Administrative Closure
Physician Privileging Issues
Marion VAMC, Marion, IL.
(2010-00689-HI-0261)

10-12399
Approved as Admin Closure
3/24/10

I. Purpose and Objectives

The purpose of this inspection was to determine the validity of allegations that physicians were performing procedures for which they were not privileged, and that privileging information is inconsistent and confusing.

II. Background

The Marion VA Medical Center (the medical center) is located in Marion, IL, and provides a broad range of inpatient and outpatient health care services. The medical center is part of Veterans Integrated Service Network (VISN) 15 and serves a veteran population of about 127,000 throughout 52 counties in southern Illinois, southeastern Indiana, and western Kentucky. It has 55 hospital beds and 60 community living center (CLC) beds.

A confidential complainant alleged that physicians were performing procedures for which they were not privileged, and that privileging information is inconsistent and confusing. Specifically, the complainant alleged that on November 12, 2009, a physician administered moderate sedation to two patients and was not privileged to do so. In addition, the complainant alleged that the Chief of Surgery had performed surgeries without proper privileges. On May 1, 2008, a temporary "Institutional Limitation of Privileges" became effective at the medical center. This limited surgical procedures to those that were low risk, outpatient procedures. Medical staff limited their practice to these areas until such time as the more complex procedures could be resumed.

The privileging process is the method by which the medical center grants the practitioner permission to independently perform specific patient care services that are deemed to be within the practitioner's scope of education, training and competence; and are within the scope and mission of the medical center. Privileges must be current, accurate, detailed, and specific to the services the practitioner provides. Privileges are managed according to VHA policy and include a privilege request process that is service specific, and are reviewed and authorized by the executive medical staff and the Director.[1]

Medical centers are responsible for providing individual provider privileging details to staff throughout the medical center on a need to know basis. In most

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

cases, this would refer to staff responsible for scheduling and providing support or assistance during procedures.

III. Scope and Methodology

We reviewed the allegations and conducted a site visit March 3-4, 2010. We interviewed the complainant, surgical staff, medical center administrative staff, and medical center leadership. We reviewed patient records, operating room (OR) schedules, quality review documents, and credentialing and privileging (C&P) files. We utilized VHA Handbook 1100.19 as our source for compliance with VHA requirements. We limited our investigation to the specific allegations and therefore cannot comment on the compliance with the entire C&P process. We did not review the process for privileges for procedures done outside the OR, such as bronchoscopies and cardiac catheterizations.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

IV. Inspection Objectives

Issue 1: Determine if a surgeon administered moderate sedation without privileges.

We substantiated that a physician administered moderate sedation, without privileges, to patients on November 12, 2009.

No patient harm or adverse outcomes were reported. The physician was new to the medical center in September 2009 and had been granted privileges for endoscopy procedures by the Professional Standards Board (PSB) and the Medical Center Director. The OR Nurse Manager checked a newly published list of providers with moderate sedation privileges and identified that the physician was not on the list. (No one was able to provide to us the date the list was published). The OR Nurse Manager contacted the C&P staff about her concerns. The C&P staff told the OR Nurse Manager that the provider needed to complete the mandatory education on moderate sedation and provide proof of current Advanced Cardiac Life Support (ACLS). The OR Nurse Manager informed the provider, who then completed the training and gave proof of ACLS to the OR Nurse Manager. It was at this time that the OR Nurse Manager thought he was clear to proceed with the procedures and his name was placed on the OR schedule. Two cases were performed on November 12. On November 16, 2009, the OR Nurse Manager was notified by the C&P department that the provider was not issued privileges for moderate sedation by the PSB, the Chief of Surgery, or the Medical Center Director.

The physician believed he had privileges for moderate sedation included in his initial request for endoscopic procedures. The medical center had a separate set

of privileges for moderate sedation. The forms were not automatically provided unless requested at the time of privileging. As a result, the new provider did not have privileges to administer sedation. The physician had completed the required training, but moderate sedation privileges were not requested until November 17 and not approved until November 23.

The medical center conducted an RCA to determine causal factors for administering moderate sedation without privileges. The RCA was completed and actions remained in progress. The medical center recently developed new service specific privilege forms that include moderate sedation.

Issue 2: Determine if the Chief of Surgery performed a procedure without privileges.

We did not substantiate that the Chief of Surgery performed a procedure without privileges.

The complainant alleged that the Chief of Surgery performed a procedure without privileges. We found that the privileges of the Chief of Surgery supported the procedures he was performing. We determined that staff misunderstood the extent of his privileges. The complainant's concern was based on an incident when non-clinical scheduling staff checked specific scheduled procedures (neurotomy) against approved general privileges (hernia repair). The OR schedule and privileges list did not match and staff believed the Chief of Surgery did not have privileges. The particular procedure performed (hernia repair) contained many processes that could be named separately (e.g., neurotomy), but according to the Chief of Surgery, were included in the overall procedure.

Issue 3: Determine if privilege information is confusing and inconsistent.

We substantiated that privileging information available to staff is confusing and inconsistent.

In December 2009, the medical center implemented a process of checking privileges prior to OR procedures in an effort to prevent the occurrence of procedures being done without privileges. This process involved staff checking a notebook and signing OR schedules, indicating approved privileges for the scheduled procedures. These checks are occurring daily in the surgery and endoscopy suites. The C&P staff copied privileging forms of all providers and placed them into three ring binders in four areas of the medical center. These binders were updated by the C&P staff when privileging changes occurred. C&P staff told us that these binders were implemented as a contingency plan for emergencies (power outages) only and that staff were to routinely check a shared electronic site for privilege information. Staff involved with surgery procedures reported using the three ring binders and that the information in these binders was incomplete, confusing, and often changed without warning. When we reviewed a binder, we found multiple privileging forms for each provider.

Some had dates crossed out and dates changed multiple times. Effective dates were unclear and some privilege requests were not signed as approved.

Clinical staff need to be able to view privileges in a concise and clear manner. In the current process, many questions arise. Staff attempting to validate privileges are in a position that requires interpreting C&P forms. Staff reported to us that they are told they have to check for signatures and dates as well as privileges. These staff are not trained in C&P or surgery.

In addition, we found risks for reoccurrence with the process. We found a Certified Registered Nurse Anesthetist (CRNA) providing services in the OR on March 2, 2010, who had privileges that lapsed in December 2009. The OR schedule was signed by the four staff as outlined by the current medical center process, indicating a check took place. Although the staff checked the privileges of the surgeons, they did not check the CRNAs.

In the C&P folders we reviewed, we found a letter dated November 2008, stating the mission of the medical center had been limited in the area of surgery. All procedures classified as American Society of Anesthesiologists Level 4 or 5, or would require an inpatient stay, were suspended. However, this was in direct conflict with physician privileges that had been granted. A list of medical center site specific privileges dated September 30, 2009, included privileges for esophageal and diverticulum resections, carotid endarterectomies, and other major vascular surgeries. This listing was prepared by C&P staff based on current approved privileges.

Privileges need to be facility specific and approved for procedures actually performed by the provider at the medical center. The November 2008 letter was issued as an interim measure to explain the licensed independent providers' reduction of privileges due to the medical center's change in complexity of services. This letter, with a current privileging cycle date and signature, was in all the C&P folders that we reviewed. According to VHA policy, privileges should have been changed to reflect actual performance.

V. Conclusions

We did not see any evidence that the C&P issues resulted in patient harm. We found that many were the result of mismanagement of administrative processes. The surgeon who administered the sedation had in fact been in practice in the private sector for many years and was fully competent to provide the services, but did not have paperwork and approval for moderate sedation. For the CRNA with lapsed privileges, the required paperwork was submitted, but had not been approved.

The professional staff in this medical center needs to be accountable for self monitoring and should only schedule procedures once they receive the final letter from the PSB stating they have been privileged. Nursing should not be expected

to interpret privileging forms and when questions arise about procedures and privileges, the final accountability should be with the appropriate service chief.

The three ring binders should be removed and the actual C&P folders used as a backup for emergencies.

The electronic posting of privileges is appropriate and should be maintained in a clear and concise manner for those who need to know.

Service Chiefs need to take a more active role in reviewing privilege request forms to assure the privileges match the capabilities of the medical center. We were informed during our visit that all physicians would be re-privileged in the near future with newly developed privileging forms that will match privileges with practice.

Results of our inspection were shared with the Acting Medical Center Director and the Chief of Staff who agreed with our assessment. The medical center has been actively taking actions to improve their C&P processes and is making progress. However, they continue to have vulnerabilities with their current C&P processes. We reported our findings to the VISN Quality Management Officer who agreed to provide 54KC with progress reports. Because several actions are in progress, we recommend administrative closure with follow-up reports to 54KC and a potential site re-visit in 6 months to review C&P processes.

original signed by

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