Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-02705-49

Combined Assessment Program Review of the Sioux Falls VA Medical Center Sioux Falls, South Dakota

January 2, 2008

Washington, DC 20420

Why We Did This Review

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

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

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

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Executive Summary

Introduction

During the week of September 10–14, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Sioux Falls VA Medical Center (the medical center), Sioux Falls, SD. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 236 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 23.

Results of the Review

The CAP review covered five operational activities. We identified the following organizational strengths and reported accomplishments:

- Reduced Infection Rates Through Clinical Collaboratives.
- Improved Utilization Management (UM) and Patient Flow.

We made recommendations in one of the activities reviewed. For this activity, the medical center needed to:

- Lock intravenous (IV) carts when not in use.
- Date multiple dose medication vials as specified by local policy.
- Maintain an accurate inventory of radioactive materials.

The medical center complied with selected standards in the following four activities:

- Business Rules.
- QM.
- Surgical Care Improvement Project (SCIP).
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia L. Solana, Director, and James Seitz, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Profile

Organization. The medical center is a secondary care facility located in Sioux Falls, SD, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics in Sioux City and Spirit Lake, IA, and in Aberdeen, SD. The medical center is part of VISN 23 and serves a veteran population of about 78,000 throughout eastern South Dakota, northwestern Iowa, and southwestern Minnesota.

Programs. The medical center provides comprehensive health care in medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and transitional care services. It has 45 acute hospital beds and 58 nursing home beds.

Affiliations and Research. The medical center is affiliated with the University of South Dakota's Sanford School of Medicine and provides training for more than 50 residents, as well as other disciplines, including anesthesia, pharmacy, medical records, pastoral care, social work, nursing, nuclear medicine, radiology, occupational therapy, physical therapy, recreation therapy, dental hygiene, and phlebotomy.

In fiscal year (FY) 2006, the medical center research program had 21 projects and a budget of $671,000. Important areas of clinical research include infectious disease, diabetes registries, sleep disturbance, lung disease self-management, anti-coagulation therapy, stroke prevalence, and mental health. Research projects in basic science include studies in brain mechanisms involving drug addictions, stress and sleep, renal function, and the mechanism of ultraviolet light damage to cells.

Resources. In FY 2006, medical care expenditures totaled $104.3 million. The FY 2007 medical care budget was $113 million. FY 2006 cumulative staffing was 658 full-time employee equivalents (FTE), including 41.7 physician, 27.7 mid-level provider, and 220.1 nursing FTE.

Workload. In FY 2006, the medical center treated 23,000 unique patients. The inpatient care workload totaled 2,811 discharges, and the average daily census, including

nursing home patients, was 86.4. Outpatient workload totaled 187,000 visits.

Objectives and Scope

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

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

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

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

- Business Rules.
- Environment of Care (EOC).
- QM.
- SCIP.
- SHEP.

The review covered medical center operations for FY 2006 and FY 2007 through August 31, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Sioux Falls VA Medical Center, Sioux Falls, South Dakota,* Report No. 04-03069-135, May 5, 2005). The medical center had

corrected all health care related conditions identified during our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 236 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strengths

Reduced Infection Rates Through Clinical Collaboratives

The medical center participated in a multi-disciplinary Intensive Care Unit (ICU) collaborative to decrease hospital-acquired infections. The components from the ICU collaborative became standards of care and contributed to improved patient outcomes. From December 2004 through June 2006, clinicians took numerous actions to reduce catheter-related blood stream infections. As a result, there have not been any blood stream infections since April 2006. The medical center also took action to reduce ventilator-associated pneumonia, and there have not been any cases since March 2006. A concurrent hand hygiene collaborative contributed to the ICU collaborative with a "foam in/foam out" campaign to encourage hand hygiene before and after patient care.

Improved Utilization Management and Patient Flow

Medical center managers established the Clinical Resource Management Department and developed a written plan to provide expertise in UM and allocation of medical resources. Numerous actions were taken to promote improvements in the delivery and appropriateness of care, manage the cost of health services provided, and mitigate impediments to efficient patient flow.

As a result of these actions, there have been improvements in medical center processes and the delivery of patient care. The average percent of inpatient admissions not meeting established criteria decreased from 11 percent in FY 2004 to 3 percent in FY 2006. There was a decrease in the number of patient transfers due to unavailable beds from 38 transfers in FY 2005 to 20 transfers in FY 2006, resulting in savings of

$811,068. The number of patient diversions to other facilities in FY 2007 decreased from 30 diversions total in the 1st and 2nd quarters to 0 (zero) in the 3rd quarter. The average patient length of stay decreased from 6.2 days in FY 2005 to 5.2 days in the 2nd quarter of FY 2007.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected infection control (IC) standards and maintained a clean and safe patient care environment. Medical centers are required to establish a comprehensive EOC program that fully meets National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.[1]

We evaluated the IC program to determine compliance with Veterans Health Administration (VHA) directives that require management to collect and analyze data to improve performance. IC staff appropriately monitored, trended, analyzed, and reported infection data to clinicians for implementation of quality improvements to reduce infection risks for patients and staff.

We conducted onsite inspections of ambulatory care areas, inpatient units, nuclear medicine, the surgical outpatient clinic, and general administration areas. We found that the medical center maintained a generally clean and safe environment. Nurse managers on the inpatient units expressed high satisfaction with the responsiveness of the housekeeping staff on their units. We identified three safety concerns that needed improvement.

Intravenous Carts.

On a medical unit, we found two unlocked IV carts containing numerous syringes, needles, and multiple dose vials of sodium chloride. Local policy requires that IV carts be locked when not in use. The open access to needles, syringes, and sodium chloride could be a danger to patients or visitors.

[1] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

Multiple Dose Medication Vials.

On one inpatient unit, we found four multiple dose medication vials that did not have a date indicating when the vials were opened. Local policy requires that vials be marked with a date when they are opened and discarded 28 days after the opening date. Without an opening date, nurses and pharmacists would have no way of knowing when they need to discard the vials.

Tritium.

We reviewed the storage, use, inventory, handling, and disposal of tritium to ensure that it is managed in compliance with Nuclear Regulatory Commission (NRC) regulations,[2] VA guidance, and VHA Directive 1105.1,[3] and all applicable local policies. We determined that the medical center did not maintain an accurate inventory of tritium in a manner consistent with VHA requirements. Tritium is a low dose radioactive compound used in research protocols that has a long period of radioactivity. It emits very small amounts of radiation and is a hazard only if taken internally. In April 2007, the Research Coordinator found tritium vials in an unlocked drawer underneath a laboratory table. In October 2007, Nuclear Medicine transferred the tritium to safe storage and arranged for a pick up by a nuclear waste company.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that IV carts are locked when not in use.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center has ordered carts with automatic locks and keyless entry for IV therapy, procedures, and medications. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires compliance with local policy regarding multiple dose medication vials.

[2] NRC Master Materials License No. 03-23853-01VA.
[3] VA's National Radiation Safety Committee Guidance and VHA Directive 1105.1, *Management of Radioactive Materials*, September 22, 2004.

The VISN and Medical Center Directors agreed with the finding and recommendation. Nurse managers are responsible for ensuring that dates are printed on multiple dose vials. Pharmacy will monitor compliance. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires an accurate inventory of radioactive materials.

The VISN and Medical Center Directors agreed with the finding and recommendation. A nuclear physicist conducted an inventory of all radioactive sources on September 17, 2007. Medical center managers have identified other processes to improve safety in the use of radioactive materials. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Business Rules

The purpose of this review was to determine whether business rules governing the computerized patient record system (CPRS) comply with VHA policy. CPRS business rules define what functions certain groups or individuals are allowed to perform in the health record.

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes the combined electronic and paper medical record and is also known as the legal health record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the times and dates recorded.

On October 20, 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. Following this guidance, OI has recommended that any editing of signed records be limited to a facility's Privacy Officer. On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all

VA medical centers to comply with the informational patch sent in October 2004.

We reviewed VHA and medical center information and technology policies and interviewed Information Technology (IT) staff. We found that IT staff had reviewed local business rules to assess compliance with VHA policy and had updated or deleted rules that were not applicable. As a result, all of the business rules the medical center provided for our review complied with VHA requirements. We made no recommendations.

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center Director, Chief of Staff, Associate Director for Patient Care, and QM personnel, and we evaluated plans, policies, and other relevant documents. For the purpose of this review, we defined a comprehensive QM program as including the following program areas:

- QM and performance improvement committees, activities, and teams.
- Patient safety functions (including healthcare failure mode and effects analyses, root cause analyses, aggregated reviews, and patient safety goals).
- Risk management (including disclosure of adverse events and administrative investigations related to patient care).
- UM (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medication management.
- Medical record documentation reviews.
- Blood and blood products usage reviews.
- Operative and other invasive procedures reviews.
- Reviews of patient outcomes of resuscitation efforts.
- Restraint and seclusion usage reviews.
- Advanced clinic access reviews.
- Efficient patient flow reviews.

We evaluated monitoring and improvement efforts in each of the program areas through a series of data management process steps. These steps were consistent with Joint Commission standards and included:

- Identifying problems or potential improvements.
- Gathering and critically analyzing the data.
- Comparing the data analysis results with established goals or benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We also evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff reprivileging process. Also, we reviewed mortality analyses to determine the level of medical center compliance with VHA guidance.

We found that the QM program provided comprehensive oversight of the quality of care. We found good senior management support and clinician participation. Generally, when problems were identified, actions were taken and adequately evaluated. We made no recommendations.

Surgical Care Improvement Project

The purpose of this review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs. In 2005, VHA adopted surgical infection performance measures (PMs) from the Centers for Medicare and Medicaid Services and the Joint Commission into its performance measurement system to improve surgical patient outcomes.

We evaluated the following VHA PMs reported for FY 2006 and quarters 1–3 of FY 2007:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given. The VHA target was 90 percent.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial

resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed. The VHA target was 87 percent.

- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing. The VHA target was 70 percent.

We reviewed the medical center's PM scores and compared them to VHA established targets. The medical center met or exceeded the target for timely antibiotic administration for the last 4 reported quarters.

For timely discontinuation of prophylactic antibiotics post-operative, the medical center did not meet the target for the last 4 reported quarters. However, key staff developed and implemented action plans to improve PM scores. The medical center provided education to staff physicians on the clinical evidence that supports discontinuing an antibiotic within the designated timeframe. The medical center also participated in the VISN 23 Surgical Site Infection Collaborative, with a goal of reducing surgical infection rates through evidence-based medical practice and standardized patient care. As a result of these initiatives, PM scores have improved and are now at 79 percent.

The medical center met or exceeded the target for controlled core body temperature for colorectal surgery for 2 of the last 3 reported quarters. The medical center developed and implemented action plans, including staff education and documentation reviews. As a result of these initiatives, PM scores are now at 80 percent.

We reviewed the medical records of 30 patients who had surgery performed during the 3rd quarter of FY 2007. The review included medical records for each of the following surgical categories: (a) colorectal, (b) vascular, and (c) orthopedic (knee or hip replacement). The medical center did not have any cases for cardiac surgery. Review results are displayed in the table on the next page.

Antibiotic administered timely	Antibiotic discontinued timely	Body temperature control (colorectal surgery)
97 percent (29/30)	83 percent (25/30)	100 percent (6/6)

Our medical record review supported the improved PM scores, demonstrating that the medical center appropriately administered and discontinued antibiotics or documented clinical exceptions. Clinicians monitored and controlled immediate post-operative body temperature for patients who had colorectal surgery.

Because we determined that the medical center had initiated appropriate corrective actions to improve care, we made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set PM results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figure 1 on the next page shows the medical center's SHEP PM results for inpatients. Figure 2 on the next page shows the medical center's SHEP PM results for outpatients.

Figure 1:

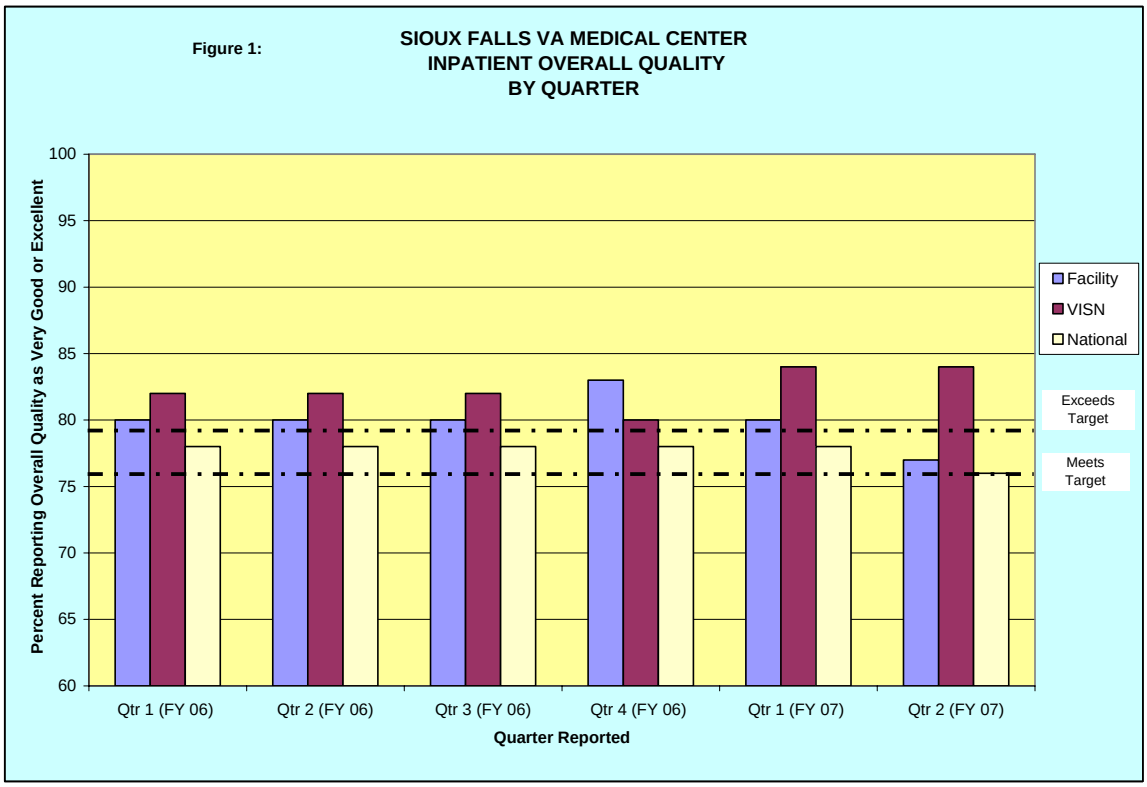
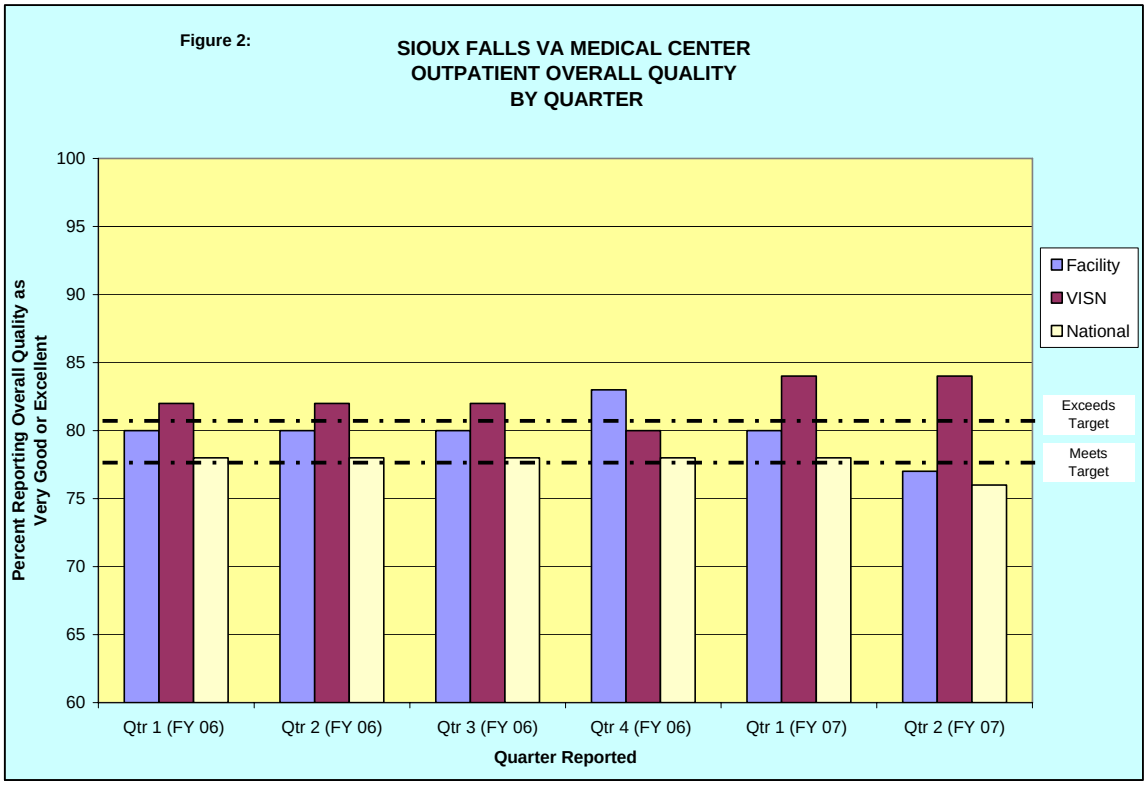


Figure 2:



The medical center has exceeded the established target for the past 6 quarters for inpatient results and 5 of the last 6 quarters for outpatient results. The medical center had identified opportunities for improvement based on the SHEP scores and had developed an action plan targeting specific services and departments. They have implemented the action plan, and there is evidence of ongoing activities and evaluation of the plan for effectiveness. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 2, 2007

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

Subject: **Combined Assessment Program Review of the Sioux Falls VA Medical Center, Sioux Falls, SD**

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

Director, Management Review Office (10B5)

I concur with the planned actions to be taken by Sioux Falls VAMC regarding the three identified recommendations. A date for completion is noted for each item.

ROBERT A. PETZEL, M.D.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 2, 2007

From: Acting Director, Sioux Falls VA Medical Center (438/00)

Subject: **Combined Assessment Program Review of the Sioux Falls VA Medical Center, Sioux Falls, SD**

To: Director, Veterans Integrated Service Network (10N23)

1. We appreciated the opportunity to review the draft Combined Assessment Program Review report for the survey conducted at the Sioux Falls VA Medical Center on September 11–13, 2007.

2. Attached are comments regarding actions taken to complete the identified items and those that are currently in process to improve and resolve non-compliance in the areas cited.

3. We would like to extend our appreciation to the IG team members for their professionalism. Their collegial manner resulted in a productive and beneficial survey process for the medical center.

(original signed by:)
STEVEN C. JULIUS

cc: Barbara Teal, Chief Quality and Resource Management (OOUR)

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that IV carts be locked when not in use.

Concur **Targeted Completion Date: January 25, 2008**

Sioux Falls VA Medical Center has ordered IV therapy, procedure and medication carts for all the units with automatic locks and keyless entry. These carts automatically lock once the drawers are shut. The narcotics drawer has a double lock which is also automatic and keyless.

The Medical Center roll-out plan is as follows:

- Pharmacy to set up transfer cart by 11/16/07.
- In-service training for all nursing staff and competencies sign off completed by 11/30/07.
- IT to attach BCMA hardware by 11/30/07.
- Roll-out IV therapy and procedure carts to all wards by 12/14/07.
- Set-up and roll-out medication carts in TCU by 12/21/07.
- Set-up and roll out medication carts in ICU/3S by 1/11/08.
- Set up and roll out medication carts in 2S by 1/18/08.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with local policy regarding multiple dose medication vials.

Concur **Targeted Completion Date: January 31, 2008**

Steps have been taken to eliminate the number of multiple dose medication vials within the medical center. We implemented the use of pre-filled sodium chloride flush syringes and have eliminated the stock of multiple dose saline vials in all areas except for the Omnicell in Urgent

Care and Surgery. All units continue to have other types of multiple dose vials (e.g., insulin).

In order to monitor compliance with the local policy, the nurse manager/designee will be checking the IV carts and medication stock cupboards daily for open vials. The nurse manager or designee will assess that a discard date is printed on the affixed label on the vial. As a cross reference, the charge nurse will ascertain all open vials have a designated discard date at the same time as the crash cart checks are completed.

All nursing staff using multiple dose vials will be retrained on the requirements regarding multiple dose vials as specified in the Medical Center's policy (center circular 119-7, Multiple Dose Medication Vials) by 12/31/07. Education will be recorded in TEMPO.

A random monthly monitor will be implemented to assess for compliance with labeling multiple dose vials. The monitor will be conducted as part of the monthly Ward Inspections by pharmacy staff, starting November 2007. Results will be reported to Nursing Executive Council (NEC) and Organizational Performance Council (OPC). Corrective actions will be documented and tracked by NEC and forwarded to OPC for information.

Evaluation method: Numerator: Number of vials with designated discard date noted on affixed label.
Denominator: total number of vials reviewed.
Data to be sorted by type of vial.
Target: 100 percent with designated discard date noted on affixed label.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires an accurate inventory of radioactive materials.

Concur **Targeted Completion Date: February 1, 2008**

The medical center has taken the following steps to address the inventory of radioactive isotopes and staff awareness. Actions taken include:

- September 13, 2007 – Conducted an inventory of any remaining isotope sources in Research & Development (R&D). The gamma counter contained a Cs-137 rod source and an I-125 rod source for calibration. There were also Geiger-Mueller survey meter check sources of Cs-137 in a safe. These sources were transferred to Nuclear Medicine and were picked up for disposal on October 10, 2007.

- September 14, 2007 – Beckman Instruments verified that there was a Cs-137 source inside of the liquid scintillation counter. Arrangements

were made with Beckman Instruments for the removal of the cesium source that is located inside the Beckman liquid scintillation counter. The removal is currently anticipated to be during the week of 11/5 or 11/12.

- September 17, 2007 – A full physical inventory of all radioactive sources was conducted by the Physicist, including the Geiger counters. No other sources were identified. All the sealed sources found in Research were found under the "generally licensed" category covered under the NRC regulations, Title 10 CFR Part 31. Our Physicist, in conjunction with the Acting Nuclear Medicine Supervisor, initiated a review of the Radiation Safety records to see if there were copies of any radioactive waste disposals or source transfers. We found the records in the R.C. Johnson VAMC files which demonstrated that there had been some disposal of R&D radioactive materials in the past. What was not found was a close-out survey of the Research labs. Next step is to review the consultant physicist reports around the time of the disposal to see if they document a final survey for radioactive contamination.

- September 19, 2007 – Research and Development Coordinator reviewed VHA Directive 1105.1 and presented findings from the OIG CAP review with the members of the Subcommittee for Research and Safety. In addition, an e-mail was sent by the Chief of Imaging to all employees notifying them on where to direct questions or concerns about any known or questionable materials that may be radioactive.

- September 26, 2007 – The Radiation Safety Officer reviewed VHA Directive 1105.1 at the Radiation Safety Committee meeting to ensure compliance with the requirements.

- October 4, 2007 – Research and Development Coordinator reviewed VHA Directive 1105.1 and OIG CAP findings at the Research and Development Committee meeting. It was agreed that isotopes would no longer be used since better non-isotope procedures are available.

Future actions include:

- A review of the policies and procedures, including those specific for potential use in research (i.e., the Research Radiation Safety Manual), to ensure proper procedural steps for control of all radioactive materials, whether used under NRC 10CFR35 or for research purposes on the VA campus in Sioux Falls by December 31, 2007.

- Present an hour "Hospital Wide General Radiation Safety" in-service to all employees by the Medical Center's Physicist by December 31, 2007.

- Develop a formal process for obtaining information on radioactive isotopes from medical center departments. Process to include verifying changes from the previous license information and assessing for any new isotopes by January 31, 2008.

- Send out an isotope inventory list to every department in the facility and have them check off what possible isotopes they might have. Also include an example of the radioactive label that would be found on each isotope to make an isotope easier for an employee to recognize. This will be on an annual basis. The initial version of the list will be sent following the "Hospital Wide General Radiation Safety" presentation.

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