Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00368-161

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

April 20, 2012

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 crime awareness briefings 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.

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
DUSHOM	Deputy Under Secretary for Health for Operations and Management
EOC	environment of care
facility	Phoenix VA Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
MM	medication management
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Phoenix VA Health Care System, Phoenix, AZ

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of February 13, 2012.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Colorectal Cancer Screening
- Medication Management
- Polytrauma
- Quality Management

The facility's reported accomplishment was the transformation of the community living center's dining room to café style dining.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Ensure environmental safety on the locked mental health units. Secure medications at all times in the outpatient mental health clinic. Protect sensitive patient information in the outpatient mental health clinic and on the locked mental health units.

Psychosocial Rehabilitation and Recovery Centers: Initiate steps to fully implement the Psychosocial Rehabilitation and Recovery Center or request a Deputy Under Secretary for Health for Operations and Management approved modification or exception.

Coordination of Care: Ensure initial follow-up appointments are addressed in discharge instructions and consistently scheduled within the timeframes requested by providers.

Moderate Sedation: Ensure that pre-sedation assessment documentation includes all required elements and that patients are appropriately monitored during moderate sedation.

Comments

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

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

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- CRC Screening
- EOC
- MM
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2010, FY 2011, and FY 2012 through February 13, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from

our prior CAP review of the facility (*Combined Assessment Program Review of the Phoenix VA Health Care System, Phoenix, Arizona,* Report No. 09-03313-59, January 11, 2010). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 216 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 121 responded. Survey results were shared with facility managers.

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.

Reported Accomplishment

CLC Dining

As part of VHA's initiative to transform the culture and environment of nursing homes, the facility's Nutrition and Food Service and CLC staff implemented a "Café Style" dining program using an interdisciplinary approach. One of the objectives of the program was designed to improve resident quality of life by providing an environment that enhances the dining experience through increased socialization and food options and greater dining flexibility. The program was implemented on a full-time basis and serves 3 meals per day, 7 days a week. After full implementation of the program, resident attendance in the CLC dining room increased from 7 to 21 attendees for breakfast and from 15 to 30 attendees for lunch and dinner.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's Substance Abuse RRTP was in compliance with selected MH RRTP requirements.

We inspected seven inpatient units (one medical, one surgical, one intensive care, two locked MH, and two CLC), the emergency department, the operating room, the Substance Abuse RRTP, and four outpatient clinics (dental, primary care, women's health, and MH). Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
X	Medications were secured and properly stored, and medication safety practices were in place.
X	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Environmental Safety. The Joint Commission requires facilities to maintain a safe, functional environment. On the locked MH units, we found that back hallways were not continuously observable by staff and that ceiling tiles were removable, exposing potential anchor points for hanging.

Medication Security. The Joint Commission requires that medications are secured from unauthorized persons. In the outpatient MH clinic, we found an unsecured medication refrigerator in an unlocked office.

Patient Privacy. The Health Insurance Portability and Accountability Act of 1996 requires patient health information to be protected from unauthorized disclosure. In the outpatient MH clinic, we found two unattended computers displaying sensitive patient information. We also found a computer monitor that could be seen from the doorway displaying sensitive patient information. On the locked MH units, we found that there was no designated area to ensure patient privacy during nursing intake assessments, so assessments were being conducted in the hallway.

Recommendations

1. We recommended that processes be strengthened to ensure environmental safety on the locked MH units.

2. We recommended that processes be strengthened to ensure that medications are secured at all times in the outpatient MH clinic.

3. We recommended that managers strengthen processes to ensure that sensitive patient information is protected in the outpatient MH clinic and on the locked MH units.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a DUSHOM approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or DUSHOM approved modification.

The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

PRRC Modification or Exception. VHA directed that facilities fully implement PRRCs by September 30, 2009, or have an approved modification or exception.[1] The facility did not have an operational PRRC, and the exception from the DUSHOM had expired on September 30, 2011.

Recommendation

4. We recommended that the facility initiate steps to fully implement the PRRC or request a DUSHOM approved modification or exception.

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 22 HF patients' medical records and relevant facility policies, and we interviewed employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
X	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[2] Six patients did not have initial follow-up appointment recommendations included in their discharge instructions. Additionally, although 14 patients had recommended follow-up appointment timeframes, 4 appointments were not scheduled as requested.

Recommendation

5. We recommended that processes be strengthened to ensure that initial follow-up appointments are addressed in discharge instructions and consistently scheduled within the timeframes requested by providers.

[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 12 medical records, and 19 training/competency records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
X	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[3] None of the medical records reviewed included all required elements of the history and physical examination and/or pre-sedation assessment. We found the following documentation deficiencies:

- Twelve records lacked the time and nature of last oral intake.
- Nine records lacked assessments of tobacco, alcohol, and/or substance abuse.
- Eight records lacked a history of any previous adverse experience with sedation.
- Seven records lacked an airway assessment.
- Three records lacked an assessment of risk, such as the American Society of Anesthesiologist Physical Status.

Intra-Procedure Monitoring. VHA requires that vital signs be documented at 5-minute intervals during a procedure where moderate sedation is used.[4] Three medical records did not contain documented evidence of vital signs taken at 5-minute intervals.

[3] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[4] VHA Directive 2006-023.

Recommendations

6. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

7. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation.

Review Activities Without Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

MM

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below details the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 20 medical records of patients with a positive traumatic brain injury screening, and 10 staff training records, and we interviewed key staff. The table below details the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The table below details the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 18–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[5]		
Type of Organization	Tertiary care medical center	
Complexity Level	1b	
VISN	18	
Community Based Outpatient Clinics	Buckeye, AZ Phoenix, AZ Globe, AZ Surprise, AZ Mesa, AZ Show Low, AZ Payson, AZ	
Veteran Population in Catchment Area	315,646	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	184	
• **CLC/Nursing Home Care Unit**	96	
Medical School Affiliation(s)	University of Arizona	
• **Number of Residents**	279	
	Current FY (through December 2011 except where noted)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$133	$483
• **Medical Care Expenditures**	$90	$410
Total Medical Care Full-Time Employee Equivalents	2,423	2,424
Workload:		
• **Number of Station Level Unique Patients**	30,366 (October 2011)	81,016
• **Inpatient Days of Care:**		
o **Acute Care**	5,869	38,211
o **CLC/Nursing Home Care Unit**	3,075	22,187
Hospital Discharges	1,004	6,830
Total Average Daily Census (including all bed types)	138	165
Cumulative Occupancy Rate (in percent)	54.7	60.9
Outpatient Visits	117,034	779,968

[5] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
MM		
1. Ensure nurses consistently document PRN (as needed) pain medication effectiveness in the Bar Code Medication Administration record within the timeframe specified in local policy.	Monitoring of PRN pain medication effectiveness has been conducted monthly and was implemented by nursing staff after the CAP. Trends and required actions have been reported to the Performance Inquiry Board and the Executive Quality Committee.	N
EOC		
2. Require the Information Security Officer to consistently participate in EOC rounds.	EOC rounds attendance has been reported at monthly EOC Committee meetings. The Information Security Officer has attended EOC rounds on a consistent basis.	N

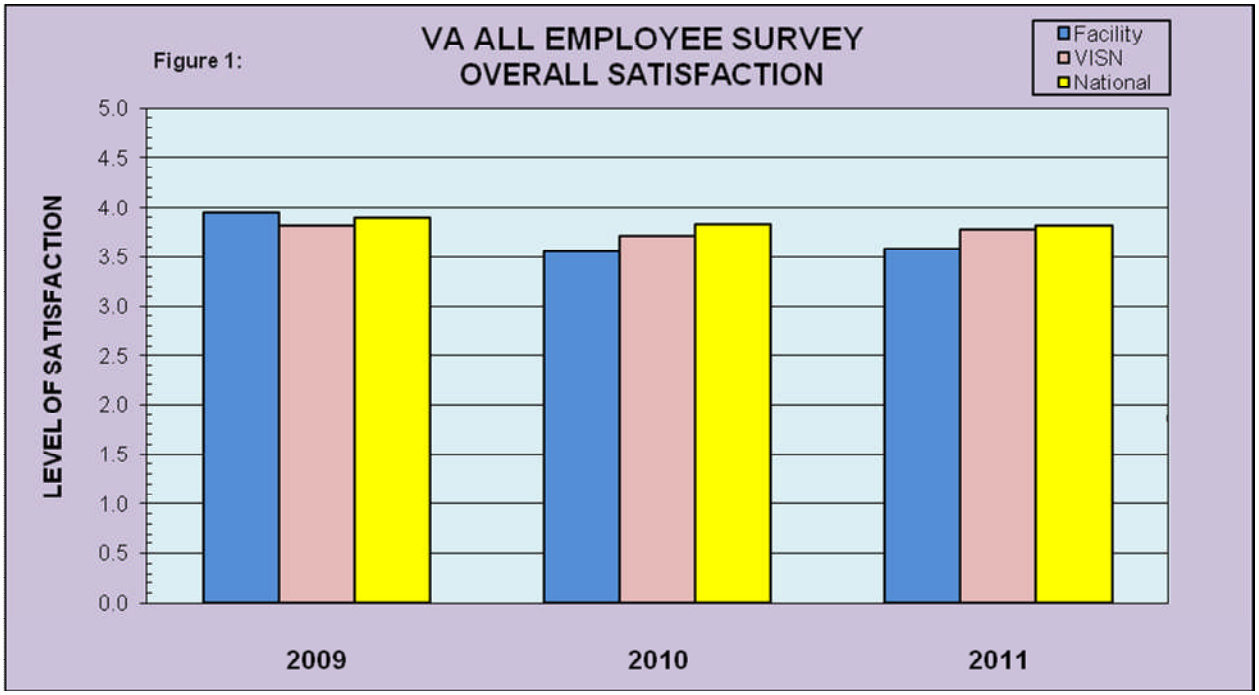
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	54.2	57.8	49.7	49.6	45.5	46.6
VISN	64.6	63.8	52.5	52.0	51.0	53.7
VHA	63.9	64.1	55.9	55.3	54.2	54.5

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[6] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[7]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	15.7	8.9	11.8	24.0	24.3	19.7
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[6] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[7] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 30, 2012

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

Subject: **CAP Review of the Phoenix VA Health Care System, Phoenix, AZ**

To: Director, San Diego Regional Office of Healthcare Inspections (54SD)

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

1. I concur with the attached draft facility response to the recommendations for improvement contained in the Combined Assessment Program Review at the Phoenix VA Health Care System.

2. If you have any questions or concerns, please contact Jennifer Kubiak, VISN 18 Quality Management Officer, at 602.222.2798 or Sally Compton, Executive Assistant to the Network Director, VISN 18 at 602.222.2692.

(original signed by:)
Susan P. Bowers

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 30, 2012

From: Director, Phoenix VA Health Care System (644/00)

Subject: **CAP Review of the Phoenix VA Health Care System, Phoenix, AZ**

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

1. Please find attached our response to the OIG Combined Assessment Program Review of the Phoenix VA Health Care System conducted February 13–17, 2012.

2. We would like to commend the OIG CAP Review Team that conducted our review. The team, led by Judy Montano, included members Josephine Andrion, Elizabeth Burns, Sandra Khan, Glen Pickens, Derrick Hudson, was consultative and professional and provided excellent feedback to our staff. Deborah Howard was the Project Leader.

3. I concur with the findings and implementation plans and subsequent actions have been completed for each recommendation.

(original signed by:)
Sharon M. Helman
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure environmental safety on the locked MH units.

Concur

Target date for completion: June 30, 2012

To strengthen and ensure environmental safety of Mental Health units, a project was initiated to place additional cameras in the back hallways of both units for surveillance. Installation is expected on June 24, 2012. Inpatient Mental Health Nursing staff continue to perform unit rounds at a minimum of every 30 minutes, throughout each shift.

Recommendation 2. We recommended that processes be strengthened to ensure that medications are secured at all times in the outpatient MH clinic.

Concur

Target date for completion: April 30, 2012

On March 1, 2012, a Work Order was placed for Engineering Service to adjust the locks in the Outpatient Mental Health Clinic room used to secure the medications in a refrigerator. On March 22, 2012, the decision was made to order a new locked medical-grade refrigerator which is anticipated to be delivered by April 30, 2012. The Outpatient Mental Health Clinic Nurse Manager and Pharmacy are performing weekly inspections to ensure the medications are secure. Inspections conducted on March 1, 8, 12, and 15, 2012, revealed 100% compliance with the requirement for secured medications. The Nurse Manager and Pharmacy will now conduct bi-weekly checks until final delivery of the medical-grade refrigerator.

Recommendation 3. We recommended that managers strengthen processes to ensure that sensitive patient information is protected in the outpatient MH clinic and on the locked MH units.

Concur

Target date for completion: July 31, 2012

A review of Privacy and Information Security Awareness training was performed for Mental Health Outpatient Clinic and Inpatient Ward staff on March 15, 2012, with 100% compliance. On March 9, 2012, Nursing Service conducted an in-service with

13 Outpatient Mental Health Clinic staff regarding Privacy and Information Security Awareness requirements. Privacy inspections for unattended computers were performed to verify compliance on March 13, 15, 20, and 22, 2012 with no findings reported. On April 1, 2012, the Chief of Psychiatry will initiate weekly privacy screen inspection rounds in the Outpatient Mental Health Clinic to ensure privacy screens are utilized. The Privacy Officer will monitor Outpatient Mental Health for compliance until 95% compliance is achieved for a minimum of a 90-day period. Ongoing privacy monitoring will be performed by the Environment of Care Rounds Team.

On February 15, 2012, secure Mental Health Units stopped the practice of nursing intake interviews in areas that did not adequately protect patient privacy. Intake interviews are now conducted in designated rooms which ensure patient privacy. On March 7, 2012, Mental Health Inpatient Nursing Unit staff received an in-service regarding privacy during patient assessment. There were 22 staff members present. Additionally, privacy guidance was provided to all staff through electronic message.

Recommendation 4. We recommended that the facility initiate steps to fully implement the PRRC or request a DUSHOM approved modification or exception.

Concur

Target date for completion: June 30, 2012

Due to facility space constraints, a Request for Exemption Memorandum was sent on December 19, 2011, through the VISN 18 Mental Health Liaison to the Office of Mental Health Services (OMHS). An update to the request was sent in February of 2012 and the Chief of Psychology continues to search for appropriate PRRC space.

Recommendation 5. We recommended that processes be strengthened to ensure that initial follow-up appointments are addressed in discharge instructions and consistently scheduled within the timeframes requested by providers.

Concur

Target date for completion: May 1, 2012

A Post Hospitalization Heart Failure Clinic was developed in December of 2011. Patient discharge instructions were developed in a new Computerized Patient Record System (CPRS) template that includes follow-up discharge instructions for this clinic.

Recommendation 6. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: July 31, 2012

To strengthen the documentation of required elements in the pre-sedation assessment, the following items are now included in the pre-procedure protocols: allergies, medication review, laboratory studies review, tobacco, alcohol, and illicit drug usage, most recent oral intake, ASA (American Society of Anesthesia) score, Mallampati score and previous adverse reactions to sedation.

Recommendation 7. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation.

Concur

Target date for completion: July 31, 2012

An inspection of hemodynamic monitors (Phillips Intellivue MP-30) was performed by Bio-Medical Engineering on March 26, 2012. The monitors in the Pulmonary Medicine Service procedural area were confirmed to be set at five minute intervals, the default setting; with zero monitors identified with settings at 10-minute intervals. Staff were provided an in-service on March 27, 2012, on performing appropriate monitoring of vital signs during moderate sedation. Effective April 1, 2012, Pulmonary Medicine Service will perform audits of Bronchoscope procedures to ensure vital sign monitoring occurs at five minute intervals. The audits will be performed until 95% compliance for a period of no less than 90 days is achieved. This data will be reported to the Invasive Procedure Committee.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Deborah Howard, RN, Project Leader Judy Montano, MS, Team Leader Josephine Andrion, MHA, RN Elizabeth Burns, MSSW Sandra Khan, RN Glen Pickens, RN, MHSM Derrick Hudson, Program Support Assistant Rich Cady, Special Agent, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southwest Health Care Network (10N18)
Director, Phoenix VA Health Care System (644/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jon Kyl, John McCain
U.S. House of Representatives: Ed Pastor

This report is available at http://www.va.gov/oig/publications/default.asp.