Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00887-204

Combined Assessment Program Review of the Marion VA Medical Center Marion, Illinois

May 20, 2013

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
CPRS	Computerized Patient Record System
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Marion 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 March 18, 2013.

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

- Environment of Care
- Medication Management – Controlled Substances Inspections
- Long-Term Home Oxygen Therapy
- Nurse Staffing

The facility's reported accomplishments were organizational trust development and a veteran centered approach to decision making.

Recommendations: We made recommendations in the following three activities:

Quality Management: Revise the local observation bed policy to include all required elements. Require that code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the codes. Include all services in the review of electronic health record quality. Revise the local blood usage policy to define criteria for the appropriateness of transfusions. Ensure the blood usage review process includes consistent reporting of transfusion appropriateness; the number of units outdated or discarded; and results of proficiency testing, peer reviews, and inspections.

Coordination of Care – Hospice and Palliative Care: Ensure that hospice and palliative consult responses are attached to the consult request in the Computerized Patient Record System.

Preventable Pulmonary Embolism: Initiate protected peer review for the two identified patients, and complete any recommended review actions.

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 16–19, for the full text of the Directors' comments.) We consider recommendation 1 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 2011, FY 2012, and FY 2013 through March 21, 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 Marion VA Medical Center, Marion, Illinois,* Report No. 08-03083-17, November 2, 2009).

During this review, we presented crime awareness briefings for 30 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 211 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

Organizational Trust Development

To achieve a culture of change in the organization, the Facility Director initiated weekly meetings with 37 facility senior leaders to discuss issues that negatively created organizational trust "taxes." All of the senior leaders had attended *Leading at the Speed of Trust*™ workshops. To further the change in the organization and in an effort to increase trust, the opportunity was extended to all supervisors. Staff ideas were requested and received on systems and processes that could improve organizational trust. As a result, seven work groups that consisted of staff, management, and union representatives developed and recommended solutions for improvements. More than 200 ideas were analyzed and researched for possible implementation. From these ideas, the facility implemented an electronic suggestion program to continue dialogue and improve trust between staff and leadership.

Veteran Centered Approach to Decision Making – "The Empty Chair"

Facility leaders implemented a veteran centered approach to decision making called the "The Empty Chair." This concept was developed after receiving a poem entitled *The Empty Chair* from one of their veterans. In each conference room, there is an empty chair with the poem attached as a reminder that staff are representing veterans and that every decision made will impact a life. Before each meeting, the chairperson acknowledges the empty chair and reminds members of their responsibility to veterans.

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 how the physician responsible for the patient is determined and that each admission must have a limited severity of illness.
	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.	
	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.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Four quarters of Critical Care Committee meeting minutes reviewed: • There was no consistent documentation that code reviews included screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.

NC	Areas Reviewed (continued)	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Four quarters of EHR Committee meeting minutes reviewed: • Not all services were included in review of EHR quality.
	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.	
X	Use and review of blood/transfusions complied with selected requirements.	Four quarters of the Blood Transfusion Committee meeting minutes reviewed: • The review process did not include consistent reporting of required data, such as the number of transfusions reviewed against criteria for appropriateness and the number of units outdated or discarded; results of proficiency testing; results of peer reviews; and results of inspections.
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	• Local policy did not define criteria for appropriateness of transfusions.

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 code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the codes.

3. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

4. We recommended that the local blood usage policy be revised to define criteria for appropriateness of transfusions and that processes be strengthened to ensure that the blood usage review process includes consistent reporting of transfusion appropriateness; the number of units outdated or discarded; and results of proficiency testing, peer reviews, and inspections.

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 inpatient units (acute care, CLC, and intensive care), outpatient clinics (occupational/physical therapy, primary care, specialty care, and speech therapy), and the emergency department. Additionally, we reviewed relevant documents and interviewed key employees and managers. 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 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.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	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.	
	Areas Reviewed for the Women's Health Clinic	
	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.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	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.	
	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.	

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 all CS Coordinators and 10 CS inspectors and inspection documentation from 10 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 21 employee training records (6 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 area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff 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 CPRS.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
X	Consult responses were attached to HPC consult requests.	• Five consult responses were not attached to the consult request in the CPRS.
	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.	
	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.	

Recommendation

5. We recommended that processes be strengthened to ensure that HPC consult responses are attached to the consult request in the CPRS.

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 32 EHRs of patients enrolled in the home oxygen program (including 2 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 23 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 3M and the CLC unit for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. 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
	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.	
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	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.	

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 seven 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. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	• One patient was identified as having potentially preventable pulmonary embolism because the patient had risk factors and had not been provided anticoagulation medication.
X	No additional quality of care issues were identified with the patients' care.	• One patient was identified as having a potentially preventable deep vein thrombosis and had not been provided anticoagulation medication.
	The facility complied with any additional elements required by VHA or local policy/protocols.	

Recommendation

6. We recommended that managers initiate protected peer review for the two identified patients and complete any recommended review actions.

[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 (Marion/657A5) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$287.4
Number of:	
• **Unique Patients**	43,550
• **Outpatient Visits**	426,604
• **Unique Employees**[c]	817
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	39
• **CLC**	60
• **Mental Health**	14
Average Daily Census: (through August 2012)	
• **Hospital**	21
• **CLC**	50
• **Mental Health**	13
Number of Community Based Outpatient Clinics	10
Location(s)/Station Number(s)	Evansville, IL/657GJ Mt. Vernon, IL/657GK Paducah, KY/657GL Effingham, IL/657GM Hanson, KY/657GO Owensboro, KY/657GP Vincennes, IN/657GQ Mayfield, KY/657GR Carbondale, IL/657GT Harrisburg, IL/657GU
VISN Number	15

[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	62.6	75.0	47.8	55.8	49.6	50.7
VISN	56.8	59.0	53.0	55.0	55.8	55.0
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	**	10.5	10.3	**	24.8	20.7
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[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.

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 30, 2013

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the Marion VA Medical Center, Marion, IL**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

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

I have reviewed and concur with the CAP review draft report recommendations and Marion VA Medical Center status response(s). Thank you for this opportunity of review as a process to ensure that we continue to provide exceptional care to our Veterans.

For additional questions, please feel free to contact Jimmie Bates, VISN 15 Quality Management Officer, at 816-701-3000 x3041.

William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 29, 2013

From: Director, Marion VA Medical Center (657A5/00)

Subject: **CAP Review of the Marion VA Medical Center, Marion, IL**

To: Director, VA Heartland Network (10N15)

Attached, please find the initial status response for the Combined Assessment Program Review of the Marion VA Medical Center.

I have reviewed and concur with the Office of Inspector General's findings. Thank you for this opportunity of review focused towards continuous performance improvement.

For additional questions, please feel free to contact Cheryl Sherrill, Quality Management Service Chief, at 618-993-4524.

Paul Bockelman

Paul Bockelman, FACHE
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

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

Concur

Target date for completion: March 21, 2013

The Medical Center Memorandum has been revised to include all the required elements. Recommend to close.

Recommendation 2. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the codes.

Concur

Target date for completion: March 21, 2013

Two subcommittees have been developed to conduct code reviews using the screening criteria listed in the VHA Directive 2008-063. An analysis of the information will be reported to the Critical Care Committee. Recommend to close.

Recommendation 3. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: June 1, 2013

The Medical Records Committee is working with clinical services to ensure reviews for each specialty are occurring. The services will provide a comprehensive report on a quarterly basis to the Medical Records Committee identifying any trends. Implementation of this recommendation is still in progress.

Recommendation 4. We recommended that the local blood usage policy be revised to define criteria for appropriateness of transfusions and that processes be strengthened to ensure that the blood usage review process includes consistent reporting of

transfusion appropriateness; the number of units outdated or discarded; and results of proficiency testing, peer reviews, and inspections.

Concur

Target date for completion: June 1, 2013

The Medical Center Memorandum is currently being revised to include the required review criteria.

Recommendation 5. We recommended that processes be strengthened to ensure that HPC consult responses are attached to the consult request in the CPRS.

Concur

Target date for completion: March 21, 2013

Education was provided to the HPC registered nurse and HPC nurse practitioner to ensure consult responses are attached to the consult. Monitoring of this process was implemented March 21, 2013, to ensure compliance. Recommend to close.

Recommendation 6. We recommended that managers initiate protected peer review for the two identified patients and complete any recommended review actions.

Concur

Target date for completion: April 25, 2013

Both protected peer reviews have been completed and will be presented in the May Peer Review meeting. Any recommended review actions will be sent through the established peer review process. Recommend to close.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	James Seitz, RN, MBA, Team Leader John Brooks, Office of Investigations Dorothy Duncan, RN, MHA Cindy Niemack-Brown, CMSW, LMHP Larry Selzler, MSPT Laura Snow, LMSW, MHCL
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Monika Gottlieb, MD Jerry Herbers, MD Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jennifer Whitehead Jarvis Yu, MS

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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.