Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02640-06

Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System Los Angeles, California

October 30, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(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	VA Greater Los Angeles Healthcare System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
MEC	Medical Executive Committee
MH	mental health
MRC	Medical Records Committee
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
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 19, 2013.

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

- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishments were the primary care – mental health integration program, a solar energy program, and a virtual pain management program.

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

Quality Management: Consistently complete peer review actions, and report them to the Peer Review Committee. Present quarterly summary reports to the Medical Executive Committee. Consistently report Focused Professional Practice Evaluation results to the Professional Standards Board. Revise the local observation bed policy to include that each observation patient must have a focused goal for the observation period and that each admission must have a limited severity of illness. Consistently perform continued stay reviews on at least 75 percent of patients in acute beds. Ensure the Cardiac Arrest Committee reviews each code episode. Require the Medical Records Committee to provide oversight and coordination of the review of the quality of electronic health record entries. Continue the recently implemented process for scanning non-VA purchased care results. Ensure that surgery and anesthesia representatives consistently attend Blood Usage Committee meetings and that results of proficiency testing and inspections by government and private entities are routinely reported to the committee. Consistently follow actions taken when data analyses indicated problems or opportunities for improvement to resolution in the Inpatient Operations Council, Medical Executive Committee, and Medical Records Committee.

Environment of Care: Ensure ventilation system covers are clean, housekeeping closets and soiled utility rooms are locked, and emergency call system cords are functional. Repair the laminate and floor in hemodialysis. Maintain Sterile Processing Service sterile storage area humidity within acceptable levels.

Medication Management – Controlled Substances Inspections: Amend facility policy to include elements required by Veterans Health Administration policy related to physical counts of automated dispensing units, quarterly trend reports, and pharmacy drug destruction. Take actions to address and correct deficiencies identified during annual physical security surveys. Consistently reconcile 1 day's dispensing from the pharmacy

to each automated unit. Perform weekly inventory verifications of automated dispensing machines. Complete and provide quarterly trend reports to the facility Director. Ensure that all controlled substances inspectors have required certification and that they receive annual updates and/or refresher training. Require that inspectors do not exceed the 3-year term limit and are given a 1-year hiatus before being reappointed. Ensure that all required non-pharmacy areas with controlled substances and all pharmacy areas are inspected monthly. Perform drug destruction and audit trail verification. Consider consulting with Pharmacy Benefits Management to ensure the controlled substances inspection program complies with Veterans Health Administration policy.

Coordination of Care – Hospice and Palliative Care: Ensure all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management: Accurately document location, stage, and/or risk scale score for all patients with pressure ulcers. Ensure all discharged pressure ulcer patients have wound care follow-up plans and receive dressing supplies prior to being discharged.

Nurse Staffing: Reassess the target nursing hours per patient day for unit 213-2 to more accurately plan for staffing and evaluate the actual staffing provided.

Follow-Up on Environment of Care Issues: Ensure that all designated employees complete annual N95 respirator fit testing and that all employees who work on locked mental health units complete annual environmental hazards training.

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 23–32, 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 seven activities and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- MH Residential Rehabilitation Treatment Program
- Follow-Up on EOC Issues

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

The review covered facility operations for FY 2012 and FY 2013 through August 19, 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 VA Greater Los Angeles Healthcare System, Los Angeles,*

California, Report No.10-01438-231, August 24, 2010). We made repeat recommendations in QM and EOC.

During this review, we presented crime awareness briefings for 579 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 566 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

Primary Care – MH Integration Program

The goal of the program is to deliver integrated medical and MH care to patients in the outpatient setting under a patient centered care model. The program provides same day access to patients when they come for their appointments, follow-up care until stabilization, ongoing provider consultation and education, and continued coverage during psychiatric emergencies. It also provides a large variety of evidence-based psychotherapy interventions at both the individual and group levels that have resulted in improved outcomes. A great majority of consults are now handled through primary care. The program's main operational principles are integration, open access, and continuity of care.

Going Green – The Solar Energy Program

The facility has successfully interconnected a majority of the solar panels installed to the electrical distribution systems at three campuses—West Los Angeles, Sepulveda, and the Los Angeles Ambulatory Care Center. The project to install carport, rooftop, and ground level solar panels was entirely funded by VA, and the estimated savings to the facility is $1.64 million annually.

The project is not yet complete. Additional carport solar panels will be installed at the West Los Angeles campus, and ground level solar panels are planned for the Sepulveda campus. The facility's solar energy program, combined with another large ongoing energy conservation project, makes it the "green energy" showcase facility for the entire VA.

Virtual Pain Management Program

The facility's Pain Management Service provides comprehensive pain management to all veterans across various settings. Through inpatient consultation, post-operative care, and discharge to outpatient or other transitional care settings, the service attempts to provide coordinated pain management across the health care continuum.

The facility's newest program is the Specialty Care Access Network Extension of Community Healthcare Outcomes Pain Video and Teleconference that connects remote community based outpatient clinic providers with the facility's pain management specialists. The primary goals of the program are to provide improved collaboration between pain specialists and primary care providers, increase access to pain treatments and education, and reduce unnecessary travel for veterans requiring this specialty service. This program has been extremely successful, especially in clinics that are approximately a 4 to 5 hour drive for veterans. Several innovations have promoted this form of virtual care, including the development of musculoskeletal examination videos, brief mini-residency in physical examination and training, and promotion of a pain management SharePoint site that is used by primary care providers for educational materials, quick access to data, and conversion charts for narcotic tables.

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 areas 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.	
X	Corrective actions from the protected peer review process were reported to the PRC.	Six months of PRC meeting minutes reviewed: • Of the three actions expected to be completed, two were not reported to the PRC.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Twenty-three profiles reviewed: • Results of six FPPEs were not reported to the Professional Standards Board. This is a repeat finding from the previous CAP review.
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include that each observation patient must have a focused goal for the period of observation or that each admission must have a limited severity of illness.
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Three quarters of continuing stay data reviewed: • For 2 quarters, less than 75 percent of acute inpatients were reviewed.
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	

NC	Areas Reviewed (continued)	Findings
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Three quarters of Cardiac Arrest Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each code episode. This was a repeat finding from the previous CAP review.
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Six months of MRC meeting minutes reviewed: • There was no evidence that the committee provided oversight and coordination of the review of the quality of entries in the EHR.
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	• The facility did not begin scanning non-VA care results into EHRs until May 2013.
X	Use and review of blood/transfusions complied with selected requirements.	Four quarters of Blood Usage Committee meeting minutes reviewed: • Clinical representatives from Surgery and Anesthesia Services did not attend two of the four meetings. • The results of proficiency testing and inspections by government or private entities were not reported to the committee.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently followed to resolution for the Inpatient Operations Council, MEC, and MRC.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy and 12 months of MEC meeting minutes reviewed: • Only two quarterly PRC summaries were presented to the MEC. This was a repeat finding from the previous CAP review.

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC and that quarterly PRC summary reports are consistently presented to the MEC.

2. We recommended that processes be strengthened to ensure that FPPE results for newly hired licensed independent practitioners are consistently reported to the Professional Standards Board.

3. We recommended that the local observation bed policy be revised to include that each observation patient must have a focused goal for the period of observation and that each admission must have a limited severity of illness.

4. We recommended that processes be strengthened to ensure that continued stay reviews are consistently performed on at least 75 percent of patients in acute beds.

5. We recommended that processes be strengthened to ensure that the Cardiac Arrest Committee reviews each code episode.

6. We recommended that the MRC provide oversight and coordination of the review of the quality of entries in EHRs.

7. We recommended that the facility continue the recently implemented process for scanning the results of non-VA purchased care into EHRs and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that representatives from Surgery and Anesthesia Services consistently attend Blood Usage Committee meetings and that the results of proficiency testing and inspections by government and private entities are routinely reported to the Blood Usage Committee.

9. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in the Inpatient Operations Council, MEC, and MRC.

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 progressive care unit (5S), the intensive care unit, acute medicine unit 4W, locked MH unit 2S, the emergency department, the CLC (buildings 213 and 215), the primary care Gold Team, hemodialysis (buildings 500 and 213), and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training and competency files (10 hemodialysis, 10 operating room, and 10 SPS). 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.	For the eight areas inspected: • Ventilation system covers were dusty in four areas. • Housekeeping closets were unlocked in two areas. • Soiled utility rooms were unlocked in six areas. • Emergency call system cords were wrapped around handrails in three areas causing the system to not activate.
	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.	

NC	Areas Reviewed for Hemodialysis	Findings
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	
	Contractors received training on bloodborne pathogens.	
	Contractor hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
X	Selected EOC/infection prevention/safety requirements were met.	• In the building 500 location, we noted damaged and/or missing laminate near the hand washing sink and in the two isolation rooms. • In the building 213 location, an unfinished floor repair created a tripping hazard.
	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.	
	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.	

NC	Areas Reviewed for SPS/RME (continued)	Findings
X	Selected requirements for SPS decontamination and sterile storage areas were met.	Sterile storage temperature and humidity level logs for 21 days in August 2013 reviewed: • For all days reviewed, sterile storage humidity levels exceeded the upper threshold of 60 percent.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

10. We recommended that processes be strengthened to ensure that ventilation system covers are clean, housekeeping closets and soiled utility rooms are locked, and emergency call system cords are functional and that compliance be monitored.

11. We recommended that the facility repair the laminate and floor in hemodialysis to ensure infection prevention and safety standards are maintained.

12. We recommended that processes be strengthened to ensure that SPS sterile storage area humidity is maintained within acceptable levels and that compliance be monitored.

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 3 Acting CS Coordinators and 11 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. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	Facility policy was consistent with VHA requirements.	Facility CS inspection policy reviewed. The policy did not include the following VHA required elements: • Requirement to perform a complete physical count of automated dispensing units in the inpatient units and clinics during the 1st month of each quarter. • Content of quarterly trend reports provided to the facility Director. • All required drug destruction elements to be completed during pharmacy inspections.
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	Annual physical security surveys for past 2 years reviewed: • Pharmacy-related security deficiencies identified by VA police in 2011 and 2012 had not yet been addressed or corrected.
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Reconciliation of 1 day's dispensing from the pharmacy to each automated machine was not performed. • Weekly inventory verification of automated machines by CS inspectors was not performed.
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	Summary of CS inspection findings for past 6 months reviewed: • There were no quarterly trend reports for the past 4 quarters.
	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.	

NC	Areas Reviewed (continued)	Findings
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: • Eight inspectors did not have current CS Drug-Diversion Inspection Certifications or documented evidence of annual updates or training. • Four inspectors were recently appointed to a second term without a 1-year hiatus and had conducted monthly inspections prior to being removed from the rotation.
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of 10 CS areas inspected during the past 6 months reviewed: • Seventeen of the 60 (28 percent) monthly inspections were not documented as completed.
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Inspection documentation for the past 6 months for the four pharmacy areas (inpatient vault, inpatient Omnicell, outpatient, and pharmacy receipt) and the emergency drug cache reviewed: • Five of the 24 monthly pharmacy inspections were not documented as completed. • Three of the 6 monthly emergency drug cache inspections were not documented as completed. • There was no evidence in monthly inspections of verification of the audit trail for destruction of 10 randomly selected drugs and no evidence of quarterly verification of drug destruction.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that facility policy be amended to include elements required by VHA policy related to physical counts of automated dispensing units, quarterly trend reports, and pharmacy drug destruction.

14. We recommended that managers initiate actions to address identified security deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are addressed and corrected.

15. 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.

16. We recommended that processes be strengthened to ensure that CS inspectors perform weekly inventory verifications of automated dispensing machines and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that quarterly trend reports are completed and provided to the facility Director.

18. We recommended that processes be strengthened to ensure that all CS inspectors have current CS Drug-Diversion Inspection Certification and that inspectors receive annual updates and/or refresher training and that compliance be monitored.

19. We recommended that processes be strengthened to ensure that inspectors do not exceed the 3-year term limit and are given a 1-year hiatus before being reappointed and that compliance be monitored.

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

21. We recommended that processes be strengthened to ensure that all pharmacy areas, including the emergency drug cache, are inspected monthly and that compliance be monitored.

22. We recommended that processes be strengthened to ensure that inspectors perform drug destruction and audit trail verification and that compliance be monitored.

23. We recommended that the facility Director consider consulting with Pharmacy Benefits Management to ensure the facility's CS inspection program complies with VHA 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, 40 EHRs of patients who had PCCT consults (including 20 HPC inpatients), and 30 employee training records (12 HPC staff records and 18 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
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• There was no evidence that 15 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

24. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[5]

We reviewed relevant documents, 28 EHRs of patients with pressure ulcers (9 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 9 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. 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
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 19 of the applicable 27 EHRs, staff did not consistently document the location, stage, and/or risk scale score.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
X	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	• Four of the applicable eight EHRs did not contain evidence of wound care follow-up plans at discharge. • Six of the applicable eight EHRs did not contain evidence that patients received dressing supplies prior to discharge.

NC	Areas Reviewed (continued)	Findings
	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

25. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, and/or risk scale score for all patients with pressure ulcers and that compliance be monitored.

26. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

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 three inpatient units (acute medical/surgical, long-term care, and MH).[6]

We reviewed relevant documents and 32 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 4EAD, CLC unit 213-2, and MH unit 2WAB 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. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Finding
	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.	
X	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	• Unit 213-2's average actual nursing hours per patient day was below the target for all three groups of days reviewed.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

27. We recommended that the nurse manager reassess the target nursing hours per patient day for unit 213-2 to more accurately plan for staffing and evaluate the actual staffing provided.

MH Residential Rehabilitation Treatment Program

The purpose of this review was to determine whether the facility's Domiciliary Care for Homeless Veterans Program and general domiciliary residential rehabilitation treatment program complied with selected EOC requirements.[7]

We reviewed relevant documents, inspected the two programs in buildings 214 and 217, and 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 residential environment was clean and in good repair.	
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
	Monthly MH Residential Rehabilitation Treatment Program self-inspections were conducted, documented, and included all required elements, work orders were submitted for items needing repair, and any identified deficiencies were corrected.	
	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	
	Written agreements acknowledging resident responsibility for medication security were in place.	
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es)	

NC	Areas Reviewed (continued)	Findings
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	
	Medications in resident rooms were secured.	
	The facility complied with any additional elements required by VHA or local policy.	

Review Activity with Previous CAP Recommendations

Follow-Up on EOC Issues

As a follow-up to recommendations from our previous CAP review, we reassessed facility compliance with N95 respirator fit testing and MH unit staff environmental hazards training.[8]

N95 Respirator Fit Testing. VHA requires facilities using N95 and other types of respirators to fit test designated employees annually. As of August 19, 2013, of the 912 designated employees, 183 (20 percent) were overdue for annual fit testing.

Environmental Hazards Training. VHA requires that all staff who work on locked inpatient MH units receive annual training on the environmental hazards that represent a threat to suicidal patients. Of the 210 employees who worked on locked MH units, 180 (86 percent) received their last training in 2010, and 20 (10 percent) received their last training in 2011.

Recommendations

28. We recommended that processes be strengthened to ensure that all designated employees complete annual N95 respirator fit testing and that compliance be monitored.

29. We recommended that processes be strengthened to ensure that all employees who work on locked MH units complete annual environmental hazards training and that compliance be monitored.

Facility Profile (West Los Angeles/691) FY 2013 through July 2013[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$883.3
Number (through August 2013) of:	
• **Unique Patients**	80,504
• **Outpatient Visits**	1,045,720
• **Unique Employees**[b]	4,247
Type and Number of Operating Beds:	
• **Hospital**	316
• **CLC**	352
• **MH**	296
Average Daily Census:	
• **Hospital**	218
• **CLC**	178
• **MH**	256
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	Santa Barbara/691GB Gardena/691GC Bakersfield/691GD Los Angeles/691GE East Los Angeles/691GF Antelope Valley/691GG San Luis Obispo/691GK Santa Maria/691GL Oxnard/691GM
VISN Number	22

[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	56.1	66.0	47.5	50.5	49.5	43.6
VISN	61.9	65.0	51.5	52.6	53.4	50.7
VHA	65.0	65.5	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2009, and June 30, 2012.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	13.2	8.7	12.3	*	*	*
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

* No data is available from the facility for this measure.

[c] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[d] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 15, 2013

From: Director, Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the VA Greater Los Angeles Healthcare System, Los Angeles, CA**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. I concur with the findings and recommendations in the report of the Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System Los Angeles, CA (Report No, not yet assigned), Recommendation 1–29.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

Stan Johnson, MHA, FACHE

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 3, 2013

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subject: **CAP Review of the VA Greater Los Angeles Healthcare System, Los Angeles, CA**

To: Director, Desert Pacific Healthcare Network (10N22)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review.

2. Should you have further questions or comments, please contact Ms. Joan Lopes, Chief, Quality Management, at (310) 268-3565.

Sincerely,

(original signed by:)
Donna M. Beiter, R.N., M.S.N.

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 actions from peer reviews are consistently completed and reported to the PRC and that quarterly PRC summary reports are consistently presented to the MEC.

Concur

Target date for completion: March 31, 2014

Facility response: Medical Staff office will ensure that peer review actions with assistance from QM are consistently completed and reported in the quarterly reports to MEC.

Recommendation 2. We recommended that processes be strengthened to ensure that FPPE results for newly hired licensed independent practitioners are consistently reported to the Professional Standards Board.

Concur

Target date for completion: January 31, 2014

Facility response: Credentialing & Privileging office will review all newly hired licensed independent practitioners to assure that FPPE is available for presentation to the Professional Standards Board.

Recommendation 3. We recommended that the local observation bed policy be revised to include that each observation patient must have a focused goal for the period of observation and that each admission must have a limited severity of illness.

Concur

Target date for completion: November 30, 2013

Facility response: GLA Observation Bed Policy will be revised by UM section to include 1) goal for observation period along with 2) limited severity of illness category.

Recommendation 4. We recommended that processes be strengthened to ensure that continued stay reviews are consistently performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: January 31, 2014

Facility response: Monitor continued stay reviews daily to ensure that target of 75% of acute patient population are reviewed.

Recommendation 5. We recommended that processes be strengthened to ensure that the Cardiac Arrest Committee reviews each code episode.

Concur

Target date for completion: March 31, 2014

Facility response: The Cardiac Arrest Committee is being reviewed for new membership. Developing a clear process of review of codes will be on the agenda with the revised committee with quarterly reports to MEC.

Recommendation 6. We recommended that the MRC provide oversight and coordination of the review of the quality of entries in EHRs.

Concur

Target date for completion: March 31, 2014

Facility response: MRC will monitor and coordinate reviews of EHR quality. Minutes will provide evidence that quality of entries have been reviewed and included in MRC reports to MEC.

Recommendation 7. We recommended that the facility continue the recently implemented process for scanning the results of non-VA purchased care into EHRs and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: Monitoring of scanned results on non-VA purchased care into EMR'S will be done on a weekly basis and results submitted to QM on a monthly basis.

Recommendation 8. We recommended that processes be strengthened to ensure that representatives from Surgery and Anesthesia Services consistently attend Blood Usage

Committee meetings and that the results of proficiency testing and inspections by government and private entities are routinely reported to the Blood Usage Committee.

Concur

Target date for completion: February 28, 2014

Facility response: Surgery and Anesthesia will ensure that representatives attend Blood Usage Committee. Pathology and Laboratory will ensure that proficiency testing results and other inspections by governmental and private entities are reported and captured in the minutes of the committee.

Recommendation 9. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in the Inpatient Operations Council, MEC, and MRC.

Concur

Target date for completion: March 31, 2014

Facility response: Executive Leadership, in conjunction with QM, will ensure that actions are consistently documented for identified problems or issues and followed up until resolved.

Recommendation 10. We recommended that processes be strengthened to ensure that ventilation system covers are clean, housekeeping closets and soiled utility rooms are locked, and emergency call system cords are functional and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: We will monitor compliance with keeping ventilation system covers clean, housekeeping and soiled utility rooms locked and emergency cords functional.

Recommendation 11. We recommended that the facility repair the laminate and floor in hemodialysis to ensure infection prevention and safety standards are maintained.

Concur

Target date for completion: January 31, 2014

Facility response: Hemodialysis laminate and floor will be repaired.

Recommendation 12. We recommended that processes be strengthened to ensure that SPS sterile storage area humidity is maintained within acceptable levels and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: Humidity levels in SPS sterile storage area will be monitored to ensure readings are within acceptable levels.

Recommendation 13. We recommended that facility policy be amended to include elements required by VHA policy related to physical counts of automated dispensing units, quarterly trend reports, and pharmacy drug destruction.

Concur

Target date for completion: January 31, 2014

Facility response: The GLA policy will be amended to include elements required by VHA policy related to physical counts of automated dispensing units, quarterly trend reports and pharmacy drug destruction.

Recommendation 14. We recommended that managers initiate actions to address identified security deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are addressed and corrected.

Concur

Target date for completion: January 31, 2014

Facility response: Identified security deficiencies in annual physical security surveys will be addressed and corrected. Evidence of compliance will be collected and maintained.

Recommendation 15. 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: January 31, 2014

Facility response: Reconciliation of one (1) day's dispensing from the pharmacy to each automated unit will be conducted and monitored for compliance.

Recommendation 16. We recommended that processes be strengthened to ensure that CS inspectors perform weekly inventory verifications of automated dispensing machines and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: Weekly inventory for automated dispensing machine by CS inspectors will be conducted and written verification of the inspection will be available for review.

Recommendation 17. We recommended that processes be strengthened to ensure that quarterly trend reports are completed and provided to the facility Director.

Concur

Target date for completion: March 31, 2014

Facility response: Quarterly trends reported to the Director will be completed and evidence of completion will be maintained.

Recommendation 18. We recommended that processes be strengthened to ensure that all CS inspectors have current CS Drug-Diversion Inspection Certification and that inspectors receive annual updates and/or refresher training and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: All CS inspectors will have current Drug-Diversion Inspection Certification with annual updates and/or refresher training. Records will be maintained to ensure compliance.

Recommendation 19. We recommended that processes be strengthened to ensure that inspectors do not exceed the 3-year term limit and are given a 1-year hiatus before being reappointed and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: The CS Coordinator will maintain a schedule to ensure inspectors do not exceed 3-year term with indication of 1-year hiatus.

Recommendation 20. We recommended that processes be strengthened to ensure that all required non-pharmacy areas with CS are inspected monthly and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: All non-pharmacy areas with CS will be inspected monthly and documented evidence of compliance will be available.

Recommendation 21. We recommended that processes be strengthened to ensure that all pharmacy areas, including the emergency drug cache, are inspected monthly and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: All pharmacy areas with CS, including the emergency cache, will be inspected monthly and documented evidence of compliance will be available.

Recommendation 22. We recommended that processes be strengthened to ensure that inspectors perform drug destruction and audit trail verification and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: CS inspectors will conduct drug destruction and audit trail verification reviews. Evidence of compliance will be available.

Recommendation 23. We recommended that the facility Director consider consulting with Pharmacy Benefits Management to ensure the facility's CS inspection program complies with VHA policy.

Concur

Target date for completion: March 31, 2014

Facility response: Program manager has initiated consultation with Pharmacy Benefits Management to ensure CS program compliance with VHA policy.

Recommendation 24. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: March 31, 2014

Facility response: All non-HPC clinical staff who provide care will receive end-of-life training and documented evidence of compliance will be available.

Recommendation 25. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, and/or risk scale score for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: Acute care staff will accurately document location, stage and/or risk scale score for all pressure ulcer patients and documented evidence of compliance will be available.

Recommendation 26. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: All discharged pressure ulcer patients will have wound care follow-up plans and receive dressing supplies prior to discharge. Written evidence of compliance will be available.

Recommendation 27. We recommended that the nurse manager reassess the target nursing hours per patient day for unit 213-2 to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: March 31, 2014

Facility response: The target nursing hours/day for Unit 213-2 will be reassessed to ensure staffing plan reflects actual staffing. Evidence of reassessment will be provided.

Recommendation 28. We recommended that processes be strengthened to ensure that all designated employees complete annual N95 respirator fit testing and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: All designated employees will complete the annual N95 respirator fit testing. Evidence of compliance will be available.

Recommendation 29. We recommended that processes be strengthened to ensure that all employees who work on locked MH units complete annual environmental hazards training and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: All employees working on locked MH units will complete the annual environmental hazards training. Evidence of compliance will be available.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Kathleen Shimoda, RN, Team Leader Daisy Arugay, MT Michael Bishop, MSW Paula Chapman, CTRS Limin Clegg, PhD Keyla Gammarano, RN, MHA Chad Joy, Special Agent Yoonhee Kim, PharmD Mary Toy, RN, MS Julie Watrous, RN, MS
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Jackelinne Melendez, MPA Simonette Reyes, RN Victor Rhee, MHS Jarvis Yu, MS

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This report is available at www.va.gov/oig.

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA 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.
- Assistant Deputy Under Secretary for Health for Clinical Operations "Interim Guidance for Ventilation Requirements in Sterile Processing Service," memorandum, January 4, 2012.
- 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 included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[8] The references used for this topic were:
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Under Secretary for Health, "Respiratory Protection Used for Infectious Disease and Annual Fit-Testing," Information Letter 10-2012-012, August 2, 2012.