Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02638-01

Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center Columbus, Ohio

October 28, 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
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Chalmers P. Wylie VA Ambulatory Care Center
FY	fiscal year
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

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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 August 12, 2013.

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

- Quality Management
- Suicide Prevention Safety Plans
- Moderate Sedation
- Management of Workplace Violence
- Long-Term Home Oxygen Therapy

The facility's reported accomplishments were improved telehealth services and a robust voluntary service program.

Recommendations: We made recommendations in the following two activities:

Environment of Care: Secure sterile supply storage and soiled utility areas at all times.

Medication Management – Controlled Substances Inspections: Develop instructions for inspections of automated dispensing machines. Include problematic trends and potential areas for improvement in quarterly trend reports. Ensure inspectors receive annual updates and/or refresher training. Require inspectors to consistently verify the number of prescription pads.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15–18, for the full text of the Directors' comments.) We consider recommendations 1, 2, 4, and 5 closed. We will follow up on the planned actions for the open recommendation until it is 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met 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 seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Suicide Prevention Safety Plans
- Moderate Sedation
- Management of Workplace Violence
- Long-Term Home Oxygen Therapy

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 August 16, 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 Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio,* Report No. 11-01101-196, June 16, 2011).

During this review, we presented crime awareness briefings for 158 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 130 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

Telehealth Program

The telehealth program increased access and care for rural veterans through expansion in the facility's community based outpatient clinics during FY 2013. The expanded programs include tele-nutrition, TeleMOVE! (weight management program), and telehealth promotion and disease prevention. Veterans living in rural areas benefit from having these programs closer to their homes because they reduce the need for long-distance travel to access many health care and specialty services.

Voluntary Service Program

The facility's Voluntary Service Program serves as a broad spectrum networking system that fosters community partnerships, influences stakeholder perceptions and behaviors, and shapes facility image. In FY 2012, the volunteer program had more than 343 regularly scheduled volunteers who contributed roughly 653,150 hours of service. In addition, more than $239,250 in monetary and in-kind contributions and activity, equipment, and comfort items were received through the donation program. In FY 2013, Voluntary Service hosted a sold-out "Valentines for Veterans" concert for the entire community featuring the legendary group *The Chi-Lites*.

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 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.	
	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 dental clinic and SPS were met.[2]

We inspected the surgical pre-operative and post-anesthesia care units; the primary care, gastroenterology, vascular, women's health, prosthetics, urgent care, and dental clinics; and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 16 employee training and competency files (6 operating room and 10 SPS). 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 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.	• Three sterile supply storage areas and one soiled utility area were unsecured.
	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 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.	
	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	

NC	Areas Reviewed for SPS/RME (continued)	Findings
	Employees received required RME training and competency assessment.	
	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 local policy.	
	Areas Reviewed for Dental Clinic	
NA	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.	
	General infection control practice requirements in the dental clinic were met.	
	Dental clinic infection control process requirements, including use of personal protective equipment, disinfection practices, RME reprocessing, compliance with single use items, and maintenance of water lines, were met.	
	Safety requirements in the dental clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

1. We recommended that processes be strengthened to ensure that sterile supply storage and soiled utility areas are secured at all times.

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 the CS Coordinator and 4 CS inspectors and inspection documentation from 10 CS areas, the outpatient pharmacy, and the emergency drug cache. 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 had not been developed.
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	Quarterly trend reports for past 4 quarters reviewed: • Reports did not include problematic trends or potential areas for improvement.
	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 CS updates and/or refresher training.
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Documentation of pharmacy CS inspections during the past 6 months reviewed: • Verification of the number of prescription pads was not consistently included.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

2. We recommended that the facility develop instructions for inspections of automated dispensing machines.

3. We recommended that processes be strengthened to ensure that quarterly trend reports include problematic trends and potential areas for improvement.

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

5. We recommended that processes be strengthened to ensure that CS inspectors consistently verify the number of prescription pads and that compliance be monitored.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide.[4]

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 10 patients assessed to be at high risk for suicide during the period December 2012–May 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
	Patients had documented safety plans.	
	Patients and/or their families participated in plan development .	
	Safety plans contained all required elements.	
	There was documented evidence that patients and/or their families received a copy of the plan.	
	Patient record flags were placed before safety plans were developed.	
	The facility complied with an additional elements required by VHA or local policy.	

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.[5]

We reviewed relevant documents, the EHRs of 10 patients who underwent moderate sedation, and 5 employee training/competency records, and we conversed with key employees. 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
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.	
	Pre-sedation documentation was complete.	
	Informed consent was completed appropriately and performed prior to administration of sedation.	
	Timeouts were appropriately conducted.	
	Monitoring during and after the procedure was appropriate.	
	Moderate sedation patients were appropriately discharged.	
	The use of reversal agents in moderate sedation was monitored.	
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.	
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.	
	The facility complied with any additional elements required by VHA or local policy.	

Management of Workplace Violence

The purpose of this review was to determine the extent to which VHA facilities managed disruptive and violent incidents.[6]

We reviewed relevant documents and Reports of Contact from five disruptive patient incidents that occurred in FY 2013, and we conversed with key employees. 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 had policies on preventing and managing violent behavior.	
	The facility had an employee training plan that addressed preventing and managing violent behavior.	
	Selected incidents were managed appropriately according to the facility's policies.	
	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.[7]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 13 patients deemed to be high risk), and we conversed with key employees. 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 local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Columbus/757) FY 2013 through July 2013[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$166.9
Number (through August 2013) of:	
• **Unique Patients**	37,058
• **Outpatient Visits**	368,558
• **Unique Employees**[b]	802
Type and Number of Operating Beds:	
• **Hospital**	NA
• **CLC**	NA
• **Mental Health**	NA
Average Daily Census:	
• **Hospital**	NA
• **CLC**	NA
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Zanesville/757GA Grove City/757GB Marion/757GC Newark/757GD
VISN Number	10

[a] All data is for FY 2013 through July 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 scores for quarters 3–4 of FY 2012 and quarters 1–2 of FY 2013 and overall outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012	FY 2013	FY 2012			
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	*	*	67.9	64.5	55.0	54.2
VISN	63.4	66.3	59.9	59.6	59.2	58.3
VHA	65.0	65.5	55.0	54.7	54.3	55.0

* The facility does not have inpatient beds.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 9/23/2013

From: Director, VA Healthcare System of Ohio (10N10)

Subject: **CAP Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. Thank you for this review and the opportunity to continue to improve the quality and services provided to Veterans.

2. I have reviewed the recommendations and corresponding actions and concur with the facility's responses.

3. If you have any questions or require additional information, please contact Jane Johnson, VISN 10 Deputy Quality Management Officer at (513) 247-4631.

for Jack G. Hetrick, FACHE
Director, VA Healthcare System of Ohio (10N10)

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 9/23/2013

From: Director, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH (757/00)

Subject: **CAP Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH**

To: Director, VA Healthcare System of Ohio (10N10)

1. Thank you for the opportunity to review the report on the Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio.

2. I have reviewed the document and concur with the recommendations. Corrective actions have been established with planned completion dates, as detailed in the attached report.

Keith Sullivan

Keith Sullivan, FACHE
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that sterile supply storage and soiled utility areas are secured at all times.

Concur

Target date for completion: September 30, 2013

Facility response: The facility inspected the sterile supply areas and carts to ensure locking mechanism are in good working order and repaired locks as needed. Random checks are performed to ensure sterile supply carts/rooms and dirty supply rooms are locked. Reinforcement with staff has been completed regarding maintaining the security of both sterile supply carts and soiled utility areas at all times.

Recommendation 2. We recommended that the facility develop instructions for inspections of automated dispensing machines.

Concur

Target date for completion: October 1, 2013

Facility response: The facility's controlled substance inspection policy was revised to include specific instructions for conducting an inspection of controlled substance medications in the Omnicell (the automated dispensing machines). Controlled Substance Inspectors (CSI) were provided training with the revised instructions and policy during the annual meeting held September 18, 2013. The revised policy is currently being routed for approval, signatures, and posting.

Recommendation 3. We recommended that processes be strengthened to ensure that quarterly trend reports include problematic trends and potential areas for improvement.

Concur

Target date for completion: April 15, 2014

Facility response: Revision to the quarterly trend report was implemented with the 3rd quarter FY 2013 report and included a summary of the monthly inspection results along with the reporting of problematic trends and potential areas of improvement. This revised report format and content was presented and discussed during the

September 18, 2013 CSI annual meeting. The quarterly trend reports will be submitted to and reviewed by the Compliance Committee for the next quarter to ensure inclusion of problematic trends and potential areas for improvement.

Recommendation 4. We recommended that processes be strengthened to ensure that CS inspectors receive annual CS updates and/or refresher training.

Concur

Target date for completion: September 18, 2013

Facility response: Annual CSI training was held on September 18, 2013 and attended by all CSIs. Agenda items included training on the Omnicell, a review and discussions of the revised inspection process and policy and quarterly trend report content. Training meeting minutes were distributed to all CSIs and attendance registered in the facility's Training Management System (TMS) for record keeping. Annual training meetings are being scheduled. Ad hoc CS meetings will be held if needed.

Recommendation 5. We recommended that processes be strengthened to ensure that CS inspectors consistently verify the number of prescription pads and that compliance be monitored.

Concur

Target date for completion: August 30, 2013

Facility response: The controlled substance inspection policy was revised to specify monthly verification of prescription pads and clarified the CSIs' inspection process requiring a monthly count of prescription pads and not the quarterly count being performed. This change was implemented with the August 27, 2013 inspection and reinforced at the annual CSI training session. The results of monthly prescription pad counts and dates of inspections will be reported monthly at the Compliance Committee meetings.

OIG Contact and Staff Acknowledgments

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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 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.
- Deputy Under Secretary for Health for Operations and Management, "Use of Enzymatic and Gels for the Processing of Reusable Medical, Surgical, and Dental Instruments," memorandum, July 23, 2010.
- 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 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] The references used for this topic were:
- Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
- Barbara Stanley, Ph.D., and Gregory K. Brown, Ph.D., *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*, August 20, 2008.

[5] References used for this topic included:
- VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
- VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.

[6] The reference used for this topic was:
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

[7] 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.