Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04227-147

Combined Assessment Program Review of the VA San Diego Healthcare System San Diego, California

March 10, 2015

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
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA San Diego Healthcare System
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration

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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 December 8, 2014.

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

- Emergency Airway Management

The facility's reported accomplishments were a 40-bed residential treatment center, Joint Commission recognition, and several successful community partnerships.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Ensure the Procedure and Anesthesia Care Council includes the Chief of Staff and Surgical Quality Nurse as members. Analyze electronic health record quality data at least quarterly. Ensure the quality control policy for scanning includes all required elements.

Environment of Care: Implement actions to address all high-risk areas, follow up on those actions, and ensure Infection and Environmental Control Committee meeting minutes document this. Ensure that employees receive training on chemical labeling/safety data sheets and that all designated critical care employees receive annual bloodborne pathogens training. Consistently document functionality checks of the community living center's elopement prevention system at least every 24 hours.

Medication Management: Educate employees that intravenous syringes are not to be used to measure oral liquid medications. Ensure that multi-dose injector pens are not stored as ward stock in patient care areas and that they contain patient specific labels.

Coordination of Care: Ensure requestors consistently select the proper consult title. Complete inpatient consults within the specified timeframe.

Magnetic Resonance Imaging Safety: Complete secondary patient safety screenings for all patients, and document resolution of all identified contraindications prior to the scan. Ensure that all Level 2 magnetic resonance imaging personnel receive required annual safety training and that appropriate barriers are in place to restrict unauthorized or accidental access to Zone IV.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Obtain and document informed consent for tissue plasminogen activator. Post stroke guidelines in all areas where patients may present with stroke symptoms, and screen patients for difficulty swallowing prior to oral intake. Provide patients with printed stroke education upon discharge, and provide employees

involved in assessing and treating stroke patients with a stroke education program. Collect and report all required data elements to the Veterans Health Administration.

Surgical Complexity: Revise the Radiology Service policy to clearly define the required on-call reporting time for computed tomography scan and magnetic resonance imaging and the on-call response time for radiology interpretation.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–34, 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 eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

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 2014 and FY 2015 through December 8, 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 San Diego Healthcare System, San Diego, California,* Report No. 11-03658-64, January 6, 2012).

During this review, we presented crime awareness briefings for 163 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 690 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

The Aspire Center

In February 2014, the facility opened the Aspire Center, a 40-bed residential treatment center, aimed at promoting recovery in veterans, particularly those who returned from the Iraq and Afghanistan wars. The Aspire Center provides temporary housing for an average of 60–120 days to veterans who do not need inpatient care but would benefit from rehabilitation services.

Joint Commission Recognition

The facility is one of 20 VA medical centers from across the Nation recognized as a Top Performer on Key Quality Measures® for 2013. This recognition distinguishes facilities that are top performers in using evidence-based care processes closely linked to positive patient outcomes. The Joint Commission recognized the facility for attaining and sustaining excellence in selected measures for heart attack, heart failure, and pneumonia.

Community Partnerships

The facility is notable for its partnership with the community and Veterans Service Organizations. Multiple initiatives resulted from these successful collaborations, including hosting the 7th National Summer Sports Clinic, managing the medical tent for the 27th year of Stand Down for homeless veterans, and partnering with the city of San Diego as a participant in initiatives to end homelessness.

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, 10 credentialing and privileging folders, 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	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.		
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	Twelve months of Procedure and Anesthesia Care Council meeting minutes reviewed: • The Chief of Staff and Surgical Quality Nurse were not members.	**1.** We recommended that the Procedure and Anesthesia Care Council include the Chief of Staff and Surgical Quality Nurse as members.
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	Clinicians appropriately reported critical incidents.		
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	Twelve months of Medical Records Committee meeting minutes reviewed: • The committee analyzed EHR quality data for only 2 quarters.	**2.** We recommended that the facility analyze electronic health record quality data at least quarterly.
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	• The scanning policy did not include the quality of the source document and alternative means of capturing data when the quality of the source document does not meet image quality controls.	**3.** We recommended that the quality control policy for scanning include the quality of the source document and alternative means of capturing data when the quality of the source document does not meet image quality controls.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

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. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

We inspected critical care, medical/surgical, MH, spinal cord injury, and CLC units; the Emergency Department; and a primary care clinic. Additionally, we reviewed relevant documents, including inspection documentation for five alarm-equipped medical devices in critical care, and 20 employee training records (10 critical care and 10 CLC) and conversed with key employees and managers. 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	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address them, and follow-up on implemented actions and included analysis of surveillance activities and data.	Six months of Infection and Environmental Control Committee meeting minutes reviewed: • Minutes did not reflect implementation of actions to address all high-risk areas. • Minutes did not reflect follow-up on actions implemented to address identified problems.	**4.** We recommended that the facility implement actions to address all high-risk areas and follow up on those actions and ensure Infection and Environmental Control Committee meeting minutes document this.
	The facility had established a process for cleaning equipment.		
X	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.	• Three employee training records did not contain evidence of chemical labeling/safety data sheet training.	**5.** We recommended that facility managers ensure employees receive training on chemical labeling/safety data sheets.
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
X	Designated critical care employees received bloodborne pathogens training during the past 12 months.	• Two of 10 critical care employees did not receive bloodborne pathogens training during the past 12 months.	**6.** We recommended that facility managers ensure all designated critical care employees receive annual bloodborne pathogens training and monitor compliance.
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
	The facility met environmental safety requirements in critical care.		
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for CLC	Findings	Recommendations
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
X	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.	• The facility did not consistently document functionality checks of the CLC elopement prevention system at least every 24 hours.	**7.** We recommended that the facility consistently document functionality checks of the community living center's elopement prevention system at least every 24 hours and that facility managers monitor compliance.
	The facility met fire safety requirements in the CLC.		
	The facility met environmental safety requirements in the CLC.		
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the medical/surgical, post-anesthesia care, and CLC units and the Emergency Department and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
X	The facility employed practices to prevent wrong-route drug errors.	• In three of the four areas inspected, employees incorrectly stated that an intravenous syringe could be used to measure liquid medications when the dose amount differs from the unit dose package supplied.	**8.** We recommended that the facility educate employees that intravenous syringes are not to be used to measure oral liquid medications and that facility managers monitor compliance.
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy reviewed, which prohibited the storage of multi-dose injector pens in patient care areas as ward stock. • The CLC unit had four multi-dose injector pens stocked, and two did not have a patient specific label.	**9.** We recommended that the facility ensure that multi-dose injector pens are not stored as ward stock in patient care areas and that they contain patient specific labels and that facility managers monitor compliance.

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 17 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. 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	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Twelve consult requests did not include "inpatient" in the title. • Five consult requests were not completed within the specified timeframe.	**10.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. **11.** We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

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.[e]

We reviewed relevant documents and the training records of 41 employees (9 randomly selected Level 1 ancillary staff and 32 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. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needs improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	• Four of the 35 EHRs (11 percent) did not contain secondary patient safety screenings prior to MRI.	**12.** We recommended that the facility complete secondary patient safety screenings for all patients immediately prior to magnetic resonance imaging and that facility managers monitor compliance.
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Sixteen of the 17 applicable EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**13.** We recommended 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 facility managers monitor compliance.
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• Five Level 2 MRI personnel (16 percent) did not receive level-specific annual MRI safety training.	**14.** We recommended that the facility ensure all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.	• Neither MRI area had effective physical barriers to prohibit unauthorized or accidental access to Zone IV.	**15.** We recommended that the facility ensure appropriate barriers are in place to restrict unauthorized or accidental access to magnetic resonance imaging Zone IV.
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

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.[f]

We reviewed relevant documents, the EHRs of 31 patients who experienced stroke symptoms, and 15 employee training records (5 Emergency Department, 5 intensive care unit, and 5 step down/direct observation unit), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, the critical care unit, and two acute inpatient units (medical/surgical and MH). 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	Recommendations
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For 19 of the 29 applicable patients, clinicians did not document evidence of completion of stroke scales.	**16.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
X	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.	• For the two patients who received tissue plasminogen activator, clinicians did not document informed consent in the patients' EHRs.	**17.** We recommended that clinicians obtain and document informed consent for tissue plasminogen activator and that facility managers monitor compliance.
X	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.	• Facility managers had not posted stroke guidelines in any of the four areas inspected.	**18.** We recommended that facility managers post stroke guidelines 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.	• For 17 of the 31 patients (55 percent), clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**19.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 29 applicable patients' EHRs contained documentation that clinicians provided stroke education to the patients/caregivers.	**20.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility provided training to employees involved in assessing and treating stroke patients.	• The facility did not provide a stroke educational program for employees.	**21.** We recommended that facility managers provide a stroke education program for employees involved in assessing and treating stroke patients and that facility managers monitor compliance.
X	The facility collected and reported required data related to stroke care.	• The facility did not collect and/or report the following data to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**22.** We recommended that the facility collect and report to the Veterans Health Administration 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.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and 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	Recommendations
X	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.	• Radiology Service policy did not clearly specify that: o Employees on call for computed tomography scans must report within 30 minutes. o Employees on call for MRI must report within 30 minutes. o Radiology interpretation on-call response must be within 30 minutes.	**23.** We recommended that Radiology Service revise its policy to clearly define the required on-call reporting time for computed tomography scan and magnetic resonance imaging and the on-call response time for radiology interpretation.
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the Veterans Integrated Service Network Chief Surgical Consultant.		.
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including the EAM coverage schedule for 30 selected dates from January 1 through June 30, 2014, and we conversed with key managers and employees. 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.

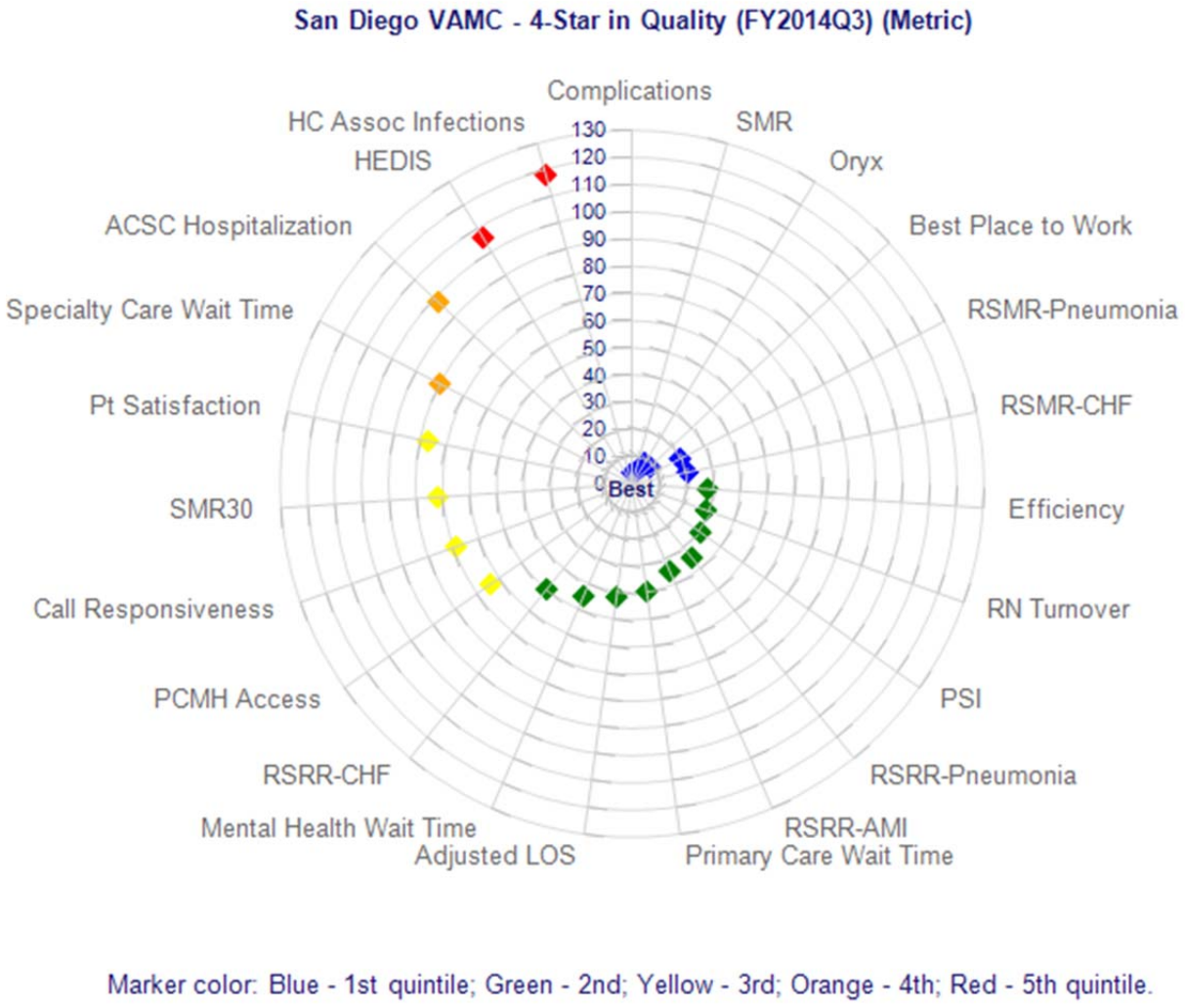
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner		
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (San Diego/664) FY 2015 through December 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$575.2
Number of:	
• **Unique Patients**	45,053
• **Outpatient Visits**	171,926
• **Unique Employees**[2]	2,822
Type and Number of Operating Beds (as of November):	
• **Hospital**	172
• **CLC**	39
• **MH**	69
Average Daily Census (as of November):	
• **Hospital**	119
• **CLC**	15
• **MH**	68
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	San Diego/664BY El Centro/664GA Oceanside/664GB Chula Vista/664GC Escondido/664GD
Veterans Integrated Service Network Number	22

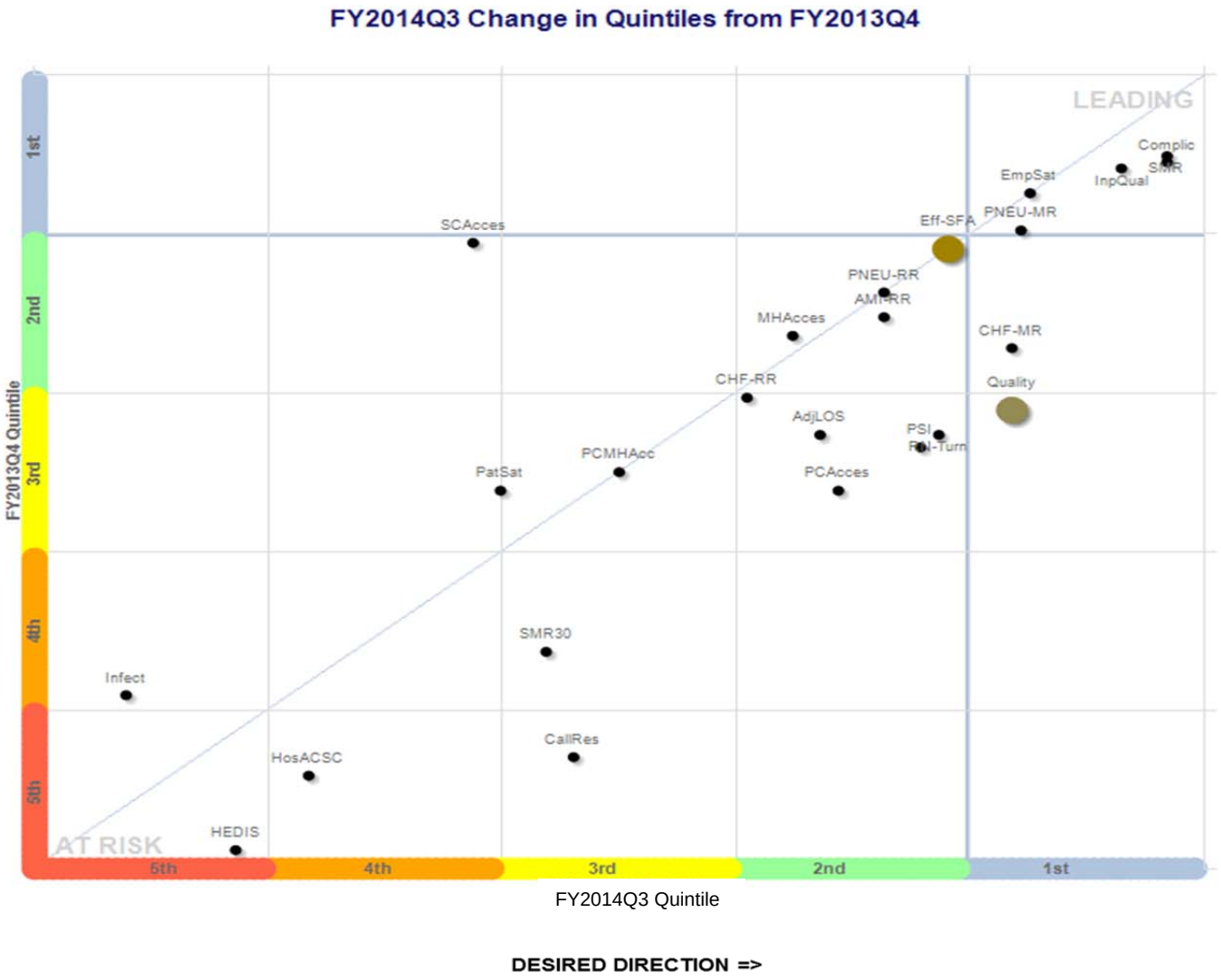
[1] All data is for FY 2015 through December 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

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
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH 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

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: February 6, 2015

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

Subject: **CAP Review of the VA San Diego Healthcare System, San Diego, CA**

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

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

1. I concur with the findings and recommendations in the report of the Status Request – Combined Assessment Program Review of the VA San Diego Healthcare System, San Diego, CA (report No. not yet assigned). Review conducted the week of December 8, 2014, for the 23 recommendations.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

Jennie Bates, RN

for Skye McDougall, PhD

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 3, 2015

From: Director, VA San Diego Healthcare System (664/00)

Subject: **CAP Review of the VA San Diego Healthcare System, San Diego, CA**

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

1. We are submitting written comments in response to the Combined Assessment Program Review completed December 8–11, 2014, at the VA San Diego Healthcare System.

2. In reviewing the report, the facility has addressed the noted recommendations and has a plan to resolve all non-compliant areas cited in the report.

3. If you have any questions regarding this response, please contact Jamel Gilliam (858) 642-1595.

FOR AND IN THE ABSENCE OF X Cynthia E. Abair
Jeffrey T. Gering, FACHE
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 the Procedure and Anesthesia Care Council include the Chief of Staff and Surgical Quality Nurse as members.

Concur

Target date for completion: January 7, 2015

Facility response: A surgical quality workgroup was established effective January 7, 2015, instead of adding the members to the Procedure and Anesthesia Care Council. This workgroup is scheduled to meet on a monthly basis, and includes the Chief of Staff and Surgical Quality Nurses as members. The surgical quality workgroup will present to MEC.

Recommendation 2. We recommended that the facility analyze electronic health record quality data at least quarterly.

Concur

Target date for completion: March 2015, with a full quarter's worth of reviews by July 2015

Facility response: The Chair of the Medical Records Committee, the Chief of Staff, and the Chief of Health Information Management Services, will ensure a robust process is established for analyzing and reporting electronic health record quality data on a quarterly basis. Quality elements will include, but are not limited to, timeliness of entry and authentication of essential elements of the medical records (including admission assessments, discharge summaries, operative reports, and brief Operative Notes). Other quality elements (such as inclusion of estimated blood loss on Procedure notes) will be identified and targeted on an ongoing basis and reported quarterly to the Medical Executive Committee. Reporting will begin in February 2015, and be ongoing.

Recommendation 3. We recommended that the quality control policy for scanning include the quality of the source document and alternative means of capturing data when the quality of the source document does not meet image quality controls.

Concur

Target date for completion: April 6, 2015

Facility response: The Medical Record Committee will ensure that the quality control policy for scanning (MCM 136-33) includes the quality of the source document and alternative means of capturing data when the quality of the source document does not meet image quality controls. The Medical Center Memorandum (MCM) will be implemented by February 27, 2015, and compliance monitoring will begin on April 6, 2015.

Recommendation 4. We recommended that the facility implement actions to address all high-risk areas and follow up on those actions and ensure Infection and Environmental Control Committee meeting minutes document this.

Concur

Target date for completion: July 1, 2015

Facility response: Minutes of the Infection and Environmental Control Committee (IECC) will reflect implementation of actions to address all areas identified as high risk in the annual IC Risk Assessment as well as actions implemented to address identified problems. Recommended changes in IECC minutes will begin immediately. Monitoring for compliance will be conducted quarterly (July, October and December 2015).

Recommendation 5. We recommended that facility managers ensure employees receive training on chemical labeling/safety data sheets.

Concur

Target date for completion: July 1, 2015

Facility response: The facility Industrial Hygienist has completed training of all areas where chemicals are used and information is obtainable with Safety Data Sheets (SDS). The process from going from Material Safety Data Sheets (MSDS) to SDS was part of the Global Harmonizing System and was completed December 22, 2014. Additionally, chemical hygiene training can be found on the Environment, Health & Safety website (SharePoint) under the headings of "Chemicals in Work Place, HAZMAT Awareness, MSDS (MSDS Online) and MSDS (CEOSH). All trainings were completed by December 22, 2014; monitoring for compliance will take place monthly thereafter.

Recommendation 6. We recommended that facility managers ensure all designated critical care employees receive annual bloodborne pathogens training and monitor compliance.

Concur

Target date for completion: May 1, 2015

Facility response: Employees receive their training in a system known as the Training Management System (TMS). The Bloodborne pathogen training content is located in two training subject areas, Bioterrorism and Administration of Blood and Blood

Components. TMS records are reviewed at the same time the employee Performance Evaluation is completed to ensure that all training due up to the date of the Performance Evaluation is completed. In review of TMS records, one RN completed the Bioterrorism training on 4-12-2014 and Administration of Blood and Blood Components on 4-5-2014. The other RN completed Bioterrorism training on 12-19-2014 and Administration of Blood Components on 12-19-2014. The monitoring system is currently in place.

Recommendation 7. We recommended that the facility consistently document functionality checks of the community living center's elopement prevention system at least every 24 hours and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2015

Facility response: The Nursing Service Clinical Policy: Use of Electronic Anti-Wandering Technologies states that the Unit Manager or designee will test the anti-wandering device daily when in use and weekly when not in use to monitor the proper functioning of the device. Documentation of the anti-wandering device functionality checks is kept in a log book on each nursing unit, including the Community Living Center.

Recommendation 8. We recommended that the facility educate employees that intravenous syringes are not to be used to measure oral liquid medications and that facility managers monitor compliance.

Concur

Target date for completion: June 15, 2015.

Facility response: The staff has been educated. A detailed email has been sent to all Nursing and Pharmacy staff (1/28/15). Additionally, the CNS group was educated by Pharmacy (1/27/15). Nursing supervisors will verbally educate all of their staff. Compliance will be monitored on EOC rounds for Medication Management.

Recommendation 9. We recommended that the facility ensure that multi-dose injector pens are not stored as ward stock in patient care areas and that they contain patient specific labels and that facility managers monitor compliance.

Concur

Target date for completion: June 15, 2015

Facility response: All Pharmacy staff has been educated that these items cannot be ward stocked. An email was sent to all staff (12/17/14) and staff will be educated at their staff meetings (2/11/15 and 2/18/15). Par levels for all pen multi-injectors have been set to zero in the Omnicells so that it cannot be loaded as ward stock (12/17/14). Compliance will be monitored at the monthly ward inspections for each area.

Recommendation 10. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: Implementation of the mandated National Consult Business Rules required modification of consult names to identify them as inpatient or outpatient. At the time this was mandated, many consult services did not have that delineation and instead relied in the existing field in the consult order in which the ordering provider designated whether the service was to be provided on an inpatient or outpatient basis. Existing consult services were re-named and, where needed, new consult services were created to be compliant with these business rules. When an existing consult service was renamed (e.g. Vascular to Vascular-Outpatient), the previously entered and completed consult requests were also renamed. This had the effect of making it appear that a consult intended for inpatient use was potentially entered into an outpatient consult request. Additionally, in order to assure timely urgent consultation and evaluation by specialty care within the Emergency Department, the facility chose to name Inpatient-focused consult requests as ED/Inpatient as the response time for these consults was intended to mirror inpatient urgency and response times. Coupled with the case-finding methodology used by the OIG, this created confusion.

VASDHS is revising the consult ordering menus to more clearly differentiate requests aimed to be responded to while the Veteran is an inpatient (or in the ED) rather than scheduled to outpatient evaluation. Additionally, VASDHS is creating specific inpatient consults menu to ensure all appropriate consults are available to requestors. Education will be provided to all clinicians upon completion of the menus. All (100%) of the facility consults service names are in compliance with the mandated National Consult Business Rules as documented by querying the VHA Consult Information Website. Consult timeliness performance is reviewed weekly by facility Executive Leadership and reported and tracked by the facility Access and Consult Management Committee.

Recommendation 11. We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: Consult timeliness is evaluated weekly by Executive Leadership and this has been modified to include focused evaluation of inpatient consult timeliness. Additional training will also be provided to consult managers on how to pull service reports and monitor compliance. VASDHS is additionally re-educating providers on the appropriate mechanisms to respond to consultation (e.g. choice of progress note title) in order to assure automatic completion of the consultation request when the patient is seen.

Recommendation 12. We recommended that the facility complete secondary patient safety screenings for all patients immediately prior to magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: April 3, 2015

Facility response: Secondary patient safety screenings are performed for all patients. Document scanners were requested to be placed at the console to allow the MR techs to scan the paperwork in PACS. Monitoring for compliance will begin April 3, 2015, and will occur monthly. Quality assessments performed by the MRI supervisor.

Recommendation 13. We recommended 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 facility managers monitor compliance.

Concur

Target date for completion: December 15, 2014.

Facility response: Personnel were informed on proper process for identifying any possible contraindications and have already began to do so. Screening has been modified to eliminate requirement for resolution of contraindications to contrast for exams without contrast. Annotations are being done on the screening form to document resolution of real contraindications to magnetic field or contrast (if contrast is used). The MRI supervisor reviews requisitions daily to monitor compliance.

Recommendation 14. We recommended that the facility ensure all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: January 3, 2015.

Facility response: All Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training, once on their first day on the job and another time when they get computer access, and yearly, thereafter. The ones that were missing were found in another file cabinet after the CAP survey was over. Now, the documentations of training are all centralized in TMS to prevent misplaced paperwork and support documentation of level 2 training. The MRI supervisor receives a weekly printout to review and monitor compliance.

Recommendation 15. We recommended that the facility ensure appropriate barriers are in place to restrict unauthorized or accidental access to magnetic resonance imaging Zone IV.

Concur

Target date for completion: March 3, 2015.

Facility response: There will be plastic chains across the Tech Control Room and MRI Suite to prevent accidental entry to zone 4 in the next 30 days. There will also be cameras and monitors as advised.

Recommendation 16. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: Currently this facility completes NIHSS stroke scales for all patients presenting with stroke-like symptoms within 24 hours. However, the review included records of patients who had stroke as an underlying diagnosis, regardless of time of onset. NIHSS stroke scales are only truly useful to document improvement with an intervention, which is only likely to occur in those presenting with symptoms <24 hours. NIHSS documentation will be monitored by staff that have yet to be identified (see #19, below). Until the staff are identified, NIHSS are recorded by the stroke fellows, who attend stroke codes activated on patients with symptoms of stroke <24 hours.

Recommendation 17. We recommended that clinicians obtain and document informed consent for tissue plasminogen activator and that facility managers monitor compliance.

Concur

Target date for completion: March 1, 2015 (time to implement pharmacy system) and iMed Consent documentation.

Facility response: Acute ischemic stroke is a neurologic emergency with tissue plasminogen activator, an FDA-approved, time-dependent treatment, for patients presenting within 3 hours of symptom onset. Given the time constraints regarding use of this FDA-approved therapy, the American Academy of Neurology has reviewed current evidence and made recommendations recommending documentation regarding a discussion of the risks, benefits, and alternatives to tPA, but not requiring a signed informed consent AAN Policy on Consent Issues for the Administration of TPA. This has been the current practice at VASDHS. While we feel that the current VHA Directive may result in patients needing TPA potentially losing the opportunity to receive a highly time-sensitive drug, we will implement use of the existing “Brain-Intravenous Injection of Tissue Plasminogen Activator (tPA)” consent using the iMED consent system and monitor compliance through pharmacy review prior to release of the drug. In the case of life-threatening emergencies, existing mechanism for obtaining surrogate consent will be followed.

Recommendation 18. We recommended that facility managers post stroke guidelines in all areas where patients may present with stroke symptoms.

Concur

Target date for completion: May 1, 2015

Facility response: The American Stroke Association has a flyer/poster using the pneumonic "FAST" to identify stroke symptoms. These will be posted in the Emergency Room, Primary Care clinics, Neurology Clinics, as well as on each inpatient floor.

Recommendation 19. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: While Neurology faculty and house staff have previously been instructed to screen patients for difficulty swallowing prior to oral intake, the Neurology service will re-educate faculty and staff immediately, and will add this instruction to new faculty and staff orientation as well as ED staff education. Neurology is in the process of identifying staff to audit charts for documentation of the screening. The staff identified will be specialized in both Stroke Case Management, as well as patient education. In the meantime, stroke fellows collect this data at stroke codes, along with NIHSS data, as above (see #16).

Recommendation 20. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: The Neurology Service has identified stroke education material (from Krames on Demand), and nurses will present to patients upon discharge. The specific educational materials are still being decided upon between Neurology and Nursing. As mentioned above, Neurology is in the process of identifying staff who will audit charts for documentation that patients were given the printed education. The nurse distributing the educational material will also document this upon discharge.

Recommendation 21. We recommended that facility managers provide a stroke education program for employees involved in assessing and treating stroke patients and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: As remarked above, warning signs of stroke from the American Stroke Association will be posted in patient care areas. In addition, warning signs of stroke will be posted on VA employee E-news. In August 2014, order sets for the emergency room regarding stroke codes and treatment of stroke patients were revised. Ongoing compliance will be monitored by the stroke nurse. Lastly, TMS offers a course entitled "Stroke Recognition Training," which can be added as a required training module for designated employees, to include VASDHS Neurologists and ER nurses. Completion of this training will be monitored by supervisors through the TMS system.

Recommendation 22. We recommended that the facility collect and report to the Veterans Health Administration 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: May 1, 2015

Facility response: VASDHS is in the process of identifying staff who will be responsible for collecting this data. This data, as with #16 and #19 above, is currently recorded by stroke fellows attending stroke codes. Furthermore, we will also implement a standardized stroke code assessment note to assist with this data collection. Performance will be collated, monitored and posted by the Neurology Service until other staff are identified.

Recommendation 23. We recommended that Radiology Service revise its policy to clearly define the required on-call reporting time for computed tomography scan and magnetic resonance imaging and the on-call response time for radiology interpretation.

Concur

Target date for completion: December 11, 2014.

Facility response: The policy was updated by Radiology Service as requested during the OIG CAP review in December 2014.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] 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.

[f] 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.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.