Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02082-82

Combined Assessment Program Review of the Hampton VA Medical Center Hampton, Virginia

January 20, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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E-Mail: vaoighotline@va.gov
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Hampton VA Medical Center
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
QM	quality management
RRTP	residential rehabilitation treatment program
SDS	same day surgery
tPA	tissue plasminogen activator
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 September 22, 2014.

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

- Community Living Center Resident Independence and Dignity

The facility's reported accomplishments were establishing the Veteran "X" program, a peer-to-peer recovery-based support group, and being recognized as a Top Performer on Key Quality Measures® by The Joint Commission.

Recommendations: We made recommendations in the following eight activities:

Quality Management: Establish a Surgical Work Group that meets monthly, includes all required members, and documents oversight of surgical performance improvement activities.

Environment of Care: Secure soiled utility rooms at all times. Ensure public restrooms on the Department of Housing and Urban Development and VA Supportive Housing floor are clean and well maintained. Maintain auditory privacy in all interview areas on the Department of Housing and Urban Development and VA Supportive Housing floor. Store sterile supplies for same day surgery/the post-anesthesia care unit in a secured room where appropriate temperature and humidity levels can be maintained.

Medication Management: Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

Coordination of Care: Ensure clinicians validate patients' and/or caregivers' understanding of the discharge instructions they provide.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on the critical care unit, in the emergency department, and on all inpatient units. Screen patients for difficulty swallowing prior to oral intake. Collect and report all required data elements to the Veterans Health Administration.

Magnetic Resonance Imaging Safety: Complete secondary patient safety screenings immediately prior to magnetic resonance imaging, and document this in the electronic health record.

Mental Health Residential Rehabilitation Treatment Program: Secure medications in residents' rooms. Ensure all domiciliary admission denials contain documentation regarding the reason for the denial.

Construction Safety: Conduct contractor tuberculosis risk assessments prior to construction project initiation.

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 25–33, for the full text of the Directors' comments.) We consider recommendation 9 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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 nine activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety
- MH RRTP
- 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 2013 and FY 2014 through September 22, 2014, 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 Hampton VA Medical Center, Hampton, Virginia,* Report No. 12-03077-122, March 4, 2013).

During this review, we presented crime awareness briefings for 98 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 370 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

Veteran "X" Program

The Veteran "X" program is an innovative, peer-to-peer, recovery-based support group to help veterans achieve and maintain a sober and healthy lifestyle of recovery. The program places an emphasis on developing the necessary life skills for success. It was selected from 3,500 entries as a top innovative recovery-oriented program and was funded for $450,000 to implement phase 1. The program has been expanded to phase 2, which includes a research component, and is being considered for funding for phase 3, which will include implementation of the program nationwide.

Top Performer on Key Quality Measures

On October 30, 2013, the facility was recognized by The Joint Commission as a Top Performer on Key Quality Measures® for exemplary performance in using evidence-based clinical processes to improve surgical care. The recognition is based on data reported about evidence-based clinical processes that are shown to improve care for veterans undergoing surgical procedures.

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 met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The Peer Review Committee was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the Peer Review Committee. • The Peer Review Committee submitted quarterly summary reports to the Medical Executive Committee. • Unusual findings or patterns were discussed at the Medical Executive Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the Medical Executive Committee.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The facility had two surgery committees (Surgical Expansion and Optimization Workgroup and Invasive Procedures/Operating Room Committee), but neither met requirements for membership and meeting frequency or provided oversight of the surgical morbidity and mortality conference or other surgical performance improvement activities.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendation

1. We recommended that the facility establish a Surgical Work Group that meets monthly, includes all required members, and documents oversight of surgical performance improvement activities such as morbidity and mortality reviews.

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 the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the SDS/PACU, intensive care, 3 East telemetry, 3 West step down, 4 East medical/surgical, and dialysis units. We also inspected the 2 South locked behavioral health, spinal cord injury, and CLC A and B units; the emergency department; the women's health clinic; the eye clinic; and the Department of Housing and Urban Development and VA Supportive Housing floor. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 13 employee training records (4 SDS, 4 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	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.	• Two of 11 soiled utility rooms were unlocked and unattended. • Two public restrooms on the Department of Housing and Urban Development and VA Supportive Housing floor were dirty, and one of the restrooms had broken floor tiles and soiled ceiling tiles.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
X	Auditory privacy requirements were met.	• Interview areas on the Department of Housing and Urban Development and VA Supportive Housing floor did not have sufficient auditory privacy.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

NM	Areas Reviewed for SDS and the PACU	Findings
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
X	Environmental safety requirements in SDS and on the PACU were met.	• SDS/PACU did not have a sterile storage room that could be secured, and sterile supplies were kept on carts in areas where temperature and humidity levels could not be maintained.
NA	SDS medical laser safety requirements were met.	
X	Infection prevention requirements in SDS and on the PACU were met.	• One soiled utility room on SDS/PACU was unlocked and unattended.
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

2. We recommended that that processes be strengthened to ensure that soiled utility rooms are secured at all times and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that public restrooms on the Department of Housing and Urban Development and VA Supportive Housing floor are clean and well maintained and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that auditory privacy is maintained in all interview areas on the Department of Housing and Urban Development and VA Supportive Housing floor and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that sterile supplies for same day surgery/the post-anesthesia care unit are stored in a secured room where appropriate temperature and humidity levels can be maintained and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For the seven patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

6. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	• Five EHRs (15 percent) did not contain documentation that clinicians validated patients' and/or caregivers' understanding of the discharge instructions they provided.
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that processes be strengthened to ensure that clinicians validate patients' and/or caregivers' understanding of the discharge instructions they provide.

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents and the EHRs of 27 randomly selected patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the emergency department, one critical care unit, and two acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the 23 applicable EHRs contained documented evidence of completed stroke scales.
NA	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted on the critical care unit, in the emergency department, or on the inpatient units.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Six of the 24 applicable EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
	Clinicians provided printed stroke education to patients upon discharge.	
NA	The facility provided training to staff involved in assessing and treating stroke patients.	
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and/or reported to VHA: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

9. We recommended that stroke guidelines be posted on the critical care unit, in the emergency department, and on all inpatient units.

10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

11. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 14 EHRs of residents (10 residents receiving restorative nursing services and 4 residents not receiving restorative nursing services but candidates for services). We also observed one resident during two meal periods, reviewed four employee training/competency records and other relevant documents, 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.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 34 employees (29 randomly selected Level 1 ancillary staff and 5 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of one MRI area. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Fifteen EHRs (43 percent) did not contain secondary patient safety screenings prior to MRI.
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and documented in the electronic health record and that compliance be monitored.

MH RRTP

The purpose of this review was to determine whether the facility's domiciliary complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the domiciliary, and interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The residential environment was clean and in good repair.	
NA	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
	Monthly MH RRTP 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).	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	

NM	Areas Reviewed (continued)	Findings
X	Medications in resident rooms were secured.	• We found unsecured medications in four of the 20 resident rooms inspected.
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on domiciliary admissions reviewed: • Of the nine domiciliary admission denials reviewed, four did not contain required documentation regarding the reason for the denial.

Recommendations

13. We recommended that processes be strengthened to ensure that medications in resident rooms are secured.

14. We recommended that processes be strengthened to ensure that all domiciliary admission denials contain documentation regarding the reason for the denial and that compliance be monitored.

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.[i]

We inspected the Expand Surgery Phase III and the Renovate Spinal Cord Injury unit projects. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	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.	
X	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	Risk assessments reviewed: • Contractor tuberculosis risk assessments were not conducted prior to either project's 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.	

NM	Areas Reviewed (continued)	Findings
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

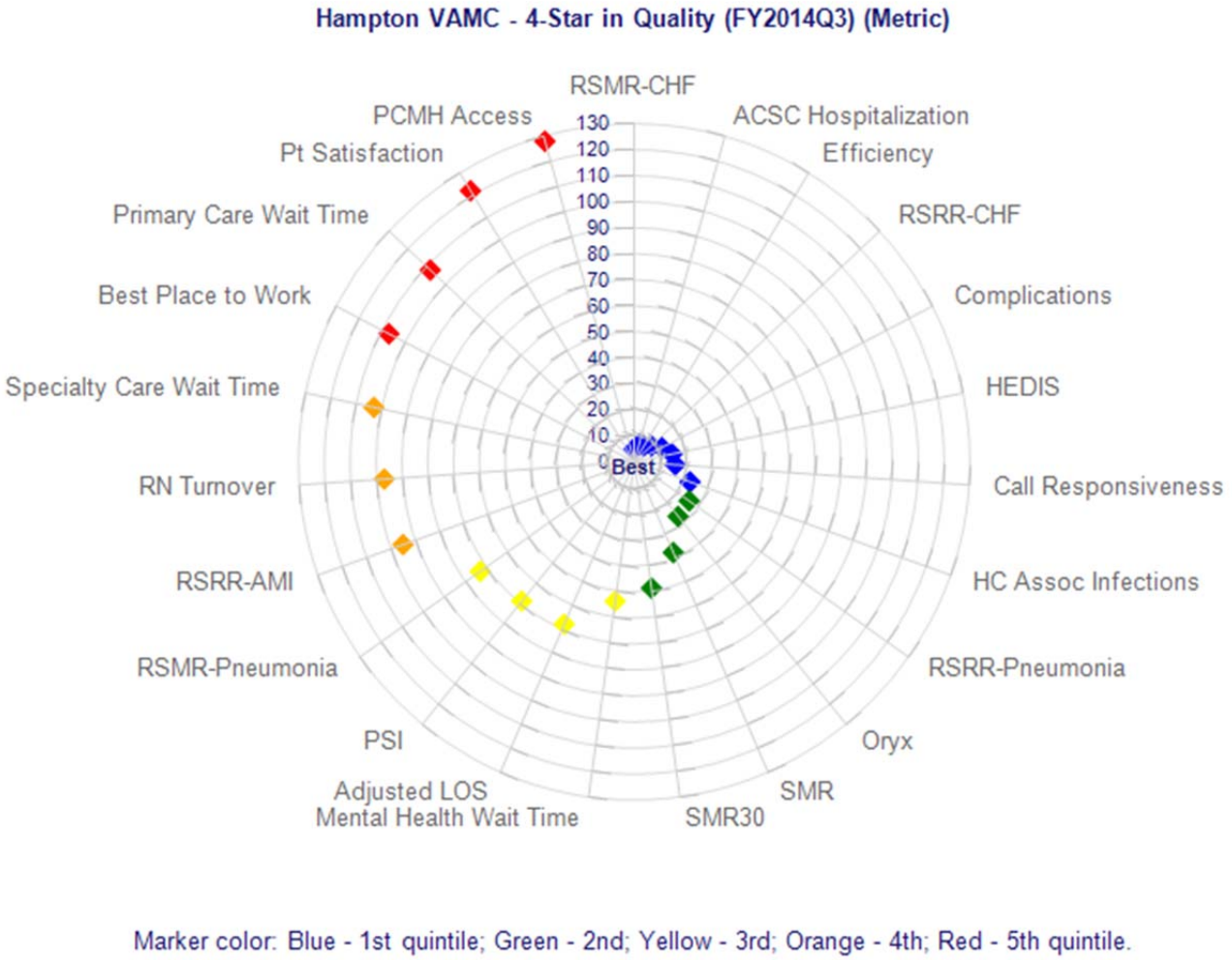
Recommendation

15. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

Facility Profile (Hampton/590) FY 2014 through August 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$280.4
Number of:	
• **Unique Patients**	45,984
• **Outpatient Visits**	435,921
• **Unique Employees**[2]	1,404
Type and Number of Operating Beds (July 2014):	
• **Hospital**	146
• **CLC**	122
• **MH**	169
Average Daily Census (July 2014):	
• **Hospital**	81
• **CLC**	64
• **MH**	142
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Norfolk/590GB Abermarle/590GC
VISN Number	6

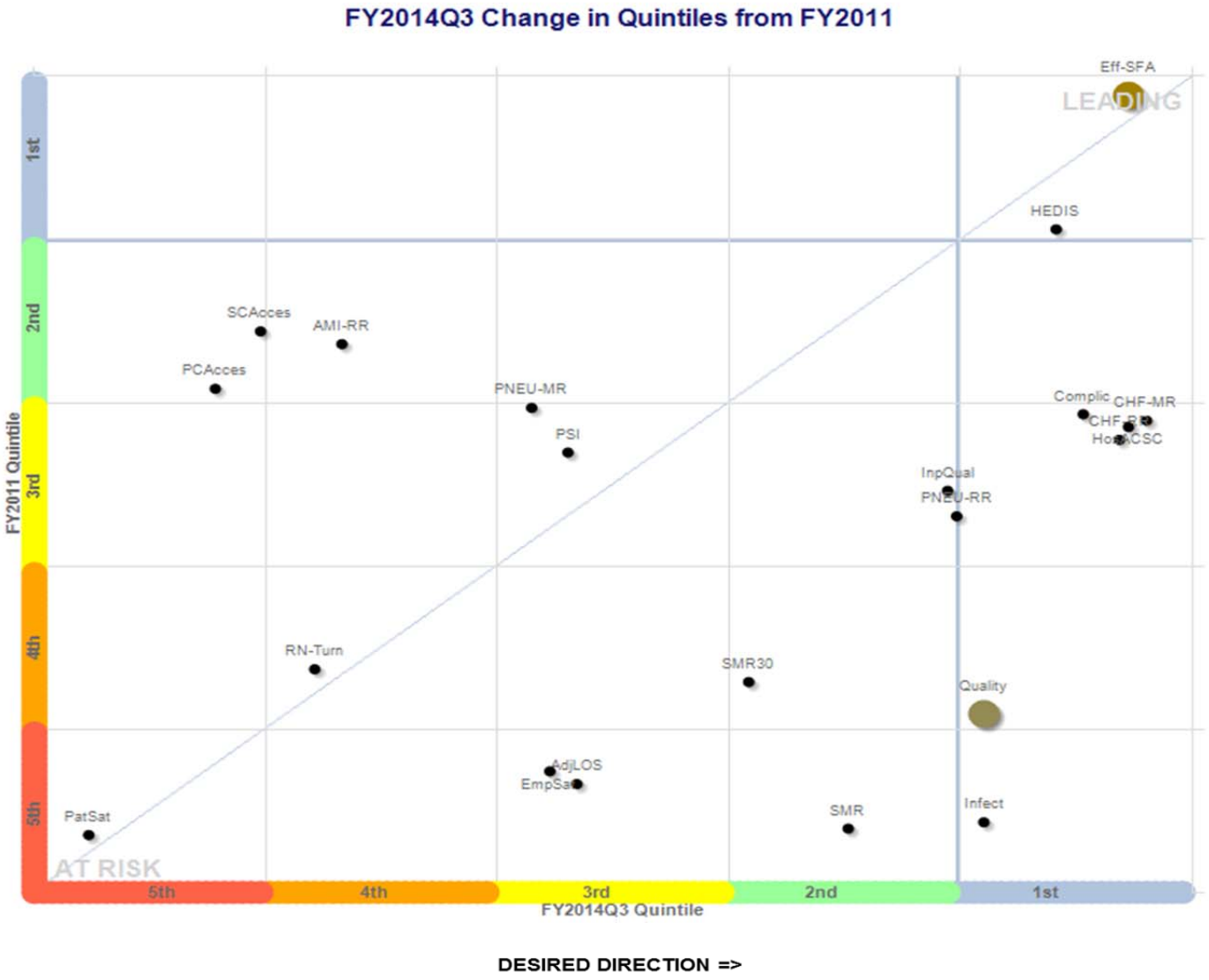
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 15, 2014

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Hampton VA Medical Center, Hampton, VA**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

1. The attached subject report is forwarded for your review and further action. I have reviewed the response of the Hampton VA Medical Center, Hampton, VA, and concur with the facility's recommendations.

2. If you have further questions, please contact Lisa Shear, VISN 6 QMO, at (919) 956-5541.

for DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 21, 2014

From: Director, Hampton VA Medical Center (590/00)

Subject: **CAP Review of the Hampton VA Medical Center, Hampton, VA**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. I have reviewed the draft report and concur with the recommendations. The findings outlined in the OIG report reflect a thorough evaluation.

2. We have implemented processes to ensure that variations in the processes are resolved.

3. If you have any questions, please contact Dr. Janet Henderson, acting Chief of Quality Management, at (757) 722-9961 ext 3535.

(original signed by:)
MICHAEL H. DUNFEE, MHA

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 the facility establish a Surgical Work Group that meets monthly, includes all required members, and documents oversight of surgical performance improvement activities such as morbidity and mortality reviews.

Concur

Target date for completion: March 31, 2015

Facility response: The Surgical Expansion and Optimization Workgroup started meeting in September 2013 and was renamed to the Facility Surgical Work Group (FSWG) September 2014. The required membership was modified September 2014 to include both the Chief of Staff and Veteran's Administration Surgery Quality Improvement Program (VASQIP) Nurse. As of November 2014, both the Invasive Procedure/Operating Room (IPOR) Committee and FSWG have oversight for Morbidity and Mortality data. Meeting minutes are maintained for both the FSWG and IPOR meetings.

Recommendation 2. We recommended that that processes be strengthened to ensure that soiled utility rooms are secured at all times and that compliance be monitored.

Concur

Target date for completion: March 31, 2015

Facility response: An electronic email was sent to the Emergency Department, Spinal Cord Injury unit, PACU and SDS staff reminding them of the requirement to ensure soiled utility rooms are kept secured at all times. Nurse Managers or designees make rounds on the units and observe the security of the soiled utility rooms. Any identified instance of non-compliance is addressed immediately by the Nurse Manager or designee. Compliance is reported monthly to the Nurse Executive Leadership Board.

Recommendation 3. We recommended that processes be strengthened to ensure that public restrooms on the Department of Housing and Urban Development and VA Supportive Housing floor are clean and well maintained and that compliance be monitored.

Concur

Target date for completion: April 30, 2015

Facility response: Immediately upon identification on September 26, 2014, both bathrooms were terminally cleaned. The Housekeeping aide assigned to this area has increased their daily monitoring of the cleanliness of these bathrooms. Additionally, the Housekeeping supervisor is performing weekly rounds to assess the cleanliness of the bathrooms. Compliance is reported monthly to the Environment of Care Committee.

A work-order has been placed to replace the broken tiles. The projected timeline to replace the broken tiles is December 2014.

Recommendation 4. We recommended that processes be strengthened to ensure that auditory privacy is maintained in all interview areas on the Department of Housing and Urban Development and VA Supportive Housing floor and that compliance be monitored.

Concur

Target date for completion: April 30, 2015

Facility response: The Hampton VA Medical Center has experienced a 30% growth in Mental Health personnel over the past three years. The Housing and Urban Development and VA Supportive Housing (HUDVASH) program has seen the most rapid growth and expansion. Over the past seven years, Social Worker Case Managers have increased from one in 2007 to twenty-eight in 2014; and are expected to further increase in the next year with the emphasis on eliminating homelessness.

To address the immediate issue of auditory privacy, Housing and Urban Development and VA Supportive Housing (HUDVASH) staffing has been adjusted to avoid multiple appointments in the shared office space to facilitate auditory privacy. Compliance is assessed by the Chief, Behavioral Health/Mental Health or designee by reviewing staffing, assessing auditory privacy and making any additional staffing adjustments as needed. Compliance is monitored monthly and reported quarterly to the Mental Health Executive Council (MHEC).

In the long term, a new 25,000 square foot Mental Health building is currently at 95% design and is slated to be completed in 2017. This will create fifty new office spaces.

In the shorter term the following is being implemented to address the space issues:

- Currently working with two community agencies for additional office space for use by Hampton VAMC staff: a Memorandum of Understanding (MOU) is currently being negotiated with a projected target date of February 28, 2015
- Additionally, working to identify a 10,000 square foot building for lease in the community with a projected target date of March 31, 2015

Recommendation 5. We recommended that processes be strengthened to ensure that sterile supplies for same day surgery/the post-anesthesia care unit are stored in a secured room where appropriate temperature and humidity levels can be maintained and that compliance be monitored.

Concur

Target date for completion: June 1, 2015

Facility response: The sterile supplies for the Same Day Surgery/Post-Anesthesia Care Unit are being relocated to a secure supply room that has tracking sensors for continuous monitoring of both temperature and humidity via the "Temp Trak" monitoring system. The timeframe to complete the movement of the sterile supplies is January 14, 2015.

Recommendation 6. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: April 1, 2015

Facility response: The Medication Reconciliation template has been revised to document the accommodations initiated for identified learning barriers as a required field. The revised template was reviewed and approved by the Medical Records Committee and an electronic message has been sent out to all clinicians explaining the revisions to the template and the requirement to document the accommodations made to address a patients identified learning barriers. Medical record audits are being performed monthly and are reported monthly to the Medical Records Committee and quarterly to the Medical Executive Board (MEB).

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians validate patients' and/or caregivers' understanding of the discharge instructions they provide.

Concur

Target date for completion: November 17, 2014

Facility response: The Clinician Discharge Instruction templates were reviewed. The Psychiatric Interim Discharge Summary Note and Psychiatry-Inpatient Continuing Care Plan templates were updated to include a mandatory checkbox to validate the patient and/or caregiver verbalized understanding of the discharge instructions and that they were given a written copy of the discharge instructions. Medical records audits are performed monthly and are reported monthly to the Medical Records Committee and quarterly to the Medical Executive Board (MEB).

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: May 29, 2015

Facility response: The National Institutes of Health (NIH) Stroke Scale Assessment has been incorporated into a Progress Note Template in the electronic medical record. This note is completed on all patients who present to the Emergency Department with signs and symptoms of stroke as well as inpatients who may develop these signs and symptoms while hospitalized. Education on completion of the NIH Stroke scale note will be completed by December 15, 2014 for all nurses who work in the Emergency Department and the acute care inpatient units. Medical records of all patients who present to the Emergency Department or are discharged from the acute care inpatient units with a diagnosis of acute stroke are reviewed monthly to verify documentation of the NIH Stroke Assessment Scale note. Results of the monthly audits are reported to the Critical Care Committee monthly and the Medical Executive Board (MEB) quarterly.

Recommendation 9. We recommended that stroke guidelines be posted on the critical care unit, in the emergency department, and on all inpatient units.

Concur

Target date for completion: October 31, 2014

Facility response: National Institutes of Health (NIH) Signs and Symptoms of Acute Stroke have been posted in the Emergency Department and all acute care inpatient units.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: April 30, 2015

Facility response: Nursing Bedside Swallowing Screen has been incorporated into a Progress Note Template in the electronic medical record. This note will be completed on all patients who present to the Emergency Department with signs and symptoms of stroke as well as inpatients who may develop these signs and symptoms while hospitalized prior to any oral intake. Education on completion of the Nursing Bedside Swallowing Screen note will be completed by December 15, 2014 for all nurses who work in the Emergency Department and the acute care inpatient units. The medical records of all patients who present to the Emergency Department or are discharged from the acute care wards with a diagnosis of acute stroke are reviewed to validate

screening of the patients for difficulty swallowing was performed and documented prior to oral intake. Results of the monthly audits are reported monthly to the Critical Care Committee and quarterly to the Medical Executive Board (MEB).

Recommendation 11. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: June 30, 2015

Facility response: Medical records of all patients who present to the Emergency Department or are discharged from the acute care wards with a diagnosis of acute stroke will be reviewed monthly beginning in January 2015 to verify documentation of completion of the NIH Stroke Scale progress note and Nursing Bedside Swallowing Screen. Beginning in February 2015, this data will be reported monthly to the Critical Care Committee and quarterly to the Medical Executive Board (MEB). VAMC Hampton is a Level 3 Stroke Receiving Center and does not administer tissue plasminogen activator (tPA). If a patient presents to the Emergency Department or is evaluated on the acute care inpatient unit within the 120 minutes of onset of symptoms, has no contraindications to tPA and with knowledge of potential adverse effects of tPA would consent to treatment, they will be emergently transferred to our nearest Stroke Treatment Center for care.

Recommendation 12. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and documented in the electronic health record and that compliance be monitored.

Concur

Target date for completion: March 31, 2015

Facility response: During April 2014, a review of medical records performed by the Chief Technologist revealed that the Magnetic Resonance Imaging (MRI) secondary patient safety screenings were not always available in the Electronic Medical Record (EMR). In April 2014, the MRI Technologists were re-instructed by the Chief Technologist on the requirement to complete the secondary patient safety screening immediately prior to performing the MRI and immediately scan the document into the EMR when the MRI is performed. This training is documented in the April 22, 2014 MRI Committee meeting minutes. The MRI Technologist also complete Level I and Level II MRI training annually which is documented in the Talent Management System (TMS).

The Chief Technologist also initiated monthly medical record audits to monitor FY 2014 compliance with completing the secondary screen immediately prior to performing the MRI and scanning the document into the EMR. The EMR audits for 3rd Quarter

FY 2014 and 4th Quarter FY 2014 reflect 100% compliance for the documentation of the secondary screening in the EMR. Results of the monthly audits are shared with the MRI Technologists and are reported to the Magnet Resonance Committee quarterly.

Recommendation 13. We recommended that processes be strengthened to ensure that medications in resident rooms are secured.

Concur

Target date for completion: April 30, 2015

Facility response: The Mental Health Residential Rehabilitation Treatment Program (MHRRTP) Nursing and Social Science Assistant (SSA) staff is responsible for checking the resident's rooms twice daily to validate the medications located in the resident's rooms are secured in their wall locker. This monitoring has been increased from once daily to twice daily and is documented on the daily checklist.

Nursing and SSA staff were re-educated on the procedures for performing the room checks, validating the medications in the residents rooms are properly secured and documenting the checks on the checklist. This training was completed by November 20, 2014.

MHRRTP residents are also educated regarding the requirement to secure their medications during daily community meetings lead by the MHRRTP Resident Leader and quarterly Town Hall meetings. Additionally, signage was placed on the inside of each resident's locker reminding them that medications are required to be secured at all times.

Any instances of non-compliance identified are documented in the resident's medical record. The Nurse Manager, SSA Supervisor or designees are notified and immediately address the non-compliance with the resident.

The Nurse Manager monitors the daily checklists utilized to document the room checks and reports monthly compliance quarterly to the Mental Health Executive Council (MHEC).

Recommendation 14. We recommended that processes be strengthened to ensure that all domiciliary admission denials contain documentation regarding the reason for the denial and that compliance be monitored.

Concur

Target date for completion: May 29, 2015

Facility response: Mental Health Residential Rehabilitation Program (MHRRTP) Licensed Independent Practitioners (LIP) that perform and document the admission screening assessment were sent an electronic message from the Chief, Behavioral Health and Mental Health reminding them that all Domiciliary admission denials must

contain documentation of the reason for the denial. Face-to-face training for the MHRRTP LIPs will also be provided and completed by December 15, 2014.

Monthly medical record reviews will be performed by the Chief, Domiciliary or designee to validate the Domiciliary admission denials contain the required documentation of the reason for the denial. Results of the monthly medical record reviews will be reported quarterly to the Mental Health Executive Council (MHEC).

Recommendation 15. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

Concur

Target date for completion: March 31, 2015

Facility response: The Construction Safety Officer updated the Hampton VA Medical Center Pre-Construction Risk Assessment/Evaluation Form to include the performance of and the documentation of a Tuberculosis Risk Assessment prior to the initiation of each construction project. The contractor provides the PPD test results to the Contracting Officer's Technical Representative (COTR) prior to the issuing of badges to the contractor employees. The Construction Safety Officer reviews the contract employees PPD test results prior to issuing badges to the contractor employees. Compliance for the documentation of the TB Risk Assessments is monitored monthly and reported monthly to the Environment of Care Committee in the Interim Life Safety Measure (ILSM)/Infection Control Risk Assessment (ICRA) Monthly Report submitted by the Construction Safety Officer.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Bruce Barnes, Team Leader Lisa Barnes, MSW Gail Bozzelli, RN Myra Conway, RN Donna Giroux, RN Randall Snow, JD Katie O'Neil, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Natalie Sadow, MBA Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

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

Endnotes

[a] 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*, October 15, 2012.
- 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.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[h] 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.

[i] 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.