Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04220-363

Combined Assessment Program Review of the Phoenix VA Health Care System Phoenix, Arizona

June 4, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Phoenix VA Health Care 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

Table of Contents

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 March 9, 2015.

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

- Medication Management
- Coordination of Care
- Emergency Airway Management

The facility's reported accomplishment was the development and implementation of a universal traveling veteran consult.

Recommendations: We made recommendations in the following five activities:

Quality Management: Include the Chief of Staff as a member of the Surgical Work Group.

Environment of Care: Ensure employees receive training on chemical labeling/safety data sheets.

Magnetic Resonance Imaging Safety: Require radiologists and/or Level 2 magnetic resonance imaging personnel to document resolution of all identified contraindications prior to the scan. Ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake, and provide printed stroke education to patients upon discharge. Ensure that employees involved in assessing and treating stroke patients receive the training required by the facility. Collect and report all required data elements to the Veterans Health Administration. Obtain required laboratory tests while assessing patients presenting with stroke symptoms.

Surgical Complexity: Ensure medicine/telemetry unit employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists.

Comments

The Acting Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–30, 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 2013, FY 2014, and FY 2015 through March 9, 2015, 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 Phoenix VA Health Care System, Phoenix, Arizona,* Report No. 12-00368-161, April 20, 2012).

During this review, we presented crime awareness briefings for 28 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 586 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 Accomplishment

Universal Traveling Veteran Consult

In March 2013, the facility implemented a universal traveling veteran consult in recognition of the need to improve the coordination of care for traveling veterans. The consult eliminates the need for multiple consult processes and has decreased inter-facility consult completion time from 45 days to less than 10 days. The facility has generated more than 1,134 consults. The consult is used by all VHA facilities.

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, 19 credentialing and privileging folders, and other relevant documents. 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
	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.	Eleven months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff was not a member.	**1.** We recommended that the Surgical Work Group include the Chief of Staff as a member.
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	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.		
	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.		

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 the CLC, critical care, medicine/telemetry, and surgical units; the Emergency Department; and a primary care clinic. Additionally, we reviewed relevant documents, including inspection documentation for three 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 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 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.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
X	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.	• Five employee training records did not contain evidence of chemical labeling/safety data sheet training.	**2.** 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		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	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.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
NA	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	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 the 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 critical care, medicine/oncology, medicine/telemetry, and medicine units 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. 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
	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 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.		
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

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 35 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. 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
	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		
	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.		
	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 43 employees (30 randomly selected Level 1 ancillary staff and 13 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 three MRI areas. 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 completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	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.		
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.	• Fourteen of the applicable 31 EHRs (45 percent) did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**3.** 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 1 MRI personnel and ensured they received level-specific annual MRI safety training.	• Nine Level 1 ancillary staff (30 percent) did not receive level-specific annual MRI safety training.	**4.** We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers 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 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 51 patients who experienced stroke symptoms, and 10 employee training records (five Emergency Department and five critical care unit), and we conversed with key employees. We also conducted onsite inspections of the CLC, critical care, medicine, and surgical units and the Emergency Department. 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.	• For 35 of the 37 applicable patients (95 percent), clinicians did not document evidence of completion of stroke scales.	**5.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
	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.		
	Facility managers posted 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 11 of the 39 applicable patients (28 percent), clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**6.** 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 30 applicable patients' EHRs contained documentation that clinicians provided stroke education to the patients/caregivers.	**7.** 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.	• Seven employees had not completed the web-based training required by the facility.	**8.** We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility 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	**9.** 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.
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy required the following laboratory tests: (1) cardiac markers, (2) partial thromboplastin time, and (3) an electrocardiogram. Of the 51 patients: • For 15 (29 percent), clinicians did not document markers of cardiac levels in the EHRs. • For eight (16 percent), clinicians did not document partial thromboplastin time in the EHRs. • For 11 (22 percent), clinicians did not document an electrocardiogram in the EHRs.	**10.** We recommended that clinicians obtain cardiac markers, partial thromboplastin time, and an electrocardiogram while assessing patients presenting with stroke symptoms and that facility managers monitor compliance.

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
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• None of the five employees on the medicine/telemetry unit had 12-lead electrocardiogram competency assessment and validation included in their competency checklists.	**11.** We recommended that facility managers ensure that medicine/telemetry unit employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists.
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 competency assessment documentation of 35 clinicians applicable for the review period January 1–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.

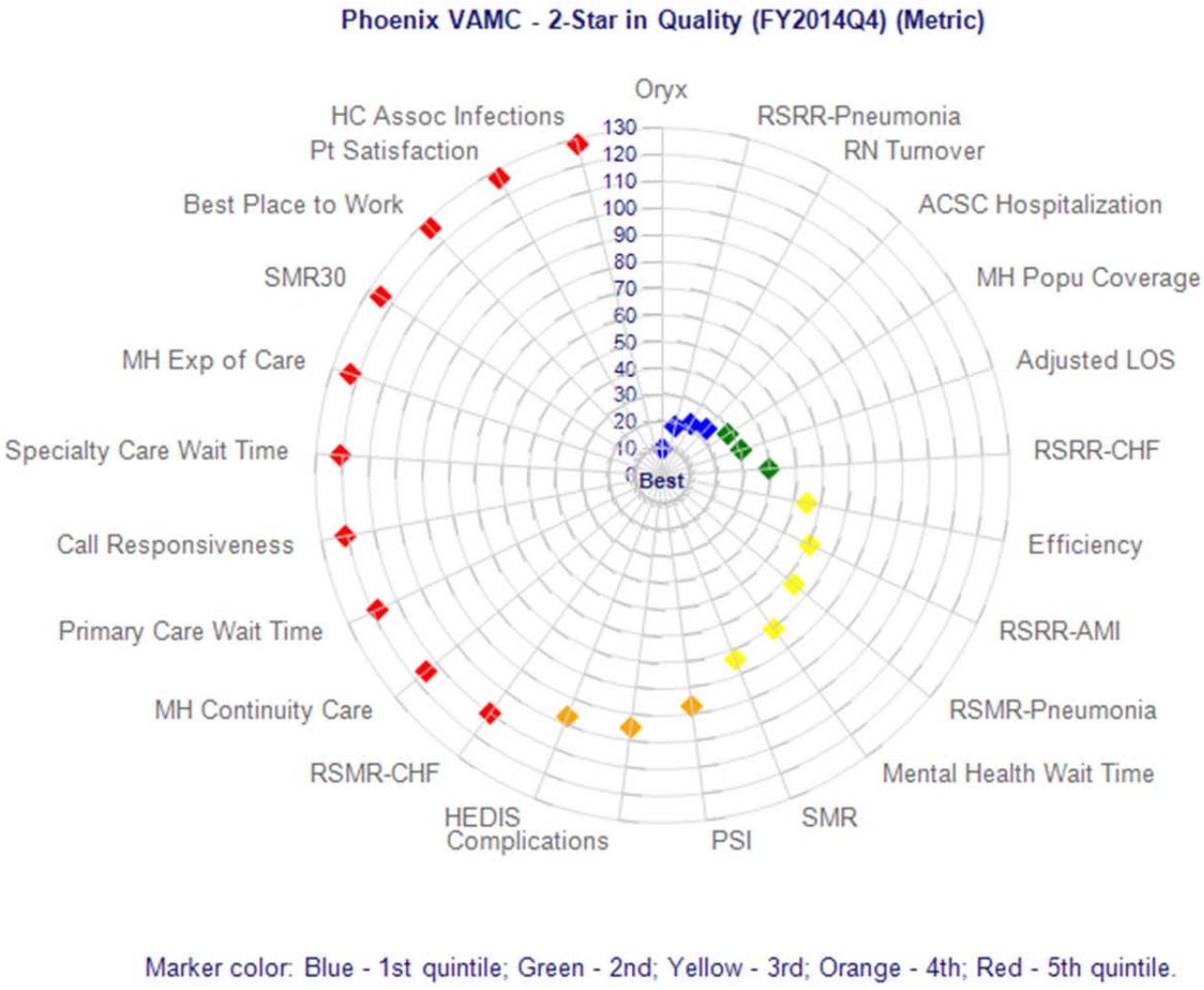
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated 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 (Phoenix/644) FY 2015 through February 2015[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$526.1
Number (as of March 17, 2015) of:	
• **Unique Patients**	64,890
• **Outpatient Visits**	406,583
• **Unique Employees**[2]	2,519
Type and Number of Operating Beds:	
• **Hospital**	166
• **CLC**	104
• **MH**	24
Average Daily Census:	
• **Hospital**	98
• **CLC**	30
• **MH**	18
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Southeast/644BY Sun City/644GA Show Low/644GB Payson/644GD Thunderbird/644GE Globe/644GF
Veterans Integrated Service Network Number	18

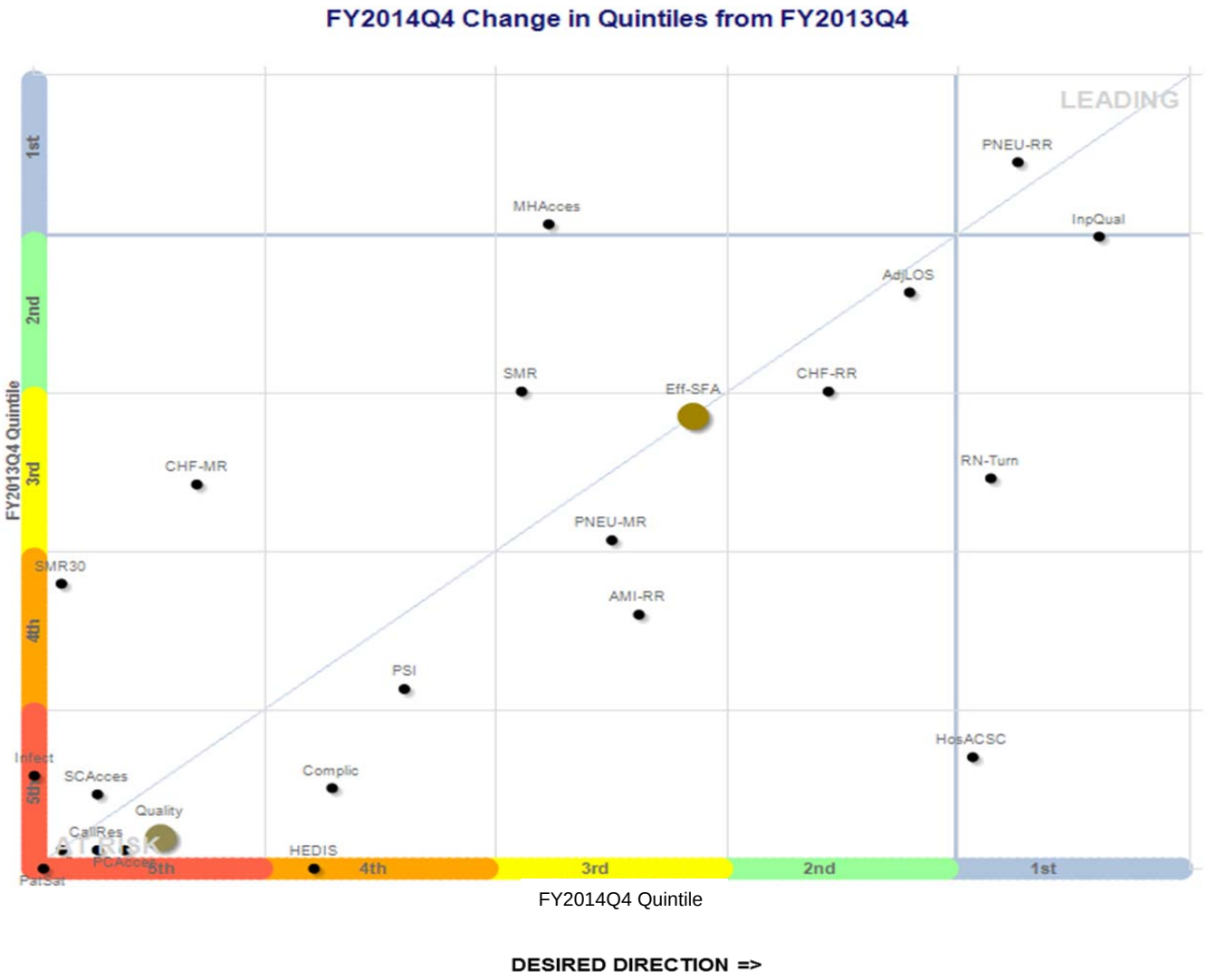
[1] All data is for FY 2015 through February 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 8, 2015

From: Acting Director, VA Southwest Health Care Network (10N18)

Subject: **CAP Review of the Phoenix VA Health Care System, Phoenix, AZ**

To: Director, San Diego Office of Healthcare Inspections (54SD)

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

1. I have reviewed and concur with the findings and recommendations in the CAP Review of the Phoenix VA Health Care System, Phoenix, AZ.

2. If you have any questions or concerns, please contact Jennifer Kubiak, VISN 18 Quality Management Officer, at 480-397-2781.

Kathleen R. Fogarty

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 30, 2015

From: Interim Director, Phoenix VA Health Care System (644/00)

Subject: **CAP Review of the Phoenix VA Health Care System, Phoenix, AZ**

To: Acting Director, VA Southwest Health Care Network (10N18)

1. Please find the facility response regarding the Office of Inspector General Combined Assessment Program (CAP) review conducted on March 9–13, 2015. Implementation and subsequent actions are currently being completed.

2. If you have any questions, please contact Michelle Bagford, Chief, Quality, Safety and Improvement, at (602) 277-5551 extension 6092.

GLEN W. GRIPPEN
Interim 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 Surgical Work Group include the Chief of Staff as a member.

Concur

Target date for completion: June 30, 2015

Facility response: The Chief of Staff is now included in the Surgery Work Group (Surgery Staff Meeting) held on the third Wednesday of every month. Attendance will be recorded each month to ensure compliance. A formal Charter is being developed to define the responsibility of the Surgery Work Group.

Recommendation 2. We recommended that facility managers ensure employees receive training on chemical labeling/safety data sheets.

Concur

Target date for completion: July 31, 2015

Facility response: Annual training regarding chemical labeling/safety data sheets is required of all staff. Managers are responsible for tracking staff completion of required training. As training for this mandatory educational program has not been consistently monitored in the past, completion rates fell below an acceptable level of 90%. In response to this temporary lapse, training completion will be tracked by the Environment of Care Committee and reported to the Administrative Executive Board on a quarterly basis.

Recommendation 3. 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: July 31, 2015

Facility response: On March 23, 2015, the MRI Safety Screening Form was modified to facilitate the documentation of resolution to safety contraindications. The modified MRI Safety Screening Form was approved by the MRI Safety Committee on April 6, 2015. On April 16, 2015 Level II MRI personnel were re-educated on the new MRI Safety Screening form, emphasizing the correct process for identifying and documenting any possible contraindications. The MRI Safety Officer will conduct

30 patient record audits monthly for evidence that contraindications were supported in the documentation of the revised MRI Safety Screening Form with an expectation that the facility will maintain 90% compliance for four months beginning April 1, 2015. Data will be reported and discussed with corrective actions addressed, if applicable, at the MRI Safety Committee.

Recommendation 4. We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: On March 23, 2015, the MRI Safety Policy was reviewed and revised to identify MRI Level I staff. On April 22, 2015, all MRI Level I staff had MRI Safety training added to the Talent Management System (TMS). All MRI Level I staff shall have current safety training on file and are required to maintain this requirement annually. The MRI Safety Officer will conduct quarterly MRI Safety Training audits to ensure compliance with MRI Safety Training with a goal of 90% compliance. Staff failing to meet the requirement will be reported to the Chief of the Radiology Department to prevent access to the MRI Zone III areas.

The MRI Safety Officer is reviewing the list of staff who are currently assigned and should be assigned MRI Level I Safety training. This review will be completed by May 8, 2015 and training will be assigned/unassigned as appropriate. As of May 1, 2015, 94% (425 of 450) staff, to whom the training was assigned, have completed the TMS training module. Supervisors will also be notified so action is taken to ensure staff education is completed.

Recommendation 5. 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: December 2015

Facility response: On March 13, 2015, the Chief Health Information Officer (CHIO) placed a note template into Emergency Department (ED) documentation templates for patients presenting with stroke symptoms. The Chief of the ED educated physician staff of the need to complete NIHSS documentation in the acute ischemic stroke (AIS) progress note template on March 20, 2015. The AIS template will ensure the facility is compliant with NIHSS guidance for the monitoring of stroke care.

On a monthly basis, Quality Management will monitor 100% of AIS cases presenting to the ED to ensure ED clinicians complete and document the AIS progress note template. We will monitor performance with a goal of 90% compliance with sustainment for two

consecutive quarters. The results of the audit will be reported to the facility Stroke Committee and to the Clinical Executive Board (CEB) on a quarterly basis.

Recommendation 6. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: December 2015

Facility response: The ED Nurse Manager directed ED staff nurses to complete the dysphagia screen for all indicated patients prior to March 27, 2015. The CHIO placed the dysphagia screen into ED documentation templates on April 27, 2015. The Quality Manager completes monthly monitoring of patients presenting to the ED as part of the acute ischemic stroke (AIS) audit which includes a dysphagia screen.

100% of acute ischemic stroke (AIS) cases presenting to the ED will be audited by Quality Management on a monthly basis to ensure clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance. The dysphagia screen is included in the AIS screen. We will monitor performance with a goal of 90% compliance with sustainment for two consecutive quarters. The results of the audit will be reported to the facility Stroke Committee and to the Clinical Executive Board (CEB) on a quarterly basis.

Recommendation 7. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: December 2015

Facility response: The Chief of the Emergency Department and ED Nurse Manager directed ED physician and nursing staff to print and document the delivery of patient education materials. The education materials were incorporated into clinician templates to ensure consistency in the process. On March 13, 2015, the CHIO ensured staff have the ability to print the educational materials directly from ED documentation templates.

The Quality Manager completes monthly monitoring of 100% of acute ischemic stroke (AIS) patients presenting to the ED to ensure clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance. Delivery of the educational material to the patient is included in the AIS screen. We will monitor performance with a goal of 90% compliance with sustainment for two consecutive quarters. This information is reported by the facility Stroke Committee to the CEB on a quarterly basis.

Recommendation 8. We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.

Concur

Target date for completion: December 2015

Facility response: Educational materials were developed for staff from the National Institute of Health documentation on stroke education. Appropriate clinical staff were identified who needed the training including physicians, nurses, physical therapists, occupational therapists, and speech therapists. Training completion is tracked by the Education Department and reported to the CEB as part of a quarterly report to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance. The facility goal is for identified staff to complete the NIH Stroke Education training course with no less than 120 days of compliance above 90%.

Recommendation 9. 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: December 2015

Facility response: The Quality Manager completes monthly monitoring of 100% of acute ischemic stroke (AIS) patients presenting to the ED. The documentation template was modified in February 2014 to include all elements of NIHSS stroke clinical guidelines. This information is captured in the medical record AIS progress note template and will be reported by the facility Stroke Committee to the CEB on a quarterly basis. The data has been added as a standing quarterly report from Stroke Committee to CEB.

The facility will report the results of audits for: (1) the percent of eligible patients given tissue plasminogen activator, (2) the percent of patients with stroke symptoms who had the stroke scale completed, and (3) the percent of patients screened for difficulty swallowing before oral intake to Veterans Integrated Service Network 18 on a quarterly basis to ensure compliance of each clinical indicator with a goal of 90% compliance with sustainment for 2 consecutive quarters.

Recommendation 10. We recommended that clinicians obtain cardiac markers, partial thromboplastin time, and an electrocardiogram while assessing patients presenting with stroke symptoms and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015 (Completed)

Facility response: AIS order sets were developed in February 2014 by the Chief of ED. All required laboratory tests are a component of that order set. As of March 31, 2015, the facility has completed the required tests 100% of the time on 100% of patients presenting with AIS to the ED.

The facility will provide documentation of the 100% compliance with the completed order sets during the first quarterly update document submission. Note: The OIG reviewed medical records from 2013. The records and results therein were performed prior to development of the current order set for required AIS laboratory tests as part of the facilities internal performance improvement program.

Recommendation 11. We recommended that facility managers ensure that medicine/telemetry unit employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists.

Concur

Target date for completion: April 24, 2015 (Completed)

Facility response: Cardiology and 4C nursing staff completed EKG competency assessment and validation for all employees on May 1, 2015, through mannequin simulation for 4C nursing employees. 100% of 4C RNs were given a written test and a simulation test which verified competency in recognizing ST elevations and depressions and staff know they are to notify providers if these are noted on EKG. The testing of competency of the nursing staff required a passing rate of 90%.

Office of Inspector General
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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.

[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.