Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00893-195

Combined Assessment Program Review of the VA Texas Valley Coastal Bend Health Care System Harlingen, Texas

May 9, 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
COC	continuity of care
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Texas Valley Coastal Bend Health Care System
FY	fiscal year
LTHOT	long-term home oxygen therapy
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
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 April 1, 2013.

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

- Quality Management
- Environment of Care
- Continuity of Care

The facility's reported accomplishments were hospice referrals and the Electronic Six-Part Folder Process Improvement Initiative.

Recommendations: We made recommendations in the following two activities:

Medication Management – Controlled Substances Inspections: Reconcile 1 day's dispensing from the pharmacy to each automated unit, and monitor compliance. Ensure controlled substances inspectors receive annual updates or refresher training. Inspect all required non-pharmacy areas with controlled substances, and monitor compliance.

Long-Term Home Oxygen Therapy: Re-evaluate home oxygen program patients for home oxygen therapy annually after the first year.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 13–16, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following five activities:

- QM
- EOC
- Medication Management – CS Inspections
- LTHOT
- COC

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 April 1, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews.

During this review, we presented crime awareness briefings for 306 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 146 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

Hospice Referrals

The liaison for hospice coordination is responsible for coordinating hospice and palliative care for all patients served by the facility. This involves reviewing all referrals for hospice care placed through a geriatrics and extended care consult, requesting appropriate EHRs, and forwarding the EHRs to the Medical Director of Home and Community Based Care for review. If a patient meets hospice criteria, the liaison and the Medical Director interview the patient, family, and staff to help determine preferences and the most appropriate setting for hospice care. Referrals are acted upon immediately so patients can be placed with the requested services within 24 hours. The liaison then confirms the plan of care for the admission. The patient's care is certified for 2 consecutive 90-day intervals and then every 60 days afterward as needed. The palliative performance scale and progress notes are reviewed at each recertification to determine the need for continued hospice care.

Electronic Six-Part Folder Process Improvement Initiative

After the facility was established, Human Resources Management Service began streamlining the employee competency folder process by developing electronic six-part folders. Electronic six-part folders allow a centralized location for services to maintain employee competency documents such as position descriptions/functional statements, orientation documentation, performance evaluations, competencies, and training. The electronic six-part folder process is continually developing as each service scans hardcopy documents. The intent is to become fully electronic by the beginning of FY 2014. The advantages created by the electronic six-part folder system include greater integrity of documentation tracking, easier access during reviews and audits, and greater accessibility for geographically separated supervisors/managers.

The Mental Health Service Line has converted all hardcopy folders to electronic six-part folders. The electronic format provides for ease of record keeping as well as ease of access and verification of required information. Many of the data sources for documents within the six-part folder have also been converted to electronic forms. For instance, service-level peer reviews provide data vital to the Focused and Ongoing Professional Practice Evaluation process. Since 2010, all staff within Psychiatry and Psychology Service Lines have been using an electronic peer review database accessed through a secure web portal. Administrators randomize and assign reviews each month. Providers are then notified when they have peer reviews ready to complete and when a peer has completed a peer review on them.

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 conversed with 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. Any 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 senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
NA	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.	
NA	Local policy for the use of observation beds complied with selected requirements.	
NA	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.	
NA	Staff performed continuing stay reviews of at least 75 percent of patients in acute beds.	
NA	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

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

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 and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected the mental health, multispecialty, orthopedic, and ophthalmology clinics and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed five SPS employee training and competency files. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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.	
	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 Hemodialysis	
NA	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
NA	Monthly biological water and dialysate testing were conducted and included required components, and identified problems were corrected.	
NA	Employees received training on bloodborne pathogens.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
NA	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
NA	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
	Selected infection prevention/environmental safety requirements were met.	
	Selected requirements for SPS decontamination and sterile storage areas 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 conversed with key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 4 CS areas and the pharmacy. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

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.	
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Although instructions required reconciliation of 1 day's dispensing from the pharmacy to each automated unit, this was not consistently done.
	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.	
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	Appointments, certifications, and training records reviewed: • CS inspectors did not receive annual updates or refresher training.
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of 4 CS areas inspected during the past 6 months reviewed: • The four required areas were not inspected monthly.
	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.	

Recommendations

1. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled and that compliance be monitored.

2. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates or refresher training.

3. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected and that compliance be monitored.

LTHOT

The purpose of this review was to determine whether the facility complied with requirements for LTHOT in its mandated Home Respiratory Care Program.[4]

We reviewed relevant documents and 34 EHRs of patients enrolled in the home oxygen program (including 2 patients deemed to be high risk), and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any 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.	
	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.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Twenty-two EHRs (65 percent) contained no documentation of a re-evaluation 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.	

Recommendation

4. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

COC

The purpose of this review was to evaluate whether information from patients' community hospitalizations at VA expense was available to VA clinic providers. Such information is essential to COC and optimal patient outcomes.

We reviewed relevant documents and 30 EHRs of patients who had been hospitalized from January to November 2012 in the local community at VA expense. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Clinical information was available to the primary care team for the clinic visit subsequent to the hospitalization.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Harlingen/740) FY 2013 through March 2013[a]	
Type of Organization	Ambulatory care
Complexity Level	Excluded
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$180.1
Number of:	
• **Unique Patients**	23,207
• **Outpatient Visits**	150,543
• **Unique Employees**[b]	466
Type and Number of Operating Beds: (through February 2013)	
• **Hospital**	NA
• **CLC**	NA
• **Mental Health**	NA
Average Daily Census: (through February 2013)	
• **Hospital**	NA
• **CLC**	NA
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Harlingen/740GA McAllen/740GB Corpus Christi/740GC Laredo/740GD
VISN Number	17

[a] All data is for FY 2013 through March 2013 except where noted.
[b] 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	*	*	45.8	39.5	41.4	47.6
VISN	57.9	60.8	48.5	48.7	45.4	49.6
VHA	63.9	65.0	55.0	54.7	54.3	55.0

* The facility has no inpatient beds.

Appendix C

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 23, 2013

From: Acting Director, VA Heart of Texas Health Care Network (10N17)

Subject: **CAP Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. Thank you for allowing me to respond to the CAP Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX.

2. I concur with the recommendations and have ensured that action plans with target dates for completion were developed.

3. If you have further questions regarding this CAP review please contact Denise B. Elliott, VISN 17 Quality Management Officer at (817) 385-3734.

Joleen Clark, MBA, FACHE
Acting Director, VA Heart of Texas Health Care Network (10N17)

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 19, 2013

From: Director, VA Texas Valley Coastal Bend Health Care System (740/00)

Subject: **CAP Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX**

To: Acting Director, VA Heart of Texas Health Care Network (10N17)

1. I concur with the findings noted in this report. Action plans have been developed and monitoring will be conducted on a regular basis.

2. Should you require additional information, please contact Cathy Mezmar, Chief, Quality Management, (956) 430-9343.

Robert M. Walton

Robert M. Walton
Director, VA Texas Valley Coastal Bend Health Care System (740/00)

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 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled and that compliance be monitored.

Concur

Target date for completion: May 31, 2013

Facility response: A mandatory training will be provided by Controlled Substance (CS) Coordinator to all CS Inspectors by May 31, 2013. PowerPoint presentation will outline inspection process, detailed required documentation of inspection forms, requirements of each phase of the inspection and mandatory training frequency of CS Inspectors. Training aids will be developed and provided for CS Inspectors as a reference. Pharmacy personnel will also provide training on the Omni cell system to CS Inspectors. Competencies on the inspection process will be recorded on a spreadsheet by CS Coordinator prior to inspections. CS Coordinator will make clinic rounds to assess competencies of new Inspectors after training has been completed. A spreadsheet will be maintained by the CS Coordinator to monitor CS Inspectors' paperwork on a monthly basis indicating completed dates.

Recommendation 2. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates or refresher training.

Concur

Target date for completion: May 15, 2013

Facility response: CS Coordinator has informed CS Inspectors that effective April 12, 2013, a curriculum within Talent Management System (TMS) has been implemented for all CS Inspectors. The curriculum will notify all CS Inspectors, CS Coordinator and Supervisors of their upcoming annual training with a 90, 60 and 30 day notification. CS Coordinator will run monthly reviews of TMS CS Inspector course to notify supervisors if CS Inspectors' training is nearing expiration. CS Coordinator will maintain a spreadsheet of completed training dates for all CS Inspectors.

Recommendation 3. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected and that compliance be monitored.

Concur

Target date for completion: May 31, 2013

Facility response: CS Coordinator will inform CS inspectors of new requirement that all facilities complete their CS Inspections of non-pharmacy areas by close of business (COB) on the 20th of each month. If the CS Coordinator does not receive CS Inspection paperwork by COB on the 20th of each month, the CS Coordinator will contact CS Inspector to determine status of inspection. This deadline allows the CS Coordinator to initiate a plan of action to ensure inspection meets compliance. CS Coordinator will conduct monthly reviews of all CS Inspectors' paperwork submitted per clinic to ensure completeness and compliance with deadline.

Recommendation 4. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

Concur

Target date for completion: June 30, 2013

Facility response: Effective May 6, 2013, the VISN prosthetics representative and vendor will compare vendor and prosthetics lists for patients prescribed home oxygen to ensure accuracy. Findings will be reported to the Home Oxygen Committee and a follow-up appointment will be scheduled to assess the need for renewal of home oxygen prescriptions prior to expiration. The Pulmonary Oxygen Team will maintain a tracking tool to monitor outstanding or pending renewals and findings will be reported at each committee meeting. Home Oxygen Committee Chair will be responsible to renew all prescriptions.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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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 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 Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- 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, the International Association of Healthcare Central Service Materiel Management, and the Association for Professionals in Infection Control and Epidemiology.

[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 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.