Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02642-21

Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, Arizona

December 3, 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	Northern Arizona VA Health Care System
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalent
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HPC	hospice and palliative care
MEB	Medical Executive Board
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of September 9, 2013.

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

- Construction Safety

The facility's reported accomplishment was the Health Care for Homeless Veterans Program.

Recommendations: We made recommendations in the following six activities:

Quality Management: Report results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners to the Medical Executive Board. Review the quality of entries in the electronic health record for all services. Monitor the electronic health record copy and paste function. Implement a quality control policy for scanning.

Environment of Care: Remove expired medications from patient care areas. Ensure lower shelves in the distribution storage area are solid and at least 8 inches above the floor. Maintain distribution storage area humidity and temperatures within acceptable levels.

Medication Management – Controlled Substances Inspections: Amend facility policy to include that the Controlled Substances (CS) Coordinator and inspectors must be free from conflicts of interest, to include that the CS Coordinator must have complete understanding of CS policies and the Veterans Health Administration inspection process, and to include requirements for new CS inspector orientation and annual training thereafter. Initiate actions to address the two identified deficiencies, and correct all deficiencies identified during annual physical security surveys. Provide quarterly trend reports to the facility Director. Ensure that all non-pharmacy areas with CS are inspected monthly, that inspections are randomly scheduled and completed on the day initiated, and that inspectors verify hard copy orders for five dispensing activities. Inspect the main pharmacy vault and pharmacy emergency cache monthly, and include all required elements in inspections.

Coordination of Care – Hospice and Palliative Care: Ensure that the Palliative Care Consult Team includes a dedicated administrative support person and that non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training. Amend facility policy to assign a minimum 0.25 full-time

employee equivalent mental health professional and an administrative support person to the team.

Pressure Ulcer Prevention and Management: Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Ensure all patients discharged with pressure ulcers receive dressing supplies prior to being discharged. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Establish staff pressure ulcer education requirements.

Nurse Staffing: Monitor the staffing methodology that was implemented in August 2013.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–32, 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

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
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Construction Safety

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

The review covered facility operations for FY 2012 and FY 2013 through September 9, 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 Northern Arizona VA Health Care System, Prescott, Arizona,* Report No. 10-02996-84, February 10, 2011).

During this review, we presented crime awareness briefings for 31 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 205 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 Accomplishment

HCHV Program

The HCHV Program is a multidisciplinary program that serves homeless veterans and those at risk for homelessness. The facility has partnered with three counties in Northern Arizona, the Public Housing Authority, the Department of Housing and Urban Development, and local community agencies to help homeless veterans and their families secure long-term housing and temporary shelter. The HCHV Program provides case management and supportive services and served approximately 200 veterans during FY 2013. The HCHV team also worked with community partners to launch the first family shelter in Northern Arizona and has participated in three separate homeless stand downs. Currently, the program has used 98 percent of the vouchers received from the Department of Housing and Urban Development – VA Supportive Housing. Additionally, during FY 2013, the HCHV Program received a 3-year accreditation from the Commission on Accreditation of Rehabilitation Facilities.

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.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Nine profiles reviewed: • None of the results of the nine completed FPPEs were reported to the MEB.
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
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.	
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Three quarters of EHR Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.

NC	Areas Reviewed (continued)	Findings
X	The EHR copy and paste function was monitored.	Three quarters of EHR Committee meeting minutes reviewed: • There was no evidence that the 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 have a policy that addressed quality control processes for scanning.
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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

2. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed for all services.

3. We recommended that processes be strengthened to ensure that the EHR copy and paste function is monitored.

4. We recommended that the facility implement a quality control policy for scanning.

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 two CLCs, the acute care medical and telemetry inpatient units, SPS and distribution, the emergency department, a primary care clinic, and outpatient surgery. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed all SPS employee training and competency files. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• There were expired medications in an automated dispensing machine in the outpatient surgery area.
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Hemodialysis	
NA	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
NA	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	
NA	Employees received training on bloodborne pathogens.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
NA	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
NA	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
	Selected infection prevention/environmental safety requirements were met.	
X	Selected requirements for SPS decontamination and sterile storage areas were met.	• Lower shelves in the distribution storage area were not solid and at least 8 inches above the floor. • Distribution storage area humidity levels were out of range for 9 of 25 days. • Distribution storage area temperatures were out of range for 17 of 25 days.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that processes be strengthened to ensure that all expired medications are removed from patient care areas.

6. We recommended that processes be strengthened to ensure that lower shelves in the distribution storage area are solid and at least 8 inches above the floor.

7. We recommended that processes be strengthened to ensure that distribution storage area humidity and temperatures are 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 the CS Coordinator and nine CS inspectors and inspection documentation from nine 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. Facility policy did not: • Address that the CS Coordinator and inspectors must be free from conflicts of interest. • Include that the CS Coordinator must have a complete understanding of CS policies and the VHA CS inspection process. • Include requirements for new CS inspector orientation and annual training thereafter.
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: • Two identified deficiencies had not been corrected, and managers did not have action plans or an explanation for why the items remained unresolved.
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
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 and quarterly trend reports for past 4 quarters reviewed: • None of the quarterly trend reports were provided to the facility Director.
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	

NC	Areas Reviewed (continued)	Findings
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of 9 CS areas inspected during the past 6 months reviewed: • Thirteen of 54 (24 percent) required monthly inspections were not conducted. • Monthly inspections were not consistently completed on the same day they were initiated. • Distinguishable patterns were identified in two inspection areas. One area had 4 inspections completed during the 2nd week of the month, and one area had 5 inspections completed during the 3rd week of the month. • Inspectors did not consistently verify hard copy orders for five randomly selected dispensing activities in all non-pharmacy areas.
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: • One monthly inspection of the main pharmacy vault was not conducted. • One monthly inspection of the emergency cache was not conducted. • Inspectors did not consistently verify the audit trail by comparing drugs held for destruction with the destroyed drugs report.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that facility policy be amended to include that the CS Coordinator and inspectors must be free from conflicts of interest and that the CS Coordinator must have a complete understanding of CS policies and the VHA CS inspection process and to include the requirements for new CS inspector orientation and annual training thereafter.

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

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

11. We recommended that processes be strengthened to ensure that all non-pharmacy areas with CS are inspected monthly, that inspections are randomly scheduled and completed on the day initiated, and that inspectors verify hard copy orders for five dispensing activities and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that the main pharmacy vault and pharmacy emergency cache are inspected monthly and that inspections include all required elements and that compliance be monitored.

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 21 employee training records (9 HPC staff records and 12 non-HPC staff records), and we conversed with key employees. 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	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• There was no evidence that nine 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
X	The facility complied with any additional elements required by VHA or local policy.	Local policy reviewed: • The policy was not consistent with VHA's requirement for a minimum 0.25 FTE MH professional and an administrative support person to be assigned to the PCCT.

Recommendations

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

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

15. We recommended that facility policy be amended to include that a minimum 0.25 FTE MH professional and an administrative support person be assigned to the PCCT.

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, 15 EHRs of patients with pressure ulcers (3 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 2 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. 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 13 of the 15 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
	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.	• Two of the applicable six EHRs did not contain evidence that patients received dressing supplies prior to discharge.

NC	Areas Reviewed (continued)	Findings
X	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.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 12 of the patients at risk for/with a pressure ulcer, EHRs did not contain evidence that education was provided.
X	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 had not developed staff pressure ulcer education requirements.
	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

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

17. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers receive dressing supplies prior to being discharged and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

19. We recommended that the facility establish staff pressure ulcer education requirements 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 two inpatient units (acute medical/surgical and long-term care).[6]

We reviewed relevant documents, and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	• Expert panels were not convened until August 16, 2013.
NA	The unit-based expert panels followed the required processes and included all required members.	
NA	The facility expert panel followed the required processes and included all required members.	
NA	Members of the expert panels completed the required training.	
NA	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

20. We recommended that nursing managers monitor the staffing methodology that was implemented in August 2013.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We inspected the CLC renovation project. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. 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 multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

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

Facility Profile (Prescott/649) FY 2013 through August 2013[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$176.9
Number (through September 2013) of:	
• **Unique Patients**	25,802
• **Outpatient Visits**	262,203
• **Unique Employees**[b]	958
Type and Number of Operating Beds:	
• **Hospital**	27
• **CLC**	85 (16 temporarily out of service due to construction)
• **MH**	120
Average Daily Census:	
• **Hospital**	11
• **CLC**	64
• **MH**	86
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Kingman/649GA Flagstaff/649GB Lake Havasu/649GC Anthem/649GD Cottonwood/649GE
VISN Number	18

[a] All data is for FY 2013 through August 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	65.5	68.7	61.5	50.6	52.4	51.7
VISN	66.7	64.9	51.1	52.5	49.9	53.3
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	**	10.9	12.4	*	*	*
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.
** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[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: November 4, 2013

From: Director, VA Southwest Health Care Network (10N18)

Subject: **CAP Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, San Diego Office of Healthcare Inspections (54SD)

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

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

2. If you have any questions or concerns, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at 480-397-2777.

Susan P. Bowers

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 1, 2013

From: Director, Northern Arizona VA Health Care System (649/00)

Subject: **CAP Review of the Northern Arizona VA Health Care System, Prescott, AZ**

To: Director, VA Southwest Health Care Network (10N18)

1. I have reviewed and concur with the findings and recommendations in the draft report of the Office of the Inspector General Combined Assessment Program Review conducted the week of September 9, 2013.

2. Corrective actions plans have been established with target completion dates, as detailed in the attached report.

for Donna K. Jacobs, FACHE
Facility 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 the results of FPPEs for newly hired licensed independent practitioners are reported to the MEB.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that the results of FPPEs for newly hired licensed independent practitioners are reported to the MEB the following steps have been taken:

The Professional Standards Board (PSB) meets in conjunction with the Medical Executive Board (MEB). Actions of the PSB were not fully documented in the MEB minutes. As of September 1, 2013, the provider(s) under review and FPPE action will be documented in the MEB minutes to include specific provider names.

The Lead Credentialer is responsible for this change. The process is monitored by use of the "Verification of Professional Practice Evaluation" form that is sent to the Service Line Manager or Designee for completion two weeks prior to the due date, along with the date the review will be taken to the MEB/PSB, the oversight committee. The Lead Credentialer will monitor timely return of the evaluation form.

In order to ensure sustainability, monitoring of documentation of PSB review of FPPEs in the MEB minutes will continue until 100% compliance is achieved in three consecutive months.

Recommendation 2. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed for all services.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that the quality of entries in the EHR is reviewed for all services, the following steps have been taken:

Chart Audit templates from each Service Line have been reviewed and approved by the Medical Records Committee (MRC). The quarterly schedule of reporting audit results at the MRC meeting has been revised and the scheduled reporting dates for each service line have been reviewed and clarified with each respective process owner. Reminder

notification will be sent to each Service Line Manager and/or respective process owner two weeks prior to their scheduled presentation date. The MRC Chairperson and Co-Chairperson are responsible for assuring these changes are made and implemented.

The MRC Chairperson or designee will provide quarterly reporting of MRC activity, including Service Line chart audit reviews with action plans for non-compliant monitors to the oversight committee, Quality Performance Board (QPB).

In order to ensure sustainability, specific tracking and monitoring of each service line chart review will be presented at the monthly QPB oversight committee and will continue until 90% compliance is achieved in three consecutive months.

Recommendation 3. We recommended that processes be strengthened to ensure that the EHR copy and paste function is monitored.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that the EHR copy and paste function is monitored, the following steps have been taken:

The Coding Compliance Specialist will assume the duty of monitoring and auditing Copy and Paste function on a monthly basis and will provide a report of non-compliant providers to the Compliance Officer. The Compliance Officer will provide training to the providers who are not in compliance with NAVAHCS Copy and Paste HCSM. Chief of Health Information Management System (HIMS) and the Compliance Officer are responsible for implementation and ongoing tracking.

Review of the copy and paste function will be monitored monthly by the Coding Compliance Specialist and the Compliance Officer. Results of the copy and paste function audits will be reviewed monthly at the MRC meeting with quarterly reporting to QPB, the oversight committee.

In order to ensure sustainability, monitoring of copy and paste function will continue as a quarterly report item to QPB until 90% compliance is achieved in three consecutive reporting periods.

Recommendation 4. We recommended that the facility implement a quality control policy for scanning.

Concur

Target date for completion: December 31, 2013

Facility response: In order to ensure that a quality control policy for scanning is implemented, the following steps have been taken:

The Chief of HIMS has developed the Quality Control for Scanning HCSM. Upon HCSM approval, all NAVAHCS staff charged with medical record scanning will receive education on the HCSM contents as presented by the Chief of HIMS and/or designee. The Chief of HIMS is responsible for this HCSM and staff education.

Tracking staff members who have received this education will be done by the Chief of HIMS and/or designee. Quarterly reports will be presented to the oversight committee, QPB, until all applicable staff have received this education and appropriate compliance is documented.

In order to ensure sustainability, quarterly reports will be presented to QPB until all applicable staff have received this education. In addition, all new employees charged with medical record scanning will receive training on this HCSM during their New Employee Orientation.

Recommendation 5. We recommended that processes be strengthened to ensure that all expired medications are removed from patient care areas.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that all expired medications are removed from the Outpatient Surgery Unit, the following steps have been taken:

Beginning November 1, 2013, the Pyxis units in the Outpatient Surgery Unit will be inventoried by a staff member from Pharmacy and the Outpatient Surgery Unit on a monthly basis. The Chief of Pharmacy and the Specialty & Diagnostics (S&D) Service Line Manager are responsible for this process.

Findings of the inventory will be documented and reported monthly to the Chief of Pharmacy and the S&D Service Line Manager with quarterly reports to the oversight committee, the Medical Executive Board.

In order to ensure sustainability, monitoring will continue until 100% compliance is achieved in three consecutive months.

Recommendation 6. We recommended that processes be strengthened to ensure that lower storage shelves in the distribution storage area are solid and at least 8 inches above the floor.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that lower storage shelves in the distribution storage area are solid and at least 8 inches above the floor, the following steps have been taken:

Shelf liners will be purchased and installed on the bottom shelf of all wire rack shelving throughout Distribution storage areas.

Logistics Service Line is responsible for purchasing and installing the shelf liners and Facilities Management Service Line is responsible for providing support to raise the bottom shelves to above 8 inches above the floor.

This shelving requirement will be added to the Environment of Care Action Item Tracking document and will be monitored by the Logistics Officer with results reported quarterly to the oversight committee, EOC/SB.

In order to ensure sustainability, monitoring of shelving requirements will continue until 100% compliance is achieved in three consecutive months.

Recommendation 7. We recommended that processes be strengthened to ensure that distribution storage area humidity and temperatures are maintained within acceptable levels and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that distribution storage area humidity and temperatures are maintained within acceptable levels and that compliance is monitored, the following steps have been taken:

A new Temp Trak (temperature monitoring system) monitoring access point will be added to the 4A Distribution area. Access and training related to this new monitoring system will be provided to the Distribution staff by the FM Service Line Assistant Manager. Logistics Service Line, FM Service Line and ISSL are responsible for this new process.

Humidity and temperature monitors with reports of non-compliance in distribution storage areas will be included in the Environment of Care Action Item tracking document and will be monitored monthly by the Assistant Facilities Manager. Results will be reported quarterly to the Oversight Committee, EOC/SB.

In order to ensure sustainability, monitoring of humidity and temperature levels will continue until 100% compliance is achieved in three consecutive months.

Recommendation 8. We recommended that facility policy be amended to include that the CS Coordinator and inspectors must be free from conflicts of interest and that the CS Coordinator must have a complete understanding of CS policies and the VHA CS

inspection process and to include the requirements for new CS inspector orientation and annual training thereafter.

Concur

Target date for completion: December 1, 2013

Facility response: In order to ensure that facility policy is amended to include that the CS Coordinator and inspectors must be free from conflicts of interest and that the CS Coordinator must have a complete understanding of CS policies and the VHA CS inspection process and to include the requirements for new CS inspector orientation, the following steps have been taken:

The Controlled Substance Coordinator has developed the Inspection of Controlled Substances HCSM No. 11-58. Upon HCSM approval, all NAVAHCS staff charged with controlled substance inspection will receive education on the HCSM contents as presented by the CS Coordinator. The new HCSM specifies that the CS Coordinator and inspectors are free from conflicts of interest and that the CS Coordinator has a complete understanding of CS policies and the VHA CS inspection process. The CS Coordinator is responsible for this HCSM and staff education.

Tracking staff members who have received this education will be done by the CS Coordinator. Quarterly reports will be presented to the Facility Director until all applicable staff have received this education and appropriate compliance is documented.

In order to ensure sustainability, quarterly reports will be presented to the Facility Director until all applicable staff have received this education. In addition, employees newly assigned to controlled substance inspection will receive training on this HCSM during their orientation to the controlled substance inspection program.

Recommendation 9. We recommended that managers initiate actions to address the two identified deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that all deficiencies identified during the annual physical security surveys are corrected, the following steps have been taken:

The deficiencies identified in the 2012 annual physical security survey were addressed via work order for a vault door and gate replacement, however, at that time, funds were not available. In October 2013, a work order was resubmitted and a purchase package developed for a new vault door and gate that meet GSA 5 requirements. After installation of the new vault door and gate, the Pharmacy SLM will notify the Chief of Police of compliance via Memorandum. Future deficiencies identified in the annual

physical security survey will be reported to the Environment of Care (EOC) Board. Action plans will be developed and reported on a monthly basis to the EOC Board until the issue is resolved. Oversight of the EOC Board tracking will be conducted by the Executive Leadership Council.

Recommendation 10. We recommended that processes be strengthened to ensure that quarterly trend reports are provided to the facility Director.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that quarterly trend reports on Controlled Substance Inspections are completed and provided to the Facility Director, the following steps have been taken:

The new HCSM on Inspection of Controlled Substances specifies that the CS Coordinator must prepare and submit a Quarterly Trends Report to the Facility Director summarizing any identified discrepancies or problematic trends and potential areas for improvement. The report is to be trended by location, drug and number of doses. The CS Coordinator will work in collaboration with facility Data Analyst to create a process for standardized data entry. Reports will be generated from data entries.

The CS Coordinator is responsible for preparing and submitting the quarterly trends report to the Facility Director.

In order to ensure sustainability, quarterly reports will be submitted to the Facility Director.

Recommendation 11. We recommended that processes be strengthened to ensure that all non-pharmacy areas with CS are inspected monthly, that inspections are randomly scheduled and completed on the day initiated, and that inspectors verify hard copy orders for five dispensing activities and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: The new HCSM on Inspection of Controlled Substances specifies that the CS Inspector conducts random, unannounced inspections that are completed on the day the inspection is initiated. The HCSM also specifies that the CS Inspector verifies that there is an order for five randomly selected dispensing activities on each unit inspected. As per Recommendation #8, all CS Inspectors will receive education on this HCSM. The CS Coordinator is responsible for this HCSM, CS Inspectors' education, and confirming the monthly inspection report contains all required information.

Tracking areas of inspection, random scheduling, verification of orders, and completion of the inspection on the day initiated will be done monthly by the CS Coordinator. Quarterly reports of this data will be presented to the Facility Director.

In order to ensure sustainability, quarterly reports will be presented to the Facility Director. Additionally, reporting to the OIG will continue until 100% compliance is achieved for three consecutive months.

Recommendation 12. We recommended that processes be strengthened to ensure that the main pharmacy vault and pharmacy emergency cache are inspected monthly and that inspections include all required elements and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: The new HCSM on Inspection of Controlled Substances specifies that the CS Inspector conducts monthly inspection of the main pharmacy vault and pharmacy emergency cache. As per Recommendation #8, all CS Inspectors will receive education on this HCSM.

The CS Coordinator is responsible for this HCSM, CS Inspectors' education, and that the monthly inspections are done in the main pharmacy vault and pharmacy emergency cache.

Tracking these areas of inspection will be done monthly by the CS Coordinator. Quarterly reports of this data will be presented Facility Director.

In order to ensure sustainability, quarterly reports will be presented to the Facility Director. Additionally, reporting to the OIG will continue until 100% compliance is achieved for three consecutive months.

Recommendation 13. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: December 1, 2013

Facility response: In order to ensure that the PCCT includes a dedicated administrative support person, the following steps have been taken:

The position description for the GEC Administrative Support Assistant will be updated to reflect that 0.25 of the FTE is dedicated to hospice/palliative care support. This update has been discussed with the current Administrative Support Assistant and she concurs with this change to her position description. The Geriatric and Extended Care (GEC) SLM is responsible for assuring this change is completed.

Recommendation 14. We recommended that processes be strengthened to ensure that 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 1, 2014

Facility response: In order to ensure that the non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training, the following steps have been taken:

The End of Life TMS module will be added as required annual education for all identified non-HPC clinical staff who care for patients at the end of life. The GEC Service Line Manager and the Palliative Care Coordinator (PCC) are responsible for assuring this training is completed by all identified non-HPC clinical staff.

With the assistance of the TMS administrator, the PCC will monitor and track monthly reports on training that has been completed. Results will be reported quarterly to the Nurse Executive Board (NEB), the oversight committee.

In order to ensure sustainability, monitoring will continue until all required staff have completed training.

Recommendation 15. We recommended that facility policy be amended to include that a minimum 0.25 FTE MH professional and an administrative support person be assigned to the PCCT.

Concur

Target date for completion: December 1, 2013

Facility response: HCSM 218-GEC-19 Palliative Care Services Program will be amended to include a minimum of 0.25 FTE MH professional and 0.25 FTE administrative support person are assigned to the PCCT. The GEC Service Line Manager is responsible for making this change. PCCT staff will receive education from the PCC related to the HCSM changes.

In order to ensure sustainability, quarterly reports will be presented to the GEC Service Line Manager until appropriate compliance is documented.

Recommendation 16. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: Education will be provided to all Acute Care RNs and CNAs on accurate documentation of location, stage, risk scale score and date pressure ulcer acquired. Education will also be provided on pressure ulcer recognition and staging. The Acute Care Nurse Manager, Acute Care Assistant Nurse Manager and the Facility Wound Care Nurse are responsible for providing this education.

Pressure Ulcer documentation will be added as a monitor to the Acute Care monthly chart audit process completed by the Acute Care Nurse Manager and the Acute Care Assistant Nurse Manager. Quarterly reports will be reviewed by the Medical Records Committee (MRC) and by the Nurse Executive Board (NEB).

In order to ensure sustainability, quarterly reports will continue until 90% compliance in three consecutive months is achieved.

Recommendation 17. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: Education will be provided to the Acute Care RNs that discharge documentation must include supplies and/or treatment items given to patients discharged with pressure ulcers. The Acute Care Nurse Manager, Acute Care Assistant Nurse Manager and the Facility Wound Care Nurse are responsible for providing this education.

Documentation of Pressure Ulcer supplies given to patients at discharge will be added as a monitor to the Acute Care monthly chart audit process completed by the Acute Care Nurse Manager and the Acute Care Assistant Nurse Manager. Quarterly reports will be reviewed by the MRC and by the NEB.

In order to ensure sustainability, quarterly reports will continue until 90% compliance in three consecutive months is achieved.

Recommendation 18. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: In order to ensure that the Acute Care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance is monitored, the following steps have been taken:

Education will be provided to the Acute Care RNs that documentation must include pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. The Acute Care Nurse Manager, Acute Care Assistant Nurse Manager and the Facility Wound Care Nurse are responsible for providing this education.

Documentation of Pressure Ulcer education will be added as a monitor to the Acute Care monthly chart audit process completed by the Acute Care Nurse Manager and the Acute Care Assistant Nurse Manager. Quarterly reports will be reviewed by the MRC and by the NEB.

In order to ensure sustainability, quarterly reports will continue until 90% compliance in three consecutive months is achieved.

Recommendation 19. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: March 1, 2014

Facility response: Education will be provided to the Acute Care RNs and CNAs as noted in Recommendations #17, #18 and #19. Additionally, annual completion of Mosby's online education and competency test will be required of all Acute Care RNs with a copy of the test maintained in the staff competency folder.

The Acute Care Nurse Manager, Acute Care Assistant Nurse Manager and the Facility Wound Care Nurse are responsible for providing this education. Completion of the Mosby's online education and competency test will be monitored monthly by the Acute Care Service Line Manager with Quarterly reports to the NEB, the oversight committee.

In order to ensure sustainability quarterly reports will continue until 100% compliance in three consecutive months is achieved.

Recommendation 20. We recommended that nursing managers monitor the staffing methodology that was implemented in August 2013.

Concur

Target date for completion: March 1, 2014

Facility response: Outbrief to the Director for final determination of target nursing hours per patient day (NHPPD) for each nursing unit will occur on November 4, 2013. The Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE) is responsible for implementation of Staffing Methodology.

Effective December 1, 2013, all nursing inpatient and long term care units will monitor actual nursing hours per patient day and will perform an analysis of monthly variance from target NHPPD exceeding 10.0%.

The Acute Care and Long Term Care Nurse Managers are responsible for monitoring, analysis of variance, and creation/implementation of corrective action plans as appropriate. Monthly results will be reported to the ADPCS/NE with quarterly reports to the oversight committee, Nurse Executive Board.

In order to ensure sustainability, monitoring will continue until 90% compliance is achieved in three consecutive months.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Sandra Khan, RN, BSN, Team Leader Josephine Biley Andrion, RN, MHA Elizabeth Burns, MSSW Deborah Howard, RN, MSN Judy Montano, MS Glen Pickens, RN, MHSM Katrina Young, RN, MSHL
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Derrick Hudson Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
VHA
Assistant Secretaries
General Counsel
Director, VA Southwest Health Care Network (10N18)
Director, Northern Arizona VA Health Care System (649/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Flake, John McCain
U.S. House of Representatives: Paul A. Gosar

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

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Materiel Management, 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 included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.