Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00032-226

Combined Assessment Program Review of the VA Palo Alto Health Care System Palo Alto, California

April 30, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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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
ENT	otolaryngology
EOC	environment of care
facility	VA Palo Alto 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 February 23, 2015.

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

- Medication Management
- Coordination of Care
- Surgical Complexity
- Emergency Airway Management

The facility's reported accomplishment was the otolaryngology telehealth program.

Recommendations: We made recommendations in the following four activities:

Quality Management: Establish a committee to provide oversight of the safe patient handling program.

Environment of Care: Ensure that employees receive training on chemical labeling/safety data sheets and that all designated critical care and community living center employees receive annual bloodborne pathogens training. Store clean and dirty items separately. Ensure personal protective equipment gowns, eye protection, and masks are available in various sizes in patient care areas.

Magnetic Resonance Imaging Safety: Conduct initial patient safety screenings. Ensure Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to imaging. 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 required annual training.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on the critical care and medical/surgical units. Provide printed stroke education to patients at discharge. Report all required data elements to the Medical Executive Board. Obtain required laboratory tests while assessing patients presenting with stroke symptoms.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–31, for the full text of the Directors' comments.) We consider recommendation 11 closed. We will follow up on the planned actions for the open recommendations 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 February 27, 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 VA Palo Alto Health Care System, Palo Alto, California,* Report No. 13-00279-156, March 28, 2013).

During this review, we presented crime awareness briefings for 699 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 679 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

ENT Telehealth Program

The ENT section of Surgical Service is the first group in the country to use telehealth in the treatment of complicated head and neck cancers. The ENT telehealth program allows patients from as far as Fresno, CA, and Albuquerque, NM, to complete a majority of their work-up and follow-up in their homes and only travel to the facility for surgical procedures.

In 2012, the facility piloted the ENT telehealth program in Albuquerque, NM. By evaluating patients remotely, the ENT program saved New Mexico patients 2,000 miles of travel and $1,500 in airfare. The program later expanded to Fresno, CA, in 2014, and it has saved Fresno patients 3,300 miles of travel and 60 hours of driving time. For those patients relying on shuttle service for transportation, there was a reduction of 120 hours for shuttle use.

The facility's goal is to expand ENT telehealth efforts with Fresno, continue with Albuquerque during less busy months, and consider providing this service to Reno and the Santa Cruz regions.

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 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
	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.		
	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The facility did not have a committee that provided oversight of the safe patient handling program.	**1.** We recommended that the facility establish a committee to provide oversight of the safe patient handling program.
	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 medical/surgical, the MH, the spinal cord injury, one critical care, and two CLC units; the Emergency Department; and a primary care clinic. We also performed a perimeter inspection of the endoscopy suite renovation construction site. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 34 employee training records (10 critical care and 24 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.		
	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.	• Twenty-four employee training records (71 percent) 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
X	The facility met infection prevention requirements.	• Two of five patient care areas had clean and dirty items stored together. • Three of five patient care areas did not have personal protective equipment gowns, eye protection, and masks available in various sizes.	**3.** We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance. **4.** We recommended that facility managers ensure personal protective equipment gowns, eye protection, and masks are available in various sizes in patient care areas and monitor compliance.
	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.	• One of the 10 critical care employees did not receive bloodborne pathogens training during the past 12 months.	**5.** We recommended that facility managers ensure all designated critical care and community living center 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.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	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.		
	Areas Reviewed for CLC		
X	Designated CLC employees received bloodborne pathogens training during the past 12 months.	• Five of the 24 CLC employees did not receive bloodborne pathogens training within the past 12 months.	See recommendation 5.
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	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.		
X	The facility met infection prevention requirements in the CLC.	• Neither of the two CLC units had personal protective equipment gowns, eye protection, and masks available in various sizes.	See recommendation 4.
	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.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	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 a CLC, a medicine, and a critical care unit and the Emergency Department and for these areas reviewed documentation of overrides and 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 38 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) employee safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 39 employees (30 randomly selected Level 1 ancillary staff and nine 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 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.		
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.	• Twenty-two of the 35 EHRs (63 percent) did not contain initial patient safety screenings. • Level 2 MRI personnel did not sign 24 of the 33 secondary patient safety screening forms (73 percent) prior to MRI.	**6.** We recommended that the facility conduct initial patient safety screenings prior to magnetic resonance imaging and that facility managers monitor compliance. **7.** We recommended that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms 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.	• None of the applicable 20 EHRs contained documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**8.** 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.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• Seventeen Level 1 ancillary staff (57 percent) did not receive level-specific annual MRI safety training.	**9.** 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.
	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 34 patients who experienced stroke symptoms, and 10 Emergency Department employee training records, and we conversed with key employees. We also conducted onsite inspections of the telemetry unit, two medical/surgical and two critical care 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 within the expected timeframe.	• For 20 of the 27 applicable patients, clinicians did not document evidence of completion of stroke scales.	**10.** 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.		
X	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.	• Facility managers had not posted stroke guidelines on one critical care and the two medical/surgical units.	**11.** We recommended that facility managers post stroke guidelines on the critical care and medical/surgical units.
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 25 applicable patients' EHRs contained documentation that clinicians provided stroke education to the patients/caregivers.	**12.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	• The facility did not report the following data to the Medical Executive Board: 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	**13.** We recommended that the facility report to the Medical Executive Board 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) prothrombin time/international normalized ratio, and (3) partial thromboplastin time. Of the 32 applicable patients: • For seven patients (22 percent), clinicians did not document markers of cardiac levels. • For five patients (16 percent), clinicians did not document prothrombin time/international normalized ratio. • For 25 patients (78 percent), clinicians did not document partial thromboplastin time levels.	**14.** We recommended that clinicians obtain cardiac markers, prothrombin time/international normalized ratio, and partial thromboplastin time 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. 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 defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	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.

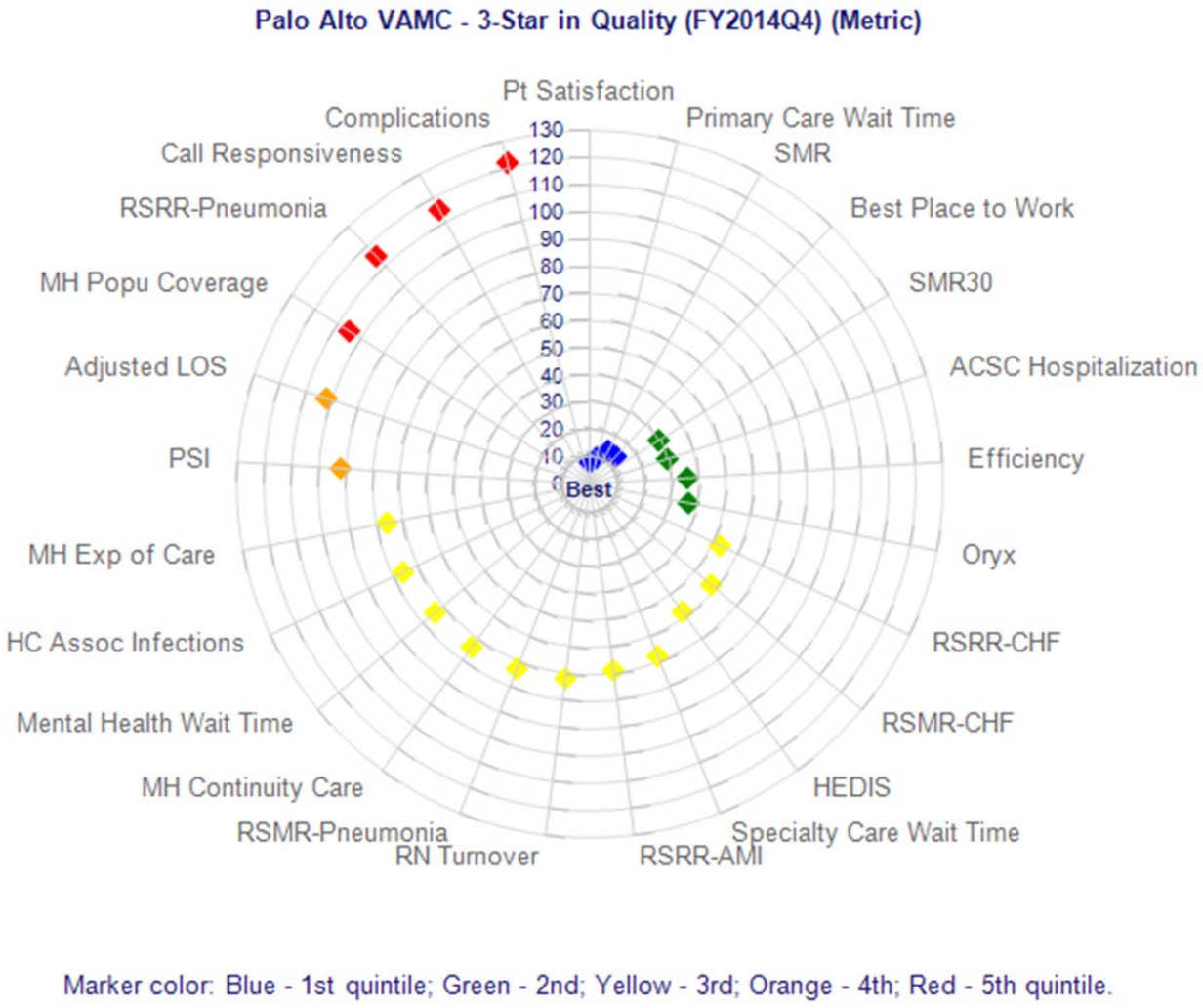
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated 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 (Palo Alto/640) FY 2015 through January 2015[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$913
Number (as of February 15, 2015) of:	
• **Unique Patients**	48,679
• **Outpatient Visits**	287,296
• **Unique Employees**[2]	4,081
Type and Number of Operating Beds:	
• **Hospital**	266
• **CLC**	360
• **MH**	172
Average Daily Census:	
• **Hospital**	175
• **CLC**	264
• **MH**	138
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	San Jose/640BY Capitola/640GA Sonora/640GB Fremont/640GC Stockton/640HA Modesto/640HB Monterey/640HC
Veterans Integrated Service Network Number	21

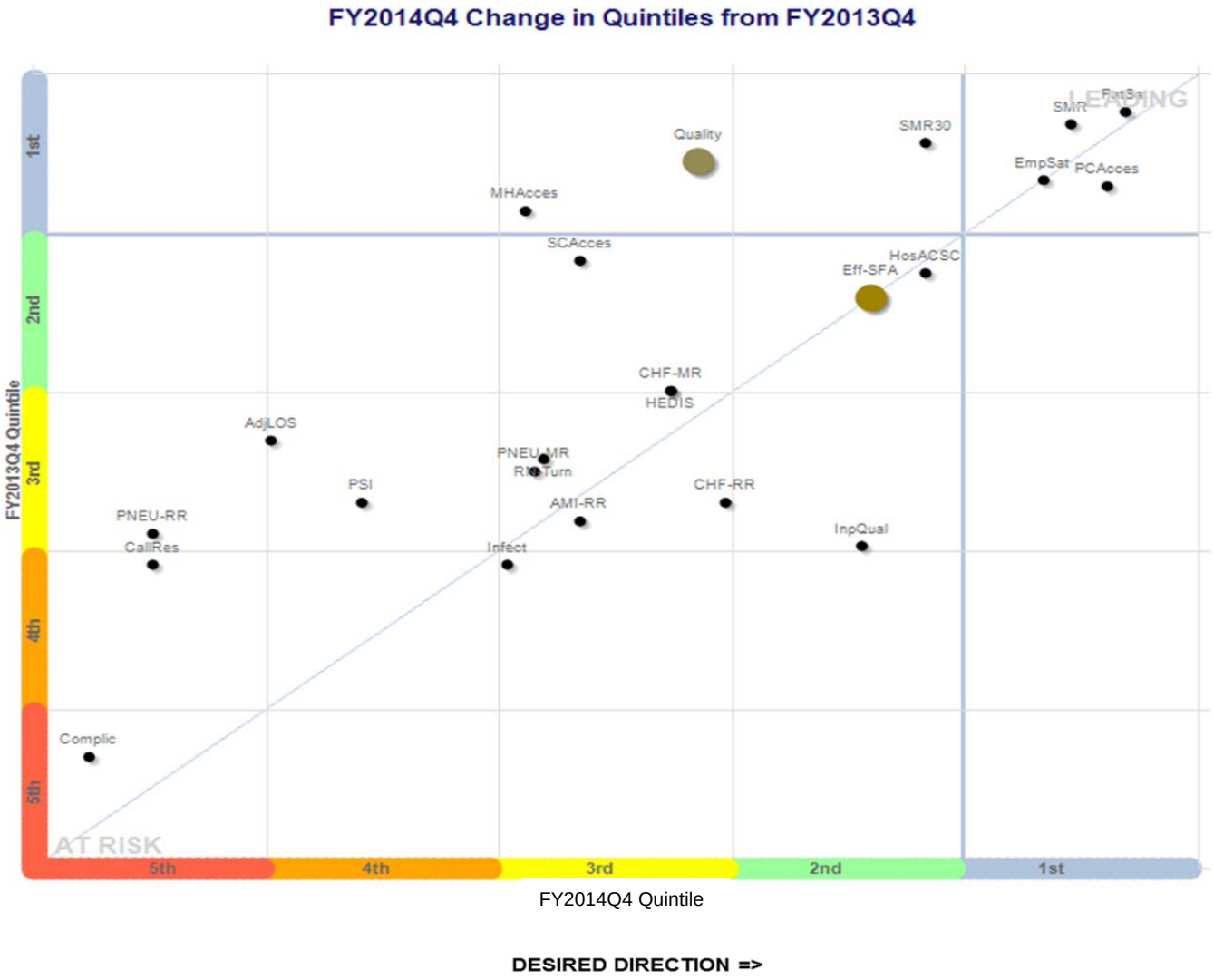
[1] All data is for FY 2015 through January 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: April 16, 2015

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Palo Alto Health Care System, Palo Alto, CA**

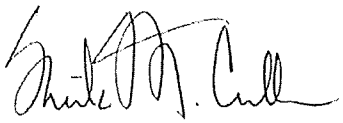
To: Director, San Diego Office of Healthcare Inspections (54SD)

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

1. Thank you for allowing Palo Alto Leadership to review the draft recommendations for the site visit conducted by your office.

2. The Facility agreed with your findings and developed a corrective action plan which is attached.

3. Should you have any questions please feel free to contact Terry Sanders, Associate Quality Manager for Network 21 at (707) 562-8370.



Sheila M. Cullen

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 14, 2015

From: Director, VA Palo Alto Health Care System (640/00)

Subject: **CAP Review of the VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations for the OIG CAP Review conducted at the VA Palo Alto Health Care System during February 23–27, 2015.

2. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing, actions to resolve these issues.

Elizabeth Joyce Freeman
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 facility establish a committee to provide oversight of the safe patient handling program.

Concur

Target date for completion: April 20, 2015

Facility response: A Safe Patient Handling & Mobility Committee (SPH&MC) was in existence at the time of the OIG Survey, but had not met for 14 months during the time when the duties of the Safe Patient Handling & Mobility Coordinator were being performed by employee acting in the role as a collateral duty. The Safe Patient Handling & Mobility Coordinator position was filled in December 2014 and the committee reinstituted in March 2015. The committee met March 30, 2015, with future meetings scheduled quarterly. The data gathered by the committee during the March meeting will be presented to the Environment of Care Committee (EOCC) April 20, 2015 and quarterly thereafter.

Recommendation 2. 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: All Health Care System employees have been assigned the Globally Harmonized System for Hazard Communications TMS module. The target is for 100% of employees to complete the training by July 1, 2015. Additionally, hazardous material inventories and Safety Data Sheets (SDSs) are available through a link on the VAPAHCS intranet home page. Monitoring for compliance with the training requirement will be performed by the Industrial Hygienist and reported monthly the (EOCC).

Recommendation 3. We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: The Environmental Management Service (EMS) and Nursing will create a process that will prevent hampers with soiled linen being taken into patient rooms. The Chief, EMS will conduct ongoing surveillance, beginning May 1, 2015 and

report compliance data to the Infection Control Committee on a monthly basis beginning June 2015.

Recommendation 4. We recommended that facility managers ensure personal protective equipment gowns, eye protection, and masks are available in various sizes in patient care areas and monitor compliance.

Concur

Target date for completion: July 15, 2015

Facility response: A taskforce, led by infection control, has been formed and charged with responsibility of determining the proper storage solution for PPE and location of units on all nursing units. The solution will be implemented no later than July 15, 2015. The taskforce will monitor the installation of storage and report progress bi-monthly to Infection Control Committee. Unit Managers will monitor PPE stocks and report compliance with ready availability to PPE to the Infection Control Committee bi-monthly, through the taskforce leader.

Recommendation 5. We recommended that facility managers ensure all designated critical care and community living center employees receive annual bloodborne pathogens training and monitor compliance.

Concur

Target date for completion: May 31, 2015

Facility response: As of April 10, 2015, 100% of Critical Care and 97% of Community Living Center (CLC) employees had completed annual blood borne pathogens training. The 7 remaining CLC employees have received reminders regarding the necessity to complete the training no later than May 31, 2015. Department managers will ensure that employees have completed annual training. Compliance with training requirements will be reported to Environment of Care Committee on a quarterly basis beginning July 2015.

Recommendation 6. We recommended that the facility conduct initial patient safety screenings prior to magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: Initial screening is performed by the radiology scheduling section at the time the MRI is scheduled with the Veteran. The Chief Radiologic Technologist reviews 100% of all MRI requests to determine if initial screening has occurred. Data regarding compliance with this requirement is collected by the Chief Radiologic Technologist and shared with the Chief, Radiology Section on a monthly basis.

Recommendation 7. We recommended that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings sign the forms prior to magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: A signature block has been added to screening forms as a reminder to MRI Level 2 personnel to acknowledge that the screening form has been reviewed and information verified. 100% of screening forms are reviewed by the Chief Radiologic Technologist to ensure the forms have been signed. Data regarding compliance with this requirement is collected by the Chief Radiologic Technologist and shared with the Chief, Radiology Section on a monthly basis.

Recommendation 8. 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: Completed

Facility response: The screen forms have been amended to include all MRI contraindications and includes a requirement that the technologist and radiologist document that (1) all potential contraindication have been addressed and the patient is cleared to proceed with the procedure and (2) pre-MRI the Veteran's orbit has been determined to be free of metallic foreign body by radiologist. Once completed the screening forms are scanned into the Veteran's electronic health record. Data regarding compliance with this requirement is collected by the Chief Radiologic Technologist and shared with the Chief, Radiology Section on a monthly basis.

Recommendation 9. 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: May 31, 2015

Facility response: All personnel as required by VHA Handbook1105.05 have been assigned the MRI Level 1 TMS module. Data regarding compliance with this requirement is collected by the Chief Radiologic Technologist and shared with the Chief, Radiology Section on a monthly basis.

Recommendation 10. 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: August 15, 2015

Facility response: All clinicians have received instruction regarding requirements for documentation of stroke scales. The Chief, Neurology Section will monitor compliance for each patient who presents with criteria of a stroke outlined in VHA Directive 2011-038 and report data quarterly to the Medical Executive Board beginning July 2015.

Recommendation 11. We recommended that facility managers post stroke guidelines on the critical care and medical/surgical units.

Concur

Target date for completion: Completed

Facility response: All clinical areas where patients may present with stroke symptoms now have stroke guidelines posted.

Recommendation 12. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: August 15, 2015

Facility response: Printed stroke education is available for all patients at discharge. Discharge planner will provide this education to patients and document in the medical record. The Chief, Neurology Section will monitor compliance and report this data to the Medical Executive Board on a quarterly basis, beginning July 2015.

Recommendation 13. We recommended that the facility report to the Medical Executive Board 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: August 15, 2015

Facility response: A process has been established to collect data regarding the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and/or the percent of patients

screened for difficulty swallowing before oral intake which will be presented by the Chief, Neurology Section to the Medical Executive Board on a quarterly basis, beginning July 2015.

Recommendation 14. We recommended that clinicians obtain cardiac markers, prothrombin time/international normalized ratio, and partial thromboplastin time while assessing patients presenting with stroke symptoms and that facility managers monitor compliance.

Concur

Target date for completion: October 1, 2015

Facility response: Standard order sets will be created to ensure that clinicians obtain cardiac markers, prothrombin time/international normalized ratio, and partial thromboplastin time while assessing patients presenting with stroke symptoms. The order sets will be completed and implemented by July 1, 2015. The Chief, Neurology Section will monitor compliance and report this data to the Medical Executive Board on a quarterly basis, beginning July 2015.

Office of Inspector General
Contact and Staff Acknowledgments

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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.

[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.