respect to six of the 28 measures, achieving VA's "aspirational goal." For 21 of the measures, the system performed at a level commensurate with facilities throughout VHA. For one of the measures, the rate of pressure ulcers, the system was more than 30 percent from the goal. In two other areas, ongoing monitoring revealed deviations from expected rates: ventilator associated pneumonia (VAP) and catheter related bloodstream infections.

Review of system documentation revealed appropriate actions in response to these issues. Preliminary results following implementation of a detailed plan for decreasing the rate of pressure ulcers indicate substantial improvement. The increased VAP rate was due to occurrences in a few individual patients, and a thorough review of the care provided for those patients revealed no deficiencies. However, additional staff training was planned. The increased rate of catheter related bloodstream infections was noted to occur transiently in patients outside the Intensive Care Unit (ICU), and the system planned close monitoring and a possible change in dressing materials.

b. Specific Patient Care Concerns

Eleven patients about whom concerns were expressed regarding quality of care were identified or alluded to by EAR survey respondents or through staff and patient interviews. These concerns are listed below.

1	A 52 year old man had severe uncontrolled hypertension and died six days after kidney transplantation.
2	A 60 year old man with severe chronic liver disease and sepsis died in the ICU. Referral for possible liver transplantation had been initiated one week prior to admission.
3	A 61 y/o man with metastatic lung cancer discussed with physicians the possible need for a blood transfusion. A transfusion was given without a physician order.
4	A 69 year old man was said to have received poor care associated with placement of a nasogastric tube by a medical resident.
5	A 56 year old man with cerebrovascular disease reported that he had inadequate pain control while hospitalized in the ICU in 2010.

[5] http://www.hospitalcompare.va.gov.

6	A 57 year old man was alleged to have been left in the same position for a long time by operating room staff, causing loss of circulation.
7	An 86 year old man treated in the ED for abdominal pain was said to have inadequate pain management while awaiting admission.
8	An 80 year old man was alleged to have received inadequate care when his leg became swollen and tender after repair of an abdominal aortic aneurysm.
9	A 68 year old man was reported to have been discharged prematurely and treated with inappropriate antibiotics for an infection following hip replacement surgery.
10	A 65 year old man had a prostate biopsy specimen incorrectly labeled with the name of a patient with the same last name and a similar Social Security number.
11	A 60 year old man with lymphoma was admitted because of shortness of breath. Staff differed regarding the method of administration of a medication.

An analysis of the care provided for these patients revealed no substantial deficiencies. In the course of reviewing the care provided for the kidney transplant patient who died (patient #1), staff identified systems improvements which have yet to be implemented (see Section 2.a.).

2. Management Effectiveness

VHA has established that senior leaders in its healthcare facilities are expected to "ensure that health care is safe, effective, patient-centered, timely, efficient, and equitable" and that the role of leaders is "reflected in accountability structures."[6] The Joint Commission requires that leaders, along with senior managers, be responsible for the definition of shared and unique responsibilities and accountabilities.[7] In addition, the governing body, senior managers, and leaders of the organized medical staff are expected to have the knowledge needed for their roles in the hospital.[8]

a. Responsiveness and Follow-through

EAR survey respondents raised concerns regarding problems with pressure ulcer management and with specimen labeling. A review of system documentation revealed appropriate actions in response to these and other identified problems. However, through the EAR survey and through multiple interviews, numerous individuals described a pervasive lack of management responsiveness. Staff reported that numerous efforts to conduct clinical activities and address a wide range of concerns were thwarted by inaction on the part of senior managers. Examples are described below.

Nurse Manager Selection Process. A unit medical director expressed concern to leadership that a nurse manager newly hired to manage a high-risk area lacked

[6] VHA Directive 2009-043, *Quality Management System* (September 11, 2009).
[7] Joint Commission Standard LD.01.02.01
[8] Joint Commission Standard LD.01.07.01

appropriate experience and was assigned supervisory responsibility for multiple clinical areas. The director also noted the absence of physician input throughout the selection process and that the COS acknowledged the concerns but did not address a potential resolution. At the time of our visit the selected manager remained in place and with several diverse areas of responsibility.

Limited Bed Availability and Increased Rate of Patient Diversions. During FY11, 315 patients were admitted to non-VA hospitals because of unavailability of system beds. During the first nine months of the current fiscal year (October 1, 2011-June 30, 2012), 484 patients were diverted, so that the number of diversions is projected to be more than double compared with the prior year.

Although several factors contribute to the increase in number of patients diverted, the primary reason for the increase was a new restriction on the number of inpatients for which resident physicians are allowed to have ongoing responsibility. The change was implemented one year ago and the number of diversions was noted to rise soon thereafter. In anticipation of the change, staff developed plans to limit its impact on patient care. At least one intervention was made, but no solution was achieved. Although several approaches were proposed, none was implemented.

The consequences of patient diversion are substantial. Patients are subjected to the risks associated with discontinuous care, including limited communication among providers and incomplete transmission of treatment records. At a teaching hospital, opportunities for learning are reduced when patients return from non-VA facilities having already completed evaluation and treatment.

Response to Review of Kidney Transplantation. Following the death of a kidney transplant patient, a multidisciplinary team conducted a review of the processes of care for patients immediately following transplantation. Strategies recommended for improvement were discussed with the Acting Director and Acting COS in January 2012. As of July 2012, several of the recommended improvements had not been implemented. In particular, an ongoing concern exists regarding physician coverage of the surgical ICU. Although medical residents are continuously on-duty for emergency care of all patients, there is no physician onsite after-hours for ongoing management of patients in the surgical ICU.

Support for CBOC Performance Improvement Activities. At the request of several CBOC supervisors, the Education Liaison for VISN 23 traveled to each CBOC in May 2011. At these visits, staff completed the Strength Deployment Inventory, an instrument designed to foster an empowering and collaborative work environment. A follow-up visit was made in June to review interventions made following the May visit. Despite sending a summary of site visit findings and making offers for an in–person or telephone conference, the liaison received no response from system leaders.

b. Communication of Management Decisions

Front-line staff and managers from multiple areas reported that the process for hiring new staff to fill vacancies was inadequate, with positions remaining vacant for prolonged and indefinite periods of time. The system Finance Board was described as having responsibility for managing the number of full-time equivalent employees, but information regarding the processes used to determine and approve vacancies was unknown to some service-level managers.

c. Delegation of Authority

The Joint Commission requires that senior managers and leaders of the organized medical staff work with the governing body to define their shared and unique responsibilities and accountabilities.[9]

Employees are assigned a diverse and significant number of responsibilities, yet we learned of examples in which they were not provided the authority to make necessary decisions and take action to fulfill their responsibilities. For example, we were told during conversations onsite that the policy and practice for flash sterilizations are inconsistent. When flash sterilization is needed, approval from a member of the leadership quadrad is required. We learned of a procedure that had to be paused mid-way in order to obtain permission to conduct flash sterilization. While this specific instance did not result in patient harm, the practice of requiring permission to perform flash sterilization appears to be fraught with the potential for harm to patients.

During onsite discussions we heard of obstacles encountered by employees in the course of their work. Employees with responsibility for producing mandatory business reports do not have the authority to obtain data directly from the clerks who manage that information. Clerks work under the supervision of nurse management and must obtain approval prior to release of the required information.

We also learned that individuals temporarily leaving a leadership role have not relinquished their authority to the individual assuming the “acting” position. Consequently, the acting member is unable to fully function within the responsibilities of the temporarily assigned position. It is unclear to middle managers to whom they should report in order to effect change and conduct daily business.

[9] Joint Commission Standard LD.01.02.01

d. Committee Reporting Processes

The Joint Commission requires that senior leaders and the entire organized medical staff assume responsibility for organizational activities in order to improve quality of care, and ensure patient safety.[10]

Our review found a lack of clarity about which medical staff committees exist, the organizational and reporting structure of those committees, and the scope of committee responsibilities. For example, the only committee outlined in the system by-laws is the Executive Committee of the Medical Staff. In addition, medical center memoranda related to organizational structures and committees do not include a list of committees. While charters for most committees exist on the committee's unique SharePoint site, there is no centralized location where someone can find the system's committee structure.

Staff at all levels also found it difficult to articulate the structure, function, and reporting processes for system committees. Concerns were expressed regarding the difficulty in accessing committee information. We found a lack of documentation of action plans, designated responsible individuals, due dates, results, and item closure.

e. Nursing Supervision

EAR respondents and staff interviewed while onsite expressed concerns over the absence of onsite evening and weekend nursing supervision and the fact that, although these concerns have been repeatedly expressed to leaders, there has been no response. Currently, there are charge nurses on each unit and an on-call nurse manager, but there is no second shift (4 pm–11 pm) or third shift (11 pm–7 am) nursing supervisor onsite able to document patient acuity and provide leadership. An after-hours Administrator on Duty is present to manage administrative functions but does not make clinical decisions. Decisions made by the on-call nursing manager are based on the census and discussion with charge nurses.

The current system of off-site supervision was reported by staff to contribute to poor patient flow, an increase in diversions, and an adversarial relationship between managers and staff on the various units. In addition, staff reported vulnerability in not having after hours access to either Clinical Application Coordinators or Information Technology staff regarding Computerized Patient Record System questions or problems.

Through onsite interviews and a review of the roles and responsibilities delegated to nursing managers, we found examples of managers being assigned simultaneous responsibility for multiple high acuity areas, presenting the potential for compromised patient safety. At the time of our review, one manager had responsibility for six high

[10] Joint Commission Standard MS.05.01.01

acuity, high risk, patient care areas. We also found nurse managers with responsibility for the supervision of social work staff without the knowledge to assess qualifications and professional standards of those clinicians.

f. CBOC Leadership

During visits we found that although each CBOC in the system has a nurse lead, all of the CBOCs lack a medical director. As a result, staff expressed that each professional group works in a 'silo' and does not communicate with one another. The reporting structure to implement change at a CBOC results in providers having to work through leaders at the parent facility to resolve issues and effect change. This results in inefficiencies, as well as impaired staff relationships.

3. Staff Morale

We found that the lack of management effectiveness caused deterioration in staff morale, and substantiated that many employees considered the culture of their work environment to be one of fear and intimidation.

VHA conducts an annual employee survey asking questions in the areas of job satisfaction, organizational assessment, civility and culture. Results from the 2012 All Employee Survey show the question with the largest reduction in score over the prior year to be "Compared to what it was two years ago, how is your overall level of satisfaction with your job?" The system score for this question was 2.80/5.00 in 2012, down from 3.07/5.00 in 2011.

Through the EAR survey and in interviews, employees reported incidents of disrespect among staff members at multiple levels of the organization. A "veil of secrecy" surrounding senior leaders reportedly fostered a pervasive feeling of mistrust. This sense was particularly notable with respect to the hiring process and the Finance Board, at which subject matter experts were not permitted to attend and for which public posting of meeting minutes was often delayed.

Frequent leadership changes and lack of role-definition led to staff confusion and uncertainty. We found mid-level managers frequently maintained multiple roles and responsibilities, sometimes with an adverse effect on performance in a single area. For example, employees reported that the lack of consistent supervisory presence on each unit contributed to a climate in which some employees felt comfortable sending personal text messages, wearing headphones, and using social media internet sites while on duty in patient care areas.

VHA Directive requires facility leaders to encourage employees to report issues affecting the quality and safety of health care.[11] However, interviews with employees revealed that lapses in civility and conduct occurred, often in front of patients, but that fear of retribution led them to avoid reporting incidents. In addition, staff described having limited knowledge about how to report an incident and little confidence that reporting would result in change. Staff reported that when efforts were made to improve processes they were told "don't go there" and "put things on hold," and one individual described threats of termination if concerns continued to be vocalized. In one clinic, repeated incidents of disrespect and bullying required mediation and ultimately staff reassignment.

We identified through interviews and observations that there is widespread concern about vacancies not being filled, lack of a consistent approach to nurse staffing across shifts and areas of the hospital, and nurses being pulled to areas of the hospital where they do not normally work. Morale among nurses is reported to be low due to a feeling of inconsistent support from nursing leadership.

Multiple staff physicians in a specialty area expressed concerns regarding clinical and administrative matters. These specialists provided evidence of service-level inefficiencies and expressed frustration with a longstanding lack of responsiveness on the part of managers and leaders.

4. System Operations

a. Planning and Routine Inspections

Planning for Drug Shortages. Drug shortages are a major area of concern for the U.S. Food and Drug Administration and clinicians across the nation. The Joint Commission requires facilities to have and implement a process to communicate medication shortages and outages and medication substitution protocols for shortages and outages to licensed independent practitioners and staff who participate in medication management.[12] While Pharmacy leadership could verbalize "typical steps" when assessing a drug shortage situation and examples of plans they have used, as of May 2012, the system lacked a written standard operating procedure or policy addressing the management of drug shortages/outages. Each instance required going to Pharmacy management for a plan which did not always occur in a timely manner.

Environment of Care Inspections and Monitoring. The Joint Commission requires facilities to monitor and analyze the EOC and to take action on identified deficiencies until resolved.[13] We reviewed monthly EOC Committee minutes and determined that they did not sufficiently reflect discussion of identified deficiencies from EOC rounds,

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[11] VHA Directive 2009-043 *Quality Management System* (September 11, 2009).
[12] Joint Commission Standard MM.02.01.01
[13] Joint Commission Standard EC.04.01.01, EC.04.01.05

progress toward resolution, and tracking of items to closure. For example, during interviews and physical inspection at the Waterloo CBOC, we found that identified EOC concerns regarding the front curb height and the timed security feature of the front door were never resolved.

The system's local EOC policy specifies required team members and the number of times per year EOC rounds are to be conducted for both the parent facility and the CBOCs. We found that EOC rounds are not conducted with the full complement of team members and/or the required number of times per year.

The Joint Commission requires that fire safety equipment and building features are maintained and inspected to meet National Fire Protection Association Life Safety Code 101.[14] We found that required CBOC inspections had not been conducted or documented. In addition, staff stated that when they contacted the parent facility for guidance or to schedule the inspections the appropriate staff failed to respond. As a result, CBOC staff reported feeling abandoned by the parent facility. We found fire drills, fire and life safety inspections and alarm testing were not completed and/or documented as required.

b. Access to Care

Respondents to the EAR survey as well as staff interviewed onsite raised concerns regarding access to care. Staff alleged that delays in access had the potential to cause patient harm. The OIG reviewed data and select cases provided by the system.

VHA has set the 2012 wait day threshold for outpatient appointments at 14 days. Every effort is to be made to schedule the appointment within 14 days of the date the provider or the patient has indicated as the "desired date." VHA has a number of measures to track how many patients waited or are waiting for care in excess of 14 days.

The ten specialty care clinics within the system having the most appointments beyond the 14 day threshold are: Podiatry, Optometry, Urology, Orthopedics, Ophthalmology, Cardiology, Mental Health, ENT, Gastroenterology, and Neurology. The largest numbers of concerns received were related to the Gastroenterology and Neurology clinics. We reviewed consult requests in these areas and confirmed access delays beyond 14 days.

Facilities also track the percent of appointments waiting 0-14 days, greater than 14 days and greater than 90 days. Compared with the other 7 facilities in VISN 23, the system had a similar rate of appointments waiting greater than 14 days (system, 20.2 percent; VISN average, 19.6 percent).

[14] Joint Commission Standard EC.02.03.05

Sleep Laboratory staff expressed the concern that delays in treatment could be an unacceptable risk for patients with complex medical problems who were referred for sleep studies. We evaluated the care provided for five patients identified by members of the hospital staff. These patients had been referred for sleep evaluation and management. One patient experienced a delay but there was no indication of patient harm. Another patient had no delay in care while two cases with delays were attributable to patient cancellations. An additional patient was said to have not received needed equipment because there was no staff available with the competence to train the patient. We did not substantiate this allegation or find any instances of patient harm due to delays.

c. Staffing

According to VHA Directive, facilities are expected to establish a staffing methodology for VHA nursing personnel,[15] and the VHA Handbook states that "CBOCs are to be structured and managed through primary care panels and are subject to current policy on VHA primary care panel size and staffing models."[16,17] Staffing within the sytem is consistent with these directives.

d. Reusable Medical Equipment (RME)

EAR survey respondents commented about problems with RME. Review of the use and reprocessing of RME at the parent facility revealed compliance with VHA standards.[18]

e. Supervision of Trainees

Teaching hospitals are required to document the supervision of patient care provided by trainees.[19] Review of a sample of progress notes entered by medical and surgical trainees revealed appropriate supervision by attending physicians and surgeons.

f. Out-of-Operating Room Airway Management

VHA inpatient facilities are expected to ensure the continuous onsite presence of staff with demonstrated competence in airway management.[20] At the parent facility respiratory therapists are on-duty at all times and respond to "Code Blue" calls. We

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[15] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel* (July 19, 2010).
[16] VHA Handbook 1006.1, *Planning and Activating CBOCs* (May 19, 2004).
[17] VHA Directive 2006-031, *Primary Care Standards* (May 17, 2006).
[18] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities* (February 9, 2009) and VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements* (June 26, 2009).
[19] VHA Handbook 1400.1, *Resident Supervision* (July 27, 2005).
[20] VHA Directive 2005-031, *Out-of-Operating Room Airway Management* (August 8, 2005).

found that all respiratory therapists had the required training and demonstrated competence in airway management.

Conclusions

This comprehensive review of quality of care, management, and operations revealed a highly competent professional staff frustrated by the persistent ineffectiveness of senior leadership. During a prolonged period when key leadership positions were held by individuals on a temporary basis, decisions were delayed or never made.

Although high quality medical care has been maintained, a pervasive lack of support for staff problem-solving is a potential threat to patient safety, and several process deficiencies were identified.

Recommendations

Recommendation 1. We recommended that the VISN Director ensure that system leaders take appropriate action in response to identified problems, and communicate action plans to staff.

Recommendation 2. We recommended that system leaders clarify organizational lines of authority and responsibility, to include expectations for committee reporting.

Recommendation 3. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds, and that fire and life safety inspections are conducted annually at the CBOCs.

Recommendation 4. We recommended that the system establish written policies for the management of drug shortages.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Healthcare Inspection review findings and recommendations and provided acceptable improvement plans. We will follow up on the planed actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 23, 2012

From: Director, VA Midwest Health Care Network (10N23)

Subject: **Healthcare Inspection – Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, IA**

To: Karen Moore, Seattle Office of Healthcare Inspections (54SE)

1. The purpose of this Memorandum is to submit the Director's Comments to Office of Inspector General's draft report of the Healthcare Inspection: Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa.

2. If you have any questions or would like to discuss this response, please contact me at 319-339-7100.

(original signed by:)
Janet P. Murphy, MBA
Director, VA Midwest Health Care Network (10N23)

Enclosure

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

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 23, 2012

From: Director, Iowa City VA Health Care System (636A8/00)

Subject: **Healthcare Inspection – Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, IA**

To: Director, VA Midwest Health Care Network (10N23)

1. The purpose of this Memorandum is to submit the Director's Comments to Office of Inspector General's draft report of the Healthcare Inspection: Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa.

2. If you have any questions or would like to discuss this response, please contact me at 319-339-7100.

(original signed by:)
Dawn Oxley, BSN, MSHCA, RN, NEA-BC, VHA-CM
Acting Director

Enclosure

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

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that system leaders take appropriate action in response to identified problems, and communicate action plans to staff.

ICVAHCS Concurs with OIG recommendation.

Action Plan:
System Leaders will take appropriate action in response to identified problems and communicate action plans to staff. Methods will include rounding units, Service line meetings, staff meetings, employee forums, Tell to the Director Program, etc.

Target Date for Completion: November 23, 2012

Recommendation 2. We recommended that system leaders clarify organizational lines of authority and responsibility, to include expectations for committee reporting.

ICVAHCS Concurs with OIG recommendation.

Action Plan:
MCM 12-01 Organizational Leadership Structure contains and outlines the Iowa City VA Health Care System organizational chart. It will be reviewed with current employees as well as new employees.

Leadership will review and update, as needed, the Medical Center Memorandum that communicates the organizational structure for Boards, Councils, Committees, and Subcommittees. It will be reviewed with current employees as well as new employees.

Target Date for Completion: November 23, 2012

Recommendation 3. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds, and that fire and life safety inspections are conducted annually at the CBOCs.

ICVAHCS Concurs with OIG recommendation.

Action Plan.

The Chair of the Environment of Care Committee has also tasked the Safety department to create a pre-established calendar for satellite and CBOC annual life safety drills and rounds for FY 2013. The Environment of Care Committee is investigating use of Environment of Care survey tools such as Sterling Services, in order to establish standardization of EOC reviews and improved follow-up processes for FY 2013.

The life safety annual drills and rounds will be completed at all external ICVAHCS locations to include CBOCs by close of FY 2012.

Target Date for Completion: November 23, 2012

Recommendation 4. We recommended that the system establish written policies for the management of drug shortages.

ICVAHCS Concurs with OIG recommendation.

Action Plan. Leadership has completed a written policy for the management of drug shortages. It is currently in the concurrence process.

Target Date for Completion: September 30, 2012

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Appendix D

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