Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03613-74

Combined Assessment Program Review of the VA Southern Nevada Healthcare System Las Vegas, Nevada

January 27, 2010

Washington, DC 20420

Why We Did This Review

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

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

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

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Executive Summary

Introduction

During the week of November 16–19, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Southern Nevada Healthcare System (the system), Las Vegas, NV. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 30 system employees. The system is part of Veterans Integrated Service Network (VISN) 22.

Results of the Review

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

- Executive Dashboard.

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

- Ensure that utilization management (UM) processes comply with Veterans Health Administration (VHA) requirements.
- Ensure that physician credentialing and privileging (C&P) processes comply with VHA requirements for privilege forms, Focused Professional Practice Evaluation (FPPE), and Ongoing Professional Practice Evaluation (OPPE).
- Address training and screening deficiencies in magnetic resonance imaging (MRI) safety.
- Address identified environment of care (EOC) deficiencies.

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

- Contracted/Agency Registered Nurses (RNs).
- Coordination of Care.
- Medication Management.

This report was prepared under the direction of Daisy Arugay, Director, Los Angeles Office of Healthcare Inspections.

Comments

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

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

Introduction

Profile

Organization. The system provides inpatient and outpatient health care services in Las Vegas, NV. Outpatient care is distributed among eight clinical sites. The system provides additional outpatient care at two community based outpatient clinics located in Henderson and Pahrump, NV. The system is part of VISN 22 and serves a veteran population of approximately 235,000 in a primary service area that includes the Nevada counties of Clark, Lincoln, and Nye.

Programs. The system provides medical, surgical, and mental health (MH) care services. It has 57 hospital beds at the Mike O'Callaghan Federal Hospital (MOFH) as part of a sharing agreement with the Department of Defense's 99th Medical Group at Nellis Air Force Base in Las Vegas.

Affiliations and Research. The system is affiliated with the University of Nevada's School of Medicine and supports 47 medical resident positions in four training programs. The system is also affiliated with the University of Nevada, Las Vegas; Touro University Nevada; Nevada State College's School of Nursing; Southern California College of Optometry; Illinois College of Optometry; and the University of Southern Nevada. In fiscal year (FY) 2009, the system research program had approximately 17 studies and a budget of $89,000. Areas of research included endocrinology, oncology, MH, and cardiology.

Resources. In FY 2009, the system's medical care expenditures totaled approximately $287.4 million. FY 2009 staffing was 1,211 full-time employee equivalents (FTE), including 128 physician and 234 nursing FTE.

Workload. In FY 2009, the system treated 40,781 unique patients and provided 14,486 inpatient bed days of care in the hospital. The inpatient care workload totaled 2,703 discharges, and the average daily census was 39.7. Outpatient workload totaled 416,086 visits.

Objectives and Scope

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

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

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

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

- Contracted/Agency RNs.
- Coordination of Care.
- EOC.
- Medication Management.
- MRI Safety.
- Physician C&P.
- QM.

The review covered system operations for FYs 2008 and 2009 and FY 2010 through November 16, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, Nevada,* Report No. 07-00472-138, May 29, 2007). We had identified improvement opportunities in the following areas: (1) patient complaints analyses, (2) efficient patient flow, and (3) Computerized Patient Record System business rules. During our follow-up review, we found sufficient evidence that program managers and staff had implemented

appropriate actions to address the identified deficiencies in these areas, and we consider these issues closed.

During this review, we also presented fraud and integrity awareness briefings to 30 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strength

Executive Dashboard

The Executive Dashboard (ED) was established in early 2009 in order to provide staff with a "one-stop shop" for data needs and to track and trend areas that are of high interest, such as patients' access to care and satisfaction. The ED is displayed in four major sections: (1) Access, (2) Quality, (3) Satisfaction, and (4) Cost Effectiveness. Since its implementation, man hours spent on data have been reduced, and clinic-specific data profiles have provided managers and staff with a snapshot of clinic performance. The most significant improvement that the system accomplished using the ED was the reduction in the number of patients waiting greater than 30 days from their desired appointments. In November 2009, the number of patients waiting more than 30 days for clinic appointments was reduced from 398 to 314, exceeding the fully successful target of 368. The ED played a significant role by providing the tool for monitoring clinic efforts to improve patients' access to care by reducing wait times.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's Director, Chief of Staff, and Chief of QM. We also

interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the system's quality of care. Also, it was evident that senior managers supported the program through participation in performance improvement (PI) initiatives and through provision of resources. However, we identified one area that needed improvement.

UM. We found evidence of training and implementation of inter-rater reliability testing of UM reviewers. We also noted collaboration between UM reviewers and case managers. However, admission and continued stay cases that did not meet criteria were inconsistently referred to the physician UM advisor (PUMA) for review. Also, during the past 12 months, a written protocol defining the types of cases that were exempt from PUMA referral was not in place, as required.[1] The UM standard operating procedure, which provides guidance without PUMA review, was only recently implemented on October 8, 2009.

Recommendation 1 We recommended that the VISN Director require that the System Director ensures compliance with VHA's UM requirements.

The VISN and System Directors agreed with the findings and recommendation. The system developed a written protocol for referring exceptions to the PUMA. Compliance will be monitored, and findings will be reported at the quarterly UM Committee meeting. The target date for completion is March 1, 2010. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for C&P of physicians. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[2] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles from various services and found that licenses were current and

[1] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.
[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

that primary source verification had been appropriately obtained. However, we identified the following areas that needed improvement.

Privilege Forms. Some of the physicians provide services at both the system and the MOFH. The current privilege forms do not designate which services the physicians will provide at each facility. VHA requires privileges to be facility specific. The Chief of Staff stated that the system is aware of the problem and is in the process of revising the privilege forms.

FPPE. FPPE is a review process to ensure the competence of newly hired physicians. Although an FPPE process and forms were discussed in the medical staff bylaws, none of the physicians hired during FY 2009 had FPPE documented, as required.

OPPE. VHA regulations require a thorough written plan with specific competency criteria for OPPE for all privileged physicians. The written plan for OPPE was incomplete because several services had not developed service-specific competency criteria. All 10 physician files reviewed contained adequate information for reprivileging. However, Professional Standards Board (PSB) meeting minutes did not reflect individualized discussion of each physician's competence to perform the privileges requested prior to reprivileging. Additionally, we noted several irregularities in the OPPE forms (blank signature blocks and unchecked boxes). These were corrected immediately.

Recommendation 2 We recommended that the VISN Director require that the System Director ensures that physician C&P processes are in compliance with VHA requirements for privilege forms, FPPE, and OPPE.

The VISN and System Directors agreed with the findings and recommendation. The system revised its privilege forms to ensure that they are site specific and implemented a new FPPE process for all newly hired physicians. The system is developing a written plan to formalize the OPPE process and will ensure that OPPE forms are complete. PSB meeting minutes will be monitored to ensure documentation of FPPE and OPPE information. The target date for completion is May 31, 2010. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

MRI service at the system is provided under contract. The MRI unit is located in a mobile trailer that is parked at the MOFH for the duration of the contract. Although the MRI unit is only available Monday through Friday, the trailer is not driven on or off the grounds. A contract technologist scans patients, and a VA radiologist reads and interprets all images. Any high-risk patients requiring MRIs with contrast media are referred to community MRI centers.

We inspected the mobile MRI area, examined patient and employee records, reviewed relevant policies, and interviewed key personnel. Patients are directly observed during an MRI exam. Two-way communication is available between the patient and the MRI technologist, and patients have access to a push-button call system.

Patients undergoing an MRI are screened using a standard questionnaire or form. The American College of Radiology (ACR) requires that the screening form become part of the patient's medical record. We examined the records of 10 patients who had MRI scans in September 2009. All had the appropriate screening forms; however, screening forms were shredded after 30 days. This practice is inconsistent with ACR guidance. Program managers informed us that they have recently instituted a new policy of scanning all screening forms and electronically attaching the forms to the patients' records. Therefore, we did not make a recommendation for this finding. However, we identified two areas that needed improvement.

Training. Personnel who have daily or periodic access to the MRI area are required to receive appropriate MRI safety training. We reviewed the training records of two MRI and seven non-MRI personnel and found that until 1 month prior to our site visit, there was no evidence of initial or ongoing annual training for non-MRI personnel. Program managers agreed that training had not been consistent. They plan to train all employees who have access to the MRI area annually and will track compliance with training requirements.

Recommendation 3 We recommended that the VISN Director require that the System Director ensures that personnel who have access to the MRI area complete safety training, as required.

The VISN and System Directors agreed with the finding and recommendation. The system has included the MRI safety training with the annual radiation safety training. Employees who have not completed this annual safety training will be required to view an MRI safety video prior to accessing the MRI area. The target date for completion is March 1, 2010. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Screening. We reviewed seven safety screening questionnaires completed by non-MRI personnel. Per ACR guidelines, any positive ("yes") responses must be addressed. Of the seven questionnaires reviewed, two contained positive responses. We did not find documented evidence that the positive responses were addressed.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires appropriate personnel to follow up on positive responses on the screening questionnaire and document actions taken.

The VISN and System Directors agreed with the finding and recommendation. The system will audit completed screening forms to ensure that all positive responses on the questionnaires are addressed. Results will be documented in radiology staff meeting minutes. The target date for completion is April 1, 2010. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the system maintained a clean, safe, and secure environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), National Institute for Occupational Safety and Health (NIOSH), and Joint Commission (JC) standards.

At the MOFH, we inspected two inpatient units (medicine/surgery and MH) and a surgical clinic. We also inspected the system's outpatient clinics and several

ancillary services' (dental, laboratory, and radiology) areas. Overall, we found the areas we inspected to be clean and well maintained.

We reviewed the system's influenza immunization rates. VHA performance measures require that actions are taken when influenza immunization rates for outpatients ages 50–64 and over 65 fall below the national targets of 66 percent and 83 percent, respectively. In FY 2009, immunization rates for both groups were below the national targets, and there was no documented action plan for improvement. While we were onsite, program managers provided us with a comprehensive action plan to ensure improved immunization rates in FY 2010. Therefore, we did not make a recommendation for this finding. However, we identified the following areas that needed improvement.

Exit Signage. The NFPA requires sufficient exit signage for safety. During our inspections of several clinic areas, we found that there was a lack of adequate signage to ensure that staff and patients could easily evacuate the premises in the event of a fire or other emergency.

Respirator Fit Testing. OSHA policy for respirator fit testing directs that individuals identified to wear an N95 respirator must undergo initial and annual fit testing and initial medical evaluation. The system's industrial hygienist (IH) had appropriately conducted N95 respirator fit testing for H1N1. However, we noted a lack of collaboration between the IH, occupational health, and infection control to ensure that all high-risk personnel were targeted for testing and that results were reported to the Infection Control Committee.

Sharps Containers. The NIOSH requires sharps containers (for disposal of needles, syringes, and other sharp objects) to be mounted at a height of 52–56" from the top of the container to floor. In several inpatient and clinic areas, we found sharps containers that did not meet the NIOSH height requirement.

Fire Extinguishers. The NFPA requires that fire extinguishers are installed no more than 5 feet above the floor (measured from the top of the extinguisher). On VA inpatient units at the MOFH, we found a number of portable fire extinguishers that violated NFPA's height requirement. Each fire extinguisher weighed approximately 20 pounds, a

potential safety hazard for personnel who may be required to utilize extinguishers installed at this height.

Recommendation 5 We recommended that the VISN Director ensure that the System Director addresses the identified EOC deficiencies.

The VISN and System Directors agreed with the findings and recommendation. All noncompliant sharps containers have been remounted at the required height. The system will conduct a review of all leased spaces to ensure adequate exit signage and will ensure that fire extinguishers are moved to a compliant height. The IH will coordinate respirator fit testing and will report results to the Infection and Prevention Control Committee each month. The target date for completion is May 1, 2010. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. The system utilized one agency RN during the past 12 months. We reviewed documents for several required components, including licensure, training, and competencies. We found that system managers had appropriate processes in place and followed them consistently. We made no recommendations.

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to optimal patient outcomes.

We reviewed the documentation for 33 intra-facility transfers and found that all transfer documentation was appropriate. Also, we reviewed the medical records of 20 patients who were recently discharged and found that 17 (85 percent) received appropriate written discharge instructions. We also found documentation that the 17 patients understood those instructions.

Additionally, we reviewed the medical records of 10 patients who were recently discharged from the acute MH unit. We found documentation that the patients had received information on how to access emergency MH care and that patients were given MH clinic appointments within 2 weeks of discharge. We also found that MH providers either arranged for follow-up appointments or contacted the patients by phone within 7 days of discharge. We made no recommendations.

Medication Management

The purpose of this review was to determine whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes in the inpatient medicine/surgery and MH units.

The system has a designated Bar Code Medication Administration (BCMA) Program coordinator who had appropriately identified and addressed problems, and we found evidence of several monitoring activities to improve BCMA procedures. However, there was no formal BCMA PI plan. While we were onsite, the BCMA Coordinator developed a formal PI plan. In addition, we found that nursing staff documented PRN (as needed) pain medication effectiveness within the timeframe specified by local policy. We made no recommendations.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the system's and VISN's overall inpatient satisfaction scores for quarters 1, 2, and 3 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[3] The target scores are noted on the graphs.

[3] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.

Figure 1:

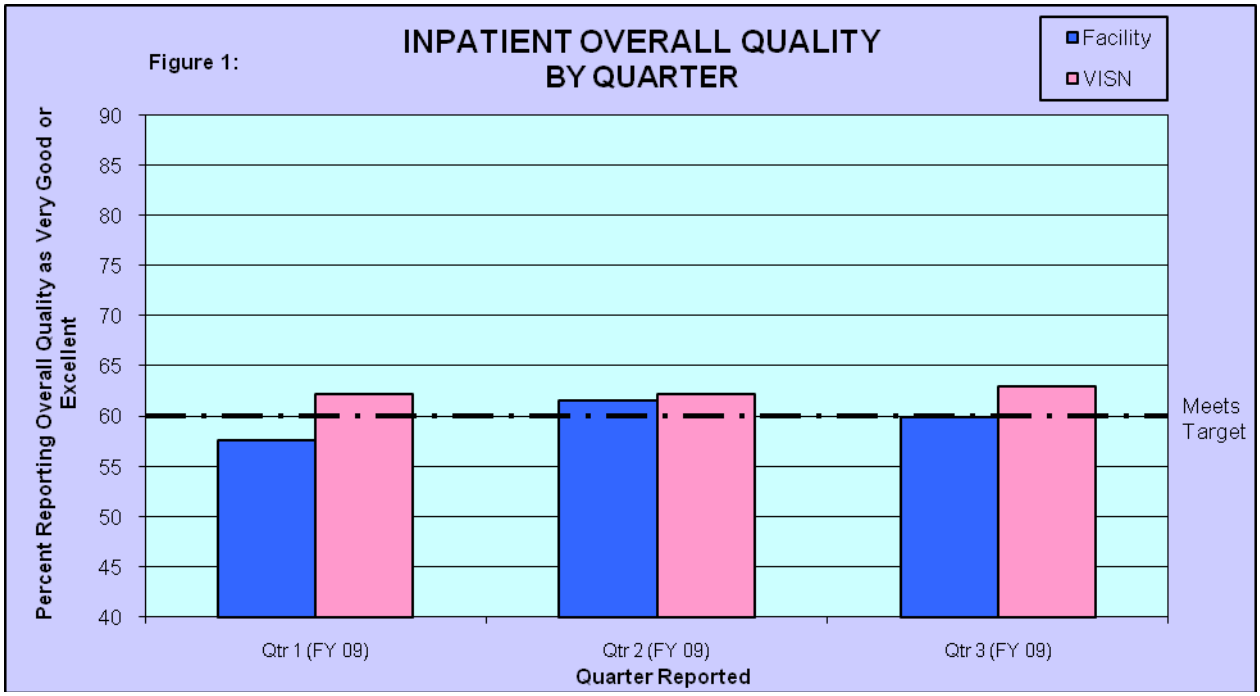
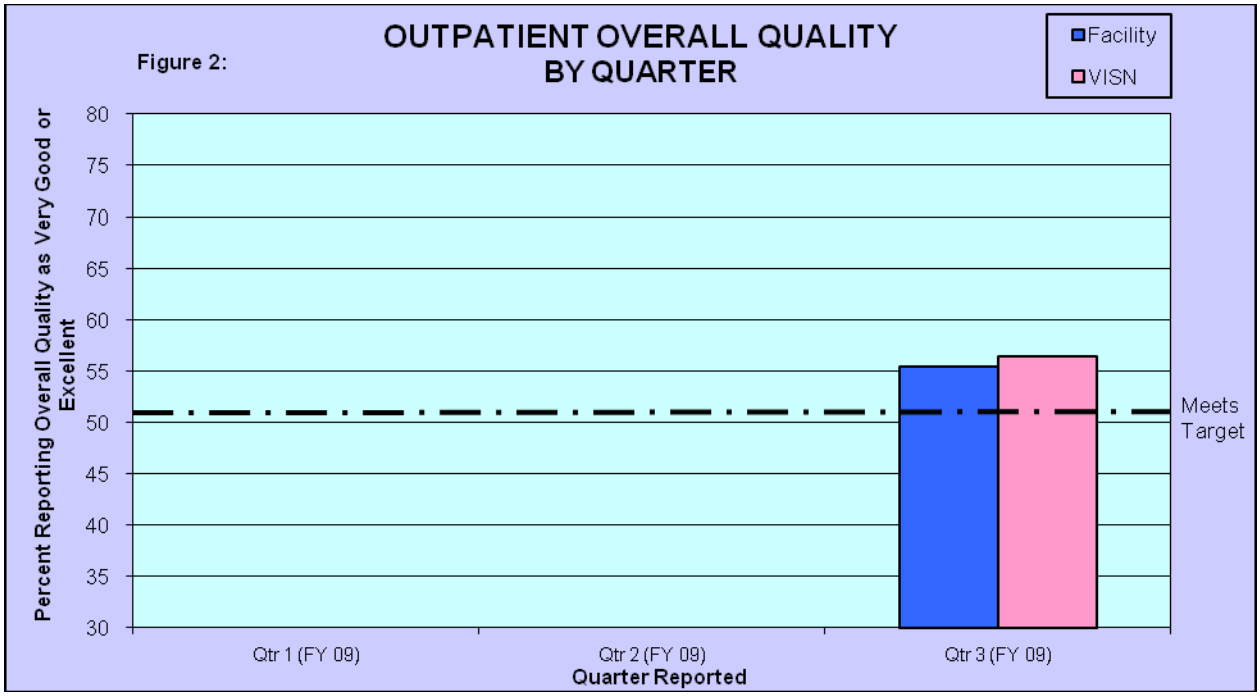
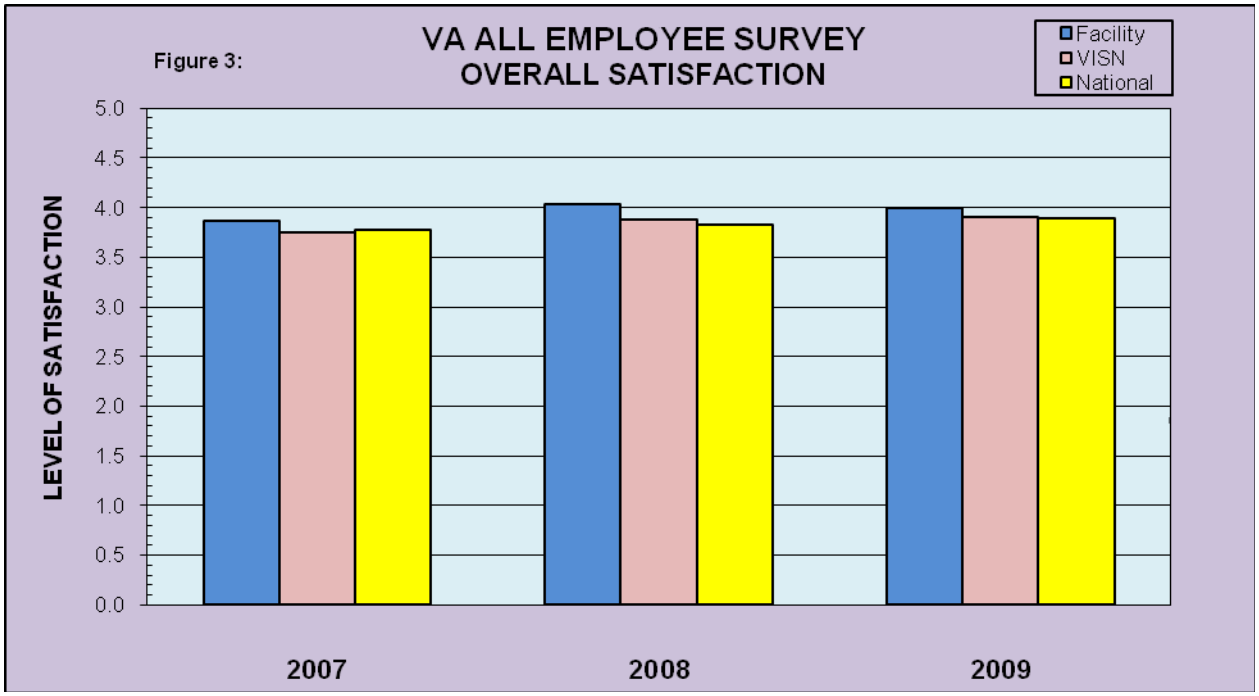


Figure 2:



Employees are surveyed annually. Figure 3 on the next page shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3:


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 20, 2010

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subject: Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, NV

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Thru: Director, Management Review Service (10B5)

1. VA Desert Pacific Healthcare Network submits the Draft Report: Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, Nevada.

2. Please contact Barbara Fallen, Deputy Network Director, VA Desert Pacific Healthcare Network, at (562) 826-5963 should you have questions or need further information.

(original signed by:)
Ronald B. Norby

Attachments

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 20, 2010

From: Director, VA Southern Nevada Healthcare System (593/00)

Subject: Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, NV

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. The attached Director's comments are submitted in response to the recommendations in the Office of Inspector General's Combined Assessment Program Report.

2. Please contact me at (702) 636-3010 if you require further assistance.

(*original signed by*:)
John B. Bright

Attachment

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director require that the System Director ensures compliance with VHA's UM requirements.

Concur

Facility's Response: A written protocol was published October 8, 2009, and approved by the UM Committee on November 12, 2009, and Medical Executive Committee on December 10, 2009. The protocol formalized in writing the existing agreed upon verbal practice for referring exceptions to the Physician Utilization Management Advisor. Compliance with the written protocol will be monitored by the Associate Quality Manager for three months and reported at the Quarterly Utilization Management Committee.

Target Completion Date: March 1, 2010**.**

Recommendation 2. We recommended that the VISN Director require that the System Director ensures that physician C&P processes are in compliance with VHA requirements for privilege forms, FPPE, and OPPE.

Concur

Facility's Response:

As of January 2, 2010, privilege forms were revised to be site specific and are in use.

FPPE: The FPPE process was implemented January 1, 2010. All new providers hired undergo an FPPE; this includes a review of three medical records monthly for three months plus one (total of 10) for each new provider as well as proctoring of three procedures, as applicable, by the service chief or designee. An audit of the Professional Standards Board (PSB) minutes will be completed by the AO for the Chief of Staff and reported to the Chief of Staff Tracking Meeting on May 31, 2010, to ensure compliance with VHA and Joint Commission standards.

OPPE: The written plan to formalize the OPPE process is in development. Each service is developing standardized OPPE criteria that will be used to monitor provider practice; the OPPE review will be

documented by the service chief every six months. The final concurrence of the OPPE forms for each service will be documented in the February 2010 PSB minutes. Effective January 1, 2010, PSB minutes reflect individualized discussion of each physician's competence to perform the privileges requested prior to reprivileging. An audit of the PSB minutes will be completed on May 1, 2010, by the AO to the Chief of Staff and documented in the Chief of Staff Tracking Meeting minutes to ensure the PSB minutes continue to reflect the discussion.

Target Completion Date: May 31, 2010.

Recommendation 3. We recommended that the VISN Director require that the System Director ensures that personnel who have access to the MRI area complete safety training, as required.

Concur

Facility's Response: All employees who have access to the MRI area will receive MRI safety training annually. Training will be tracked to ensure compliance. As of November 2009, MRI Level 1 safety training was included with the annual Radiation Safety training. Any employee not completing the annual Radiation Safety and MRI Safety class must view the MRI safety video prior to accessing the MRI. Training will be documented. Level II training was completed by the MRI technician and support staff, the MRI Safety Director, Chief Technologist, and Radiology Service Chief and documented in November 2009. A copy of the MRI safety training was provided to the Michael O'Callaghan Federal Hospital (MOFH) security force and fire department. Attendance rosters of the annual training will be maintained by the VA radiology program. Additionally, any other non-MRI personnel will receive training on a case-by-case basis prior to granting access. This training will be documented by radiology staff and retained as required.

Target Completion Date: March 1, 2010.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires appropriate personnel to follow up on positive responses on the screening questionnaire and document actions taken.

Concur

Facility's Response: All personnel accessing the MRI trailer are screened using a standard questionnaire. Effective November 2009, all positive ("yes") responses are addressed per ACR guidelines and reviewed by the MRI personnel, the radiologist reading the MRI, or the MRI Safety Director. The MRI staff comment on the form regarding the actions taken for the "yes" response. The questionnaire or form will be

kept by the MRI support staff at the MRI trailer for reference. Any changes to non-MRI personnel medical condition will require a new screening form. An audit of screening forms will be conducted by the Chief, Radiology Service and documented in the Radiology Staff Meeting minutes April 1, 2010, to ensure compliance.

Target Completion Date: April 1, 2010

Recommendation 5. We recommended that the VISN Director ensure that the System Director addresses the identified EOC deficiencies.

Concur

Facility's Response:

Exit Signage: The locations with inadequate signage that were identified during the review are the Radiology Department, 1st Floor, Central Clinic, and the West Clinic back hallway area. All of the leased clinic spaces, including these spaces, have a properly executed Certificate of Occupancy by the Authority Having Jurisdiction (AHJ), the City of Las Vegas Department of Building and Safety, indicating that at the time of issuance the structure was in compliance with the various ordinances of the city regulating building construction or use. In order to assure continued compliance with NFPA standards, a review of all leased clinic spaces will be conducted. The review will be completed by the VASNHS Chief, FMS, and the Safety Officer and documented in the March 2010 Environment of Care Committee Minutes. (April 1, 2010)

Respirator Fit Testing: Membership on the VASNHS Infection Control Committee includes the Infection Control Nurse, Industrial Hygienist, and a representative from the Occupational Health program. In addition, the Industrial Hygienist now reports to Occupational Health. The Industrial Hygienist will attend the Occupational Health bi-weekly meetings beginning January 19, 2010, and provide a list of high risk employees who require a Medical Clearance evaluation. After the Occupational Health provider completes and documents the Medical Clearance in OHRS, notification will be sent by encrypted email to the Industrial Hygienist. The Industrial Hygienist will coordinate and document the completion of the fit test. The Industrial Hygienist will report the percentage of high risk staff who are fit-tested on the N95 respirator to the Infection Prevention and Control (IPC) Committee on the 5th of every month. This will be documented in the IPC Committee minutes monthly and audited by the IPC Nurse for three months to ensure compliance. The IPC nurse will report these results to the Quality and Performance Improvement Committee. (May 1, 2010)

Sharps Containers: The clinical spaces that have sharps containers have all been re-evaluated to include the Mike O'Callaghan Federal Hospital,

and all affected sharps containers found out of compliance have been remounted to the required height of 52 to 56 inches. No further action is required.

Fire Extinguishers: The MOFH is under Air Force management. Facility Maintenance at the MOFH indicated the fire extinguishers currently installed more than five (5) feet above the floor will be moved to a compliant height as soon as new cabinets can be ordered and installed. The required cabinets are currently on order. The VASNHS leadership will continue to monitor through completion of the project. (May 1, 2010)

Target Completion Date: May 1, 2010.

OIG Contact and Staff Acknowledgments

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