DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

MAY 7 2012

In Reply Refer To:

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036-4505

RE: OSC File No. DI-11-3203

Dear Ms. Lerner,

This addendum responds to questions raised by the Office of Special Counsel (OSC) regarding the subject report. VA's Office of the Medical Inspector (OMI) provides the following information in response to the OSC's request:

Issue

OSC requested additional information describing corrective actions the Medical Center is going to take to address the inadequate cleaning allegation. When OMI conducted the site visit they found overflowing trash cans.

Response

The Medical Center immediately instituted an on-call system providing pager and cell phone numbers to call if there are any cleaning issues needing immediate service, between normal cleaning schedules. The Chief, Environmental Management Service set a response time of 15 minutes during weekdays and 30 minutes on nights and weekends. This is monitored daily, and any delays are reported to the Chief, Technologist. Outcomes are reported by Environmental Management and by Imaging Services to leadership on the first Monday of each month. These measures are in addition to establishing two Environmental Management Service shifts: one from 7:00 a.m. to 3:30 p.m., and a second from 3:30 p.m. to 12:00 midnight.

Issue

OSC requested more information on the sample size that was reviewed by OMI in responding to the allegation of failure to properly reconcile patient medication.

Response

As is OMI's usual practice in this type of investigation, we assess the complaint by interviewing the complainant, individuals identified by the complainant, others that work in the area to include the supervisor and non-supervisory personnel, assess any report of adverse events, and in some

cases, such as this one, do a non-probability selection of patients to review. We reviewed 10 patient records of Veterans who had been prescribed Metformin for the months of October and November (FY 2011) and who had received radiologic imaging studies requiring the administration of intravenous iodinated contrast agents to evaluate for policy compliance. The total number of patients who were taking Metformin and had a CT scan with injection of iodinated contrast was 87 for the 2 month period, October through November 2011.

Issue

OSC has requested for us to disclose the names of the list of witnesses that were interviewed.

Response

VA is still deciding how to deal with the issue of disclosing witness names and is unable to provide the names at this time.

Respectfully,

John R. Pierce, M.D.
Medical Inspector