Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02081-41

Combined Assessment Program Review of the VA Northern California Health Care System Mather, California

December 1, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	VA Northern California Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
tPA	tissue plasminogen activator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of September 15, 2014.

Review Results: The review covered seven activities. We made no recommendations in the following activity:

- Medication Management

The facility's reported accomplishments were a drive-thru flu clinic, the Decompressing a Full House 100-day Project, and a consolidated outpatient surgical services building.

Recommendations: We made recommendations in the following six activities:

Quality Management: Report Focused Professional Practice Evaluation results for newly hired licensed independent practitioners to the Medical Executive Committee. Ensure the Surgical Work Group meets monthly, includes the Chief of Staff as a standing member, and documents its review of National Surgical Office reports. Review the quality of entries in the electronic health record at least quarterly. Require the Medical Records Committee to meet quarterly.

Environment of Care: Implement actions to address high-risk areas, and document those actions in Infection Control Function Team meeting minutes. Clean rolling equipment and weight scales routinely, and repair damaged furniture in patient care areas or remove it from service. Replace the eye clinic waiting room carpet to avoid tripping hazards.

Coordination of Care: Require clinicians to validate patients' and/or caregivers' understanding of the discharge instructions they provide.

Acute Ischemic Stroke Care: Revise facility policy to address screening patients for difficulty swallowing and the difference in approach to patients presenting within and after 2 hours of onset of symptoms. Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake, and provide patients with printed stroke education upon discharge. Ensure employees involved in assessing and treating stroke patients receive the training required by the facility. Collect and report to the Provision of Care Committee the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake. Obtain a partial thromboplastin time while assessing patients presenting with stroke symptoms.

Community Living Center Resident Independence and Dignity: Ensure employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

Magnetic Resonance Imaging Safety: Conduct and document initial patient safety screenings. Ensure radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan. Revise facility policy to fully meet Veterans Health Administration requirements. Hold quarterly Magnetic Resonance Imaging Safety Committee meetings, and conduct biannual safety inspections.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–31, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

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 quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2013 and FY 2014 through September 14, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Northern California Health Care System, Sacramento, California,* Report No. 12-03074-29, November 9, 2012). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 191 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 540 responded. We shared summarized results with facility managers.

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.

Reported Accomplishments

Drive-Thru Flu Clinic

In 2013, the facility's hospital in Mather offered its first drive-thru flu clinic. The clinic was well received by patients, and plans are underway to expand to three facility community based outpatient clinics—Martinez, McClellan, and Oakland. The facility received a grant from VHA's National Center for Health Promotion and Disease Prevention to help fund clinic expansion.

Decompressing a Full House 100-Day Project

In June 2013, the facility implemented the Decompressing a Full House 100-Day Project to improve flow for patients urgently in need of a higher level of care. When the hospital is full, staff alert leadership of patients requiring beds. Daily afternoon meetings with the Chiefs of Staff, Nursing Service, and associated stakeholders are held to clear roadblocks and expedite placement for individual patients. The PACU is used to house critically ill patients, and the emergency department is used as a temporary holding area for inpatients. Patient flow is maintained, and transfers are made according to the newly established protocols. There have been no adverse events, and stakeholder satisfaction with the new protocols is high.

Consolidated Outpatient Surgical Services

In April 2014, the facility constructed a 20,000 square foot consolidated outpatient surgical services building for orthopedic, vascular, podiatry, general, thoracic, and plastic surgery clinics. There are five procedure rooms in the building where cases requiring local anesthesia are performed. In addition, plans are underway to hire more staff to expand services in the near future to include moderate sedation cases. The

building is environmentally sound and receives 70 percent of its energy from solar sources. During the design and construction phase of the project, the facility's goal was to attain a Silver level certification in Leadership in Energy and Environmental Design. Instead, the facility surpassed its goal and earned a Gold certification.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
X	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Thirty-three profiles reviewed: • Of the 30 Focused Professional Practice Evaluations completed, results of 6 (20 percent) were not reported to the MEC. This was a repeat finding from the previous CAP review.
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met 8 times over the past 12 months. Eight months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff was not a standing member. • There was no evidence that National Surgical Office reports were reviewed.
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	The 4 months of available Medical Records Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
X	The facility met any additional elements required by VHA or local policy.	Facility Medical Records Committee charter reviewed: • There was no evidence that the committee met quarterly as delineated in the charter.

Recommendations

1. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

2. We recommended that the Surgical Work Group meet monthly, include the Chief of Staff as a standing member, and document its review of National Surgical Office reports.

3. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed at least quarterly.

4. We recommended that the Medical Records Committee meet quarterly.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the intensive care, one mental health, one medical surgical inpatient, and three CLC units. We also inspected the primary care, women's health, and eye clinics; the emergency department; SDS; and the PACU. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 32 employee training records (19 SDS, 8 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	Infection prevention risk assessment and 2 months of Infection Control Function Team meeting minutes reviewed: • Minutes did not reflect that actions were implemented to address high-risk areas.
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Three of nine patient care areas had dirty rolling equipment, and one area had a dirty patient weight scale. • Two of nine patient care areas had damaged furniture.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
X	Environmental safety requirements in the eye clinic were met.	• The waiting room carpet was old and had several tears, which presented tripping hazards.
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Infection Control Function Team meeting minutes document those actions.

6. We recommended that processes be strengthened to ensure that rolling equipment and patient weight scales are cleaned on a routine basis and that damaged furniture in patient care areas is repaired or removed from service.

7. We recommended that the eye clinic waiting room carpet be replaced to avoid tripping hazards.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 33 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 23 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	• Two of the nine applicable EHRs did not contain documentation that clinicians validated patients' and/or caregivers' understanding of the discharge instructions they provided regarding wound care/dressing changes.
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

8. We recommended that processes be strengthened to ensure that clinicians validate patients' and/or caregivers' understanding of the discharge instructions they provide.

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 38 randomly selected patients who experienced stroke symptoms, and 15 employee training records (5 emergency department, 5 intensive care unit, and 5 inpatient care unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, the critical care unit, and an acute inpatient unit. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility's stroke policy/plan/guideline addressed all required items.	• The facility's policy did not address: o Screening for difficulty swallowing o The difference in approach to patients presenting within and those presenting outside the defined 2-hour timeframe
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Twenty of the 36 applicable EHRs (56 percent) did not contain documented evidence of completed stroke scales.
	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Twenty-two of the 37 applicable EHRs (59 percent) did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 34 applicable EHRs contained documentation that stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• Six employee training records did not contain documented evidence of completion of the web-based training required by the facility.
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and/or reported to the Provision of Care Committee: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake

NM	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy reviewed: • Twenty-three of the 38 applicable EHRs (61 percent) did not contain documented evidence of a completed partial thromboplastin time test.

Recommendations

9. We recommended that the facility's stroke policy be revised to address screening patients for difficulty swallowing and the difference in approach to patients presenting within and after 2 hours of onset of symptoms, that the policy be fully implemented, and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

12. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

14. We recommended that the facility collect and report to the Provision of Care Committee the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

15. We recommended that processes be strengthened to ensure that clinicians obtain a partial thromboplastin time test while assessing patients presenting with stroke symptoms and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 12 EHRs of residents (10 residents receiving restorative nursing services and 2 residents not receiving restorative nursing services but candidates for services). We also observed 3 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Seven employee training records did not contain evidence of completed training for range of motion. • Four employee competency records did not contain evidence of competency assessment for range of motion. • Three employee training/competency records did not contain evidence of completed training and competency assessment for resident transfers.

NM	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

16. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 47 employees (27 randomly selected Level 1 ancillary staff and 20 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas—one at Martinez and one at Mather. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Seven EHRs (20 percent) did not contain initial patient safety screenings.
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Three of the eight applicable EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	

NM	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by VHA or local policy.	VHA and facility MRI safety policies reviewed: • Facility policy did not fully meet VHA requirements. For example, with the exception of police officers, facility policy did not delineate Level 1 training for other staff such as housekeeping, biomedical, and nursing. • Although facility policy required quarterly MRI Safety Committee meetings and biannual safety inspections at each location, in FY 2014, there was only one committee meeting, and no MRI-specific safety inspections were conducted.

Recommendations

17. We recommend that that processes be strengthened to ensure that initial patient safety screenings are conducted and documented in the electronic health records and that compliance be monitored.

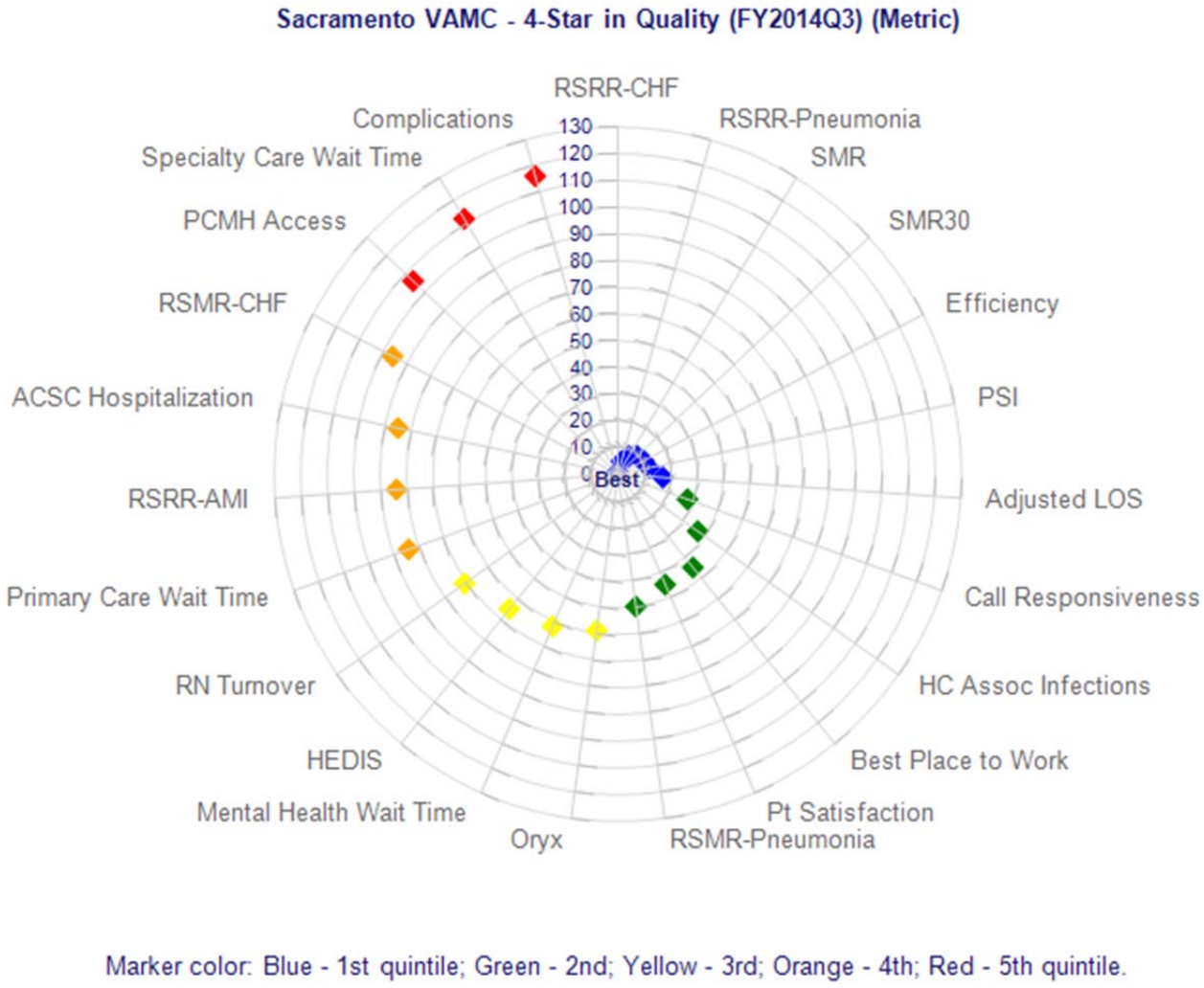
18. We recommend that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

19. We recommended that facility policy be revised to fully meet VHA requirements and that processes be strengthened to ensure that quarterly Magnetic Resonance Imaging Safety Committee meetings are held and biannual magnetic resonance imaging safety inspections are conducted and that compliance be monitored.

Facility Profile (Mather/612) FY 2014 through August 2014[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$572.9
Number of:	
• **Unique Patients**	88,041
• **Outpatient Visits**	902,845
• **Unique Employees**[2]	2,492
Type and Number of Operating Beds (July 2014):	
• **Hospital**	60
• **CLC**	120
• **Mental Health**	NA
Average Daily Census (July 2014):	
• **Hospital**	47
• **CLC**	114
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Redding/612B4 Oakland/612BY Fairfield/612GD Vallejo/Mare Island/612GE Martinez/612GF Chico/612GG McClellan/612GH Yuba City/612GI
VISN Number	21

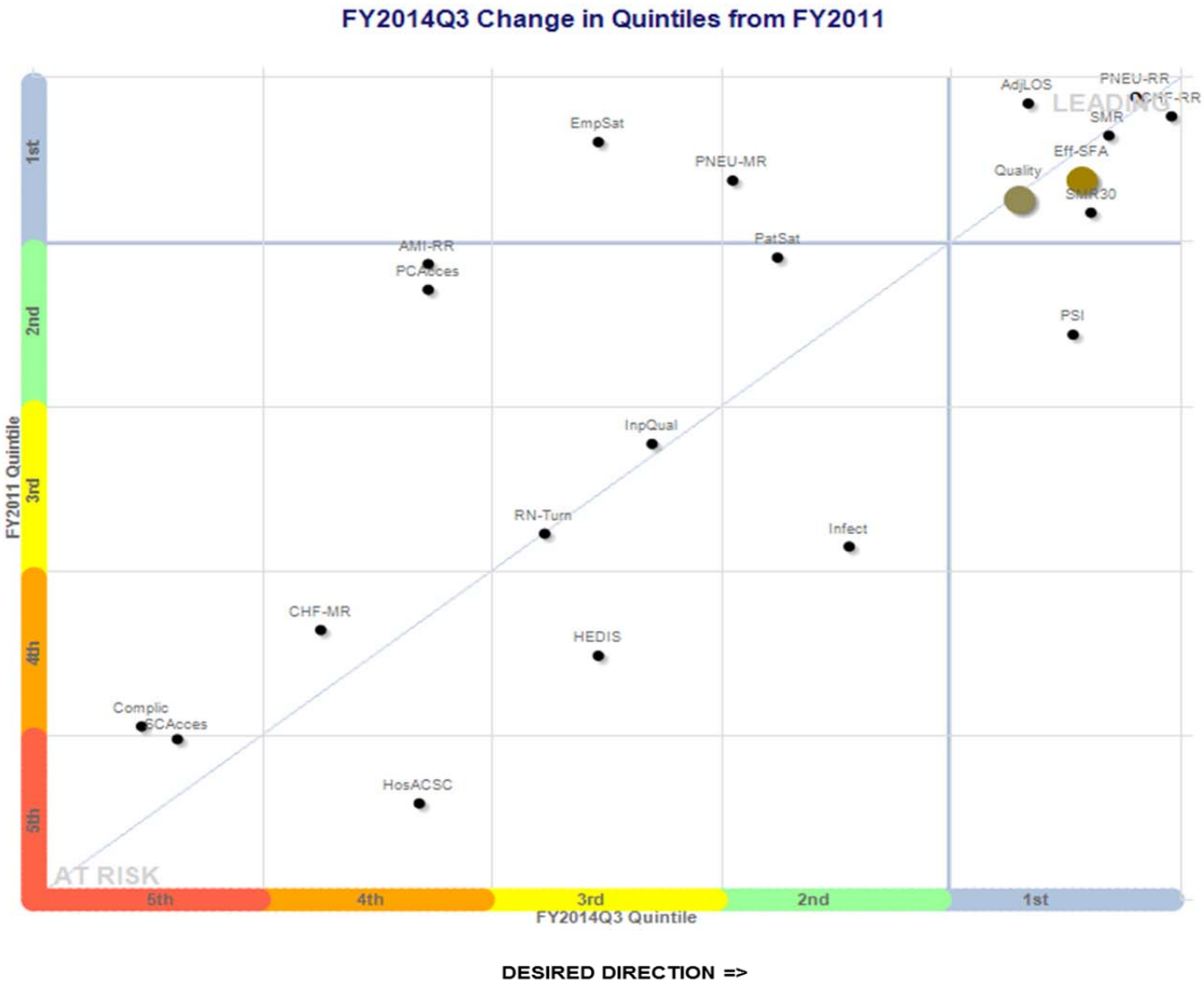
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
Mental Health Status	Mental health status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
Mental Health Wait Time	Mental health wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 10, 2014

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Northern California Health Care System, Mather, CA**

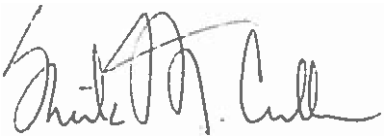
To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Attached is the action plan developed by the Northern California Health Care System in response to the recommendations received during their recent OIG CAP review as well as the Facility Director's memo.

2. The Facility concurs with the findings and will ensure the corrective action plan is implemented.

3. If you have any questions please contact Terry Sanders, Associate Quality Manager for V21 at (707) 562-8370.



Sheila M. Cullen

Attachments

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 5, 2014

From: Director, VA Northern California Health Care System (612/00)

Subject: **CAP Review of the VA Northern California Health Care System, Mather, CA**

To: Director, Sierra Pacific Network (10N21)

I wish to extend my thanks to the Office of the Inspector General (OIG) for conducting a professional review of the organization. The recommendations contained in the Combined Assessment Program (CAP) report have been reviewed. Attached are the facility responses addressing each recommendation.

Sincerely,

(*original signed by:)*
David Stockwell, 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 1. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

Concur

Target date for completion: April 1, 2015

Facility Response: To ensure that all (100%) Focused Professional Practice Evaluations are reported to the Medical Executive Committee (MEC) timely and documented in the minutes; the following is being implemented by the Medical Staff Office personnel:

- Medical Staff Office has a vacancy that is in the process of being converted to an FPPE Coordinator position whose primary duty would be continual monitoring for FPPEs.
- All FPPEs reported to the MEC are required to be submitted on or before the cutoff date. Any FPPEs received in the Medical Staff Office after the cutoff date will be reported at the following month's meeting. This will allow time for Medical Staff Office personnel to update the appropriate tracking log and ensure the FPPEs is reported during the meeting and included in the minutes.
- Report hand carried FPPEs (not on the agenda) at the following MEC meeting.
- The FPPE tracking log has been modified to include the date of the MEC meeting and that the FPPEs were reported and closed out.
- To bolster the process and confirm that newly hired Licensed Independent Practitioners (LIPs) are consistently reported to the MEC, Medical Staff office personnel will cross-check FPPEs due with new hires on agendas and minutes. The FPPE Coordinator will be included on e-mails when the FPPE form is sent to the provider's proctor.
- The FPPE Coordinator will be included on all e-mails concerning initial hires being processed out-of-committee.
- The provider's Entrance on Duty (EOD) date will be obtained from the initial hiring tracking log.
- A Compliance Dashboard will be reported monthly by Medical Staff Office Personnel to the MEC and Quality Management.

Recommendation 2. We recommended that the Surgical Work Group meet monthly, include the Chief of Staff as a standing member, and document its review of National Surgical Office reports.

Concur

Target date for completion: December 8, 2014

Facility Response: The Operating Room Committee was renamed the "Surgical Work Group". The Chief of Surgery is the appointed chair of this committee and an alternate has been designated to ensure continuity for a monthly meeting (100% of the time) in the absence of the chair. The Chief of Staff is now a full member and recurring meetings for this committee are on his schedule. An acting Chief of Staff will be designated in absence of the Chief of Staff. The National Surgical Office Report comes out quarterly and will be reviewed when available. Attendance results and minutes will be forwarded to Quality Management by the Administrative Officer of the Surgical Service to verify attendance and discussion of the National Surgical Office Report (as available). Of note, the 3rd quarter National Surgical Office Report was reviewed on 9/23/14, which was documented in the minutes.

Recommendation 3. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed at least quarterly.

Concur

Target date for completion: April 1, 2015

Facility Response: A policy will be drafted to provide guidance on the process of completing quality reviews of the electronic health record by the Chief, Health Information Management. These reviews will be completed at the department level for clinical services and will include entries in the following areas: progress notes, reports, labs, chief complaint summaries, history and physicals, orders, and consults. The status of these aggregated reviews will be reported quarterly by the Chief, Health Information Management to the Medical Records Committee (a subordinate committee to the Medical Executive Council) and Quality Management beginning December 18, 2014.

Recommendation 4. We recommended that the Medical Records Committee meet quarterly.

Concur

Target date for completion: November 20, 2014

Facility Response: While the Medical Records Committee (MRC) attempts to meet monthly, they are scheduled to meet quarterly and it is expected that they will meet at least four times for FY15. The MRC is currently evaluating their membership and this committee includes both a chair and co-chair. Meetings will resume regularly effective

November 20, 2014. The outcomes of the MRC are reported to the Medical Executive Council by the Chief, Health Information Management and minutes of the attendance will be forwarded to Quality Management for tracking.

Recommendation 5. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Infection Control Function Team meeting minutes document those actions.

Concur

Target date for completion: January 5, 2015

Facility Response: The Infection Control Functional Team will include High Risk Areas as identified in the annual Infection Control Risk Assessment as a standing agenda and will be discussed at each Infection Control Functional Team meeting (100% of the time). The high risk areas will be reported quarterly by the Infection Control Nurse and reviewed for actions, status and on-going monitoring at the Infection Control Functional Team meetings and minutes will be forwarded to Quality Management.

Recommendation 6. We recommended that processes be strengthened to ensure that rolling equipment and patient weight scales are cleaned on a routine basis and that damaged furniture in patient care areas is repaired or removed from service.

Concur

Target date for completion: December 1, 2014

Facility Response: A standard operating procedure will be drafted/updated to provide guidance on staff responsibility as it relates to rolling equipment and patient scales. Staff will be trained on this new policy once finalized. Additionally, a wheel chair cleaning machine was just purchased in October 2014. The Nurse Managers have been advised of this cleaning equipment. The new process will involve staff identifying equipment that needs cleaning and taking it to environmental services for washing. This will be monitored quarterly by the Quality & Assurance Program Analyst, Engineering & Facilities Management Service using a log that will track equipment needed for cleaning and actual equipment cleaned, which will be reported at the Environment of Care (EOC) Committee and Quality Management. Target 90%.

Any damaged or broken equipment/furniture requires form 22-37 to be completed by staff and sent to environmental services for repair or replacement. This process has been reiterated with the staff in October 2014 and will be monitored using the log mentioned above by Engineering & Facilities Management Service during EOC rounds and findings reported quarterly by the Quality & Assurance Program Analyst, Engineering & Facilities Management Service to the EOC Committee and Quality Management. Target 90%.

Recommendation 7. We recommended that the eye clinic waiting room carpet be replaced to avoid tripping hazards.

Concur

Target date for completion: April 1, 2015

Facility Response: This was added to the Northern California Health Care System projects list in October 2014 and a project manager will be assigned. It is anticipated that the replacement will occur early in 2015. The area is regularly monitored by the Environment of Care (EOC) team, and was just reviewed on 10/23/14. No obvious tripping hazards were noted. The status of this project will be reported by the Chief of Projects, Engineering & Facilities Management Service to the EOC Committee and Quality Management.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians validate patients' and/or caregivers' understanding of the discharge instructions they provide.

Concur

Target date for completion: December 1, 2014

Facility Response: The nursing discharge template will be revised to reflect the patients/caregivers level of understanding regarding discharge instructions ensuring completion of this discharge component. The organization is also adopting the Engineered Care – Project Red discharge instructions. This new process will enable providers and nursing staff to provide clear and concise discharge instructions to include patients/caregivers discharge instructions on wound care/dressing changes and other home care instructions specific to the patient. The revised template will ensure that Patient/Caregiver understanding is inclusive of these instructions. Monitoring of the implementation and documentation will be completed by the Clinical Nurse Leader, Medical Surgical Unit and will be reported at the Patient Flow Committee and Quality Management. Target 90%.

Recommendation 9. We recommended that the facility's stroke policy be revised to address screening patients for difficulty swallowing and the difference in approach to patients presenting within and after 2 hours of onset of symptoms, that the policy be fully implemented, and that compliance be monitored.

Concur

Target date for completion: January 6, 2015

Facility Response: Policy Statement 11-134, Acute Ischemic Stroke Management, will be revised to address screening for difficulty swallowing. It has been determined that this screening is occurring, but was not reflected in the policy statement. The Emergency Department Nurse Manager will monitor cases and report results quarterly

to the Critical Care Committee and Quality Management. Target 90%. During the CAP Review, the Chief of Staff recommended that the policy not differentiate the approach to patients presenting within and those presenting outside the defined tPA time frame, in order to allow for professional autonomy in determining appropriate tests to order. The OIG Inspector noted concurrence with this recommendation.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: January 6, 2015

Facility Response: Chief, Emergency Medicine will ensure that staff are trained and that they document in Computerized Patient Record System (CPRS) on the Physician Acute Stroke Rapid Assessment template according to National Institutes of Health Stroke Scale (NIHSS) for each stroke patient. Compliance will be monitored by the Emergency Department Nurse Manager and reported quarterly to the Critical Care Committee and Quality Management. Target 90%.

Recommendation 11. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: January 6, 2015

Facility Response: Emergency Department Nurse Manager (NM) will ensure that staff are trained that that patients are screened for difficulty swallowing prior to oral intake and document such screening in Computerized Patient Record System (CPRS). Compliance will be monitored by the Emergency Department Nurse Manager and reported quarterly to the Critical Care Committee and Quality Management. Target 90%.

Recommendation 12. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: January 6, 2015

Facility Response: Chief Nurse, Acute Care will provide education to staff and ensure that staff provides printed stroke education to patients from Krames-on-Demand and documents this was completed in CPRS on the Nursing Discharge Note Stroke template. Chief Nurse, Acute Care will monitor for compliance and report quarterly to the Critical Care Committee and Quality Management. Target 90%.

Recommendation 13. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target date for completion: January 6, 2015

Facility Response: Physicians and Nursing staff that will be caring for stroke patients will complete the National Institute of Health Stroke Scale (NIHSS) training and certification program according to Policy Statement 11-134. The training will be assigned as a mandatory class in Talent Management System (TMS). Training will be required for new staff and then annually thereafter. The training completion will be monitored monthly by the supervisor (until the 90% target is reached then annually thereafter), and results will be reported by the Emergency Department Nurse Manager and Chief, Emergency Medicine to the Critical Care Committee and Quality Management. Target 90%.

Recommendation 14. We recommended that the facility collect and report to the Provision of Care Committee the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: January 6, 2015

Facility Response: Chief, Emergency Medicine or designee will collect and report quarterly to the Critical Care Committee that reports to the Provision of Care Committee and Quality Management the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake. Target 90%.

Recommendation 15. We recommended that processes be strengthened to ensure that clinicians obtain a partial thromboplastin time test while assessing patients presenting with stroke symptoms and that compliance be monitored.

Concur

Target date for completion: December 15, 2014

Facility Response: Chief, Emergency Medicine will work with the Clinical Applications Coordinators to develop a CVA order set in CPRS that will include the partial thromboplastin time test for patients presenting with stroke symptoms. Applicable providers will be educated on the new order set during their monthly staff meeting in November. Nursing staff will be notified of this by way of email with reinforcement

during their December staff meeting. Compliance will be monitored monthly by the Emergency Department Nurse Manager and reported quarterly to the Critical Care Committee and Quality Management. Target 90%.

Recommendation 16. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

Concur

Target date for completion: January 31, 2015

Facility Response: A review of training and competency records for staff that perform restorative services was completed in October 2014. Continual monitoring and reporting on the themes related to resident independence and dignity are discussed at the Community Living Center/Community Rehabilitation & Extended Care (CLC/CREC) Quality Improvement (QI) monthly meeting.

1. The seven staff missing evidence of completed training for range of motion (ROM) have received training as required.
2. The four staff missing evidence of completed competency assessment for ROM have completed competency training as required.
3. The three staff missing evidence of completed competency/training for resident transfers completed training as required.
4. The Nurse Educator and Restorative Nurse will begin repeat training for all staff performing Restorative Nursing on ROM and resident transfers beginning 10/27/14. Target is 90% compliance by 1/31/15.
5. Restorative Nursing competency for ROM and resident transfer will be part of new employee orientation and will be completed within 90 days of employment. Tracking will be documented in the CLC/CREC Quality Improvement monthly meeting minutes and reported to Quality Management.

Recommendation 17. We recommend that that processes be strengthened to ensure that initial patient safety screenings are conducted and documented in the electronic health records and that compliance be monitored.

Concur

Target date for completion: January 6, 2015

Facility Response: The Clinical Application Coordinators have been appointed to revise the level 1 screen form in Computerized Patient Record System (CPRS) to ensure that initial patient safety screening is conducted and documented. The new level 1 screening form will contain the following elements to capture safety screening documentation.

- Form in CPRS has been changed to be more thorough with additional questions, while also eliminating the ability of providers to bypass by indicating “patient not available for screening.”

- Form will print and be attached to the order. Both will be scanned into the Picture Archiving Communication Systems (PACS).
- If screening form is not completed, the order is cancelled with (newly added) reason "Level 1 Magnetic Resonance Imaging (MRI) contraindication screening not completed."
- 20 audit forms will be completed per month by the MRI Safety Officer, Radiology Service to monitor compliance of completed Level 1 screening and reported to the MRI Safety Committee and Quality Management. Target 90%.

Recommendation 18. We recommend that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: January 6, 2015

Facility Response: The following processes will be implemented to ensure that documentation exists for all Magnetic Resonance Imaging (MRI) contraindications with the associated monitoring.

- All identified contraindication items checked "yes" are to be initialed to verify they've been checked. All higher level items (designated by asterisk) are to be explained in detail on the back page of the form.
- The MRI Screening form is now printed/signed by the technologist and scanned.
- A postings section in CPRS is used to document (alert) contraindications to MRI.
- 20 audit forms will be completed monthly by the MRI Safety Officer, Radiology Service to monitor compliance of resolution to contraindications and reported at the MRI Safety Committee and Quality Management.

Recommendation 19. We recommended that facility policy be revised to fully meet VHA requirements and that processes be strengthened to ensure that quarterly Magnetic Resonance Imaging Safety Committee meetings are held and biannual magnetic resonance imaging safety inspections are conducted and that compliance be monitored.

Concur

Target date for completion: January 6, 2015

Facility Response: A new Standard Operating Procedure (SOP) was revised on 10/1/2014 which fully meets VHA requirement stated in the handbook.

- Quarterly MRI Safety Committee meetings have been scheduled. The last meeting took place 10/8/2014.
- Biannual MRI safety inspections will be conducted: One risk assessment by a physicist and one safety inspection by a member of the MRI Safety Committee.

Monitoring of compliance for any citations and notices from the risk assessment and inspection will be addressed and tracked during the quarterly MRI Safety Committee meetings and reported to Quality Management.

OIG Contact and Staff Acknowledgments

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Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.

Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:

- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.