Wednesday, April 04, 2018

Phoenix VA cited for leaving chemicals, other dangerous items near veterans with mental health problems

by Eric Hannel | March 06, 2018 03:28 PM

The Phoenix VA Health Care Center in Phoenix is seen in this file photo from April 28, 2014. Among other problems, a recent Joint Commission report said that the hospital's medication workroom in oncology was "unclean and cluttered, the sink and faucet contained sediments, and a medication bottle inside the cabinet was sticky," increasing the risk of contamination of medications. (AP Photo/Ross D. Franklin)
Ross D. Franklin

The Department of Veterans Affairs' healthcare system in Phoenix failed to lock up dangerous chemicals and plastic bags in a supply closet that could have been accessed by veterans with mental health problems and suicidal tendencies, according to report from a group that inspects and offers accreditation for healthcare facilities.

That was one of three high-risk issues found in the report by the Joint Commission, which has not been made public but was obtained by the Washington Examiner.

The report was recently sent to the VA after its unannounced visit to the VA facilities in Phoenix, and the facility said the report has already been acted upon."The triannual (unannounced) Joint Commission Survey identified areas we needed to focus on, which we did immediately by identifying and implementing plans of correction that addressed each and every one of the commission's findings," Medical Center Director Rima Nelson said in a statement.

That statement added that the Phoenix VA system is "continually seeking ways to modernize and improve the care we deliver to our Veterans," and said the Joint Commission on Monday conducted a "validation survey" that found the office had "successfully addressed all of the commission's findings."

Still, the findings are just the latest in a string of poor reports for the Phoenix VA office, which was the epicenter of the VA wait-time scandal in 2014. That scandal revealed veterans died while waiting for care, VA offices around the country were manipulating data, and employees altered the length of time a veteran waited for healthcare from the department.

Specifically, the Joint Commission, who was back in Phoenix yesterday, found that a housekeeping closet in the mental health unit was stuck open, making "potentially harmful items" accessible to "patients with acute mental health issues and suicidal ideation."

Another high-risk problem found was inaccurate descriptions of drugs for some of the patients. The report found one example of a patient who was recommended Propofol at a dosage that was ten times higher than what he was actually prescribed.

Similarly, it found that respiratory care ordered for patients was "different than those carried out and documented in the medical record."

The report also cited a "lack of oversight by unit leadership in holding staff accountable" for the disinfection of hemodialysis machines used to remove unwanted waste products from blood, failure to maintain documentation, and for proper hepatitis screening. The report did not identify if patients had poor healthcare outcomes due to the failures identified.

The report identified a pattern of moderate risks that included a failure to maintain medication refrigerator temperature logs, which according to past VA Insector General reports could impact potency and shelf-life.

A related problem was a finding that at least one employee "had the combination to the medication room" even though his role did not require him to have access. Unauthorized access to medication and improper disposal of medication is of concern given drug diversion problems at VA hospitals.

Another section of the report said the medication workroom in oncology was “unclean and cluttered, the sink and faucet contained sediments, and a medication bottle inside the cabinet was sticky," increasing the risk of contamination of medications.

It found a series of low-risk problems, including a pattern of failure to establish a plan of care for a patient's needs upon admission, and a lack of time frames for resolving patient care goals.

Dr. Sam Foote, a former VA physician and whistleblower, told the *Washington Examiner* that the report is representative "of a lack of workforce or one which lacks pride in their work, which in either case reflects poorly on Phoenix VA management."

The Joint Commission Report did not provide insight into the causes of the many failures still occurring across the Phoenix VA healthcare system.

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