Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00030-202

Combined Assessment Program Review of the Martinsburg VA Medical Center Martinsburg, West Virginia

April 16, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
ED	Emergency Department
EHR	electronic health record
EOC	environment of care
facility	Martinsburg VA Medical Center
FY	fiscal year
ICU	intensive care unit
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
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 January 12, 2015.

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

- Coordination of Care
- Magnetic Resonance Imaging Safety

The facility's reported accomplishments were receiving national recognition and distinction from The Joint Commission's Top Performer on Key Quality Measures® program and receiving the Marsha Goodwin-Beck Award for Excellence in Geriatric Leadership.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Review privilege forms annually. Ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training and that practitioners' folders do not contain licensure verification information. Require that Code Blue Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Environment of Care: Ensure patient care areas are clean. Secure sterile supply cabinets when not in use. Remove outdated commercial supplies from examination rooms. Ensure employees lock computers and secure sensitive patient information.

Medication Management: Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake. Collect and report all required data elements to the Veterans Health Administration.

Surgical Complexity: Ensure that intensive care unit, Emergency Department, and medical/surgical (4A) unit employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented. Require that post-anesthesia care competency assessment and validation is included in competency checklists and completed and documented for intensive care unit employees.

Emergency Airway Management: Ensure completion of initial clinician emergency airway management competency assessment prior to granting privileges. Require that clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges and includes all required elements.

Mental Health Residential Rehabilitation Treatment Program: Correct deficiencies identified during monthly domiciliary self-inspections, and document correction. Ensure written agreements are in place acknowledging resident responsibility for medication security. Require that residents secure medications in their rooms.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 30–39, 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
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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
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM
- MH RRTP

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 2014 and FY 2015 through January 12, 2015, 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 Martinsburg VA Medical Center, Martinsburg, West Virginia,* Report No. 12-00882-232, July 27, 2012).

During this review, we presented crime awareness briefings for 47 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 308 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

Key Quality Measure Recognition Award

The facility earned the distinction of Top Performer on Key Quality Measures® and national recognition by The Joint Commission for attaining and sustaining excellence in accountability measure performance. The Joint Commission's program is based on data reported in the previous year about evidence-based clinical processes that are shown to be the best treatments for certain conditions, including heart attack, heart failure, pneumonia, and surgical care. The facility earned this award for its heart failure, pneumonia, and surgical care services.

Excellence in Geriatric Leadership

The facility's CLC/palliative unit nurse manager received the Marsha Goodwin-Beck Award for Excellence in Geriatric Leadership. The award is given to an individual health care provider in a leadership position who has demonstrated excellence in supporting direct patient care providers and in providing geriatric education and training and geriatric health care policy leadership.

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, 11 credentialing and privileging folders, and other relevant documents. 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	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• The Medical Executive Committee did not review privilege forms annually. • Of the 11 licensed independent practitioners' folders reviewed, 10 practitioners' EAM privileges were not appropriate for their skills and training. • All of the 11 licensed independent practitioners' folders contained licensure verification information.	**1.** We recommended that the Medical Executive Committee review privilege forms annually and document the review. **2.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training. **3.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain licensure verification information.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.	Twelve months of Code Blue Committee meeting minutes reviewed: • Code reviews did not include screening for clinical issues prior to code that may have contributed to the occurrence of the code.	**4.** We recommended that Code Blue Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
NA	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

We inspected the ICU; the acute MH (6A) and medical/surgical (4A) units; the CLC areas (A, B, 5A, and 5C); primary care (CPC-1, 2, and 3); the women veterans' health, ophthalmology, and hematology/oncology clinics; and the ED. We also performed a perimeter inspection of the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) construction site. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 50 employee training records (10 critical care and 40 CLC) and conversed with key employees and managers. 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	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Three of nine patient care areas had dirty sharps container wall mounts, bases of rolling equipment items, and horizontal room surfaces. • One of nine patient care areas had an unlocked sterile supply cabinet with needles and other items that should not be accessible to the public.	**5.** We recommended that facility managers ensure patient care areas are clean and monitor compliance. **6.** We recommended that the facility secure sterile supply cabinets when not in use and that facility managers monitor compliance.
X	The facility met infection prevention requirements.	• Two of nine patient care areas had outdated commercial supplies in examination rooms.	**7.** We recommended that the facility promptly remove outdated commercial supplies from examination rooms and that facility managers monitor compliance.
	The facility met medication safety and security requirements.		
X	The facility met privacy requirements.	• One of nine patient care areas had examination rooms with unlocked and unattended computers and documents displaying sensitive patient information on the desks.	**8.** We recommended that facility managers ensure employees lock computers and secure sensitive patient information when they leave the area and monitor compliance.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
	The facility met environmental safety requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
	The facility met environmental safety requirements in the CLC.		
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the medical/surgical unit (4A), the ED, the ICU and CLC-A and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not establish employee training and minimum competency requirements for users.	**9.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 37 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. 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	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: Provide training in the use of the computerized consult package Review and manage consults		
	Consult requests met selected requirements: Requestors included the reason for the consult. Requestors selected the proper consult title. Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met 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.[e]

We reviewed relevant documents and the training records of 35 employees (27 randomly selected Level 1 ancillary staff and eight 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 the MRI area. 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	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.		
	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.		
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers 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 facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

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.[f]

We reviewed relevant documents, the EHRs of 20 patients who experienced stroke symptoms, and 15 employee training records (5 ED, 5 ICU, and 5 acute inpatient unit), and we conversed with key employees. We also conducted onsite inspections of the ED, the ICU, and the medical/surgical unit (4A). 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	Recommendations
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Clinicians did not document evidence of completion of stroke scales for any of the 12 applicable patients.	**10.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For four of the 20 applicable patients, clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**11.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
	Clinicians provided printed stroke education to patients upon discharge.		
	The facility provided training to employees involved in assessing and treating stroke patients.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility collected and reported required data related to stroke care.	• The facility did not collect and/or report the following data to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**12.** We recommended that the facility collect and report to the Veterans Health Administration 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.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 38 employees, and we conversed with key managers and employees. 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	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Six of 10 employees on the ICU did not have 12-lead electrocardiogram competency assessment and validation included in their competency checklists. • None of the 10 employees on the ICU had 12-lead electrocardiogram competency assessment and validation documentation completed. • None of the 10 employees in the ED had 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented. • None of the 10 employees on the medical/surgical unit (4A) had 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented.	**13.** We recommended that facility managers ensure that intensive care unit, Emergency Department, and medical/surgical unit (4A) employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented. **14.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed and documented for employees on the intensive care unit.

NM	Areas Reviewed (continued)	Findings	Recommendations
		• None of the 10 employees on the ICU had post-anesthesia care competency assessment and validation included in their competency checklists and completed and documented.	
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 11 clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and 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	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	• Neither of two applicable clinicians had EAM competency assessment completed prior to granting of EAM privileges.	**15.** We recommended that the facility ensure assessment of clinicians for emergency airway management competency prior to granting of privileges and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• Six of nine applicable clinicians did not have reassessments for continued EAM competency completed at the time of renewal of privileges. • Of the six clinicians with reassessments for continued EAM competency: o Four did not have clinician-specific EAM data reviewed. o Two did not have documentation of all required subject matter content elements. o Three did not have evidence of successful demonstration of all required procedural skills on airway simulators or mannequins. o Four did not have evidence of successful airway management and intubation of at least one patient in the preceding 2 years, written certification of airway management competency from the evaluating superior at the non-VA facility, or successful demonstration of airway management and intubation skills to the facility subject matter expert.	**16.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges and includes all required elements and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

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

We reviewed relevant documents, inspected the domiciliary, and conversed with 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.

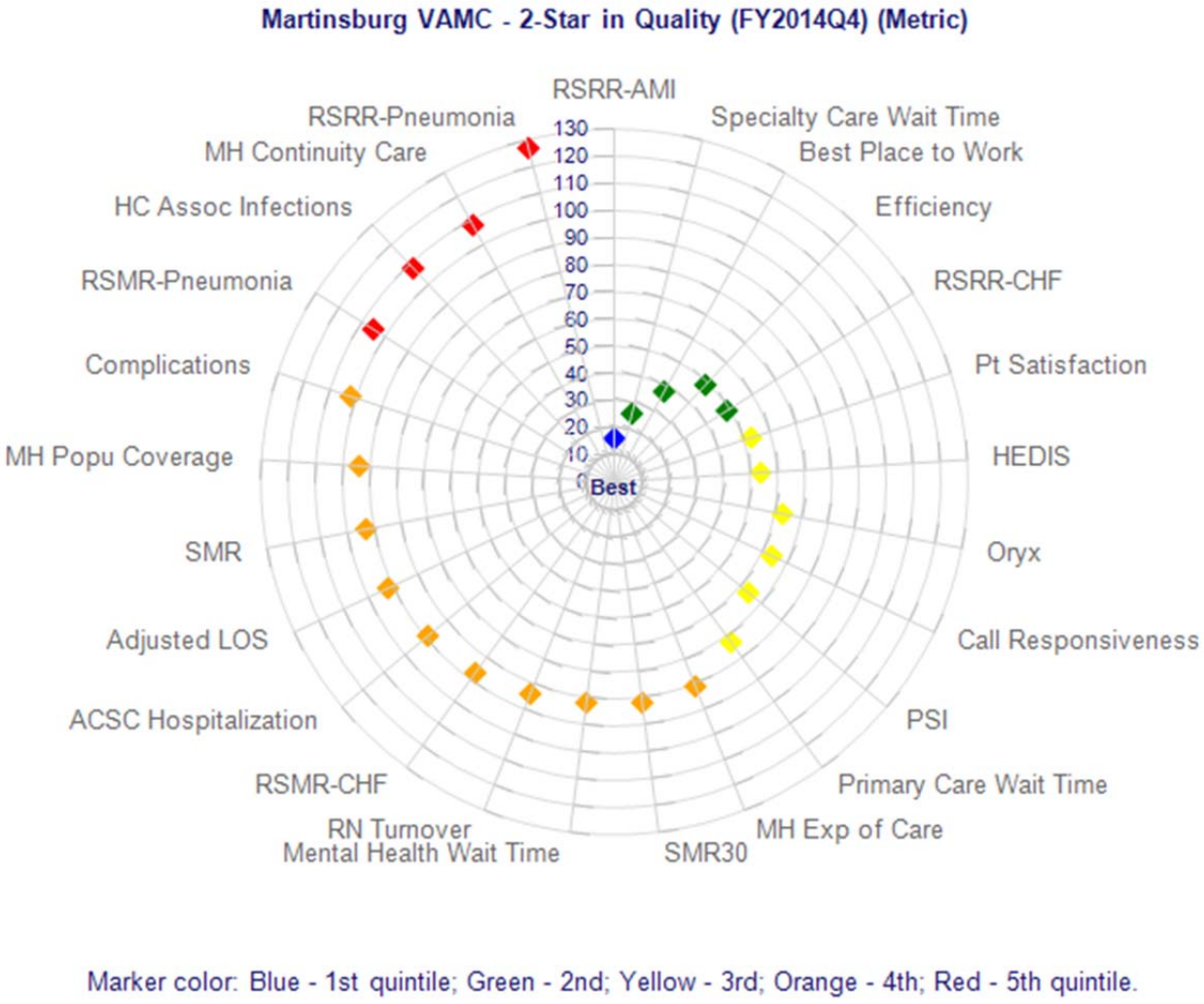
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	Six months of domiciliary self-inspection documentation reviewed: • Documentation did not reflect correction of 80 of 316 identified deficiencies.	**17.** We recommended that the facility correct the identified deficiencies in the domiciliary and that documentation reflect correction.
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
X	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.	• The domiciliary did not have written agreements in place.	**18.** We recommended that domiciliary managers ensure that written agreements are in place acknowledging resident responsibility for medication security.
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
NA	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
X	Residents secured medications in their rooms.	• One resident room on Pod B and two on Pod C contained unsecured medications.	**19.** We recommended that domiciliary program managers ensure residents secure medications in their rooms and monitor compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Martinsburg/613) FY 2015 through January 2015[1]	
Type of Organization	Tertiary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$299
Number (as of February 15, 2015) of:	
• **Unique Patients**	26,684
• **Outpatient Visits**	177,103
• **Unique Employees**[2]	1,318
Type and Number of Operating Beds:	
• **Hospital**	71
• **CLC**	121
• **MH**	265
Average Daily Census:	
• **Hospital**	48
• **CLC**	117
• **MH**	255
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Cumberland/613GA Hagerstown/613GB Stephens City/613GC Franklin/613GD Petersburg/613GE Harrisonburg/613GF Fort Detrick/613GG
VISN Number	5

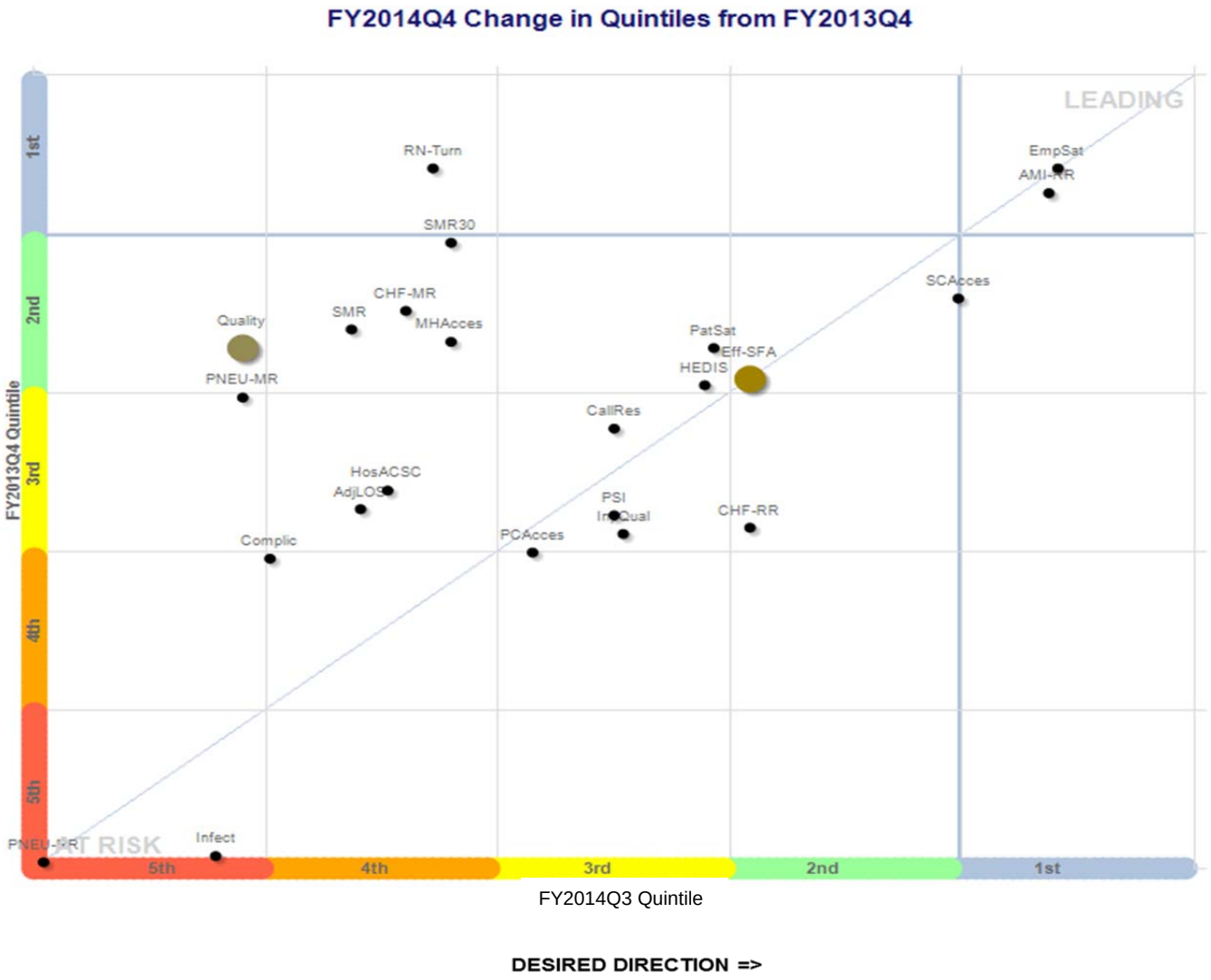
[1] All data is for FY 2015 through January 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

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

Acting VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 20, 2015

From: Acting Director, VA Capitol Health Care Network (10N5)

Subject: **CAP Review of the Martinsburg VA Medical Center, Martinsburg, WV**

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

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

1. I have reviewed and concur with the findings of this report. Specific corrective actions have been provided for the recommendations.

2. If you have any questions or require additional information, please contact Jeffrey Lee, VISN 5 Quality Management Officer at (410) 691-7816.

(original signed by:)
Joseph A. Williams, Jr.

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 5, 2015

From: Director, Martinsburg VA Medical Center (613/00)

Subject: **CAP Review of the Martinsburg VA Medical Center, Martinsburg, WV**

To: Acting Director, VA Capitol Health Care Network (10N5)

1. I have reviewed the draft report and concur with the findings in the report.

2. The corrective actions for each recommendation have been provided.

3. Should you have any questions, please contact V. Denise O'Dell, Chief of Quality Management at (304) 263-0811 ext. 4035.

(original signed by:)
Timothy J. Cooke
Medical Center 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 the Medical Executive Committee review privilege forms annually and document the review.

Concur

Target date for completion: March 31, 2015

Facility response: In accordance with our Medical Staff By-Laws, the facility's Executive Council of the Medical Staff – Credentialing and Privileging (ECMS-C&P), annually reviews all clinical privilege forms to ensure they are correctly and adequately reflecting the Services being provided at the facility. The Council has created an annual reporting schedule as a means to track when the Service will present their clinical privilege forms for review.

As of 3/11/15 all Services have presented their clinical privilege forms to ECMS-C&P with the exception of Medical Service delineations. The presentation of these Medical Service delineations is on the 3/23/15 ECMS-C&P meeting agenda.

Recommendation 2. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.

Concur

Target date for completion: June 30, 2015

Facility response: In accordance to local policy, Medical Center Memorandum (MCM) 112-7: Out-of-Operating Room Airway Management (OORAM), licensed independent practitioners that have specific privileges or scope of practice for airway management should be trained and documented competent according to the stipulations of this policy before they can perform airway management in this facility. Services (i.e. Medical Service and Emergency Department) that have individuals privileged or have scope of practice to perform airway management will ensure that appropriate skills and training are maintained and up-to-date. Training reports are pulled monthly and a spreadsheet is being used to monitor and track compliance status. Training compliance is reported monthly to the Invasive Procedure Review Committee (IPRC). As of this reporting, Medical Service has a 77% compliance to all three of the competency elements (TMS completion of the didactic program, skills assessment using patient simulators, successful demonstration on an actual patient). Medical Service staffs that are deficient are scheduled in the Operating Room (OR) to complete the last competency

component. A 100% compliance is expected by April 30, 2015. For the Emergency Department (ED), Fee basis contracts as well as the Locums contract agreements have been amended to include provisions for completion of the OORAM competency training. All ED providers are expected to reach 100% compliance by 6/30/15.

Recommendation 3. We recommended that the facility ensure that licensed independent practitioners' folders do not contain licensure verification information.

Concur

Target date for completion: May 1, 2015

Facility response: Credentialing and Privileging (C&P) staff are reviewing the practitioners' files and removing all licensure verification information.

Recommendation 4. We recommended that Code Blue Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: June 30, 2015

Facility response: The Cardiopulmonary Resuscitation (CPR) Committee reviews all codes and rapid responses during their monthly meetings. The chairpersons of the CPR Committee have been tasked to assess all codes with emphasis on screening for any clinical issues prior to the code that may have contributed to its' occurrence. Their reviews will then be presented and further discussed in the monthly CPR Committee meeting starting 3/19/15. This report would be reflected on the monthly minutes of the meeting. Target is 100% screening of all codes monitored by Quality Management for three consecutive months to ensure compliance. This documentation would be included as part of the CPR Committee quarterly reporting presentation to the Executive Council of the Medical Staff – Performance Improvement (ECMS-PI) starting on 5/11/15.

Recommendation 5. We recommended that facility managers ensure patient care areas are clean and monitor compliance.

Concur

Target date for completion: March 27, 2015

Facility response: The Chief of Environment Management Service established a review procedure for supervisors. Supervisor will review proper cleaning procedures and the Weekly Supervisor Inspection log with the employees. Supervisor will review the patient care areas in CPC 1, 2 and 3 weekly utilizing the Weekly Supervisor Inspection log.

Recommendation 6. We recommended that the facility secure sterile supply cabinets when not in use and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: All sterile supply cabinets in the Primary Care areas, specifically Comprehensive Primary Care 1 (CPC-1), had been secured and locked when not in use. Deficiency in CPC-1 had been addressed on date of finding, 01/15/15. For sustained compliance, each Patient-Aligned Care Team (PACT) staff has been obligated to check security of the sterile supply cabinets in their area routinely. For reporting and documentation purposes, securing sterile supply cabinets has been added to the Environment of Care (EOC) checklist for the EOC monthly inspections. Target is 100% compliance (secured vs. unsecured) for 3 consecutive months. Compliance documentation report is monitored monthly by the Primary Care (PC) Nurse Manager and submitted to the Safety Office for presentation to the Environment of Care Council.

Recommendation 7. We recommended that the facility promptly remove outdated commercial supplies from examination rooms and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: All outdated commercial supplies in the Primary Care examination rooms had been removed. Deficiency had been addressed on date of finding, 01/15/15. For sustained compliance, each Patient-Aligned Care Team (PACT) staff has been obligated to routinely check for outdates of commercial supplies in their areas. For reporting and documentation purposes, checking for outdates was highlighted in the Environment of Care (EOC) checklist for the EOC monthly inspections. Target is 100% compliance (pass vs. fail) for 3 consecutive months. Compliance documentation report is monitored by the Primary Care (PC) Nurse Manager and submitted to the Safety Office for presentation to the Environment of Care Council.

Recommendation 8. We recommended that facility managers ensure employees lock computers and secure sensitive patient information when they leave the area and monitor compliance.

Concur

Target date for completion: May 31, 2015

Facility response: All employees are required to complete Talent Management System (TMS) VA-10176: VA Privacy and Information Security Awareness and Rules of Behavior training on an annual basis which stresses the importance of locking computers. As of this reporting, 3/19/15, a 100% compliance was noted for those clinical staff assigned this education. The facility's Information Security Officer (ISO) has agreed to approve "NewsByte" emails to all employees and conduct random physical security checks throughout with immediate report back to the Service Chief. The Public Affairs Office will publish these NewsBytes on a bi-weekly basis.

Recommendation 9. We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: Medical Center Memorandum (MCM 119-18), Omnicell Automation, has been revised and updated in the facility's intranet on 3/10/15 to include employee training and minimum competency requirements for users. Security Agreements, with knowledge and approval from the Information Security Officer (ISO), are maintained by Pharmacy Service. Competencies are kept by the facility managers/supervisors in the employee's competency folder.

Recommendation 10. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: May 31, 2015

Facility response: As per local policy, Medical Center Memorandum (MCM) 111-14 – Acute Ischemic Stroke, National Institutes of Health (NIH) stroke scales for each stroke patient needs to be done and documented in the Computerized Patient Records System (CPRS). A Nursing Stroke Protocol template has been active and must be utilized to achieve this purpose. In conjunction, a local course has been developed in TMS, VA 3813511: MOC-Nursing-Stroke Recognition Training, to assist in educational training. As of this reporting, 3/11/15, a 100% compliance was noted for those clinical staff assigned this education. Compliance on the completion of the National Institutes of Health (NIH) stroke scales for each stroke patient is being monitored and documented by the Program Analyst for Medical Service. That Program Analyst has developed a Performance Improvement (PI) tool to guide in tracking. Data will be reported monthly to the ICU Committee and quarterly to the Quality, Safety, and Value Council starting May 13, 2015 during their reporting schedule.

Recommendation 11. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: May 31, 2015

Facility response: As stated in our local policy, Medical Center Memorandum (MCM) 111-14 – Acute Ischemic Stroke, dysphagia screening before oral intake needs to be done and documented in the Computerized Patient Records System (CPRS). A Dysphagia Nursing Screen template has been active and must be utilized to achieve this purpose. In conjunction, a local course was prior developed in TMS, VA 3813511: MOC-Nursing-Stroke Recognition Training, to assist in educational training. As of this reporting, 3/11/15, a 100% compliance was noted to those clinical staff assigned this education. Compliance on the completion of the dysphagia screening with patients for difficulty in swallowing prior to oral intake is being monitored and documented by the Program Analyst for Medical Service. The said Program Analyst has developed a performance improvement (PI) tool to guide in tracking. Data would be reported monthly to the ICU Committee and quarterly to the Quality, Safety, and Value Council starting May 13, 2015 during their reporting schedule.

Recommendation 12. We recommended that the facility collect and report to the Veterans Health Administration 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: May 31, 2015

Facility response: As per local policy, Medical Center Memorandum (MCM) 111-14 – Acute Ischemic Stroke, Medical Service had been collecting and entering data on use of the tissue plasminogen activator (r-tPA) in the Data Management Warehouse since August 2014. Percentage completion of stroke scale for patients with stroke symptoms and percentage of screening for patients with difficulty of swallowing prior to oral intake are monitored for compliance by the Program Analyst for Medical Service. The said Program Analyst has developed a performance improvement (PI) tool to guide in tracking. This will be presented monthly to the ICU Committee and quarterly to the Quality, Safety, and Value Council starting May 13, 2015 during their reporting schedule.

Recommendation 13. We recommended that facility managers ensure that intensive care unit, Emergency Department, and medical/surgical unit (4A) employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and completed and documented.

Concur

Target date for completion: June 30, 2015

Facility response: On 1/28/15, TMS-NFED 100114: Electrocardiogram 12 Lead was assigned to all nurses in the intensive care unit, emergency department, and medical/surgical unit (4A) and added to their competency requirements. This educational training describes steps the nurse takes when performing a 12-lead electrocardiogram. After completion of TMS module, a performance and return demonstration warranted. Intensive care unit and emergency department staff are at 100% compliance as of 2/23/15. The medical/surgical unit is expected to have the 12-lead electrocardiogram competency assessment and validation completed by June 30, 2015. Completed competency checklist is maintained in the staff's competency folder.

Recommendation 14. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed and documented for employees on the intensive care unit.

Concur

Target date for completion: Completed

Facility response: Nursing Service, together with Education Service, had updated the intensive care unit based orientation packet to include post-anesthesia care competency assessment and validation. 100% compliance for employees in the intensive care unit is expected on 3/20/15. Completed competency checklist is maintained in the staff's competency folder.

Recommendation 15. We recommended that the facility ensure assessment of clinicians for emergency airway management competency prior to granting of privileges and that facility managers monitor competency.

Concur

Target date for completion: June 30, 2015

Facility response: As per local policy, Medical Center Memorandum (MCM) 112-7: Out-of-Operating Room Airway Management (OORAM), Licensed Independent Practitioners (LIPs) and non-LIPs who will be performing out of operating room airway management, other than anesthesia professionals, must demonstrate subject matter expertise and procedural skills. Following demonstrated competency, LIPs and Non-LIPs may be granted privilege or a scope of practice to perform out-of-OR airway

management. Services (i.e. Medical Service and Emergency Department) that have individuals privileged or have scope of practice to perform airway management will ensure that appropriate skills and training are met and appropriately documented according to the conditions of the policy prior to granting of such privilege. Program Analyst for Medical Service has instituted a checklist to ensure that the OORAM training was completed prior to start date for those who have requested OORAM as a specific privilege. For the Emergency Department (ED), Emergency Airway Management (EAM) was taken out as a core privilege for the ED providers and made as a requested specific privilege. ED providers are required to complete all elements of the specified OORAM competency within a reasonable time period. Education Service had put in a major effort to facilitate availability of the OORAM patient-simulated training competency component to the providers. Program Analyst for Primary Care Service has instituted a checklist to ensure that all elements of the OORAM competency training were completed prior to granting of the OORAM specific privilege. Compliance and training status are reported monthly to the Invasive Procedure Review Committee (IPRC). As of date, there are no new or incoming ED providers. Existing ED providers' Fee basis contracts as well as the Locums contract agreements have been amended to include provisions for completion of the OORAM competency training. All ED providers are expected to reach 100% compliance by 6/30/15.

Recommendation 16. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges and includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: As per local policy, Medical Center Memorandum (MCM) 112-7: Out-of-Operating Room Airway Management (OORAM), clinicians who have previously been determined as trained competent under their OORAM provider privilege must be reassessed for continued competency at the time of reappraisal for privileging in the case of Licensed Independent Practitioners (LIPs) or during annual competency assessment in the case of non-LIPs (i.e. Respiratory Therapists). The Program Analysts for Medical Service and Primary Care have both instituted a checklist to monitor and track compliance status of their providers in preparation for renewal of the OORAM privilege. OORAM competency compliance has been included as part of the mid-year and annual providers evaluation. Compliance and training status are reported monthly to the Invasive Procedure Review Committee (IPRC). As of date, ED providers' Fee basis contract as well as the Locums contract agreements have been amended to include provisions for completion of the OORAM competency training. All ED providers are expected to reach 100% compliance by 6/30/15. Once the conditions for competencies are met, the specific privilege may be granted. The Service Chief for both areas are to ensure that reassessment for continued emergency airway management competencies are completed at the time of renewal of privileges.

Credentialing and Privileging, for their part, alerts the services of upcoming renewals a month in advanced to ensure all documentation processes are in place.

Recommendation 17. We recommended that the facility correct the identified deficiencies in the domiciliary and that documentation reflect correction.

Concur

Target date for completion: May 31, 2015

Facility response: Monthly meetings occur between Facility Management Service (FMS) and Mental Health to review open work orders. These meetings allow FMS to provide status updates for any open work orders and estimated times of completion.

Recommendation 18. We recommended that domiciliary managers ensure that written agreements are in place acknowledging resident responsibility for medication security.

Concur

Target date for completion: March 31, 2015

Facility response: Patients sign a document at orientation that has the following statement: "I understand that I am responsible for insuring that all my medications are to be secured in my room locker at all times." This document is scanned into the patient record.

Recommendation 19. We recommended that domiciliary program managers ensure residents secure medications in their rooms and monitor compliance.

Concur

Target date for completion: May 20, 2015

Facility response: Domiciliary (DOM) Health Technicians daily SharePoint room check log will be modified to include new columns reflecting that they have visibly checked the room for unsecure medication and that they have informed the Program Manager in writing via CPRS note that the patients' medications were unsecure. Program Managers will follow-up with the patient and document in CPRS any consequences of this action.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available at **www.va.gov/oig**.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] 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.

[f] 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.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[i] 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.