Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01673-240

Combined Assessment Program Review of the Tuscaloosa VA Medical Center Tuscaloosa, Alabama

July 11, 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
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Tuscaloosa VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 May 20, 2013.

Review Results: The review covered six activities. We made no recommendations in the following two activities:

- Medication Management – Controlled Substances Inspections
- Nurse Staffing

The facility's reported accomplishments were the geriatric suicide screening tool and the Green House® Project.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure that Focused Professional Practice Evaluations for newly hired licensed independent practitioners are reported timely to the Medical Executive Committee.

Environment of Care: Ensure that inpatient bathrooms are clean and that damaged furniture in patient care areas is repaired or removed from service. Secure mental health inpatient unit nurses' stations and medication rooms from unauthorized access, and ensure furniture meets safety requirements. Require that Sterile Processing Service employees responsible for reprocessing activities receive annual competency assessments.

Coordination of Care – Hospice and Palliative Care: Ensure that the Palliative Care Consult Team includes a dedicated administrative support person.

Construction Safety: Ensure that the multidisciplinary committee responsible for construction and renovation oversight includes all required members and that construction site inspection documentation includes all the required elements.

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 16–20, for the full

text of the Directors' comments.) We consider recommendations 5–8 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, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Nurse Staffing
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012 and FY 2013 through May 20, 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 Tuscaloosa VA Medical Center, Tuscaloosa, Alabama,* Report No. 10-00050-247, September 15, 2010).

During this review, we presented crime awareness briefings for 106 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 138 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

Geriatric Suicide Screening Tool

The 2012 Consolidated Assistance Review and Evaluation results indicated that screening veterans for suicide on admission was not included in the Geriatrics and Extended Care Services admission process. While many veterans in CLCs are verbal and able to communicate suicidal ideation, others are non-verbal; therefore, a tool was needed that would better identify risks for this population regardless of whether they were able to verbalize or not. A team comprised of the Suicide Prevention Coordinator, a neuro-psychiatrist, a psychologist, a QM registered nurse, and the Chief of Social Work Service was formed to research the best indicators for veterans who communicate non-verbally. The team was unable to find a suicide screening tool specific to non-verbal veterans but found and reviewed research articles that provided non-verbal indications for depression. The team added these signals as part of the suicide screening tool now used for all admissions to the CLC. Any positive screenings are referred to providers for further evaluation.

The Green House® Project

The Magnolia House is the second Green House® within the VA system to open its doors. It is a caring home operating under the Green House® Project model for inpatient long-term care. The Magnolia House is a self-contained home designed to look and feel like a real home. It houses 10 veterans who have met the criteria for admission to long-term care, and each veteran has a private bedroom and bathroom. Specially trained "universal workers," who provide a wide range of assistance, staff the home and provide personal care, activities, meal preparation and service, light housekeeping, and laundry service. At the facility, these "universal workers" are referred to as Guardians. Guardians underwent an extensive training program and function as a self-managed work team partnered with the clinical support team for the veterans who live in the home.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We 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. 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 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.	
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Nine profiles reviewed: • Of the nine FPPEs completed, results of five were not reported timely to the MEC.
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.	
	Staff performed continuing stay reviews on 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.	

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

Recommendation

1. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are reported timely to the MEC.

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 five CLCs; two MH inpatient units; a primary care, a dental, and a podiatry clinic; and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed all SPS employee training and competency files. 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 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.	
X	Environmental safety requirements were met.	• Inpatient bathrooms in 4 of 10 patient care areas inspected were not clean. • We found damaged furniture in 2 of the 10 patient care areas inspected.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VA National Center for Patient Safety MH EOC Checklist requirements reviewed. On the two acute MH inpatient units: • Nurses' stations and medication rooms were not secured from unauthorized entry. • Furniture was not secured or heavy enough to prevent it from being used to cause injury or moved to block a door.

	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.	
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.	
X	Employees received required RME training and competency assessment.	• Annual competency assessments were not documented for two SPS employees.
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.	

Recommendations

2. We recommended that processes be strengthened to ensure that inpatient bathrooms are clean and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that damaged furniture in patient care areas is repaired or removed from service.

4. We recommended that processes on the acute MH inpatient units be strengthened to ensure that nurses' stations and medication rooms are secured from unauthorized entry and that furniture meets safety requirements.

5. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities receive annual competency assessments.

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

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we 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
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	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.	
	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.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

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

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 inpatient units (long-term care and MH).[5]

We reviewed relevant documents and 22 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for Patriots' Point (CLC unit) and acute MH unit 1 for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. 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
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
	The unit-based expert panels followed the required processes and included all required members.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The 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.	

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.[6]

We inspected the primary care upgrade project. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we conversed with key employees and managers. 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
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 multidisciplinary committee did not include all required members.
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	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.	Site inspection documentation for 2 quarters reviewed: • Site inspection documentation did not include all required elements.
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

7. We recommended that the facility ensure the multidisciplinary committee responsible for construction and renovation oversight includes all required members.

8. We recommended that processes be strengthened to ensure that construction site inspection documentation includes all the required elements.

Facility Profile (Tuscaloosa/679) FY 2013 through March 2013[a]	
Type of Organization	Secondary
Complexity Level	3
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$133.8
Number (through April 2013) of: • **Unique Patients**	13,884
• **Outpatient Visits**	118,139
• **Unique Employees**[b]	765
Type and Number of Operating Beds: • **Hospital**	87
• **CLC**	198
• **MH**	84
Average Daily Census: • **Hospital**	73
• **CLC**	90
• **MH**	72
Number of Community Based Outpatient Clinics	0
Location(s)/Station Number(s)	NA
VISN Number	7

[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 FY 2012		**Outpatient Scores 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	*	*	54.0	58.7	59.0	64.9
VISN	63.3	65.9	51.8	51.3	50.6	51.1
VHA	63.9	65.0	55.0	54.7	54.3	55.0

* The facility does not have acute inpatient beds.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 25, 2013

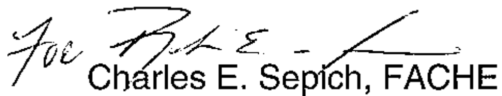
From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Tuscaloosa VA Medical Center, Tuscaloosa, AL**

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

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

I concur with the recommendations and approve of the action plans as outlined by the Tuscaloosa VA Medical Center.



Charles E. Sepich, FACHE

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 13, 2013

From: Director, Tuscaloosa VA Medical Center (679/00)

Subject: **CAP Review of the Tuscaloosa VA Medical Center, Tuscaloosa, AL**

To: Director, VA Southeast Network (10N7)

1. I concur with the recommendations presented in the Combined Assessment Program Review of the Tuscaloosa VA Medical Center.

2. Attached are the facility actions taken as a result of these findings.

3. Thank you for these opportunities for improvement. The OIG Team conducted the audit in a very professional and consultative manner which made the site visit productive and educational for our staff.

4. If you have additional questions or need further information, please contact me at (205) 554-2000, ext. 2201.

(original signed by:)
Maria R. Andrews, MS, FACHE
Director, Tuscaloosa VA Medical Center (679/00)

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 FPPEs for newly hired licensed independent practitioners are reported timely to the MEC.

Concur

Target date for completion: 6/1/13

Facility response: FPPE Tracker for LIP New Hires spreadsheet has been developed with headings for "FPPE Initiated, FPPE Completed and FPPE Reported to MEC/PSB" for tracking for Medical Executive Committee. New Hires LIP – Initial FPPE memo and successful completion memo have been scanned and quality controlled into VetPro under LIP Personal Profile Section. Appointment Screen under "Comments" will have leading comment added: NOTE: Successful Completion of FPPE on "X-date." Comments section will be saved with no other additions or deletions.

Recommendation 2. We recommended that processes be strengthened to ensure that inpatient bathrooms are clean and that compliance be monitored.

Concur

Target date for completion: 7/1/13, On-going

Facility response: EMS will assign a Floor Care Tech team to do detailed cleaning of each bathroom floor on each unit daily until all have been corrected. Over the next 90 days contract services will begin grout repair, sealing the floors, and caulking around the toilets. In addition EMS will develop PD's and submit PMC requests for floor care technicians that will largely focus on maintaining floors through non-destructive cleaning practices using approved methods and products. EMS will establish an annual budget for grout maintenance and repair.

Recommendation 3. We recommended that processes be strengthened to ensure that damaged furniture in patient care areas is repaired or removed from service.

Concur

Target date for completion: 7/1/13

Facility response: Damaged items will be reupholstered and/or repaired.

Recommendation 4. We recommended that processes on the acute MH inpatient units be strengthened to ensure that nurses' stations and medication rooms are secured from unauthorized entry and that furniture meets safety requirements.

Concur

Target date for completion: 10/1/13

Facility response: Short term actions are complete, including removal of items from the desk surface, surveillance of the desk surface hourly, replacement of phone cords to shorter cords, a VA Police officer in Building 137 from 1500–0700 hrs, meeting with staff members to assess and support their perception of safety concerns and recommended unit changes, removal of torn furniture and easily lifted chairs, placement of a duress alarm in anteroom of G3-116, and assigning a nursing staff member to observe and assist the nurse assigned during the medication pass have been completed. Intermediate and long term items are pending with a target date of 7/31/13. Construction items are pending funding from VISN and have a target date of the end of FY 13.

Recommendation 5. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities receive annual competency assessments.

Concur

Target date for completion: 6/1/13

Facility response: Competency binders have been updated and will continue to be maintained and updated to ensure that SPS employees responsible for reprocessing activities have received annual competency assessments.

Recommendation 6. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: 6/1/13

Facility response: An administrative support position has been filled.

Recommendation 7. We recommended that the facility ensure the multidisciplinary committee responsible for construction and renovation oversight includes all required members.

Concur

Target date for completion: 6/1/13

Facility response: Center Memorandum 001-21, Safety Program, Chapter 15, Construction Safety, is being updated to include Employee Health representative.

Recommendation 8. We recommended that processes be strengthened to ensure that construction site inspection documentation includes all the required elements.

Concur

Target date for completion: 5/22/13

Facility response: The Construction Safety Site Inspection form has been updated to include time and attendance.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. Senate: Jeff Sessions, Richard C. Shelby
U.S. House of Representatives: Terri A. Sewell

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.
- 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 Material 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 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] 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.

[6] 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.