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Office of Healthcare Inspections

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Healthcare Inspection

Access and Quality of Care Concerns Phoenix VA Health Care System Phoenix, Arizona and Delayed Test Result Notification Minneapolis VA Health Care System Minneapolis, Minnesota

June 23, 2016

Washington, DC 20420

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Executive Summary

At the request of Congressman Timothy J. Walz, the VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the validity of allegations at the Phoenix VA Health Care System (VAHCS), Phoenix, AZ, concerning the Emergency Department (ED), Phoenix VAHCS cleanliness, Allergy Clinic, VA Police Department, outpatient pharmacy services, and primary care provider (PCP) assignment. A single, additional allegation involved test result notification at the Minneapolis VAHCS, Minneapolis, MN. Specifically, the allegations were:

- During a visit to Phoenix VACHS's ED in 2015, a patient experienced a greater than 6-hour length of stay (LOS), and many patients left the ED without being seen after waiting for 6 or more hours.
- ED staff did not maintain auditory confidentiality.
- The patient had to wait almost 2 hours after discharge from the ED to receive a medication prescription.
- Another ED patient was left unattended in the Radiology Department.
- The Phoenix VAHCS was filthy.
- Allergy Clinic staff did not properly dispose of oral thermometer probe covers.
- VA police was observed on one occasion inappropriately managing a disruptive patient.
- The pharmacy did not always provide or refill medication prescriptions.
- A patient, whose preferred facility was the Minneapolis VAMC,¹ did not have an assigned PCP at the Phoenix VAHCS [when temporarily relocating to Phoenix during the winter].
- A patient was not told the results of a magnetic resonance imaging completed in 2013 at the Minneapolis VAHCS.

We substantiated that a patient experienced an ED length of stay (LOS) greater than 6 hours on a day in 2015 that many patients left the ED without being seen. The LOS patients experienced that day was the longest ED patients had experienced during the reviewed time period March 1, 2014, through March 31, 2015, and was likely caused by an unforeseeable episode of increased demand and other factors, which combined to result in extraordinary delays of care in the Phoenix VAHCS's ED. However, Phoenix VAHCS' ED median wait time for discharged patients (190 minutes) for the reviewed time period did not exceed the Veterans Health Administration's LOS threshold and was similar to LOS data of three Phoenix area Medicare-certified hospitals that were within

¹ VHA Directive 2007-016. *Coordinated Care Policy for Traveling Veterans*, May 9, 2007. A preferred facility is that VHA facility for which veterans express their preference as their principal location of care and at which the major portion of their primary care is provided. This Directive was rescinded on April 22, 2015, after the events discussed in this report, and replaced by VHA Directive 1101.01, *Coordinated Care Policy for Traveling Veterans*.

3.3 miles of the Phoenix VAHCS. We determined an effective mechanism was not in place for ED staff to quickly recognize episodic, increased demand events and to adjust processes.

We substantiated that examination areas separated by curtains created a risk for inadvertent protected health information disclosure and that patients brought to the Radiology Department from the ED were not always supervised. We identified a system weakness related to the timeliness of prescription delivery practices for discharged ED patients.

We substantiated that some Phoenix VAHCS treatment and public areas were not clean. We determined that Environmental Management Services' Housekeeping understaffing was a contributing factor. We substantiated that Allergy Clinic staff did not consistently dispose of oral temperature probe covers properly. We could not substantiate the allegation that a VA police officer mishandled a veteran. We substantiated that the Phoenix VAHCS pharmacy should have provided a patient a recommended antimalarial medication or an appropriate substitution.

Because a patient's preferred facility was the Minneapolis VAHCS, we did not substantiate allegations that the Phoenix VAHCS pharmacy should have provided the patient with more than short-term supplies of medications or that the Phoenix VAHCS pharmacy should have refilled a one-time only prescription. We substantiated that the patient was not assigned a PCP at the Phoenix VAHCS because the patient's preferred facility was the Minneapolis VAHCS where he was assigned a PCP as required. We substantiated that staff at the Minneapolis VAHCS did not ensure a patient received magnetic resonance imaging results within 14 days, as required by policy.

We made 10 recommendations regarding ED care timeliness, auditory privacy, patient supervision, pharmacy services, housekeeper staffing and cleanliness, standard precautions, and test result notification.

Comments

The Veterans Integrated Service Network, the Phoenix VA Health Care System and the Minneapolis VA Health Care System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 19–28 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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Purpose

At the request of Congressman Timothy J. Walz, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the Phoenix VA Health Care System (VAHCS) in Phoenix, AZ. The purpose of the inspection was to assess the merit of allegations concerning the Emergency Department (ED), Phoenix VAHCS cleanliness, the Allergy Clinic, the VA Police Department, outpatient pharmacy services, and primary care provider (PCP) assignment. OIG's site visit to the Phoenix VAHCS was unannounced. A single, additional allegation involved test result notification at the Minneapolis VAHCS, Minneapolis, MN.

Background

Phoenix VAHCS Profile. The Phoenix VAHCS is part of Veterans Integrated Service Network (VISN) 18. It is a 166-bed, complexity level 1b² system serving veterans in central Arizona. It provides a broad range of inpatient and outpatient medical services, including a 24-bed ED.

In 2009, because of steadily increasing ED demand, Phoenix VAHCS leadership requested and received approval to renovate and expand the ED; the construction project began in April 2015. With a spring 2016 planned completion, the project will add 9,333 square feet of new space and renovate 13,000 square feet of existing space.

Minneapolis VAHCS Profile. The Minneapolis VAHCS, located in Minneapolis, MN, is a part of VISN 23. It is a 200-bed, complexity level 1a tertiary facility that provides primary, specialty, surgical, mental and behavioral health, extended care, and rehabilitative services.

Triage and the Emergency Severity Index. The purpose of triage in the ED is to identify patients who require immediate, life-saving treatment and prioritize all presenting patients' care. Veterans Health Administration (VHA) requires that a Registered Nurse (RN) triage all patients who present to the ED and assign acuity (illness severity) levels based on the Emergency Severity Index (ESI).³ The ESI triage algorithm tool uses key decision points that divide patients into five levels from 1 (requires immediate, life-saving intervention) to 5 (least resource intensive).⁴

Tracking ED Patient Flow To Promote Efficiency. VHA requires that facilities with an ED use the Emergency Department Integration Software (EDIS) tracking program for

² The five levels of hospital complexity are: 1a, 1b, 1c, 2, and 3, in descending order of complexity with level 1a the most complex and level 3 the least complex. VA determines facility complexity based upon a formula that considers the patient population, the patient risk, the level of intensive care unit and complex clinical programs, as well as education and research indices.

³ VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010. This VHA Handbook was scheduled for recertification on or before the last working day of May 2015, and has not yet been recertified.

⁴ Agency for Healthcare Research and Quality. *Emergency Severity Index (ESI) A Triage Tool for Emergency Department Care Version 4*. Implementation Handbook 2012 Edition.

data entry and ED patient flow management.⁵ EDIS provides real-time data about patient flow, wait times, and length of stay (LOS) to assist in policy development and system redesign for improved patient flow. VA’s Emergency Medicine Management Tool (EMMT) uses EDIS data to analyze and report on the operational performance of VA EDs and Urgent Care Clinics. ED managers can use EMMT data to improve ED productivity and standardization, and to improve patient flow.

LOS is a key indicator of ED patient flow. Extended LOS due to ED crowding (lack of space and/or resources to provide timely emergency care) has the potential to compromise medical care⁶ and can lead to patients leaving without being seen.⁷

Emergency Department Performance Metrics. VHA establishes ED performance metric goals (targets) and minimum standards (thresholds) on a fiscal year (FY) basis. FY 2015 performance metric targets and thresholds discussed in this review are displayed in Table 1.

Table 1. VHA FY 2015 ED Performance Metric Targets and Thresholds

	Metric	Target	Threshold
Length of Stay	Median Total Patient LOS (discharged and admitted)	<=*200 minutes	>=**300 minutes
	Median Discharged Patient LOS	<=150 minutes	>=210 minutes
	Median Admitted Patient LOS	<=240 minutes	>=360 minutes
Patient Flow	Median Door to Triage Time	<=15 minutes	>=20 minutes
Service Measure	Percent Left Without Being Seen	<=3 percent	>=5 percent

Source: *Emergency Medicine Management Tool User Manual*

* Less than or equal to. ** More than or equal to.

Communicating Test Results. VHA Directive 2009-019, *Ordering and Reporting Test Results*,⁸ was the controlling Directive during the time pertinent to this review. This Directive stated that test results were to be communicated to patients no later than 14 calendar days from the date on which the results became available to the ordering practitioner. The Directive further stated that abnormal results requiring immediate attention were to be communicated in a timeframe that minimized risk to the patient. On October 7, 2015, VHA rescinded Directive 2009-019 and replaced it with VHA Directive 1088, *Communicating Test Results to Providers and Patients*.⁹ Directive 1088

⁵ VHA Directive 2011-029, *Emergency Department Integration Software (EDIS) for Tracking Patient Activity in VHA Emergency Departments and Urgent Care Clinics*, July 15, 2011.

⁶ ED crowding has been associated with increased mortality. Sun BC, et al. *Effect of Emergency Department Crowding on Outcomes of Admitted Patients*, *Ann Emerg Med.* 2013; 61: 605–611.

⁷ IOM report: *The Future of Emergency Care in the United States Health System*. Institute of Medicine. Academy of Emergency Medicine, 2006;13(10):1081–1085.

⁸ VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

⁹ VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

established the general rule that test results not requiring further action be communicated within 14 calendar days from the date on which the results are available and results requiring action be communicated within 7 calendar days from the date on which the results are available.

Allegations. In May 2015, Congressman Timothy J. Walz forwarded a letter to the OIG. Summarized below are allegations concerning the Phoenix VAHCS outlined in the letter and/or clarified during interviews with OIG.

During a visit to Phoenix VACHS's ED in 2015, a patient experienced a greater than 6-hour LOS and many patients left the ED without being seen (LWBS) after waiting for 6 or more hours. Additionally, ED staff did not maintain auditory confidentiality, the patient had to wait almost 2 hours after discharge from the ED to receive a medication prescription, and another ED patient was left unattended in the Radiology Department. Further:

- The Phoenix VAHCS was filthy.
- Allergy Clinic staff did not properly dispose of oral thermometer probe covers.
- VA police was observed on one occasion inappropriately managing a disruptive patient.
- The pharmacy did not always provide or refill medication prescriptions.
- A patient, whose preferred facility was the Minneapolis VAMC,¹⁰ did not have an assigned PCP at the Phoenix VAHCS [when temporarily relocating to Phoenix during the winter].
- A patient was not told the results of a magnetic resonance imaging (MRI) completed in 2013 at the Minneapolis VAHCS.

Scope and Methodology

We conducted this inspection from June 24 through September 30, 2015. We conducted an unannounced, onsite inspection at the Phoenix VAHCS June 29 through July 1, observed ED operations, and conducted environment of care inspections. We also interviewed the Acting Phoenix VAHCS Director and leadership staff who oversee the services discussed in this report, including day and night shift ED nurses and housekeepers. We interviewed the Minneapolis VAHCS's Chief of Orthopedics by telephone as well as other individuals with knowledge concerning the events discussed in the report, and conferred with the VHA Chief Consultants for Pharmacy Benefits Management and Preventive Medicine.

¹⁰ VHA Directive 2007-016. *Coordinated Care Policy for Traveling Veterans*, May 9, 2007. A preferred facility is that VHA facility for which veterans express their preference as their principal location of care and at which the major portion of their primary care is provided. This Directive was rescinded on April 22, 2015, after the events discussed in this report, and replaced by VHA Directive 1101.01, *Coordinated Care Policy for Traveling Veterans*.

We reviewed the electronic health records (EHRs) of 130 patients who presented to the Phoenix VAHCS's ED on the day in question and the EHRs of 26 patients who had MRIs ordered by the Minneapolis VAHCS orthopedic service in November 2014. We also reviewed computer-processed data obtained from VHA's Support Service Center (specifically, EMMT and EDIS data), relevant Phoenix VAHCS and Minneapolis VAHCS policies and procedures, Environmental Management Services (EMS) housekeeping vacancy data, use of force investigative and security incident reports, disruptive behavior data and Disruptive Behaviors Committee meeting minutes, and patient advocate complaints. Lastly, we reviewed relevant ED crowding literature and Department of Health and Human Services non-VA ED data.¹¹

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

¹¹ Medicare.gov, Hospital Compare Website.

<https://www.medicare.gov/hospitalcompare/details.html?msrCd=prmt2grp5&ID=030002,030037,030024&stsltd=AZ>
Accessed on August 17, 2015.

Case Summary

At the time of our review, the patient was in his mid-60s with a medical history that included hypertension, allergic rhinitis, and asthma. He was an established VHA patient prior to the events discussed in this report. His documented preferred facility was the Minneapolis VAHCS. During the winter months, the patient lived in the Phoenix area and received care as needed at the Phoenix VAHCS. The patient's medical history pertinent to this review follows.

In 2013, the patient sought emergency dental treatment at the Phoenix VAHCS. The dentist noted that the patient's blood pressure was elevated and advised the patient to go to one of the medical clinics. Later that day, the patient was evaluated at a Phoenix VAHCS medical clinic; his blood pressure remained elevated. The patient reported he had been taking two antihypertensive medications prescribed by his Minneapolis PCP. After speaking with the patient, the patient's Minneapolis VAHCS PCP added an additional antihypertensive medication.

Ten weeks later, the patient had an orthopedic consult at Minneapolis VAHCS to evaluate left knee pain. The orthopedist ordered an MRI of the patient's left knee and noted, "We will see him back in the clinic in six weeks after his MRI." The MRI was completed, and the results were available to the orthopedist within 3 weeks. The patient later cancelled an orthopedic appointment scheduled in the new year.

In early 2014, the patient was in the Phoenix area when he contacted the Minneapolis VAHCS call center and requested medication to prevent malaria and diarrhea prior to traveling to Central America. The patient's Minneapolis PCP placed an infectious disease consult. A Minneapolis VAHCS infectious diseases specialist recommended two medications for traveler's diarrhea and a combination tablet for malaria prophylaxis.¹² The specialist advised the patient to go to a Phoenix VAHCS clinic where a VA provider could see the recommendations.

The patient presented to the Phoenix VAHCS ED and requested the recommended medications. After conferring with the Phoenix VAHCS staff, the ED provider noted that the patient could receive the diarrhea medications from the Phoenix VAHCS's outpatient pharmacy, but it was not VA policy to provide the antimalarial for personal travel. The ED provider wrote a prescription for the recommended antimalarial to be filled at a non-VA pharmacy.

Later in 2014, the patient presented at the Phoenix VAHCS's ED and stated that he was having trouble getting his blood pressure prescription medications. He also complained of a headache and chronic back pain. His blood pressure was mildly elevated. The ED provider wrote short term (bridge supply) prescriptions and documented that the patient

¹² Malaria, a disease spread by mosquitos, can cause death and occurs in parts of Central America. <http://www.cdc.gov/malaria/resources/pdf/fsp/drugs/atovaquoneproguanil.pdf> (accessed September 10, 2015).

believed his medications were sent to the wrong address.¹³ A Minneapolis VAHCS provider subsequently changed the patient's prescribed blood pressure medications to decrease the risk of an interaction occurring between his blood pressure medications and his allergy shots.

Four months later, the patient had an orthopedic appointment at the Minneapolis VAHCS. The provider documented discussing the results of the 2013 MRI of the left knee with the patient and noted, "The patient winters in Arizona, and he did not follow up at his scheduled [early 2014] appointment."

Five months later, the patient was seen in the Minneapolis VAHCS Allergy Clinic. His blood pressure at that time was mildly elevated.

In 2015, the patient went to the Phoenix VAHCS Allergy Clinic for a routine appointment. His blood pressure was mildly-moderately elevated during 2 measurements.¹⁴ He complained of a headache and stated that the previous night he had felt dizzy and blood pressure readings at home had been elevated. Clinic staff instructed him to go to the ED for an evaluation. The patient registered in the ED after lunch. Twenty minutes after registration, his blood pressure was moderately elevated. The ED triage RN documented that the patient was in the ED for hypertension and noted he was in no acute distress. The patient was triaged as an ESI level 3 and advised to wait in the ED waiting area.

An ED physician started an EHR note 373 minutes after registration. The physician prescribed an additional antihypertensive medication and advised the patient to follow-up with his PCP. The physician documented, in part, the following:

Denies dizziness at present. Denies neurological changes but admits chronic peripheral neuropathy. No weight changes. States he has been compliant to his medications. Resolved HA [headache] from this morning and reports no dizziness in the ER [emergency room] or today. Yesterday was doing pushups and admits having been dizzy for a short time.

At 418 minutes after registration, the patient's blood pressure was essentially unchanged. An ED RN documented that the patient was to be discharged home, that he received discharge teaching, and that he was to follow up with his PCP in 1 week. The patient's LOS was 419 minutes (6 hours and 59 minutes). The patient also received an additional blood pressure medication from the pharmacy prior to leaving the Phoenix VAHCS. The EHR does not record the time the patient received the medication.

¹³ VHA policy requires that patients with routine medications need to provide a temporary address, phone number, and dates of travel to the appropriate staff at their preferred facility prior to going on extended travel.

¹⁴ When an initial blood pressure reading is elevated, a repeat blood pressure reading is taken after waiting one to three minutes to check for accuracy.

Inspection Results

Issue 1: Emergency Department Length of Stay and Left Without Being Seen

We substantiated that the patient experienced an LOS greater than 6 hours during a 2015 ED visit, and that many patients left the ED without being seen. The LOS patients experienced that day was the longest ED patients had experienced during the time frame of March 1, 2014, through March 31, 2015, and was likely caused by an unforeseeable episode of increased demand and other factors, which combined to result in extraordinary delays of care in the Phoenix VAHCS's ED. However, the Phoenix VAHCS ED median wait time for discharged patients (190 minutes) over the period reviewed did not exceed VHA's LOS threshold and was similar to three non-VA Phoenix hospitals' LOS data. We determined an effective mechanism was not in place for ED staff to quickly recognize episodic, increased demand events, and adjust processes.

2015 ED Visit

Case Patient's Quality of Care. The patient indicated he was satisfied with the care he received with the exceptions of the time he had to wait to be seen by an ED provider and to receive the prescribed medication. We reviewed the care he received that day and determined the patient was not harmed by the wait to be examined by an ED provider or receive the medication. The patient was not in distress and had a history of hypertension when he arrived at the ED. The triage RN performed an assessment that was within the VHA door to triage performance metric threshold. The triage RN's decision to return the patient to the waiting area after the triage assessment was appropriate because the patient was not experiencing hypertensive urgency or a hypertensive crisis.¹⁵

Performance Metrics. Although the Phoenix VAHCS met the door to triage performance metric threshold on the day in question, it did not meet LOS and LWBS performance metrics. (See Table 2.)

¹⁵ The American Heart Association states that hypertensive urgency or emergency exists with severely elevated blood pressure "defined as" 180 mmHg or higher systolic or 110 mmHg or higher diastolic with associated symptoms that include chest pain, back pain, weakness, vision changes, severe headache, nose bleed, shortness of breath, or anxiety.

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/AboutHighBloodPressure/Hypertensive-Crisis_UCM_301782_Article.jsp.

Table 2. Day of ED Visit Phoenix VAHCS and National Performance Metrics

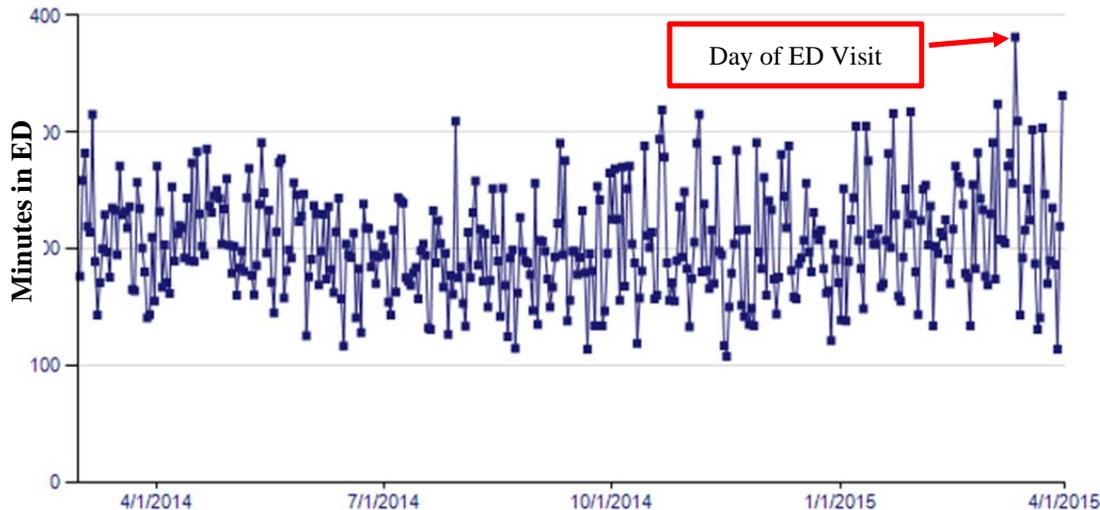
Day of ED Visit	Door to Triage	Total Patient LOS	Discharged Patient LOS	Median Admitted Patient LOS	Percent Left Without Being Seen
Phoenix VA	16 minutes [^]	382 minutes [*]	446 minutes [*]	574 minutes [*]	34.6 percent [*]
National FY15 Target	15 minutes	<=200 minutes	<=150 minutes	<=240 minutes	<=3 percent
National FY15 Threshold	20 minutes	>=300 minutes	>=210 minutes	>=360 minutes	>=5 percent

Source: EMMT, 2015

+Green: Met the goal. ^Yellow: Between the goal and the threshold. *Red: Greater than the threshold.

The median total (all patients who registered including those who were discharged home) LOS on the day of the patient’s ED visit, was 382 minutes. (See Table 2.) Seventy-two (55 percent) of all 130 patients registered that day experienced a LOS greater than 6 hours. Of the 72 patients whose LOS was greater than 6 hours, 17 (24 percent) left without being seen. The median LOS for the 130 patients who registered on the day in question was the longest during the time period of March 1, 2014, through March 30, 2015. (See Figure 1.)

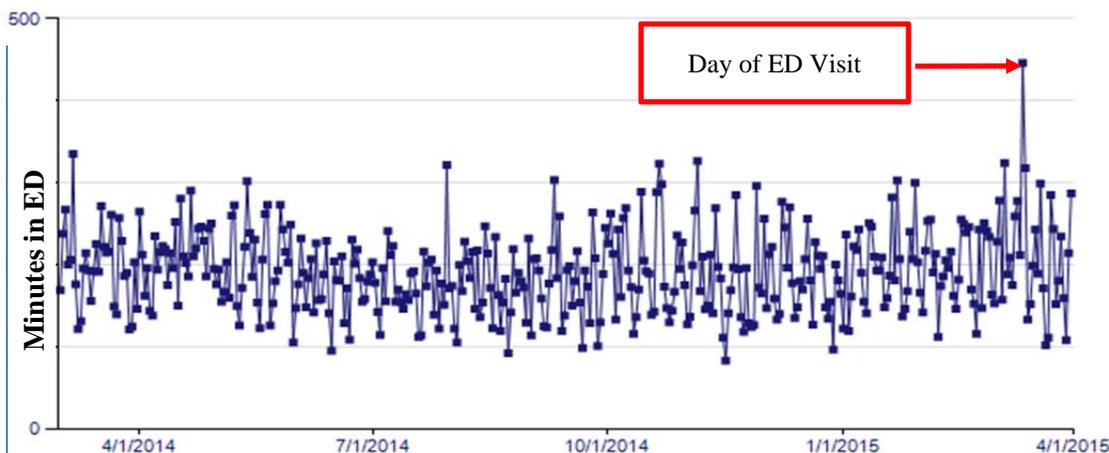
Figure 1. Median Total LOS Trend March 1, 2014–March 31, 2015



Source: Emergency Medicine Management Tool depicting March 1, 2014, through March 31, 2015 data.

The median LOS for patients discharged home on the day in question, was 446 minutes the highest LOS for the time period reviewed. (See Figure 2.)

Figure 2. Median Discharged Patient LOS Trend March 1, 2014–March 31, 2015



Source: Emergency Medicine Management Tool depicting March 1, 2014, through March 31, 2015 data.

We compared Phoenix VAHCS, VISN 18, and VHA National, March 1, 2014, through March 30, 2015, door to triage, LOS, and LWBS data. During that time frame, on average, the Phoenix VAHCS met the target or was between the target and the threshold, with the exception of LWBS. VHA nationally was between the LWBS target and the threshold. (See Table 3.)

Table 3. March 1, 2014–March 31, 2015, Performance Metrics

March 1, 2014, through March 30, 2015	Door to Triage	Total Patient LOS	Discharged Patient LOS	Admitted Patient LOS	Percent Left Without Being Seen
National FY15 Target	15 minutes	<=200 minutes	<=150 minutes	<=240 minutes	<=3 percent
National FY15 Threshold	20 minutes	>=300 minutes	>=210 minutes	>=360 minutes	>=5 percent
Phoenix VA	14 minutes+	206 minutes^	190 minutes^	315 minutes^	7.3 percent*
VISN 18	15 minutes+	198 minutes+	179 minutes^	338 minutes^	6.2 percent*
VHA National	12 minutes+	168 minutes+	149 minutes+	302 minutes^	3.4 percent^

Source: EMMT, March 01, 2014 through March 31, 2015.

+Green: Met the goal. ^Yellow: Between the target and the threshold. *Red: Greater than the threshold

Comparable Non-VA Length of Stay and Left Without Being Seen Data

Hospital Compare is a Department of Health and Human Services Centers for Medicare and Medicaid Services database that contains information about the quality of care at

over 4,000 Medicare-certified hospitals across the country.¹⁶ Using the most recent Hospital Compare data (FY 2014), we compared the Phoenix VAHCS's FY 2014 LOS and LWBS EMMT data to three Phoenix area Medicare-certified hospitals that were within 3.3 miles of the Phoenix VAHCS.¹⁷

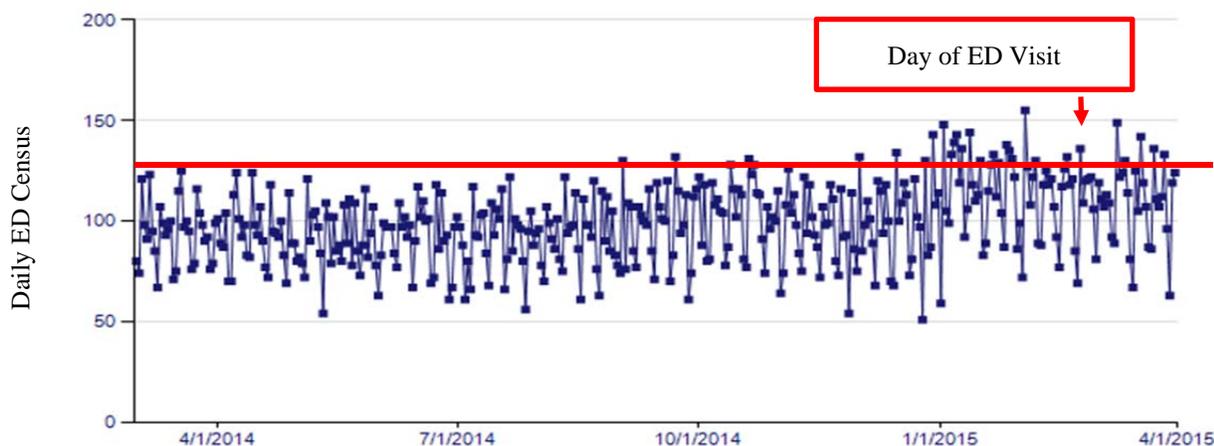
The Phoenix VAHCS's FY 2014 median LOS for discharged patients was 191 minutes. During that same period, the LOS for the three non-VA Phoenix area hospitals ranged from 165 to 216 minutes.

The Phoenix VAHCS's FY 2014 LWBS percentage was 7.6. During the same period, the LWBS percentage for the three non-VA Phoenix area hospitals ranged from 1 to 2 percent. Hospital Compare data for FY 2014 also showed the Arizona statewide and national average for LWBS patient was 2 percent.

Potential Contributing Factors to the Excessive Length of Stay and Number of Patients who Left Without Being Seen

Daily ED Census. More patients registered (130) to be seen in the ED than average on the day in question. From March 1, 2014, through March 31, 2015, the daily census ranged from 51 to 155 patients and averaged 99.3 patients per day (23.6 percent fewer than the number registered to be seen on the day in question). During the 395 days of the time period reviewed, more than 130 patients registered in 1 day on 23 of those days (5.8 percent). (See Figure 3.)

Figure 3. March 1, 2014–March 31, 2015, Daily ED Census



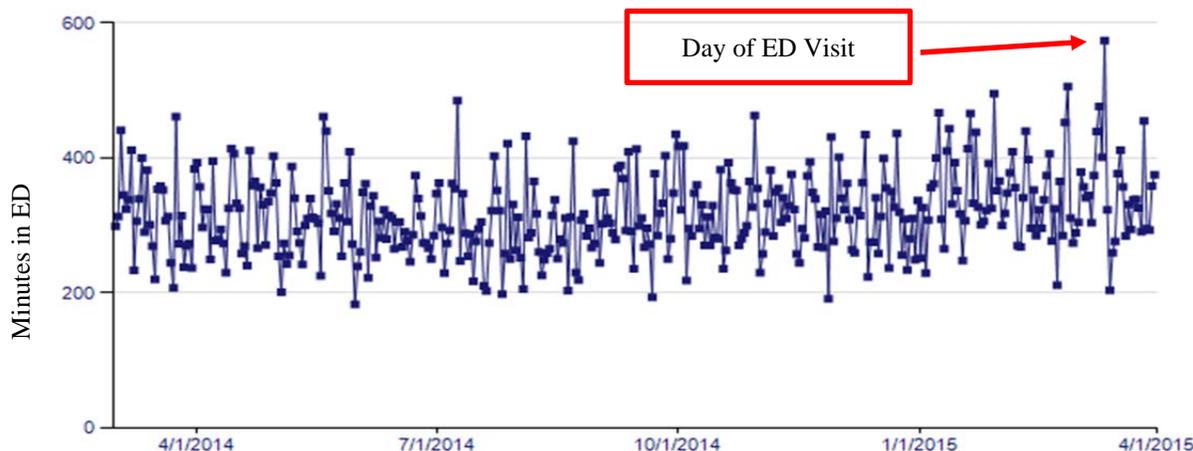
Source: *Emergency Medicine Management Tool* depicting March 1, 2014, through March 31, 2015 data.

¹⁶ The Department of Health and Human Services, Centers for Medicare and Medicaid, <https://www.medicare.gov/hospitalcompare/search.html> accessed September 2, 2015.

¹⁷ The three Phoenix area hospitals used for comparison were Banner University Medical Center, St. Luke's Medical Center, and St. Joseph's Hospital and Medical Center.

Admitted Patient LOS. On the day in question, the median time in the ED for admitted patients was 574 minutes.¹⁸ (See Figure 4.) The Phoenix VAHCS's Intensive Care Unit (ICU) was at capacity, and the Phoenix VAHCS was on diversion status continuously from the day before the patient's visit to the day after, due to a lack of available ICU beds.¹⁹ Because the ICU was at capacity, admitting patients may have required more ED staff time. Additionally, patients awaiting admission may have occupied ED beds longer due to ICU beds being unavailable and those patients required more ED staff attention.

Figure 4. March 1, 2014–March 31, 2015, Median Admitted Patient LOS



Source: *Emergency Medicine Management Tool* depicting March 1, 2014, through March 31, 2015 data.

Patient Admissions and Transfers. More patients were admitted and more patients were discharged than average on the day in question; of the 130 patients who presented, 14.6 percent were admitted and 3.8 percent were transferred. In comparison, the average Phoenix VAHCS admission rate was 14.2 and the average transfer rate was 2.2 percent from March 1, 2014, through March 31, 2015. Additionally, five of the six patients waiting admission to the inpatient mental health unit required one-on-one observation while in the ED, which affected the ability to move waiting patients through the Phoenix VAHCS.

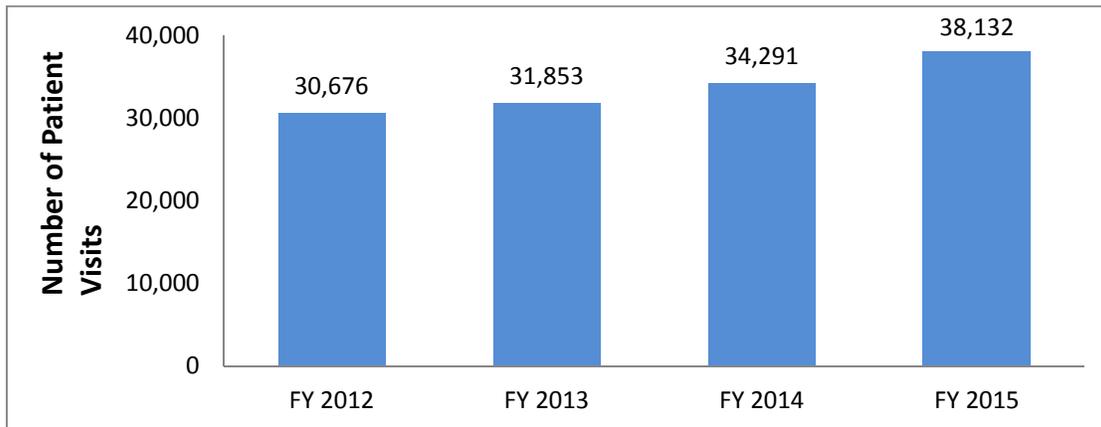
Phoenix VAHCS Actions To Meet Emergency Department Demand

The Phoenix VAHCS has continued to experience steadily increasing ED demand since the construction project approval in 2009. In FY 2015, 24.3 percent more patients sought ED care at the Phoenix VAHCS than in FY 2012. (See Figure 5.)

¹⁸ Admitting time is measured from the time a patient presents to the ED until admission to the system. A high Median Admitted Patient LOS would reflect long admission times.

¹⁹ Diversion is a temporary status for a health care facility, in which the system informs local emergency medical services that its beds are full and it cannot take new patients.

Figure 5. Emergency Department Visits by Fiscal Year 2012 Through 2015



Source: Emergency Medicine Management Tool data.

Phoenix VAHCS leadership addressed the increasing demand by hiring additional ED staff and increasing the number of ED examination areas. In August 2015, there were 18 more RN positions than in FY 2014. ED staffing included 17.5 full-time equivalent (FTE) physicians, 2 FTE physician assistants, 44 FTE registered nurses (RN) (2 of the RNs were designated as mental health RNs). In addition to the 44 FTE RNs working in the ED, 2 RNs were orienting to the ED and 3 RNs had accepted ED RN positions and were in the hiring process. A psychiatrist was hired to provide additional 24/7 coverage in the ED because many ED patients required mental health evaluations.

In June 2015, the Phoenix VAHCS developed an ED patient flow dashboard to evaluate the reasons for delays in patient care. However, ED staff told us they had no formal process in place to address episodic demand increases. We discussed the LOS and LWBS data with the ED Medical Director, who stated that attempts are made to shift provider coverage as allowed within the 80-hour week to cover the patient care workload.

We determined that the most likely cause of the increased LOS and patients who LWBS on the day in question, was due to an unforeseeable episode of increased demand, which resulted in overcrowding. We determined the ED leadership did not have an effective mechanism in place for staff to quickly recognize episodic, increased demand events and adjust processes that would reduce excessive wait times, discourage patients from leaving without being seen, or systematically monitor waiting patients in the waiting area. Additionally, based on the Phoenix VAHCS's LWBS data in comparison to similar VHA and non-VA data, we determined leadership did not have an effective mechanism to decrease the percentage of patients who leave the ED without being seen during times with average demand.

Issue 2: Emergency Department Auditory Privacy, Patient Supervision, and Pharmacy Services

We substantiated that examination areas separated by curtains created a risk for inadvertent protected health information disclosure and that patients brought to the Radiology Department from the ED were not always supervised. We identified a system weakness related to the timeliness of prescription delivery practices for discharged ED patients.

Auditory Privacy. The ED examination area lacked walls or enough space to maintain confidentiality because the examination chairs were close together and separated only by curtains. An interviewee told us that although a doctor pulled the curtain when the provider examined him in the ED, conversations could still be overheard. He also stated that he saw a nurse in the examination area ask questions without closing the curtain and with no consideration for patient confidentiality. We substantiated the allegation that the examination chairs were separated by curtains, and other patients and visitors could possibly hear conversations. However, we determined that the Phoenix VAHCS examination areas complied with applicable standards.²⁰ While we could not substantiate that an ED nurse asked confidential questions in an open group without closing the curtain, we determined the patient's recollection that an ED nurse asked the patients confidential information in an open group was plausible.

VHA requires that the physical layout of an ED comply with applicable standards.²¹ Curtains in the ED enable movement of equipment and people and allow for direct observation when needed. The Department of Health and Human Services health information privacy guidance does not require private rooms or sound proofed areas to avoid the possibility that a conversation is overheard; however, the guidance requires that health care providers reasonably safeguard patient health information.²²

The ED nurse manager told us that staff attempt to talk in low tones to protect patient privacy and, if a physical exam is required, the patient is moved to a more private area. However, we determined that patients' health information could not be reasonably safeguarded if ED staff fail to close the available curtain when asking patients protected health information and that the proximity of the examination chairs to each other created a risk that protected health information could be inadvertently disclosed even with the curtains closed.

Patient Supervision. An interviewee stated that another patient (Patient 2) told him that staff left him (Patient 2) alone in the Radiology Department for an hour as he waited for a radiology test. We attempted but were unable to identify Patient 2 or any similar complaints reported to the patient advocate.

²⁰ VHA Directive 1051, *Standards for Nomenclature and Operations in VHA Facility Emergency Departments*, February 14, 2014.

²¹ Ibid.

²² U.S. Department of Health and Human Services Health Information Privacy Frequently Asked Questions Website. <http://www.hhs.gov/ocr/privacy/hipaa/faq/safeguards/197.html> (accessed August 31, 2015).

ED staff told us that alert and oriented patients were escorted to the Radiology Department by volunteers or ED staff and left in the Radiology Department's waiting area. We learned that Radiology Department desk staff are not available to monitor patients in the waiting area after normal business hours.

Pharmacy Services. We identified a system weakness related to the timeliness of prescription delivery practices for ED patients. A patient told us that he had to wait almost 2 hours after he was discharged from the ED to receive a prescribed medication. The EHR does not record the time the patient received medications. We learned that outpatient pharmacy services staff deliver medications to the ED once per hour until 10:00 p.m., and it was not unusual for a patient to wait 1.5 hours for a medication to be delivered.

Issue 3: Cleanliness

We substantiated that the ED treatment and public areas near the ED and Allergy Clinic were not clean and determined that EMS Housekeeping Services understaffing was a contributing factor.

We conducted unannounced inspections of several areas at the Phoenix VAHCS. The grout and tile in the public bathrooms nearest the ED and Allergy Clinic were stained and did not appear as though they had been recently cleaned. We observed debris behind and beside an automatic teller machine in the hall next to the ED, as well as next to and under the beverage vending machine in the ED waiting area; neither area had been swept by the afternoon of the following day. We also noted debris under shelving in the ED clean linen room and the medical supply room, and the ED floors did not look clean.

EMS Housekeeping Services had 121 authorized FTE, but 55 of the FTE (45 percent) were vacant. We learned ED housekeeping staff were regularly asked to assist other inpatient units to prepare patient rooms for ED admissions. ED leadership and staff told us that ED nursing staff often had to clean the ED, and ED cleanliness quality checks did not occur due to the understaffing.

Issue 4: Thermometer Probe Cover Disposal

We substantiated that Allergy Clinic staff taped bags (intended to hold used thermometer probes) to blood pressure machines, which potentially exposed patients to the oral secretions of others. The Joint Commission requires the use of standard precautions²³ to reduce the risk of infection.²⁴ The Allergy Clinic manager said the practice of disposing thermometer probes in taped bags was not expected practice.

²³ Standard precautions are a set of infection control practices used to prevent transmission of diseases.

²⁴ The Joint Commission Edition, IC.02.01.01 EP 2 Standard, February 1, 2015.

Issue 5: VA Police Disruptive Behavior Management

We could not substantiate the allegation that last year a VA police officer mishandled a veteran at the Phoenix VAHCS. We received a report that a VA police officer was observed throwing a veteran to the ground and spraying the veteran with pepper spray.²⁵

Phoenix VAHCS staff documented 716 episodes of disruptive behavior during FY 2014.²⁶ Five of the 716 reports (0.7 percent) stated that force (pepper spray, use of baton, drawing or using a firearm) was used during the interaction. We reviewed the five reports and determined that VA police review each incident where use of force was initiated. Additionally, the chairperson of the Disruptive Behavior Committee, a Phoenix VAHCS level interdisciplinary committee that reviews all disruptive behavior reports, stated that no injuries had been reported as a result of disruptive behavior incidents in FY 2014.

Issue 6: Continuity and Coordination of Care²⁷

Pharmacy Prescription Services

Antimalarial. We substantiated that the patient should have received the recommended antimalarial medication or a substitute VHA National Formulary (VANF) antimalarial. The VANF is a listing of all drugs and supplies that must be available for prescription at all VA facilities.²⁸ One of the purposes of the VANF is to promote a “uniform pharmacy benefit.”²⁹ Although the medication the Minneapolis infectious diseases provider recommended was not on the VANF during the timeframe of the request, appropriate substitutions were on the VANF. The VHA Chief Consultants of Pharmacy and Preventive Medicine both told us there was no VA policy to deny patients on personal travel preventive medications and that the patient should have received the recommended medication or an appropriate VANF substitute.

Medication Bridge Supply.³⁰ We did not substantiate that the patient should have received more than a bridge supply of medications from the Phoenix VAHCS in 2014. According to VA policy, if a traveling patient has run out or is close to running out of a medication that protocol permits dispensing, pharmacy staff at non-preferred facilities

²⁵ Pepper spray is a temporarily disabling aerosol that is composed partly of capsicum oleoresin and causes irritation and blinding of the eyes and inflammation of the nose, throat, and skin.

²⁶ Disruptive behavior is defined by the facility as behavior by any individual that is intimidating, threatening, dangerous, or that has or could jeopardize the health and safety of patients, employees or individuals at the facility.

²⁷ VHA Directive 2007-016, *Coordinated Care Policy for Traveling Veterans*, May 9, 2007.

²⁸ VHA Handbook 1108.08, *VHA Formulary Management Process*, February 26, 2009. This VHA Handbook was scheduled for recertification on/or before the last working day of February 2014 and had not yet been recertified.

²⁹ *Ibid.*

³⁰ A “bridge supply” is a temporary supply of medications, generally 1-10 days’ worth, to ensure availability of needed medications until the patient can receive an initial or refill prescription from the usual source.

are to provide the patient with a bridge supply of medications to meet his/her immediate needs.³¹

30 Day Only Prescription Order. We substantiated that the Phoenix VAHCS did not refill the blood pressure medication prescription the patient received during his ED visit; however, we determined the Phoenix VAHCS pharmacy could not fill the prescription. The prescription was a 30-day, one-time prescription, and the patient was instructed to follow-up with his PCP for further evaluation.

Assignment of a Primary Care Provider

We substantiated that the patient was not assigned a PCP at the Phoenix VAHCS; however, the patient's preferred system was the Minneapolis VAHCS where he was assigned to a PCP, as required.³² VHA Directive 2007-016 directs VHA personnel to ensure that all veterans receiving care at more than one VHA system have their care coordinated by the preferred facility and that non-preferred facilities expedite care provided to traveling veterans with unexpected medical needs. We also determined the patient's care was generally coordinated as required and, as demonstrated in this report's case summary examples, the Phoenix VAHCS expedited his care when he presented with unexpected medical needs and coordinated his allergy care with Minneapolis VAHCS.

Test Result Notification

We substantiated the allegation that the patient did not receive timely notification of a 2013 left knee MRI by his assigned MN PCP. At that time, VHA policy required that test results be communicated to patients no later than 14 calendar days from the date on which the results were available to the ordering practitioner.^{33,34} The patient was not notified of his 2013 MRI results for several months.

To evaluate the Minneapolis VAHCS Orthopedic Clinic notification practices, we reviewed the EHRs of all 26 patients who had MRIs ordered by Orthopedic Clinic staff during the same time frame that the patient underwent an MRI in 2014, and found that 13 of the 26 patients (50 percent) were not notified of the test results within 14 days.³⁵

Conclusions

Extended LOS due to ED crowding (lack of space and/or resources to provide timely emergency care) has the potential to compromise medical care and can lead to patients

³¹ VHA Directive 2007-016, *Coordinated Care Policy for Traveling Veterans*, May 9, 2007.

³² Ibid.

³³ VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

³⁴ Minneapolis VA Health Care System Policy #PE-07, *Reporting Test Results to Patients*, September 19, 2011.

³⁵ We selected this time period to potentially capture the veteran population receiving an orthopedic MRI who might also be a traveling veteran and would not be available for a follow-up appointment.

leaving without being seen. Determining how quickly patients are seen is one factor in determining the quality of care an ED provides.

The LOS patients experienced on the day in question was the longest ED patients had experienced during the time period March 1, 2014, through March 31, 2015, and was likely caused by an unforeseeable episode of increased demand and other factors. Multi-factorial conditions that day combined to result in extraordinary delays of care in the Phoenix VAHCS's ED. Due to steadily increasing demand, the ED physical space was limited; more patients registered and required admission and/or transferred to another hospital than on an average day; the ICU was at capacity; and mental health patients awaiting admission required one-on-one supervision. These conditions likely led to an ED LOS greater than any other day from March 1, 2014 to March 31, 2015. Fifty-five percent of the patients who presented to the ED on the day in question experienced a discharge LOS that exceeded VHA's 210 minute threshold, the number of patients who left without being seen (34.6 percent) exceeded VHA's 5 percent threshold, and 24 percent of the patients who left without being seen that day had waited more than 6 hours before leaving.

We substantiated that examination areas separated by curtains created a risk for inadvertent protected health information disclosure and that patients brought to the Radiology Department from the ED were not always supervised. We identified a system weakness related to the timeliness of prescription delivery practices for discharged ED patients.

We substantiated that some facility treatment and public areas were not clean. We determined that EMS Housekeeping Services understaffing was a contributing factor. We substantiated that Allergy Clinic staff did not consistently dispose of oral temperature probe covers properly. We could not substantiate the allegation that a VA police officer mishandled a veteran. We substantiated that the Phoenix VAHCS pharmacy should have provided the patient a recommended antimalarial medication or an appropriate substitution. Because the patient's preferred facility was the Minneapolis VAHCS, we did not substantiate the Phoenix VAHCS pharmacy should have provided the patient with more than short-term supplies of medications or that the Phoenix VAHCS pharmacy should have refilled a one-time only prescription. We substantiated that the patient was not assigned a PCP at the Phoenix VAHCS because the patient's preferred facility was the Minneapolis VAHCS where he was assigned to a PCP, as required. We also substantiated that Minneapolis VAHCS did not ensure the patient received magnetic resonance imaging results within 14 days, as required by policy.

We made 10 recommendations regarding emergency department care timeliness, auditory privacy, patient supervision, pharmacy services, housekeeper staffing and cleanliness, standard precautions, and test result notification.

Recommendations

1. We recommended that the Acting Veterans Integrated Service Network 18 Director assign a team to review the Phoenix VA Health Care System Emergency Department

processes and develop a plan to improve Emergency Department access and flow during times of increased demand.

2. We recommended that the Acting Veterans Integrated Service Network 18 Director assign a team to review the Phoenix VA Health Care System Emergency Department processes and develop a plan to decrease the number of patients who leave the Emergency Department without being seen by a provider.
3. We recommended that the Phoenix VA Health Care System Director review current verbal communication practices in the Emergency Department and determine what steps are reasonable to safeguard patient information.
4. We recommended that the Phoenix VA Health Care System Director assess Emergency Department medication prescription delivery practices to identify potential opportunities to improve pharmacy services.
5. We recommended that the Phoenix VA Health Care System Director ensure all patients in the Radiology Department are supervised.
6. We recommended that the Phoenix VA Health Care System Director assess Environmental Management Services staffing needs and take appropriate actions.
7. We recommended that the Phoenix VA Health Care System Director ensure environment of care concerns identified in this report are corrected and that compliance be monitored.
8. We recommended that the Phoenix VA Health Care System Director ensure Allergy Clinic staff use standard precautions when disposing used thermometer covers and that compliance be monitored.
9. We recommended that the Phoenix VA Health Care System Director ensure patients receive recommended preventive medications or are offered substitutions if the medication is not on the VA National Formulary.
10. We recommended that the Minneapolis VA Health Care System Director ensure that test results are communicated to patients as required.

Acting VISN 18 Director Comments

Department of Veterans Affairs

Memorandum

Date: December 28, 2015

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

Subj: Healthcare Inspection—Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Please find the VA Southwest Health Care Network response to the Office of the Inspector General Health Inspection conducted from June 24 through September 30, 2015, report entitled, *Access and Quality of Care Concerns Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota*.
2. If you have questions, please contact Terri Elsholz, VISN 18 Deputy Quality Management Officer at 480-397-2782.



Kathleen R. Fogarty

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 the Acting Veterans Integrated Service Network 18 Director assign a team to review the Phoenix VA Health Care System Emergency Department processes and develop a plan to improve Emergency Department access and flow during times of increased demand.

Concur

Target date for completion: July 29, 2016

VA Southwest Health Care Network response: Phoenix VA Health Care System (PVAHCS) has taken significant proactive steps since the OIG visit to address issues related to access and flow during times of increased demand. Veterans Integrated Service Network (VISN) 18 will assign a VISN multi-disciplinary team to review PVAHCS Emergency Department (ED) flow processes. The team will develop a comprehensive action plan for the facility to improve ED access and flow during times of increased demand.

Recommendation 2. We recommended that the Acting Veterans Integrated Service Network 18 Director assign a team to review the Phoenix VA Health Care System Emergency Department processes and develop a plan to decrease the number of patients who leave the Emergency Department without being seen by a provider.

Concur

Target date for completion: July 29, 2016

VA Southwest Health Care Network response: VISN 18 will assign a VISN multidisciplinary team to review PVAHCS ED processes. The team will develop a comprehensive action plan by July 29, 2016 for the facility to decrease the number of patients who leave the ED without being seen by a provider. In the interim, PVAHCS' Primary Care is supporting the ED by providing a follow-up process for those patients that do choose to leave without being seen. The PACT teams are responsible for reaching out to the Veteran as a follow up to the ED visit.

Phoenix VA Health Care System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 24, 2015

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

Subj: Healthcare Inspection—Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Radiology Test Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota

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

1. Please find the Phoenix VA Health Care System response to the Office of the Inspector General Health Inspection conducted from June 24 through September 30, 2015, Draft report entitled, *Access and Quality of Care Concerns Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota*.
2. If you have questions, please contact Michelle Bagford, Chief, Quality Safety and Improvement, at (602) 277-5551, extension 6092.



DEBORAH AMDUR, MSW
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 3. We recommended that the Phoenix VA Health Care System Director review current verbal communication practices in the Emergency Department and determine what steps are reasonable to safeguard patient information.

Concur

Target date for completion: January 29, 2016

Phoenix VAHCS response: Maintaining patient privacy is a top priority for the Phoenix VA Health Care System (PVAHCS). Before new employees report to work they are required to complete mandatory Privacy training. This training must also be completed by every employee on a yearly basis. PVAHCS currently has two Privacy Officers who are very active and committed to ensuring patient privacy practices are in effect throughout the hospital.

PVAHCS continues to implement strategies to ensure patient privacy within existing spaces pending an addition which will enhance patient privacy throughout the ED. Currently, auditory panels have been added to the reception area to improve patient privacy as well as maintaining physical space between functions (i.e., distance between check-in window and waiting room). In addition, all current ED staff will be required to review Medical Center Policy PO-01, Privacy Policy, dated September 24, 2013, for maintaining "reasonable safeguards" in relation to auditory privacy within the ED.

Recommendation 4. We recommended that the Phoenix VA Health Care System Director assess Emergency Department medication prescription delivery practices to identify potential opportunities to improve pharmacy services.

Concur

Target date for completion: March 31, 2016

Phoenix VAHCS response: Currently, prescriptions for patients seen in the Emergency Department (ED) are filled through two methods:

- 1) When the Medical Center Outpatient Pharmacy is open (Monday-Friday 8:00am – 6:00pm and Saturday 9:00am – 3:30pm), patients discharged from the ED are serviced by the Outpatient Pharmacy. Patients present to pharmacy and pull a number to see a pharmacist. Medications are reviewed with the patient and counseling is provided by the pharmacist. Medications are then filled and

dispensed to the patient. The goal to fill medications from the point of pharmacist counseling is 30 minutes or less.

- 2) When Outpatient Pharmacy is closed, medications for the ED are filled by the Inpatient Pharmacy and delivered to ED by pharmacy staff or picked up from the Inpatient Pharmacy by ED Nursing staff. Non-controlled substance medications are delivered by pharmacy every hour. Controlled Substance medications are picked up from pharmacy by nursing staff as needed. Medications filled by Inpatient Pharmacy are given to the patient in the ED.

Pharmacy staffing has increased since this incident occurred. Two pharmacist FTEE were approved and hired in fall of 2014 to assist with medication related issues in the ED. Outpatient Pharmacy staff also increased with four pharmacist FTEE approved and hired in 2015. Outpatient Pharmacy wait times will be reviewed to assess the impact additional FTEE has had by January 31, 2016. This report will be submitted to Executive Clinical Leadership in February to provide information regarding the potential need for additional staff resources.

Pharmacy and ED Nursing Leadership met on December 21, 2015, to discuss the medication delivery process. Conclusions and Recommendations are as follows:

Opportunities for improvement to deliver medications to ED patients in a more expeditious manner were identified. Therefore, a flow chart is being created showing the medication delivery process for ED prescriptions by January 31, 2016. This flow chart will be shared with staff to ensure a consistent understanding of the process.

Recommendation 5. We recommended that the Phoenix VA Health Care System Director ensure all patients in the Radiology Department are supervised.

Concur

Target date for completion: Complete

Phoenix VAHCS response: An ED Working Group was initiated in July 2015; the Diagnostics team addressed patients being sent to and returned from the Radiology Department in a controlled, supervised fashion. The team developed a "Ticket to Ride" system, which limited and controlled the number of patients who were to be sent to Radiology from the ED; there are two tickets for computerized tomography scans and four tickets for routine radiography. Patients are signed in and out of the ED by the Unit Clerk so patients can be tracked. They are then escorted to Radiology and received directly by a Radiology Technician, who performs the procedure and directly returns the patient to the ED through transport. The ticket exchange creates the limit and supports the supervision of ED patients in the Radiology Department.

After hours, Inpatients are not sent unless the Radiology Technologist contacts the ED. These patients are also escorted. This process also controls the number of patients in the Radiology Department at any given time and assures staff availability to supervise the patients.

Recommendation 6. We recommended that the Phoenix VA Health Care System Director assess Environmental Management Services staffing needs and take appropriate actions.

Concur

Target date for completion: September 30, 2016

Phoenix VAHCS response: On September 8, 2015, an open continuous job announcement was posted to USA Jobs. The establishment of the continuous job announcement is two-fold; (1) to ensure a consistent pool of available applicants; and, (2) to decrease the processing time for hire when vacancies occur. The current announcement has yielded 29 job offers which are in various stages of the on-boarding process.

To promote retention of Environmental Management Services (EMS) staff and a clean facility 26 Medical Supply Aide positions were created at the GS-2 level. On September 2, 2015, Human Resource Service posted an announcement on USAJobs for 26 Medical Supply Aides; with 26 individuals (and alternates) selected. During FY16Q1, PVAHCS on-boarded nine (9) of the 26 Medical Supply Aides; the other 17 Medical Supply Aide positions are in various stages of the on-boarding process.

On October 5, 2015, to support EMS staffing needs, PVAHCS obtained contractual services of a qualified hospital housekeeping vendor for one year to clean approximately 170,000 square feet of an ambulatory care area. The intent of the contract is to allow Environmental Management Services to ensure a clean and safe environment, while recruiting for permanent staffing.

Recommendation 7. We recommended that the Phoenix VA Health Care System Director ensure environment of care concerns identified in this report are corrected and that compliance be monitored.

Concur

Target date for completion: Complete

Phoenix VAHCS response: Environmental Management Services has formally addressed all cleanliness issues identified in the OIG Report. The public bathroom adjacent to the ED has had the grout and tile restored through a contractor. All debris located in the ED waiting room has been fully cleaned. The ED linen and medical supply rooms have been cleaned and all floors in the ED, with the exception of one staff office, have been stripped and waxed. On July 24, 2015, Environmental Management Services (EMS) implemented a quality control checklist which also serves as a supervisor shift hand-off tool in the Emergency Department (ED) to ensure environment of care concerns would be addressed consistently. At the same time, Environmental Management Service established twenty-four hour housekeeping coverage for the ED to enhance the environment of care. Ongoing compliance with the standards

established within the checklist will be reported to the Environment of Care Committee on a quarterly basis.

Recommendation 8. We recommended that the Phoenix VA Health Care System Director ensure Allergy Clinic staff use standard precautions when disposing used thermometer covers and that compliance be monitored.

Concur

Target date for completion: Complete

Phoenix VAHCS response: The use of bags taped to the rollaround vital sign machines to dispose of sublingual thermometer probe covers was discontinued immediately upon notification of the concern for cross-contamination.

In June 2015, the PVAHCS Allergy Clinic transitioned from the use of electronic oral thermometer probes to electronic temporal (forehead) thermometers. This transition prevents the potential for cross-contamination that could have occurred with the oral thermometer probe covers.

On July 7, 2015, the Nurse Manager informed all staff in an email that the transition had occurred and reinforced the process for cleaning the temporal thermometers between patients.

Recommendation 9. We recommended that the Phoenix VA Health Care System Director ensure patients receive recommended preventive medications or are offered substitutions if the medication is not on the VA National Formulary.

Concur

Target date for completion: March 31, 2016

Phoenix VAHCS response: Provision of Preventive Medicine and Travel Vaccines was reviewed with Pharmacy service staff during the July 13, 2015, Pharmacy All Staff Meeting. Staff were educated that personal travel preventive medications have no leisure travel restrictions.

The antimalarial drug, Malarone, was added to the VA National Drug Formulary in April 2014 and is in the PVAHCS Pharmacy drug file as an orderable item on the VA formulary. Additional education will be provided to Pharmacy and Medical Staff on Preventive Medicine options for Veterans.

Additionally education about electronic drug resource subscriptions will be provided to Pharmacy and Medical staff to assist with identifying substitutions for medications not on the VA National Formulary.

Acting VISN 23 Director Comments

**Department of
Veterans Affairs**

Memorandum

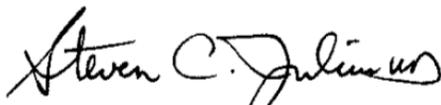
Date: December 28, 2015

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

Subj: Healthcare Inspection—Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Radiology Test Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed the response and concur with the Minneapolis VA HCS action plan for the one MVAHCS finding noted in Recommendation 10.
2. Please contact Patrick J. Kelly at MVAHCS should you have additional questions on the Minneapolis portion of the report at 612-725-2101.



Steven C. Julius, MD
Acting VISN 23 Network Director

Minneapolis VA Health Care System Director Comments

**Department of
Veterans Affairs**

Memorandum

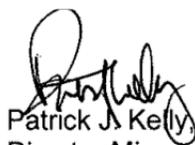
Date: December 28, 2015

From: Director, Minneapolis VA Health Care System (681/00)

Subj: Healthcare Inspection—Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Radiology Test Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota

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

1. Thank you for the opportunity to review the draft report for the Minneapolis VA Health Care System (MVAHCS) portion of the subject OIG Healthcare Inspection.
2. I concur with the MVAHCS specific Recommendation 10 and have Included our corresponding action plan.
3. Please contact me should you have additional questions on the Minneapolis portion of the report at 612-725-2101.



Patrick J. Kelly, FACHE
Director Minneapolis VA Health Care System

Comments to OIG's Report

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

OIG Recommendations

Recommendation 10. We recommended that the Minneapolis VA Health Care System Director ensure that test results are communicated to patients as required.

Concur

Target date for completion: June 15, 2016

Minneapolis VA Health Care System response: The MVAHCS Chief of Staff has appointed a Results Reporting Task Force which was launched on December 11, 2015 to specifically address and develop procedures to ensure Veterans receive test results notification in accordance with Veterans Health Administration (VHA) Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009 and VHA Directive 1088 *Communicating Test Results to Providers and Patients*, October 7, 2015. More specifically the Task Force will evaluate and update any necessary changes as it relates to local Minneapolis VAHCS policy PE-07 Reporting Test Results to Patients. In addition, education and training regarding results reporting expectations and time frames was provided to the Specialty Care Orthopedics Service Chief and section staff. Effectiveness of compliance will be assessed by monthly chart audits in Orthopedics MRI with 90% compliance. We will continue to monitor results until three consecutive months of 90% compliance is achieved. Audit results will be provided to Service Chief for feedback to ensure on-going compliance.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Sherrian Pater, RN, Team Leader Stephanie Hensel, RN Thomas Jamieson, MD Larry Selzler, MSPT

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