Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00889-206

Combined Assessment Program Review of the Salem VA Medical Center Salem, Virginia

May 30, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CPR	cardiopulmonary resuscitation
CS	controlled substances
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Salem VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
IOW/IOW	Improving Our Work Is Our Work
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PE	pulmonary embolism
PR	peer review
QM	quality management
RAI/MDS	Resident Assessment Instrument Minimum Data Set
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 25, 2013.

Review Results: The review covered eight activities and one follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following two activities:

- Medication Management – Controlled Substances Inspections
- Coordination of Care – Hospice and Palliative Care

The facility's reported accomplishment was the Improving Our Work Is Our Work initiative to identify organizational improvement opportunities.

Recommendations: We made recommendations in the following six activities and in the follow-up area:

Quality Management: Require the Critical Care Committee to review each cardiopulmonary resuscitation episode. Continue to monitor the electronic health record copy and paste function. Consistently scan the results of non-VA purchased diagnostic tests into electronic health records. Ensure that the blood usage and review process includes the number of transfusions and number reviewed for appropriateness, the results of proficiency testing, peer reviews when transfusions did not meet criteria, and results of inspections by government or private entities. Require that when data analyses indicate problems or opportunities for improvement, actions taken are consistently followed to resolution in utilization management, outcomes of resuscitation, and Resident Assessment Instrument Minimum Data Set quality reviews.

Environment of Care: Ensure Environment of Care Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure. Require that the Infection Control Committee implements and documents actions to address high-risk areas and that minutes consistently reflect analysis of surveillance activities. Ensure floors, ventilation system outlets, and horizontal surfaces in patient care areas are clean, and monitor compliance. Routinely inspect mattresses, pillows, geri-chairs, and treatment table mats, and repair or remove from service those with compromised surfaces. Remove expired commercial supplies from patient care areas. Ensure Women's Health Clinic exit signage is properly oriented and visible from all hallways.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly. Require that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education is documented. Ensure the Home Respiratory Care Committee evaluates patient safety-related events for home oxygen patients and

planning for patients discontinued from home oxygen therapy to determine whether additional actions are warranted.

Nurse Staffing: Ensure all members of unit 4H/4J's expert panel receive the required training prior to the next annual staffing plan reassessment.

Preventable Pulmonary Embolism: Complete protected peer review for the identified patient and any recommended review actions.

Construction Safety: Ensure that the Construction Safety Committee oversees construction and renovation activities, that the policy outlining the responsibilities of the committee is followed, that the multidisciplinary team conducts site visits at the specified frequency, and that meeting minutes contain discussion of site conditions and any required follow-up. Conduct contractor tuberculosis risk assessments prior to construction project initiation. Ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes. Require that designated employees receive initial and/or refresher construction safety training, and monitor compliance.

Follow-Up on Emergency/Urgent Care Operations Issues: Ensure that emergency department staff document discharge instructions and evaluate patient and/or caregiver understanding of the instructions. Require the process for requesting and granting emergency department staff privileges to comply with Veterans Health Administration policy.

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 20–29, for the full text of the Directors' comments.) We consider recommendations 12 and 17 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 eight activities and one follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable PE
- Construction Safety
- Follow-Up on Emergency/Urgent Care Operations Issues

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 28, 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 Salem VA Medical Center, Salem, Virginia, Report No. 08-03077-04, October 6, 2009). We made repeat recommendations in QM and emergency/urgent care operations.

During this review, we presented crime awareness briefings for 157 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 245 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 Accomplishment

IOW/IOW

The facility is engaged in identifying organizational improvement opportunities through the IOW/IOW initiative. This initiative is aimed at transforming the facility towards a culture of continuous improvement. Projects are identified to improve work areas and to ensure front line staff members are closely involved in improvement efforts.

The facility educated staff members on the IOW/IOW initiative and then charged staff with leading projects which were aligned with the facility's strategic goals. The Facility Director encouraged staff members to be involved in at least one IOW/IOW project for FY 2013. The system redesign process was used to track projects. Successes and lessons learned from the initiatives are presented during quarterly town hall meetings. One IOW/IOW project resulted in the reduction of the myocardial perfusion stress test backlog from 8 weeks to 1 week.

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 PR process were reported to the PR Committee.	
	Focused Professional Practice Evaluations for newly-hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	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.	
X	The CPR review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Six months of Critical Care Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each CPR episode.
	There was an EHR quality review committee, and the review process complied with selected requirements.	

NC	Areas Reviewed (continued)	Findings
X	The EHR copy and paste function was monitored.	Twelve months of EHR Committee meeting minutes reviewed: • Copy and paste function monitoring did not begin until June 2012. This was a repeat finding from the previous CAP review.
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Thirty EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Fifteen test results (50 percent) were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Four quarters of the Blood Usage Committee meeting minutes reviewed: • Committee review did not include the number of transfusions and number reviewed for appropriateness, the results of proficiency testing, PRs when transfusion did not meet criteria, or results of inspections by government or private (peer) entities.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	Corrective actions were not consistently followed to resolution for utilization management, outcomes of resuscitation, and RAI/MDS quality reviews.
	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 processes be strengthened to ensure that the Critical Care Committee reviews each CPR episode.

2. We recommended that the facility continue to monitor the EHR copy and paste function.

3. We recommended that processes be strengthened to ensure that results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

4. We recommended that processes be strengthened to ensure that the blood usage and review process includes the number of transfusions and number reviewed for appropriateness,

the results of proficiency testing, PRs when transfusions did not meet criteria, and results of inspections by government or private (peer) entities.

5. We recommended that processes be strengthened to ensure that when data analyses indicate problems or opportunities for improvement, actions taken are consistently followed to resolution in utilization management, outcomes of resuscitation, and RAI/MDS quality reviews.

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 the ED; the primary care, women's health, surgical specialty, and dialysis clinic areas; the CLC physical therapy and hospital physical therapy, occupational therapy, and kinesiotherapy clinic areas; the medical and surgical intensive care and step down units; inpatient units 4H (surgery), 4J (medicine), 8-1 and 8-2 (MH); and the CLC. 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
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions were tracked to closure.
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	Infection control risk assessment and 6 months of Infection Control Committee meeting minutes reviewed: • Minutes did not reflect that actions were implemented to address high-risk areas.
X	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.	Six months of Infection Control Committee meeting minutes reviewed: • Minutes did not consistently reflect analysis of surveillance activities.
	The facility had a policy that detailed cleaning of equipment between patients.	
X	Patient care areas were clean.	• All units/areas inspected had dirty floors, ventilation system outlets, and horizontal surfaces.
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• On the inpatient MH units, we found multiple mattresses, a pillow, and a geri-chair with compromised surfaces. • In 4 of the 12 patient care areas, we found expired commercial supplies, such as hand sanitizer and antibacterial soap.
	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.	
X	Fire safety requirements were met.	• Exit signage was not visible from all hallways and provided incorrect directional instructions.
	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	
X	Patient care areas were clean.	• All therapy clinics inspected had dirty floors, ventilation system outlets, and horizontal surfaces.
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• In the CLC physical therapy clinic, we found a treatment table mat and a geri-chair with compromised surfaces and expired antibacterial soap.
	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

6. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

7. We recommended that processes be strengthened to ensure that Infection Control Committee actions are implemented to address high-risk areas and that committee minutes document those actions.

8. We recommended that processes be strengthened to ensure that Infection Control Committee minutes consistently reflect analysis of surveillance activities.

9. We recommended that processes be strengthened to ensure that floors, ventilation system outlets, and horizontal surfaces in patient care areas are clean and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that mattresses, pillows, geri-chairs, and treatment table mats are routinely inspected and that those with compromised surfaces are repaired or removed from service.

11. We recommended that processes be strengthened to ensure that expired commercial supplies are removed from patient care areas.

12. We recommended that processes be strengthened to ensure that women's health clinic exit signage is properly oriented and visible from all hallways.

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 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 25 employee training records, 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
	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 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, and goals of care for the end of life were addressed.	
	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.	

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 18 EHRs of patients enrolled in the home oxygen program (including 9 patients deemed to be high risk), 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
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	• We found no evidence that program activities were reviewed 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.	
X	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	• Two high-risk patients' EHRs did not contain documentation of education on the hazards of smoking while oxygen was in use at the required intervals.
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
X	The facility complied with any additional elements required by VHA or local policy.	Local policy on continuous improvement of patient safety and risk management activities reviewed: • Home Respiratory Care Committee minutes did not reflect discussion and/or follow-up of high-risk patients involved in fire-related events and planning for patients discontinued from home oxygen therapy after signing a home oxygen Against Medical Advice statement.

Recommendations

13. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

14. We recommended that processes be strengthened to ensure that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education be documented.

15. We recommended that processes be strengthened to ensure that the Home Respiratory Care Committee evaluates patient safety-related events for home oxygen patients and planning for patients discontinued from home oxygen therapy to determine whether additional actions are warranted.

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 13 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 4J/4H and CLC unit 2-2 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. 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.	
X	Members of the expert panels completed the required training.	• Two of the 12 members of unit 4H/4J's panel had not 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.	

Recommendation

16. We recommended that all members of unit 4H/4J's expert panel receive the required training prior to the next annual staffing plan reassessment.

Preventable PE

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

We reviewed relevant documents and 29 EHRs of patients with confirmed diagnoses of PE[a] January 1–June 30, 2012. We also 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." Two patients were identified for further discussion from the initial EHR review. The facility had previously conducted an appropriate review of one patient's care.

NC	Areas Reviewed	Findings
X	Patients with potentially preventable PE received appropriate anticoagulation medication prior to the event.	• One patient was identified as having a potentially preventable PE because the patient had risk factors and had not been provided anticoagulation medication.
	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.	

Recommendation

17. We recommended that managers complete protected PR for the identified patient and 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.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[8]

We inspected the MH construction project. Additionally, we reviewed relevant documents and 30 training records (10 contractor records and 20 employee records), and we 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." The Construction Safety Committee began meeting in November 2012. In January 2013, the policy outlining responsibilities of the committee was approved, and multidisciplinary safety team site inspections began.

NC	Areas Reviewed	Findings
X	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	• The facility's Construction Safety Committee did not oversee construction and renovation activities. • The policy outlining the responsibilities of the committee and team was not followed.
X	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	• The contractor tuberculosis risk assessment was not completed prior to the start of the project.
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	• Required site inspections were not conducted by the multidisciplinary team.
X	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	Infection Control Committee minutes for past 2 quarters reviewed: • There was no documentation of infection surveillance activities related to the project.
X	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	Construction Safety Committee minutes for 3 months reviewed: • There was no discussion of construction site conditions.
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Ten employee records did not contain evidence of initial and/or refresher construction safety training.

NC	Areas Reviewed (continued)	Findings
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

18. We recommended that processes be strengthened to ensure that the Construction Safety Committee oversees construction and renovation activities, that the policy outlining the responsibilities of the committee is followed, that the multidisciplinary team conducts site visits at the specified frequency, and that meeting minutes contain discussion of site conditions and any required follow-up.

19. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

20. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes.

21. We recommended that processes be strengthened to ensure that designated employees receive initial and/or refresher construction safety training and that compliance be monitored.

Review Activity with Previous CAP Recommendations

Follow-Up on Emergency/Urgent Care Operations Issues

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with VHA requirements for (1) monitoring ED staff discharge instruction documentation and evaluating patient and/or caregiver understanding of the discharge instructions and (2) granting ED staff out-of-operating room airway management privileges.

Discharge Instructions. The facility self-reported that it had not monitored compliance with documentation of ED discharge instructions although this action was to be implemented in response to a previous CAP review recommendation. The facility plans to begin reporting compliance monitoring results to the Medical Records Committee in the 3rd quarter of FY 2013.

Provider Privileges. VHA requires that clinical managers ensure the competence of clinicians who perform out-of-operating room airway management.[9] VHA also requires setting-specific privileges that are justified with evidence that a practitioner has (a) performed the procedure and (b) had good outcomes when performing the procedure. We found that 3 of 10 ED physician training folders lacked adequate documentation to justify out-of-operating room airway management privileges.

Recommendations

22. We recommended that processes be strengthened to ensure that ED staff document discharge instructions and evaluate patient and/or caregiver understanding of the discharge instructions.

23. We recommended that processes be strengthened to ensure that the process for requesting and granting ED staff privileges complies with VHA policy.

Facility Profile (Salem/658) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$296.5
Number of:	
• **Unique Patients**	36,493
• **Outpatient Visits**	401,743
• **Unique Employees**[c]	1,338
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	182
• **CLC**	90
• **MH**	26
Average Daily Census: (through August 2012)	
• **Hospital**	98
• **CLC**	48
• **MH**	24
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Tazewell/658GA Danville/658GB Lynchburg/658GC Staunton/658GD Wytheville/658GE
VISN Number	6

[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	57.2	65.4	63.3	55.6	63.9	56.2
VISN	59.5	64.6	49.7	49.7	49.7	51.5
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	17.5	11.2	10.2	19.6	27.6	21.7
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 26, 2013

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Salem VA Medical Center, Salem, VA**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

1. Attached is the action plan developed by the Salem VA Medical Center in response to the recommendations received during their recent OIG CAP review.

2. The Facility concurs with the findings and will ensure the corrective action plan is implemented.

3. If you have any questions please contact Lisa Shear, VISN 6 QMO, at (919) 956-5541.

(original signed by:)
DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 26, 2013

From: Director, Salem VA Medical Center (658/00)

Subject: **CAP Review of the Salem VA Medical Center, Salem, VA**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Thank you for the opportunity to review the OIG report on the CAP Review of the Salem VA Medical Center. We concur with the recommendations, and will ensure completion as described in the implementation plan.

2. Please find attached our responses to each recommendation provided in the attached plan.

3. If you have any questions regarding the response to the recommendations, feel free to call me at (540) 982-2463.

(original signed by:)
MIGUEL H. LAPUZ, MD, MBA

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 processes be strengthened to ensure that the Critical Care Committee reviews each CPR episode.

Concur

Target date for completion: April 25, 2013

Facility response: The Critical Care Committee (CCC) now has a standing monthly agenda item for reviewing each CPR episode (Code Blue). As of the April 25, 2013, meeting, the minutes will include an analysis of the aggregated data for all the required review elements. For each individual event, reasons for failure to rescue will be reviewed as indicated, and clinical warning signals prior to each event will be screened for. Further, the CCC minutes will clearly identify concerns with individual resuscitation episodes, including related discussion, analysis and necessary action plans. The CCC will report monitoring to the Executive Board of Clinical Affairs (EBCA) monthly until closure and quarterly thereafter. Identified concerns from CCC will be reflected in the EBCA minutes.

Recommendation 2. We recommended that the facility continue to monitor the EHR copy and paste function.

Concur

Target date for completion: June 30, 2012

Facility response: Since June of 2012, copy and paste has been documented in the Medical Records Committee minutes. By the end of June 2013, a twelve month track record of this standing agenda item will have been reported. Monitoring continues through the Medical Records Committee with monthly reporting until closure and quarterly thereafter to the EBCA.

Recommendation 3. We recommended that processes be strengthened to ensure that results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: December 31, 2013

Facility response: A collaborative effort has been initiated by the Medical Center to implement a strengthened process to assure that unauthorized emergent non-VA

purchased care results will be scanned into the electronic health record. There is agreement between Health Administration Service and the Centralized Fee Unit leadership that the quality of scanning and the completeness of the patient record would be monitored (QI) on a monthly basis until closure, quarterly thereafter, and results presented to the Medical Records Committee as a standing agenda item by the Chief, HIMS. Any barriers to success will be identified and adjustments to the process will be made.

Recommendation 4. We recommended that processes be strengthened to ensure that the blood usage and review process includes the number of transfusions and number reviewed for appropriateness, the results of proficiency testing, PRs when transfusions did not meet criteria, and results of inspections by government or private (peer) entities.

Concur

Target date for completion: April 18, 2013

In order to strengthen the process, all required items have been added as standing agenda items for the Blood Usage Committee under recurring reports. The number of transfusions administered and reviewed are now routinely captured in the minutes. Proficiency results, peer review results not meeting criteria, and inspection results are recorded in the Blood Usage Committee minutes. The Blood Usage Committee reports quarterly to EBCA for oversight.

Recommendation 5. We recommended that processes be strengthened to ensure that when data analyses indicated problems or opportunities for improvement, actions taken are consistently followed to resolution in utilization management, outcomes of resuscitation, and RAI/MDS quality reviews.

Concur

Target date for completion: May 31, 2013

Facility response: The Medical Center is implementing a strengthened process to ensure that corrective actions identified in committee meetings are documented and followed to resolution. Committee chairpersons and/or their representatives and recorder will attend a class on committee documentation. Minutes training for these three committees will be completed by May 31, 2013. A review of this strengthened process will be incorporated for these identified committees with monitoring reported monthly until closure and quarterly thereafter to the EBCA.

Recommendation 6. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

Concur

Target date for completion: January 31, 2013

Facility response: The EOC has an action tracking tool that includes open items, required actions, responsible parties, and completion dates and reflects the action taken to correct deficiencies with dates of completion. The Committee's discussion of agenda items are captured in the minutes and include the completion of deficiencies as noted in the action tracking log. A monitor of the utilization of the action tracking tool tracking issues to closure and review of documentation of EOC Committee discussion of findings will be reported monthly until closure and quarterly thereafter to the Administrative Executive Board (AEB) to assure consistent documentation and action item completion.

Recommendation 7. We recommended that processes be strengthened to ensure that Infection Control Committee actions are implemented to address high-risk areas and that committee minutes document those actions.

Concur

Target date for completion: May 31, 2013

Facility response: The Infection Control Committee chairperson and/or their representative and recorder will attend a class on committee documentation to include documentation actions followed to conclusion. Minutes training should be completed by May 31, 2013. A review of this strengthened process will be incorporated for this identified committee with monthly monitoring until closure, quarterly thereafter, reported to the EBCA. Infection Control Committee minutes will contain sufficient detail to clearly document actions implemented for high-risk areas.

Recommendation 8. We recommended that processes be strengthened to ensure that Infection Control Committee minutes consistently reflect analysis of surveillance activities.

Concur

Target date for completion: May 31, 2013

Facility response: The Infection Control Committee chairperson and/or their representative and recorder will attend a class on committee documentation to include documentation actions followed to conclusion. Minutes training should be completed by May 31, 2013. A review of this strengthened process will be incorporated for this identified committee with monthly monitoring until closure, quarterly thereafter, reported to the EBCA. Infection Control Committee minutes will contain sufficient detail to clearly document consistent analysis of surveillance activities.

Recommendation 9. We recommended that processes be strengthened to ensure that floors, ventilation system outlets, and horizontal surfaces in patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: April 4, 2013

Facility response: Terminal cleaning of patient care areas was completed April 4, 2013. The weekly Environment of Care (EOC) rounds have been expanded to three times per week. Each area will be reviewed two times per year with additional time to assure comprehensive identification of deficiencies. Issues identified and monitored during the EOC rounds are tracked through completion by the EOC Committee. Facilities Management Service (FMS) and Environmental Management Department (EMD) Leadership will review a standardized work checklist to increase quality assurance checks of areas for compliance with cleanliness and standards at the May 31, 2013 staff meeting. Results will be reported as a percentage of compliance and will be reported monthly through the EOC Committee. Additionally, a "Quality Card" depicting visual and narrative descriptions of cleaning processes and procedures has been developed and will be provided to each EMS employee and attached to each EMS cleaning cart. Target date for implementation of the cards is July 1, 2013. EOC rounds findings will be reported monthly until closure, quarterly thereafter, to the Administrative Executive Board to assure consistent documentation and action item completion.

Recommendation 10. We recommended that processes be strengthened to ensure that mattresses, pillows, geri-chairs, and treatment table mats are routinely inspected and that those with compromised surfaces are repaired or removed from service.

Concur

Target date for completion: May 1, 2013

Facility response: A full sweep of the inpatient mental health unit was conducted in April. All compromised surfaces will be repaired or removed by May 1, 2013. Replacement mattresses and pillows were ordered on April 24, 2013. Mattress, pillow, chair, and treatment table mat inspections have been added to the EOC rounds checklist and will be monitored by the Interior Designer and nursing staff. Checks will also be conducted through the EMD quality assurance check process and monthly rounds with Nurse Managers of the inpatient units for verification and assurance of replacement items being provided as warranted. Deficiencies are tracked through the EOC deficiency report and reported to the EOC Committee.

Recommendation 11. We recommended that processes be strengthened to ensure that expired commercial supplies are removed from patient care areas.

Concur

Target date for completion: May 3, 2013

Facility response: Nurse Managers and Environmental Management will implement monthly rounds in each patient care unit using a consistent evaluation tool to proactively address expired supplies and team approaches to common environmental issues present on the patient care unit. Compliance monitoring will be reported monthly until closure in the Nurse Executive Committee.

Recommendation 12. We recommended that processes be strengthened to ensure that women's health clinic exit signage is properly oriented and visible from all hallways.

Concur

Target date for completion: April 5, 2013

Facility response: New exit signs were installed in the Women's Health Clinic area on April 5, 2013. All signage now adheres to NFPA 101, Section 7.10.1.2 and NFPA 101, Section 7.10.2. We request this recommendation be closed.

Recommendation 13. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Concur

Target date for completion: February 14, 2013

Facility response: The Chief of Staff now reviews and signs the minutes for the Home Respiratory Care Committee to ensure awareness of the committee activities. The Home Respiratory Care Committee is scheduled to meet quarterly and additionally at the call of the chair when high-risk issues are identified. Home Oxygen Program activities are summarized and presented quarterly to the EBCA, which is chaired by the Chief of Staff.

Recommendation 14. We recommended that processes be strengthened to ensure that high-risk home oxygen patients receive education on the hazards of smoking while oxygen is in use at the required intervals and that the education be documented.

Concur

Target date for completion: February 14, 2013

Facility response: We strengthened the educational process of high risk home oxygen patients by modifying the intake form and CPRS template to clearly identify and re-educate high risk patients. Reassessment will occur every six months, or sooner if there is a high-risk event. Education is provided by Home Oxygen Coordinators as well as Commonwealth Home Health Care and reported to the EBCA for oversight.

Recommendation 15. We recommended that processes be strengthened to ensure that the Home Respiratory Care Committee evaluates patient safety-related events for home oxygen patients and planning for patients discontinued from home oxygen therapy to determine whether additional actions are warranted.

Concur

Target date for completion: February 14, 2013

Facility response: The Home Respiratory Care Committee is scheduled to meet quarterly and additionally at the call of the chair when high-risk issues arise. The Home Respiratory Care Committee documents discussion of patient safety events as a standing agenda item and follow-up appropriate for high-risk patients involved in fire related events. Prior to a patient being discontinued for home oxygen AMA, a plan will be determined through the Home Respiratory Care Committee.

Recommendation 16. We recommended that all members of unit 4H/4J's expert panel receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: May 31, 2013

Facility response: Members of the current panel for unit 4H/4J completed training on April 29, 2013. New unit-based panels have been formed for the October staffing methodology review. All members of the unit panels will have training certificates validated by May 31, 2013.

Recommendation 17. We recommended that managers complete protected PR for the identified patient and any recommended review actions.

Concur

Target date for completion: March 27, 2013

Facility response: Peer Review performed on identified patient with Peer Committee Review completed on March 27, 2013. The Peer Review Committee reports quarterly to the EBCA. We request that this item be closed.

Recommendation 18. We recommended that processes be strengthened to ensure that the Construction Safety Committee oversees construction and renovation activities, that the policy outlining the responsibilities of the committee is followed, that the multidisciplinary team conducts site visits at the specified frequency, and that meeting minutes contain discussion of site conditions and any required follow-up.

Concur

Target date for completion: April 3, 2013

Facility response: The multidisciplinary safety team is now conducting the construction inspections as required in VHA Directive 2011-036. CS Committee minutes will include inspection results, deficiencies noted, and an action item log to track completion of identified deficiency items to closure not corrected at the time of the inspection. A monthly report from the CS Committee will be provided until closure quarterly thereafter, to the EOC Committee for oversight.

Recommendation 19. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

Concur

Target date for completion: April 30, 2013

Facility response: The Infection Control Risk Assessment (ICRA) document was revised in February, 2013 to include TB Risk Assessment on new construction projects. TB actions based on findings will be recorded in the minutes of the Infection Control Committee and Construction Safety Committee prior to initiation of construction projects.

Recommendation 20. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes.

Concur

Target date for completion: May 31, 2013

Facility response: The Infection Control Committee chairperson and/or their representative and recorder will attend a class on committee documentation to include documentation actions followed to conclusion. Minutes training should be completed by May 31, 2013. A review of this strengthened process will be incorporated for this identified committee with monthly monitoring until closure, quarterly thereafter, reported to the EBCA. Infection Control Committee minutes will contain sufficient detail to clearly document consistent analysis of surveillance activities related to construction projects.

Recommendation 21. We recommended that processes be strengthened to ensure that designated employees receive initial and/or refresher construction safety training and that compliance be monitored.

Concur

Target date for completion: April 25, 2013

Facility response: All current members of the Construction Safety Committee have received the initial 30 hours of required OSHA training as of April 25, 2013. Compliance will be monitored by the Facility Construction Safety Officer (FCSO) monthly until closure, and quarterly thereafter, through the Construction Safety (CS) Committee with results reported via the minutes. In addition to other local training options, an OSHA 10 Hour Construction Safety Training program is scheduled for May 17, 2013.

Recommendation 22. We recommended that processes be strengthened to ensure that ED staff document discharge instructions and evaluate patient and/or caregiver understanding of the discharge instructions.

Concur

Target date for completion: February 14, 2013

Facility response: Processes for discharge instructions and patient/family education were strengthened in the emergency department through staff education and template. Ten percent [review] of discharge instructions and patient/family understanding of those instructions was re-instituted with results of the first quarter FY2013 reported on February 14, 2013 to the Medical Records Committee. There is monitoring monthly by the nurse manager in the Emergency Department with results reported quarterly to the Medical Records Committee.

Recommendation 23. We recommended that processes be strengthened to ensure that the process for requesting and granting ED staff privileges complies with VHA policy.

Concur

Target date for completion: February 28, 2013

Facility response: A new process for privileging all ED physicians for Out of OR Airway Management was put in place in January 2013. This included a Competency Assessment with required didactics, simulation and either experience with intubations or direct observation of technique in the OR. All ED physicians completed this process in February 2013. All new ED physicians are required to complete this competency assessment as part of their ED Credentialing and Privileging. Additionally, all ED physicians will complete this when re-credentialed. Credentialing reports monthly to EBCA.

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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.

[8] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.

[9] The reference used for this topic was:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.