



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Telemetry Unit Issues
John Cochran Division,
St. Louis VA Medical Center
St. Louis, Missouri

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Executive Summary

At the request of the Honorable Russ Carnahan, United States Representative from Missouri, the VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed the validity of allegations related to the availability of personal protective equipment (PPE) and blood pressure machines, staff compliance with isolation precautions, and functionality of equipment on the telemetry unit at the John Cochran Division of the St. Louis VA Medical Center, St. Louis, MO.

We substantiated that PPE was not always available on the telemetry unit; however, this issue was resolved prior to our site visit. We substantiated that blood pressure machines may not have always been available on the telemetry unit; however, we determined that staff could secure additional machines through Logistics Service as needed for patient care. We did not substantiate that staff did not follow proper isolation precautions when caring for infectious patients. We substantiated that some equipment needed for patient care on the telemetry unit was non-functional at the time of the complaint; however, actions had been taken by management or were ongoing to address the issues prior to our visit. We also noted that managers established an executive office action line for staff to report their concerns to leadership. As the issues reviewed had largely been addressed and resolved at the time of our visit, we made no recommendations.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Telemetry Unit Issues, John Cochran Division, St. Louis VA Medical Center, St. Louis, Missouri.

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations forwarded to us by the Honorable Russ Carnahan, United States Representative from Missouri, related to the availability of personal protective equipment (PPE) and blood pressure machines, staff compliance with isolation precautions, and the functionality of equipment on the telemetry unit at the John Cochran Division (JCD) of the St. Louis VA Medical Center (STLVAMC), St. Louis, MO.

Background

The STLVAMC is a two-division, tertiary care facility in Veterans Integrated Service Network 15. JCD is located in downtown St. Louis, MO. It has 136 acute care beds and provides acute medical and surgical services and a wide range of specialty care. The JCD also operates a 28-bed telemetry unit that, due to scheduled renovations, temporarily relocated from ward 7N to ward 7S on August 23, 2010.

PPE is specialized clothing such as gowns, gloves, masks, shoe covers, and hair covers that are worn by caregivers to protect against the transmission of infectious agents. Isolation precautions are special precautionary practices and procedures used in the care of patients with contagious or communicable diseases. The type of infectious disease dictates the isolation precautions used to prevent the spread of the disease.

In August 2010, clinical staff members sent a letter to Congressman Carnahan alleging multiple issues on the telemetry unit at the JCD, as follows:

- PPE, specifically gowns, were not always available.
- Automated blood pressure machines were not always available.

- Staff did not always comply with isolation precaution requirements.
- Automated blood pressure machines did not give blood pressure readings during two Code K (respiratory and cardiac arrest events) incidents in August 2010.
- Fundascopes (used for eye examinations) and otoscopes (used for ear examinations) had been inoperable for over 3 years.
- The fax machines and call light system had been nonoperational for an extended period of time.

The clinical staff members indicated that these issues had been ongoing for weeks to years and that written communications and personal meetings with facility managers over the previous 8–10 months had not resolved the problems.

The clinical staff members also cited personnel-related issues, which were outside of the OIG's purview and are not addressed in this report.

Scope and Methodology

We visited the JCD November 16–18, 2010. We interviewed the clinical staff members, Associate Director for Patient Care Services, Medical Center Associate Director, and Logistics Service¹ staff. We also interviewed telemetry unit staff including the acting nurse manager, registered nurses, licensed practical nurses, and nursing assistants. We reviewed patient advocate information, email messages and other documents provided by the clinical staff members and interviewees, infection control monitoring data and meeting minutes, Critical Care Committee meeting minutes and post-Code K evaluations, and equipment preventive maintenance records and work order logs.

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.

Inspection Results

Issue 1: Availability of PPE and Blood Pressure Machines

We substantiated that PPE was not always available on the telemetry unit; however, management resolved this issue prior to our site visit. Staff told us that prior to September 2010 they did not have sufficient numbers of cloth gowns, which required laundering, available to care for isolation precaution patients. The JCD converted to disposable gowns in September 2010, and staff confirmed that gowns are now routinely available.

¹ Logistics Service is responsible for providing equipment for patient use throughout the facility.

We substantiated that blood pressure machines may not have always been available on the telemetry unit; however, we determined that staff could secure additional machines through Logistics Service as needed for patient care. One of the clinical staff members explained that the telemetry unit had four standard blood pressure machines, and if one was used on an isolation patient, the practice was to leave the machine in the patient's room until the patient was discharged, transferred, or no longer required isolation precautions. The machine would then be sent to Logistics Service for cleaning. The clinical staff member reported that this practice resulted in a shortage of blood pressure machines available for use on other telemetry patients.

Managers told us that staff had been instructed to contact Logistics Service when equipment such as blood pressure machines were needed, and nursing staff we interviewed were aware of the process to secure replacement equipment. None of the telemetry staff interviewed could recall any instances when they were unable to obtain additional blood pressure machines.

The STLVAMC purchase of disposable gowns and staff's ability to obtain equipment when needed from Logistics Service appear to have resolved the issues.

Issue 2: Compliance with Isolation Precautions

We did not substantiate that staff did not routinely follow proper isolation precautions when caring for infectious patients. During our interviews with the unit staff, we learned of one instance when a nurse did not follow procedure and entered an isolation room without any PPE. Managers addressed the nurse's conduct appropriately.

Infection control monitors and committee minutes from January 1, 2009, through July 31, 2010, did not reflect any infection spikes or outbreaks on the telemetry unit which might be indicative of staff non-compliance with isolation precautions.

Issue 3: Functionality of Equipment

We substantiated that some equipment needed for patient care on the telemetry unit was non-functional at the time of the complaint.

Fundascope and Otoscope: Managers confirmed that fundascope and otoscope in some telemetry unit rooms were occasionally rendered non-functional because parts (such as earpieces and connectors) were removed and used in other areas. Managers reported that missing parts have been repeatedly replaced; however, the problem continues to recur. Managers have instructed staff to conduct a daily inventory upon arrival and contact Logistics Service to obtain replacement parts, as needed. Staff confirmed that they are able to secure the necessary items and parts through Logistics Service.

Fax Machine: We reviewed work order reports and confirmed that the old 7N fax machine was problematic. At the time of our visit, the fax machine had been replaced, and staff reported that the replacement fax machine functioned properly.

Call Lights: Managers confirmed that the nurse call light system on 7N had significant repair issues due to age and inability to obtain replacement components. There were 54 work orders submitted for call light system repairs between January 1, 2010, and August 23, 2010. The average turnaround time for repairs during that time period was 19 days. Since the relocation to 7S, there have not been any problems with, or work orders related to, the call light system.

Code K Events: We found no evidence to support the allegation that automated blood pressure machines malfunctioned during two Code K events in August 2010. Local policy requires analysis of Code K events to include equipment issues. The clinical staff members could not provide the dates or patient names for the Code K events. Therefore, we reviewed post-Code K report forms and Critical Care Committee meeting minutes from June 1–October 31, 2010, to determine whether any equipment malfunctioned during codes. We found no documented evidence of equipment malfunctions during any of the Code K events. We further determined that all automated blood pressure machines received appropriate annual preventive maintenance checks in 2010.

We noted that in Code K situations, some patients may experience irregular blood flow which would not be detected by an automated blood pressure machine. As such, this condition could give the appearance that the blood pressure machine was not functional. Staff confirmed that they use a manual blood pressure device if the automated blood pressure machine does not provide a reading.

In February 2010, managers implemented a mechanism for staff to anonymously report concerns to leadership through an executive office action line. We reviewed a sample of telemetry unit-related complaints and found that, in general, management responded to the identified concerns and had documented follow up in email strings.

Conclusions

We substantiated that PPE was not always available on the telemetry unit; however, management resolved this issue prior to our site visit. We could not substantiate that staff did not routinely follow proper isolation precautions when caring for patients or that equipment was unavailable. We substantiated that some equipment needed for patient care on the telemetry unit was non-functional at the time of the complaint; however, actions had been taken or were ongoing to address the issues prior to our visit. Managers established the executive office action line to allow staff to anonymously report their concerns to leadership. As the issues reviewed had largely been addressed and resolved at the time of our visit, we made no recommendations.

Comments

The VISN and Medical Center Directors agreed with our findings (see Appendixes A and B, pages 6–7, for the Directors' comments). We made no recommendations and plan no further actions.

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 15, 2011

From: Director, VA Heartland Network (10N15)

Subject: **Healthcare Inspection – Telemetry Unit Issues, John Cochran Division, St. Louis VA Medical Center, St. Louis, Missouri**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Service (10B5)

1. Thank you for the opportunity to review this report. I concur with the report and have no comments.
2. Should you need additional information, please contact our office at (816)-701-3000.

(original signed by:)
JAMES R. FLOYD, FACHE
Director, VA Heartland Network VISN 15

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 16, 2011

From: Director, St. Louis VA Medical Center, John Cochran
Division (657/00)

Subject: **Healthcare Inspection – Telemetry Unit Issues, John Cochran
Division, St. Louis VA Medical Center, St. Louis, Missouri**

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review this report. I concur with the report and have no comments.
2. Should you need additional information, please contact our office at (314)-289-7651.

(original signed by:)

RIMAANN O. NELSON, RN, MPH/HSA
Director, St. Louis VA Medical Center

OIG Contact and Staff Acknowledgments

OIG Contact	Toni Woodard, Project Leader Atlanta Office of Healthcare Inspections
Acknowledgments	Susan Zarter

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