Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02986-67

Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, Arizona

February 5, 2009

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 October 14–17, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Northern Arizona VA Health Care System (the system), Prescott, AZ. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 266 system employees. The system is part of Veterans Integrated Service Network (VISN) 18.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strength and reported accomplishment:

- Professional Practice Evaluation.

We made recommendations in three of the activities reviewed. For these activities, the system needed to:

- Specify an appropriate timeframe in the local policy for documentation of pain medication effectiveness.
- Consistently document pain medication effectiveness in a timely manner.
- Label items in medication refrigerators in accordance with accreditation standards.
- Include the participation of the Information Security Officer (ISO) in environment of care (EOC) rounds, as required.
- Display suicide prevention posters and brochures in highly visible areas throughout the system.
- Maintain storage areas properly and secure sharp instruments.
- Conduct EOC rounds more frequently in the emergency department (ED) and address any deficiencies identified.

The system complied with selected standards in the following five activities:

- Coordination of Care.
- Pharmacy Operations and Controlled Substances (CS) Inspections.
- QM.

- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Linda G. DeLong, Director, and Karen Moore, Associate Director, Dallas Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–18, for the full text of the Directors' comments.) We will follow up on the planned action for Recommendation 4 until it is completed.

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

Introduction

Profile

Organization. The system provides a continuum of primary and secondary level medical, rehabilitative, and long-term care to veterans residing in northern Arizona. Also, primary level ambulatory care, screening services, and mental health services are provided through five community based outpatient clinics located in Kingman, Lake Havasu City, Bellemont, Cottonwood, and Anthem, AZ. The system is part of VISN 18 and serves a veteran population of about 67,000 throughout a primary service area that includes parts of five counties in northern Arizona.

Programs. The system provides primary and secondary inpatient medicine and ambulatory care, including general medicine, ambulatory surgery, mental hygiene, and selected specialized medical clinics. Rehabilitative care consists of a four-bed inpatient physical medicine rehabilitation unit with an active rehabilitation therapy department, an outpatient substance abuse treatment program, and a vocational rehabilitation/job training program. Long-term care consists of a community living center (CLC),[1] a geriatric evaluation and management program, and domiciliary care. Dementia, hospice, and respite programs are available within the CLC.

Affiliations and Research. The system is affiliated with Midwestern University's Arizona College of Osteopathic Medicine for 30-day rotations (clerkships) for third and fourth year medical students. The system also provides clinical training opportunities for nursing and allied health care professions through affiliations with several other universities. Currently, the system does not conduct research.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled $118 million. The FY 2009 medical care budget is projected to be $122 million. FY 2008 staffing was 725 full-time employee equivalents (FTE), including 28 physician and 219 nursing FTE.

Workload. In FY 2008, the system treated 23,002 unique patients and provided 7,453 inpatient days in the hospital, 22,245 inpatient days in the CLC, and 30,923 inpatient days in the domiciliary. The inpatient care workload totaled

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

2,104 discharges, and the average daily census, including CLC and domiciliary patients, was 166. Outpatient workload totaled 237,706 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 eight activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Pharmacy Operations and CS Inspections.
- QM.
- SHEP.
- Staffing.

The review covered system operations for FYs 2007, 2008, and 2009 through October 14, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the system *(Combined Assessment*

Program Review of the Northern Arizona VA Health Care System, Prescott, Arizona, Report No. 04-02331-17, November 2, 2005). In that report, we identified improvement opportunities for colorectal cancer management. During the follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address the identified deficiencies, and we consider the issue closed.

During this review, we also presented fraud and integrity awareness briefings for 266 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 Strength

Professional Practice Evaluation

The system had specific forms and processes to collect, aggregate, and monitor provider-specific data. This is a Joint Commission (JC) requirement for focused and ongoing professional practice evaluation.

The system uses general information applicable to all providers and specific data for each discipline. The information collected includes: (a) peer review "triggers" and non-protected peer review data; (b) six areas of general competencies defined by The JC; (c) provider-specific data customized to each discipline (such as blood utilization data, mortality, pharmacy, tort claims, non-protected peer reviews, patient complaints/compliments, utilization management data, clinical reminder reports, suicide data); and (d) clinical pertinence chart reviews (specific to each specialty). The information is aggregated every 6 months for each provider. Other VA facilities have sought to use this model.

Results

Review Activities With Recommendations

Medication Management

The purpose of this review was to evaluate whether Veterans Health Administration (VHA) facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the telemetry and intensive care unit, the acute medical unit, and the CLC (CLC I and CLC II). We found appropriate use of patient armbands to correctly identify patients prior to medication administration. However, we identified the following areas that needed improvement.

Pain Medication Effectiveness. VHA regulations[2] and local policy require that the effects of pain medications be monitored. Local policy did not define an appropriate timeframe for documentation of pain medication effectiveness. We reviewed 19 patient records for documentation of pain medication effectiveness. We noted that 112 (76 percent) of 148 administered doses of pain medications were documented for effectiveness. Also, we found that the times between pain medication administration and documentation of patient response to the medication ranged from 1 minute to 185 hours. Without appropriate documentation and follow-up, clinicians could not be assured that patients' pain was effectively managed.

Unlabeled Medication. Accreditation standards require that medications brought into the system by patients' families be safely managed. In the medication refrigerator on CLC I, we found two unlabeled alcoholic beverages. There was a written doctor's order, and the patient's family had supplied the beverages. However, there were no labels on the bottles to identify ownership in order to monitor usage and ensure safe management. While we were onsite, the pharmacy supplied bar code labels to affix to the bottles.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires local policy to specify an

[2] VHA Directive 2003-021, *Pain Management*, May 2, 2003.

appropriate timeframe for documentation of pain medication effectiveness.

The VISN and System Directors agreed with the CAP review finding and recommendation. The system revised the local policy to specify that pain medication effectiveness must be evaluated within 1 hour for medications given orally and within 30 minutes for medications given intravenously. Effectiveness will be documented by the end of the shift in which the medication is administered. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires clinicians to consistently document pain medication effectiveness in a timely manner.

The VISN and System Directors agreed with the CAP review finding and recommendation. They reported that all licensed practitioners who administer pain medications are responsible for documenting administration and effectiveness in the Bar Code Medication Administration system in a timely manner. A daily medication effectiveness report will be monitored by the nurse manager, or designee, of each unit. Each unit will report monthly to the Clinical Inpatient Service Line manager of their respective unit. The compliance requirement will be 100 percent. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that items in medication refrigerators are labeled.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that the issue identified during the CAP review was resolved immediately. All items now placed in medication refrigerators by non-pharmacy staff will be labeled with full patient identification information. The corrective action is acceptable, and we consider this recommendation closed.

Environment of Care

The purpose of this review was to determine if the system maintained a safe and clean health care environment. The system is required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and JC standards. The infection control (IC)

program was evaluated to determine compliance with VHA directives based on the management of data collected and processes in which the data was used to improve performance.

We inspected the telemetry and intensive care unit, the acute medical unit, the CLC, the domiciliary, two primary care clinics, and specialty clinics. The system maintained a generally clean environment. The IC program monitored and reported data to clinicians for implementation of quality improvements. However, we identified the following conditions that needed improvement.

Environment of Care Rounds. EOC rounds conducted by the system's inspection team allow each discipline participating on the team to identify and correct discrepancies, unsafe working conditions, and other regulatory violations. Representation from each discipline enables the team to cover the system in depth, and participation by each discipline's representative or designee should be documented. A Deputy Under Secretary for Health for Operations and Management (DUSHOM) memorandum issued on March 5, 2007, requires the ISO to be included as a team member on EOC rounds. The ISO was not represented on EOC rounds.

Suicide Prevention Information. A DUSHOM memorandum issued on December 7, 2007, requires suicide prevention posters and brochures to be displayed in highly visible areas throughout the system. During our review, we found two posters displayed in the primary care clinics and one displayed in the domiciliary. We were informed that suicide prevention posters had been recently received; however, they were not consistently displayed in highly visible areas throughout the system.

Equipment Storage. According to OSHA, aisles and passageways in storage areas should be kept free of obstruction. Throughout the system, we observed that rooms designated as storage areas had excessive amounts of equipment, materials, and supplies. We found that the inpatient units utilized empty patient rooms, bathrooms, and a shower room for storage. The items being stored, such as a treatment cart, a dirty laundry cart, clean linen carts, and blood pressure monitoring devices, were used for daily care. Other equipment stored included fans, beds, scales, medication carts, a television, computer stands, and extra

wheelchairs. Also, on CLC II, the door to a patient room only opened halfway due to an excessive amount of equipment.

Unsecured Sharp Instruments. Sharp instruments should be secured in an effort to minimize risks and provide a safe environment for patients, staff, and visitors. A treatment cart on CLC I was unlocked and contained four pairs of scissors.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that the ISO participate in EOC rounds.

The VISN and System Directors agreed with the CAP review finding and recommendation. They reported that the ISO will participate in EOC rounds. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that suicide prevention posters and brochures are displayed in highly visible areas throughout the system.

The VISN and System Directors agreed with the CAP review findings and recommendation. They reported that an additional 30 suicide posters were placed throughout the facility while the CAP review team was onsite. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that storage areas are maintained properly and that sharp instruments are secured.

The VISN and System Director agreed with CAP review findings and recommendation. They reported that a centralized equipment storage area has been established. Also, every clinical area throughout the facility will keep treatment carts locked and sharp items secured at all times that carts are not under the immediate supervision of facility staff. The corrective actions are acceptable, and we consider this recommendation closed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility emergency/urgent care operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health

conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the system's ED and triage environments for cleanliness and safety.

The system's ED is open 24 hours per day, 7 days per week, as required for an ED. It is located within the main hospital building, and emergency services provided are within the system's patient care capabilities. In addition, the system had an appropriate policy for managing patients whose care may exceed the facility's capability.

We reviewed the medical records of patients who presented in the ED with acute mental health conditions and found that patients were managed appropriately. In addition, we determined that patient transfers complied with applicable policy.

We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. We also found that managers had appropriately documented nursing competencies. However, we found one area that needed improvement.

Emergency Department Environment of Care Rounds. We conducted EOC rounds in the ED and the triage area and found space to be limited. During our rounds, we found two functional wall oxygen flow meters in the patient waiting area that were unattended. In the clean linen room, we found sterile bottles for an upcoming procedure on the floor in a biohazard container and clean laundry bags on top of dirty garbage cans. In addition, inpatient examination rooms were being utilized for equipment storage. While we were onsite, managers immediately corrected the deficiencies found during ED EOC rounds.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires staff to conduct more frequent ED EOC rounds and address any deficiencies identified.

The VISN and System Directors agreed with CAP review findings and recommendation. They reported that any extra equipment in the ED or the triage area is now removed daily and stored in the centralized storage area. The ED nurse manager has instituted daily EOC rounds in the ED to identify and resolve issues immediately. The corrective

actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met local, VHA, and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of nine inpatients who had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes.

We determined that clinicians appropriately managed nine of nine intra-facility transfers. We found transfer notes from sending units to receiving units and documentation that nursing assessments were performed by the receiving units in accordance with established timeframes.

We reviewed nine medical records of discharged patients and found that all patients received appropriate written discharge instructions. We also found documentation indicating that the patients understood the instructions. We made no recommendations.

Pharmacy Operations and Controlled Substances Inspections

The purpose of this review was to evaluate whether VHA facilities had adequate controls to ensure pharmacy security and proper management of CS. We also determined whether processes were in place to monitor polypharmacy (patients prescribed multiple medications), especially in vulnerable populations.

We reviewed VHA regulations governing pharmacy and CS security, and we assessed whether the system's policies and practices were consistent with VHA regulations.[3] We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns, and we interviewed appropriate Pharmacy Service and Police and Security Service

[3] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

personnel as necessary. Additionally, we reviewed policies and procedures and interviewed appropriate personnel to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy.

Pharmacy Controls. Our review showed that the system had appropriate policies and procedures to ensure the security of the pharmacies and CS. CS inspections were conducted according to VHA regulations. Training records showed that the CS Coordinator (CSC), the alternate CSC, and all 12 inspectors received appropriate training to execute their duties. The pharmacies' internal environments were secure, clean, and well maintained. The biosafety cabinet, where sterile intravenous medications were prepared, complied with VHA regulations[4] and IC standards.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[5] Some literature suggests that that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[6]

Our review showed that managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate. We made no recommendations.

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively

[4] VHA Handbook 1108.6.
[5] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.
[6] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

supported the program's activities. We interviewed the system's Director, Chief of Staff, and Chief of QM. We also interviewed QM personnel and several other service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the system's quality of care. Appropriate review structures were in place for the 15 program activities reviewed. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the system had developed staffing guidelines for nurses, and we found them to be adequate.

The system uses hours per patient day (HPPD) as the primary staffing methodology. We reviewed staffing for four inpatient units for 12 total shifts. We found that guidelines for nurse staffing were generally met in all areas reviewed and that specific actions had been taken to ensure safe patient care. Overall, we found that according to the HPPD model, the system had adequate nursing staff. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA facilities use quarterly survey 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 performance measure (PM) target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients. Facilities are expected to address areas that fall below target scores. Figures 1 and 2 on the next page show the system's SHEP PM results for inpatients and outpatients, respectively.

Figure 1:

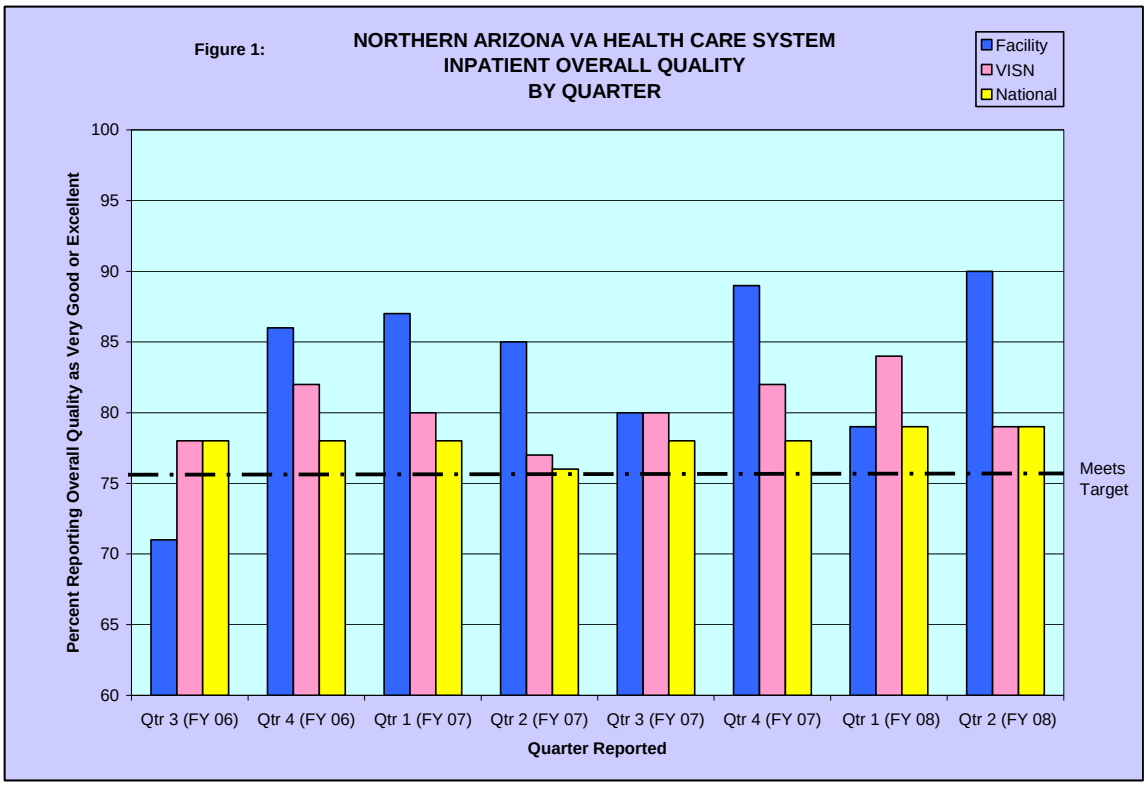
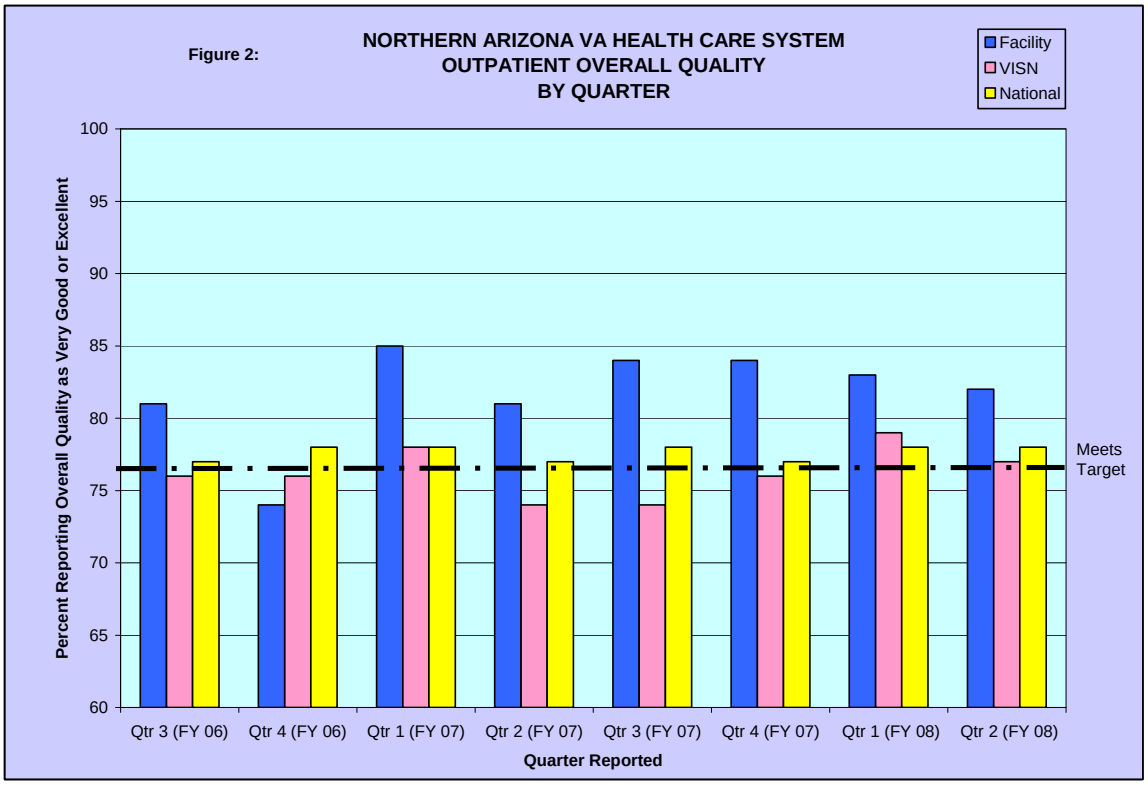


Figure 2:



The system had exceeded the established targets for both inpatient and outpatient scores in 7 of the last 8 quarters of available data. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 22, 2008

From: Director, VA Southwest Health Care Network (10N18)

Subject: **Combined Assessment Program Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, Dallas Healthcare Inspections Division (54DA)

Director, Management Review Service (10B5)

I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program review at the Northern Arizona VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 12, 2008

From: Director, Northern Arizona VA Health Care System (649/00)

Subject: **Combined Assessment Program Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, VA Southwest Health Care Network (10N18)

Thank you for allowing us the opportunity to review and respond to the subject report.

The following are our plans of action designed to correct those areas for which recommendations were provided.

Susan A. Angell, MSW, Ph.D.

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 System Director requires local policy to specify an appropriate timeframe for documentation of pain medication effectiveness.

Concur

Target Date: December 1, 2008 (complete)

HCSM 118-NE-11 has been revised to specify that pain medication effectiveness must be evaluated within one hour for medications given orally, and 30 minutes for medications given intravenously. All pain medication effectiveness will be documented by the end of the shift in which the medication is administered.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires clinicians to consistently document pain medication effectiveness in a timely manner.

Concur

Target Date: December 12, 2008 (complete)

Process established and in place: (1) All licensed practitioners who administer pain medication are responsible to document administered pain medication and the effectiveness of that medication in BCMA in a timely manner appropriate to that medication and the condition of the patient. All licensed practitioners who administer medications run a PRN medication effectiveness report in BCMA at the end of their shift and document effectiveness of administered medications. (2) Effective December 1, 2008, a daily PRN medication effectiveness report will be monitored by the NM of each unit, or their designee. (3) Effective Jan. 5, 2009, each unit will report a monthly monitor (for the previous month) to Clinical Inpatient Service Line Managers for their respective units. Compliance requirement will be 100%.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that items in medication refrigerators are labeled.

Concur

Target Date: December 12, 2008 (complete)

The issue identified during survey was resolved immediately while surveyors were present. A process has been established that all items placed in the medication refrigerator by non-Pharmacy staff will be labeled with a patient label with full patient identification information.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that the ISO participate in EOC rounds.

Concur

Target Date: October 29, 2008 (complete)

The previous NAVAHCS process involved ISO and Privacy Officer performing weekly rounds. This process allowed for increased effectiveness during the rounds, significantly increased frequency of rounds, and decreased disruption to the area being visited. Although it appears redundant, based on the direction of the IG/CAP Surveyor, the ISO has joined the EOC rounds and continues the rounds described above. The findings from the expanded rounds have been incorporated into the Sterling Readiness Round report.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that suicide prevention posters and brochures are displayed in highly visible areas throughout the system.

Concur

Target Date: October 15, 2008 (complete)

At the time of the IG/CAP Survey, suicide prevention posters were present in the three most highly visible areas for veterans (Primary Care, Mental Health, and the Canteen). The IG/CAP Surveyor requested a specific poster be displayed. The poster was obtained, and an additional 30 posters were placed throughout the facility while the surveyor was present.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that storage areas are maintained properly and that sharp instruments are secured.

Concur

Target Date: October 23, 2008 (complete)

A centralized clinical equipment storage area has been established. SPD Staff perform daily rounds each evening to check clean storage areas throughout the facility for additional equipment that has accumulated throughout the day. Any clean clinical equipment stored in the clinical areas above the established thresholds is removed and stored in the centralized storage area. SPD staff is available by cell phone and will deliver requested clinical equipment from the centralized storage area to the clinical areas. Every clinical area throughout the facility will maintain treatment carts locked and sharps secured at all times that carts are not under the immediate supervision of facility staff. Staff assigned to provide treatment to patients will assume primary responsibility to maintain treatment cart security. Nursing Managers will perform random weekly cart/sharps security checks.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires staff to conduct more frequent ED EOC rounds and address any deficiencies identified.

Concur

Target Date: October 23, 2008 (complete)

A centralized clinical equipment storage area has been established. SPD Staff perform daily rounds each evening to check clean storage areas throughout the facility for additional equipment that has accumulated throughout the day. Any clean clinical equipment stored in the clinical areas above the established thresholds is removed and stored in the centralized storage area. SPD staff is available by cell phone and will deliver requested clinical equipment from the centralized storage area to the clinical areas. The Emergency Department Nurse Manager has instituted daily EOC rounds in the Emergency Department to identify and resolve issues immediately.

OIG Contact and Staff Acknowledgments

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