Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00378-202

Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, West Virginia

May 30, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Louis A. Johnson VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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 11, 2013.

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

- Medication Management – Controlled Substances Inspections
- Long-Term Home Oxygen Therapy
- Preventable Pulmonary Embolism

The facility's reported accomplishments were collaborating with the Clarksburg Mission to establish transitional housing for returning female veterans and increasing the telehealth services offered at the facility.

Recommendations: We made recommendations in the following four activities:

Quality Management: Revise the local observation bed policy to include all required elements, and gather data about observation bed use.

Environment of Care: Ensure that all fire extinguishers have signs in accordance with National Fire Protection Association standards and that construction workers remove cardboard boxes in the outpatient pharmacy or store them off the floor.

Coordination of Care – Hospice and Palliative Care: Ensure that the Palliative Care Consult Team includes a dedicated administrative support person and that all hospice and palliative care staff and other clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Nurse Staffing: Implement the mandated staffing methodology for nursing personnel.

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 15–19, for the full text of the Directors' comments.) We consider recommendations 4 and 5 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

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism

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 2012 and FY 2013 through February 11, 2013, 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 Louis A. Johnson VA Medical Center, Clarksburg, West Virginia, Report* No. 09-01685-154, June 30, 2009). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 35 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 210 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

Transitional Housing for Homeless Female Veterans

The facility, in conjunction with the Clarksburg Mission, identified a need for transitional housing for returning female veterans. The facility worked with the Clarksburg Mission to transform the second floor of the mission into an area designed to house three female veterans. A local artist helped to decorate and design the area, which includes a bedroom, living room, kitchen, bathroom, and laundry area. Additionally, the Clarksburg Mission provides an area for eight male veterans.

Telehealth

The facility's telehealth program was expanded this year to provide better access and care to rural veterans. The facility established a telehealth amputee program with VA Butler Healthcare; tele-insomnia with the Philadelphia VA Medical Center; and a telehealth traumatic brain injury program with the Lebanon and Huntington VA Medical Centers. In addition, telehealth services to the community based outpatient clinics have expanded to include tele-nutrition, TeleMOVE, tele-coumadin, tele-post-traumatic stress disorder exposure therapy, and telehealth promotion and disease prevention. The addition of these programs has decreased the need for veterans living in extremely rural areas to travel long distances for care, increased the availability of specialty services, and allowed more veterans to receive the care they need closer to home.

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 complied with selected requirements within its QM program.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include a clear delineation of the responsible service or physician, assessment expectations, a focused goal, limited severity of illness, or clinical conditions appropriate for observation.
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	• The facility did not gather observation bed use data.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	

NC	Areas Reviewed (continued)	Findings
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the local observation bed policy be revised to include all required elements.

2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

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.[2]

We inspected medicine-surgery, same day surgery, mental health, the intensive care unit, the CLC, the oncology clinic, the women's health clinic, the emergency department, the outpatient pharmacy, and two physical medicine and rehabilitation therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
X	Fire safety requirements were met.	• Three fire extinguishers did not have signage identifying the location of the extinguishers. This was a repeat finding from the previous CAP review.
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• Construction activities in the outpatient pharmacy resulted in workers leaving cardboard boxes that contained building materials on the floor throughout the area.
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

NC	Areas Reviewed for the Women's Health Clinic	Findings
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
NA	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

3. We recommended that the all fire extinguishers have signage in accordance with National Fire Protection Association standards.

4. We recommended that processes be strengthened to ensure that construction workers remove cardboard boxes in the outpatient pharmacy promptly or store them off the floor.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from 7 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 10 HPC staff, there was no evidence that 2 had end-of-life training. • Of the 15 non-HPC staff, there was no evidence that 14 had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	

NC	Areas Reviewed (continued)	Findings
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

5. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

6. We recommended that processes be strengthened to ensure that all HPC staff and other clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 11 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).[6]

We reviewed relevant documents and interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
X	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	• The facility had not implemented the mandated staffing methodology for nursing personnel.
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that the facility implement the mandated staffing methodology for nursing personnel.

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and eight EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Facility Profile (Clarksburg/540) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$166.7
Number of:	
• **Unique Patients**	22,566
• **Outpatient Visits**	263,803
• **Unique Employees[c] (as of last pay period in FY 2012)**	639
Type and Number of Operating Beds:	
• **Hospital**	51
• **CLC**	27
• **Mental Health**	21
Average Daily Census: (through August 2012)	
• **Hospital**	39
• **CLC**	24
• **Mental Health**	14
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Tucker County/540GA Wood County/540GB Gassaway-Braxton County/540GC Monongalia County/540GD
VISN Number	4

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	75.3	74.5	64.4	60.1	63.4	72.8
VISN	66.9	65.4	59.5	60.5	59.3	60.8
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	16.1	10.2	12.4	21.2	23.2	18.3
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[d] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[e] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 23, 2013

From: Director, VA Healthcare Network (10N4)

Subject: **CAP Review of the Louis A. Johnson VA Medical Center, Clarksburg, WV**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

I have reviewed the information provided by the Louis A. Johnson Medical Center and I am submitting it to your office as requested. I concur with all responses and target dates.

If you have any questions or require additional information, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

(original signed by:)
Michael E. Moreland, FACHE

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 23, 2013

From: Director, Louis A Johnson VA Medical Center (540/00)

Subject: **CAP Review of the Louis A. Johnson VA Medical Center, Clarksburg, WV**

To: Director, VA Healthcare Network (10N4)

The findings from the Louis A. Johnson VA Medical Center Combined Assessment Program (CAP) review by the Office of the Inspector General (OIG) conducted the week of February 11, 2013 have been reviewed.

Attached are the facility responses addressing each recommendation including actions that are in progress and those that have already been completed.

(original signed by:)
Beth Brown, MS, FACHE, VHA-CM

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 local observation bed policy be revised to include all required elements.

Concur

Target date for completion: June 28, 2013

Facility response: The facility will publish a policy statement that contains all elements required by VHA Directive 2010-011 dated March 4, 2010, Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds.

Recommendation 2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: June 28, 2013

Facility response: The facility will implement a process to appropriately monitor observation bed usage, analyze the data related to observation usage, and establish a quarterly topical report that analyzes the appropriateness of observation bed usage. Observation bed usage report will be submitted for discussion/oversight to the facility Medical Executive Council (MEC). MEC oversight will be reported to the facility Executive Leadership Board.

Recommendation 3. We recommended that the all fire extinguishers have signage in accordance with National Fire Protection Association standards.

Concur

Target date for completion: June 3, 2013

Facility response: Fire extinguisher signage was rectified for the three locations identified by February 14, 2013. Fire extinguisher signage validation has been added to the weekly Environment of Care review and checklist. Signage compliance will be reported monthly for 6 months, then quarterly to the facility Environment of Care Committee.

Recommendation 4. We recommended that processes be strengthened to ensure that construction workers remove cardboard boxes in the outpatient pharmacy promptly or store them off the floor.

Concur

Target date for completion: May 1, 2013

Facility response: This finding addresses boxes in the installation area during the active installation of cabinetry. The facility will implement a plan to communicate a reminder to all contractors regarding the presence of cardboard boxes during project installations. Additionally, Environment of Care rounds will continue to include the monitoring of inappropriate use of cardboard boxes throughout the facility.

Recommendation 5. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: March 15, 2013

Facility response: A 0.25 FTEE dedicated administrative support person was assigned to the Palliative Care Consult Team effective March 15, 2013.

Recommendation 6. We recommended that processes be strengthened to ensure that all HPC staff and other clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: June 28, 2013

Facility response: The organization will develop and implement a plan to meet the Hospice and Palliative Care education requirement for all staff who interact with end of life Veterans, specifically the staff assigned to Community Living Center, Intensive Care Unit, and the Emergency Department. Additionally, all staff in the above listed areas will receive the required education with documentation.

Recommendation 7. We recommended that the facility implement the mandated staffing methodology for nursing personnel.

Concur

Target date for completion: July 31, 2013

Facility response: Develop and document the appropriate processes to ensure that each phase of the Nurse Staffing Methodology is completed for all care units. The phases that will be implemented include: Data collection phase by April 12, 2013;

Recommendations submitted by Unit-Expert Based Panels by May 31, 2013; Review of facility Expert Panel by June 30, 2013; and Review by Facility Leadership with implementation roll out by July 31, 2013.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Gail Bozzelli, RN, Team Leader Bruce Barnes Myra Conway, RN Katharine Foster, RN Donna Giroux, RN Randall Snow, JD Natalie Sadow-Colón, MBA, Program Support Assistant Timothy Barry, Special Agent, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare Network (10N4)
Director, Louis A. Johnson VA Medical Center (540/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Joe Manchin, III; John D. Rockefeller, IV
U.S. House of Representatives: David McKinley

This report is available at www.va.gov/oig.

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Directive 2008-007, *Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, February 4, 2008; VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1330.01, Health Care Services for Women Veterans, May 21, 2010.
- VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic were:
- VHA Directive 2006-021, *Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected*, May 1, 2006.
- VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] The reference used for this topic was:

- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80–98.