Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00077-352

Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina

May 21, 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
EHR	electronic health record
EOC	environment of care
facility	William Jennings Bryan Dorn VA Medical Center
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration

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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 March 16, 2015.

Review Results: The review covered eight activities and a follow-up review area from the previous Combined Assessment Program review.

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

Quality Management: Ensure that licensed independent practitioners who perform emergency airway management have the appropriate privileges and that licensed independent practitioners' folders do not contain non-allowed information. Require that the Surgical Work Group documents its review of National Surgical Office reports and surgery performance improvement activities and reviews all surgical deaths with identified problems or opportunities for improvement. Ensure the Accident Review Board provides oversight of the safe patient handling program and gathers, tracks, and shares patient handling injury data. Analyze reports of electronic health record quality review results at least quarterly, and include most services in the review of electronic health record quality.

Environment of Care: Document functionality checks of the community living center's elopement prevention system at least every 24 hours.

Medication Management: Complete Emergency Department/urgent care center monthly medication storage area inspections. Revise the policy for safe use of automated dispensing machines to include oversight of overrides and minimum competency requirements for users.

Coordination of Care: Ensure requestors consistently select the proper consult title.

Magnetic Resonance Imaging Safety: Ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training.

Acute Ischemic Stroke Care: Complete National Institutes of Health stroke scales for each stroke patient within the expected timeframe. Post stroke guidelines on critical care and acute inpatient units. Provide printed stroke education to patients upon discharge. Ensure employees involved in assessing and treating stroke patients receive the training required by the facility. Collect and report all required data elements to the Veterans Health Administration.

Surgical Complexity: Revise the computed tomography scan on-call policy to require a 30-minute reporting time.

Emergency Airway Management: Ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients. Require the Facility Director to ensure designated clinicians have properly completed and granted privileges or scopes of practice.

Follow-Up on Quality Management: Ensure that subordinate committees report data to the appropriate oversight committee and that the oversight committee reviews and analyzes data, takes appropriate action, and tracks actions to completion.

Comments

The Interim 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 27–37, 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 eight activities and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM
- Follow-Up on QM

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 FYs 2012–2014 and FY 2015 through March 19, 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 William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina,* Report No. 12-00371-157, April 18, 2012*).* We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 91 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 365 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.

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, 10 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.	• Of the 10 licensed independent practitioners trained in EAM whose folders we reviewed, five did not have signed and approved privileges to perform EAM. • All 10 licensed independent practitioners' folders contained non-allowed information.	**1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate privileges. **2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed 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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	Twelve months of Surgical Work Group meeting minutes reviewed: • The group did not review National Surgical Office reports. • The group did not monitor surgery performance improvement activities. Several surgical deaths that occurred May 1, 2013–April 30, 2014, had identified problems or opportunities for improvement: • The Surgical Work Group did not review these deaths.	**3.** We recommended that the Surgical Work Group document its review of National Surgical Office reports and surgery performance improvement activities. **4.** We recommended that the Surgical Work Group review all surgical deaths with identified problems or opportunities for improvement.
	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	Ten months of Accident Review Board meeting minutes reviewed: • The board did not provide oversight of the safe patient handling program. • The board did not gather, track, and share patient handling injury data.	**5.** We recommended that the Accident Review Board provide oversight of the safe patient handling program and gather, track, and share patient handling injury data.
X	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.	Twelve months of Medical Executive Board meeting minutes reviewed: • The board did not analyze reports of EHR quality review results at least quarterly. • The board did not review the quality of entries in the EHR from most services. This was a repeat recommendation from the previous CAP review.	**6.** We recommended that the Medical Executive Board analyze reports of electronic health record quality review results at least quarterly and include most services in the review of electronic health record quality.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A correction process if scanned items have errors. • 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 Emergency Department/urgent care center, acute MH, 2 West – medicine/surgery, 4 West – medicine/surgery, the progressive care unit, primary care clinic – Red, the pulmonary specialty care clinic, the medical intensive care unit/cardiac care unit, the surgical intensive care unit, CLC 1, CLC 2, and CLC 3. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 50 employee training records (20 critical care and 30 CLC) and 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 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.		
	The facility met environmental safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	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.		
	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.		

NM	Areas Reviewed for CLC	Findings	Recommendations
	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.		
X	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.	• The facility did not document functionality checks of the CLC elopement prevention system at least every 24 hours.	**7.** We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and that facility managers monitor compliance.
	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.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for Construction Safety	Findings	Recommendations
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	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 intensive care unit/cardiac care unit, CLC 3, the progressive care unit, and 2 West – medicine/surgery 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 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
	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.		
NA	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.		
X	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.	• Four of six monthly medication storage area inspections were missed in the Emergency Department/urgent care center.	**8.** We recommended that facility managers ensure Emergency Department/urgent care center monthly medication storage area inspections are completed and monitor compliance.
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 include oversight of overrides and minimum competency requirements for users.	**9.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides 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.		
	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 30 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. 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
	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		
X	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.	• Eight consult requests (27 percent) did not include "inpatient" in the title.	**10.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
	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) employee safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 30 employees (15 randomly selected Level 1 ancillary staff and 15 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 physical inspections of two MRI areas. 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
	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.		
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• Two Level 1 ancillary staff did not receive level-specific annual MRI safety training.	**11.** We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

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 49 patients who experienced stroke symptoms, and 10 employee training records (five Emergency Department and five 4 West – medicine/surgery), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department/urgent care center, the medical intensive care unit/cardiac care unit, the surgical intensive care unit, 2 West – medicine/surgery, 4 West – medicine/surgery, and the progressive care unit. 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.	• For 11 of the 25 EHRs that contained documented evidence of stroke scales, clinicians did not complete scales within the expected timeframe.	**12.** We recommended that clinicians complete National Institutes of Health stroke scales for each stroke patient within the expected timeframe 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.		
X	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.	• Facility managers had not posted stroke guidelines on the medical intensive care unit/cardiac care unit, the surgical intensive care unit, 2 West – medicine/surgery, 4 West – medicine/surgery, and the progressive care unit.	**13.** We recommended that facility managers post stroke guidelines on the medical intensive care unit/cardiac care unit, the surgical intensive care unit, 2 West – medicine/surgery, 4 West – medicine/surgery, and the progressive care unit.
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided printed stroke education to patients upon discharge.	• For 18 of the 28 applicable patients, clinicians did not document in the EHRs that they provided stroke education to the patients/caregivers.	**14.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
X	The facility provided training to employees involved in assessing and treating stroke patients.	• Two employees had not completed the training required by the facility.	**15.** We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.
X	The facility collected and reported required data related to stroke care.	The facility did not collect and report the following data to VHA: • Percent of eligible patients given tissue plasminogen activator • Percent of patients with stroke symptoms who had the stroke scale completed • Percent of patients screened for difficulty swallowing before oral intake	**16.** 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 20 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
X	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.	• Radiology Service's policy did not clearly specify that employees on call for computed tomography scans must report within 30 minutes.	**17.** We recommended that Radiology Service revise the computed tomography scan on-call policy to require a 30-minute reporting time.
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	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 Veterans Integrated Service Network 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 15 clinicians applicable for the review period January 1–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	• Two of six clinicians with initial EAM competency assessment did not have evidence of successful demonstration of all required procedural skills on patients before placement on the out of operating room airway management coverage list.	**18.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients before placement on the out of operating room airway management coverage list and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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		
	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.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	VHA and local policies include processes for completing and approving scopes of practice and clinical privileges. • Between January 8, 2014, and March 6, 2015, clinicians performed at least 14 out of operating room intubations under a scope of practice or clinical privilege that had not been properly completed and granted. o There were 10 intubations performed by clinicians without signed and approved EAM privileges. o There were four intubations performed by a clinician who did not complete the required operating room rotation prior to approval of the scope of practice.	**19.** We recommended that the Facility Director ensure designated clinicians have properly completed and granted privileges or scopes of practice.

Review Activity with Previous CAP Recommendations

Follow-Up on QM

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with QM/performance improvement committee oversight.

QM/Performance Improvement Committee Oversight. During our previous CAP review, we found that the facility's subordinate committees did not report data to the QM/performance improvement oversight committee to enable the committee to review and analyze data, take action, or track actions as necessary. The facility has undergone several revisions to their overall QM program, and current local policies require that the Quality Improvement Board and the Medical Executive Board report data and QM processes to the Executive Leadership Council, which is the oversight committee. While the facility made enhancements to the overall QM program and has modified some QM processes and local policies to reflect the new reporting structure, including Quality Safety Value element reporting to the Quality Improvement Board, some further policy updates and strengthening are required to ensure that the subordinate committees report data to the Executive Leadership Council for review and analysis, appropriate actions, and tracking of actions to completion. Because the new process is still evolving and requires further refinements to demonstrate sustainability and full implementation of a facility-wide QM program, we made a repeat recommendation.

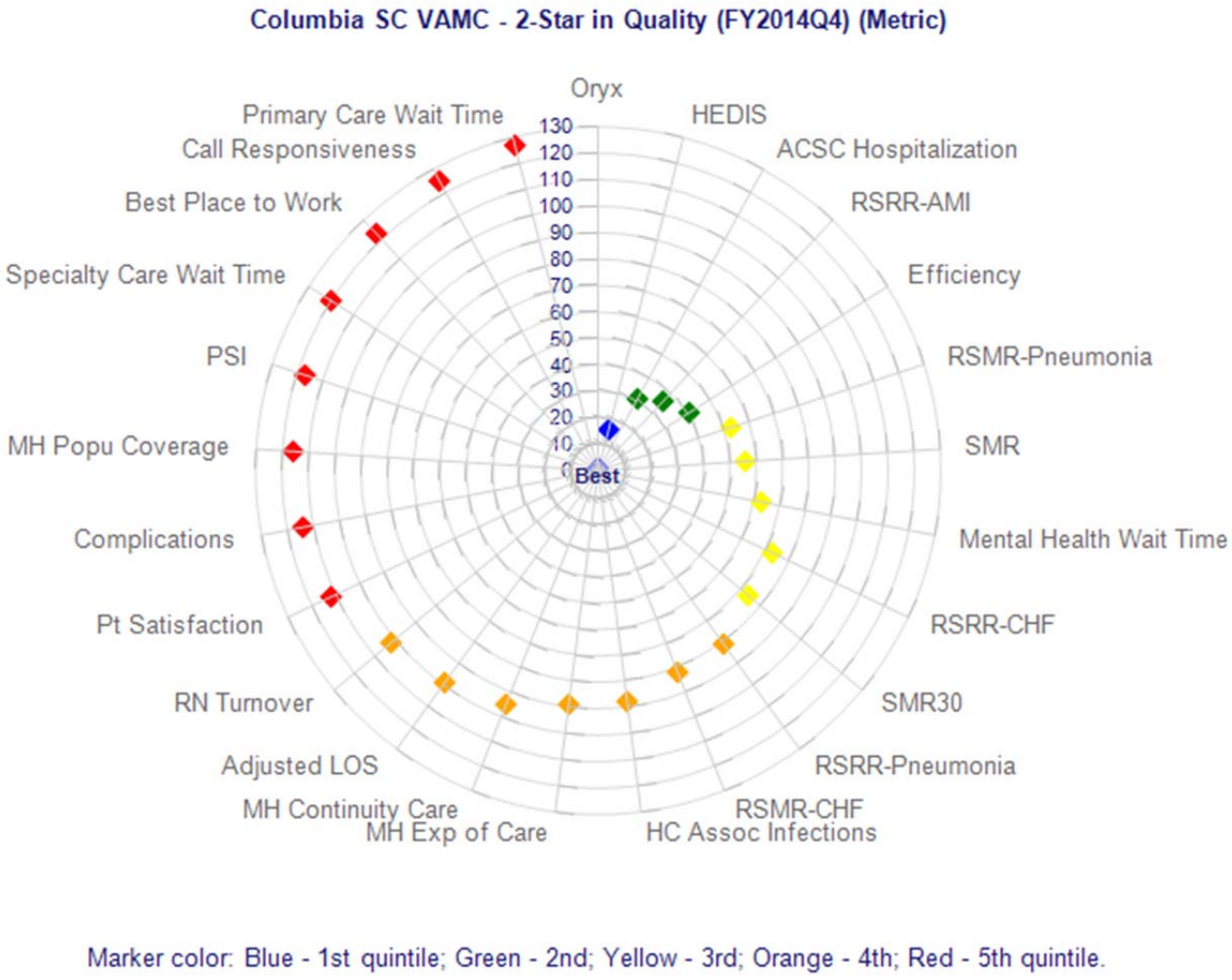
Recommendation

20. We recommended that the facility ensure that subordinate committees report data to the appropriate oversight committee and that the oversight committee reviews and analyzes data, takes appropriate action, and tracks actions to completion.

Facility Profile (Columbia/544) FY 2015 through February 2015[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$405
Number (as of March 17, 2015) of:	
• **Unique Patients**	64,626
• **Outpatient Visits**	418,394
• **Unique Employees**[2]	1,966
Type and Number of Operating Beds:	
• **Hospital**	112
• **CLC**	94
• **MH**	17
Average Daily Census:	
• **Hospital**	70
• **CLC**	64
• **MH**	14.72
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Greenville/544BZ Florence/544GB Rock Hill/544GC Anderson/544GD Orangeburg/544GE Sumter/544GF Spartanburg/544GG
Veterans Integrated Service Network Number	7

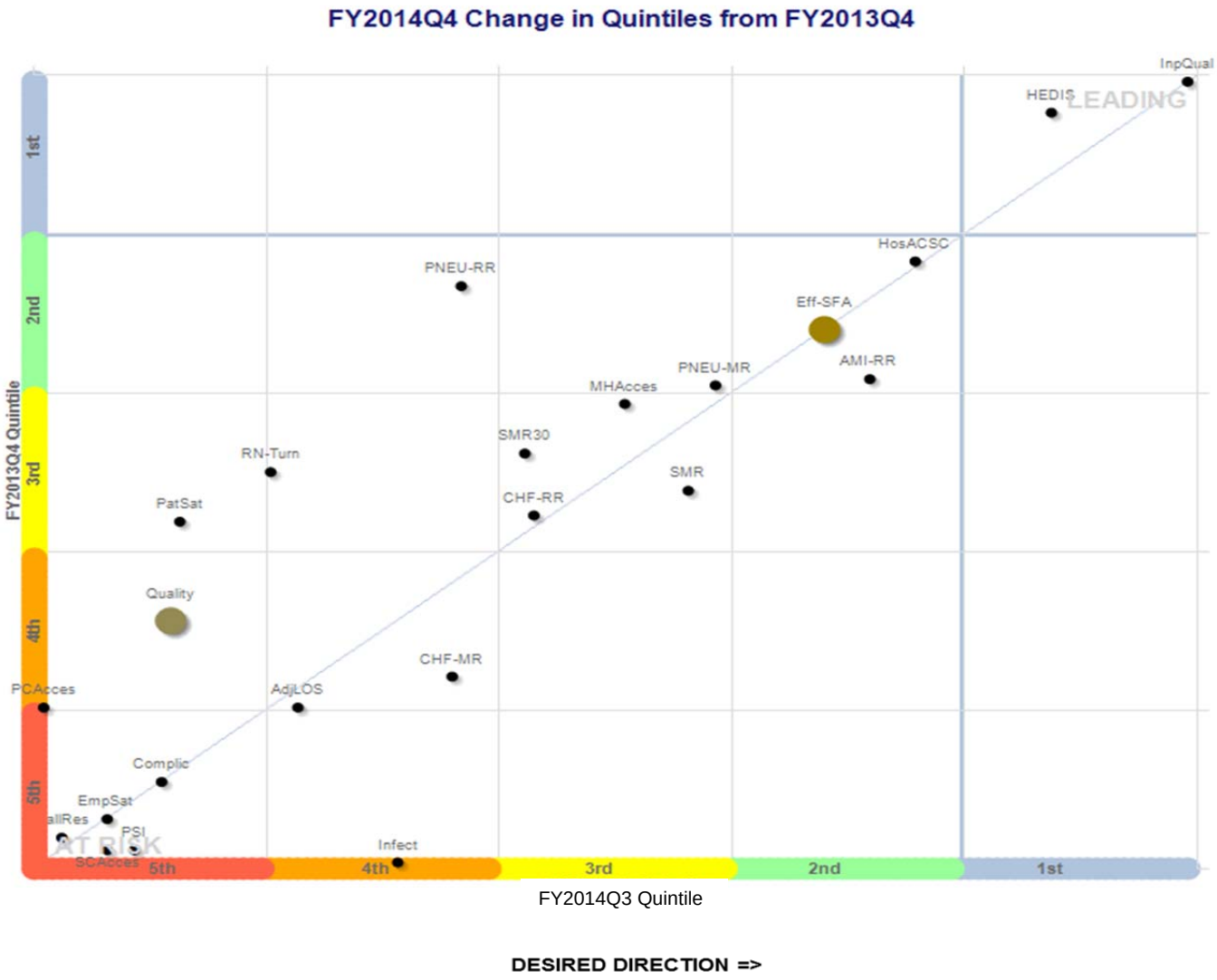
[1] All data is for FY 2015 through February 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



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 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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

Appendix C

Interim Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: 4/23/2015

From: Interim Director, VA Southeast Network (10N7)

Subject: **CAP Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

1. This is in response to the CAP Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC.

2. I have reviewed your recommendations as a result of your assessment during the OIG Combined Assessment Program review and concur with Columbia VAMC's response.

3. I appreciate the opportunity to provide continuing improvements in support of caring for our Veterans.

4. If you have any questions or require further information, please contact Bridget Schausten, Chief, Quality Management, Columbia VAMC (803) 776-4000, x7731.

Thomas C. Smith III, FACHE

Attachments

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: 4/23/2015

From: Director, William Jennings Bryan Dorn VA Medical Center (544/00)

Subject: **CAP Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC**

To: Interim Director, VA Southeast Network (10N7)

1. William Jennings Bryan Dorn VA Medical Center would like to thank the Office of Inspector General (OIG) Team for the recommendations based on their assessment during the OIG Combined Assessment Program review.

2. I have reviewed the draft report and concur with the recommendations.

Timothy B. McMurry
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 facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate privileges.

Concur

Target date for completion: May 15, 2015

Facility response: Although the 5 licensed independent practitioners trained in emergency airway management (EAM) had the required credentials to perform EAM, were reviewed by the service chief, and the Medical Executive Board for Credentialing and Privileging recommended approval, they did not have signed, approved privileges on file for EAM. Privileging packets have been sent to those providers that did not have signed emergency airway management privileges. Once verifications are obtained, the files will be presented to the Medical Executive Board for Credentialing and Privileging. Recommendations of the board will be sent to the Director for approval and signature.

Recommendation 2. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: July 30, 2015

Facility response: The facility licensed independent practitioners' (LIP) folders do not contain licensure verification information. In section I of the two-part folder, the facility determined the need to maintain copies of certification for Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) (when required). These are not licensure documents, but certifications. While not prohibited by VHA Handbook 1100.19, Appendix A, p. A-1, which states that Section I is application, reappraisal, and local Medical Facility information, the facility concedes to the Director, Medical Staff Affairs (C&P), Office of Safety and Risk Awareness (10A4E) and accepts this recommendation.

In accordance with VHA Directive 1177, official tracking of ACLS and BLS certifications will be through the Talent Management System (TMS) at the service level. The ACLS and BLS training is currently set up in TMS for certification every 2 years. The staff member and supervisor listed in TMS will get a reminder within 90 days, 60 days, and 30 days and every week thereafter until training is documented as complete in TMS. Once training is completed, Nursing Education will notify Facility Education who will document completion in TMS. Effective May 15, 2015, the credentialing and privileging

staff will have LIPs enter their ACLS and BLS certifications in VetPro beginning with initial applicants and upcoming reappraisals. The remainder of the staff will enter these certifications at the time of reappointment. Two-part credentialing and privileging folders will revert to one-part folders until such time as facility specific information is identified. Quality Management will audit 10 credentialing and privileging folders each month to monitor compliance.

Recommendation 3. We recommended that the Surgical Work Group document its review of National Surgical Office reports and surgery performance improvement activities.

Concur

Target date for completion: April 15, 2015
Target date for completion of monitoring: July 30, 2015

Facility response: The Facility Surgical Work Group (FSWG) agenda and minutes were restructured to meet the requirements of VHA Handbook 1102.01. Although the FSWG has been discussing the National Surgery Office (NSO) reports and surgical performance improvement activities and reporting both to the Medical Executive Board (MEB), the discussion and actions have not been documented in the FSWG minutes. Effective April 15, 2015, the National Surgical Office reports and surgery performance improvement activities have been added as recurring agenda items for reporting, discussion, and action (when indicated) with supporting documentation reflected in the FSWG minutes. The Chief of Staff and Chief of Surgery will monitor FSWG minutes to ensure compliance.

Recommendation 4. We recommended that the Surgical Work Group review all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: April 15, 2015
Target date for completion of monitoring: July 30, 2015

Facility response: The FSWG agenda and minutes were restructured to meet the requirements of VHA Handbook 1102.01 with review of surgical deaths as a recurring agenda item. Effective April 15, 2015, Morbidity and Mortality Review has been added as recurring agenda item for reporting, discussion, and action (when indicated) with supporting documentation reflected in the FSWG minutes. The Chief of Staff and Chief of Surgery will monitor FSWG minutes to ensure compliance.

Recommendation 5. We recommended that the Accident Review Board provide oversight of the safe patient handling program and gather, track, and share patient handling injury data.

Concur

Target date for completion: September 30, 2015

Facility response: Facility Medical Center Memorandum (MCM) 544-812-26 will be revised to comply with VHA Directive 2010-032. The Safe Patient Handling Coordinator will review injury data weekly through the Automated Safety Incident Surveillance Tracking System (ASISTS) data base and present a more in-depth analysis of this data at the monthly Safe Patient Handling Committee meeting which reports to the EOC Board. The Safe Patient Handling Committee will assume responsibility for gathering, tracking, and sharing the data with the EOC Board. The Safe Patient Handling Committee Chair will report monthly to the EOC Board beginning in June 2015. The Chair of the EOC Board will monitor the reports from the Safe Patient Handling Committee to ensure compliance.

Recommendation 6. We recommended that the Medical Executive Board analyze reports of electronic health record quality review results at least quarterly and include most services in the review of electronic health record quality.

Concur

Target date for completion: August 30, 2015

Facility response: The Medical Records Committee was established in January 2015. The committee coordinates the medical record review processes; analyzes the various ongoing medical record review audit findings; and reviews corrective actions by services. In the May 2015 Medical Record Committee meeting, the committee will determine the reporting schedule and determine parameters for the Point of Care reviews. Results of service health record reviews, findings from health record completion monitors, and monthly delinquent record statistics will be reported quarterly to the Medical Executive Board.

Recommendation 7. We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and that facility managers monitor compliance.

Concur

Target date for completion: Completed March 19, 2015
Target date for completion of monitoring: July 30, 2015

Facility response: Nursing has developed a log for the Community Living Center to track the elopement prevention Wanderguard System security checks. The Wanderguard System is checked daily to ensure the system is functioning

appropriately. Nurse Managers monitor compliance of functionality checks on an ongoing basis. If compliance should fall below 100% compliance, the Nurse Manager will provide corrective action.

Recommendation 8. We recommended that facility managers ensure Emergency Department/urgent care center monthly medication storage area inspections are completed and monitor compliance.

Concur

Target date for completion: Completed April 1, 2015
Target date for completion of monitoring: July 30, 2015

Facility response: In March 2015, pharmacy implemented more stringent monitoring to ensure compliance with monthly medication inspections that utilizes a spreadsheet of all medication storage areas, and assigned technicians to inspect each area by the 20th of each month. The Pharmacy secretary will monitor compliance with the inspections. The inspection checklist will be reviewed by the Quality Management pharmacist on the 21st of each month and any findings will be communicated to Nurse Managers on units identified with deficiencies. In addition, an alert will be sent to the supervisory pharmacists to inform them when staff members have not completed their assigned inspections. Pharmacy supervisors will ensure that all inspections are completed. Pharmacy will monitor compliance monthly with an expected compliance rate of 100%.

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

Concur

Target date for completion: Completed March 23, 2015

Facility response: Medical Center Memorandum 544-119-6, Medication Management: Automated Dispensing Machine Access and Administration, dated March 23, 2015 has been revised, approved, and published to meet all requirements.

Recommendation 10. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: Completed April 30, 2014

Facility response: Effective May 1, 2014, all Inpatient and Outpatient consult titles are in compliance with VHA Consult Business Rules. Compliance with utilizing correct consult titles is monitored monthly through our facility consult management committee. Our local Consult Management policy governs timeframes for appropriate action for inpatient consultation and urgency.

Recommendation 11. We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: May 30, 2015
Target date for completion of monitoring: July 30, 2015

Facility response: The required staff profiles will be updated in the Talent Management System for Level 1 annual Magnetic Resonance Imaging training. The training will include all required personnel as required by VHA Handbook 1105.05. The Magnetic Resonance Imaging Safety Committee Chair will monitor compliance of the training and report quarterly to the Magnetic Resonance Imaging Safety Committee and to the Environment of Care Board.

Recommendation 12. We recommended that clinicians complete National Institutes of Health stroke scales for each stroke patient within the expected timeframe and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: With our experience at Dorn over the last two years, we realize that the time frame in the Dorn Stroke Memorandum allowing for completion of the National Institute of Health stroke scale is restrictive beyond what is expected in the National VHA Stroke Directive and what is necessary for excellent patient care. Therefore, the facility memorandum will be modified to bring it in line with the National Directive and current practice.

Emergency Department practitioners have already received written instructions as to the policy and expectations for the National Institute of Health stroke scale to be completed. Neurology providers have been given verbal reminders of its importance.

All Emergency Department and Neurology providers have completed National Institute of Health stroke scale training. Both groups have been instructed of the location of the note template in CPRS.

Compliance rates with completion of the National Institute of Health stroke scale will be monitored in the Stroke Task Force and Cardiovascular Emergency Committee on a quarterly basis. Appropriate action will be taken to assure practitioner compliance.

Recommendation 13. We recommended that facility managers post stroke guidelines on the medical intensive care unit/cardiac care unit, the surgical intensive care unit, 2 West – medicine/surgery, 4 West – medicine/surgery, and the progressive care unit.

Concur

Target date for completion: April 15, 2015

Facility response: The Stroke Guidelines, which are included currently in each unit's stroke binder, will be reprinted and appropriately posted.

Recommendation 14. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: For patients being discharged from Dorn to home, the discharging physician will check the discharge instruction request for disease specific instructions for Stroke to be provided to the patient and appropriate family members. For patients who are being transferred to another facility, the discharging physician will write an order to have the appropriate written education on Stroke from Mosby's printed and given to the patient and or family.

The hospitalists' teams will be educated on the proper procedure by the Stroke Director via email and a briefing in person at in-service. The resident will be informed of their responsibility by their attending medicine physicians at the beginning of each rotation.

We will review compliance rates with Educational Material being provided to Stroke Patients at the time of discharge or transfer in the Stroke Task Force and Cardiovascular Emergency Committee on a quarterly basis. Appropriate action will be taken to assure practitioner compliance.

Recommendation 15. We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.

Concur

Target date for completion: May 31, 2015

Facility response: Each Service who has employees involved in assessing and treating stroke patients will present a plan for training of their personnel and training new personnel to the Stroke Task Force at the April 30, 2015 meeting. The Stroke Task Force and the Cardiovascular Emergency Committee will review compliance rates with training on a quarterly basis. Appropriate action will be taken to assure practitioner compliance.

Recommendation 16. 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 15, 2015

Facility response: Neurology has established a process to collect data regarding 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. This data will be reported monthly to the VA Inpatient Evaluation Center (IPEC) and quarterly to the Medical Executive Board via the Stroke Task Force and the Cardiovascular Emergency Committee.

Recommendation 17. We recommended that Radiology Service revise the computed tomography scan on-call policy to require a 30-minute reporting time.

Concur

Target date for completion: May 1, 2015

Facility response: The Radiology on-call policy has been revised to require a 30-minute reporting time.

Recommendation 18. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients before placement on the out of operating room airway management coverage list and that facility managers monitor compliance.

Concur

Target date for completion: May 30, 2015

Facility response: Anesthesiology has developed a comprehensive checklist for Bag Valve Mask Requirement, Direct Laryngoscopy Requirement, Laryngeal Mask Airway (LMA) Requirement, and Video Laryngoscopy (60° blade). This checklist clearly indicates when each requirement was completed in the Operating Room. Each of these requirements will have an individual completion date. When training in the Talent Management System, SIMLAB, and operating room requirements have been completed, the provider's documentation will be submitted with his request for privileges to the Medical Executive Board for Credentialing and Privileging for approval. Compliance with training requirements will be monitored through the privileging process.

Recommendation 19. We recommended that the Facility Director ensure designated clinicians have properly completed and granted privileges or scopes of practice.

Concur

Target date for completion: May 15, 2015

Facility response: Although the 5 licensed independent practitioners trained in emergency airway management (EAM) had the required credentials to perform EAM, were reviewed by the service chief, and the Medical Executive Board for Credentialing and Privileging recommended approval, they did not have signed, approved privileges on file for EAM. Privileging packets have been sent to those providers that did not have signed emergency airway management privileges. Once verifications are obtained, the files will be presented to the Medical Executive Board for Credentialing and Privileging. Recommendations of the board will be sent to the Director for approval and signature. For certified respiratory therapists, intubations are in the performance standards of the professional standards set at the national level. The existing process for new certified respiratory therapists requires didactic instruction, completion of the Talent Management System training module, and an operating room rotation with hands-on competency assessment by anesthesia. This is completed during the service level orientation. During the timeframe covered by this review, the facility operating room was shut down, thus preventing the hands-on assessment. Once the operating room re-opened, the certified respiratory therapists completed the required hands-on competency assessment be anesthesia. Effective April 1, 2015, new certified respiratory therapists will not be assigned to work independently until all components of service level new employee orientation are completed.

Recommendation 20. We recommended that the facility ensure that subordinate committees report data to the appropriate oversight committee and that the oversight committee reviews and analyzes data, takes appropriate action, and tracks actions to completion.

Concur

Target date for completion: June 30, 2015

Facility response: Since the previous OIG CAP visit, the facility has redefined its committee structure and demonstrated progressive, sustained improvement in this area. In August 2014, the Quality Improvement Board was established as the senior-level committee responsible for key quality, safety, and value functions and routinely reviews aggregated data, serves in a committee role to support the organizational improvement program and embrace concepts and methods of a High Reliability Organization. The Executive Leadership Board has been transitioned to the Executive Leadership Council. Effective November 26, 2014, the Executive Leadership Council subordinate committee reporting has been strengthened to include data reporting with review and analysis, appropriate actions, and tracking of actions to completion. The Quality Improvement Board serves as a supplemental supporting board to the Executive Leadership Council

and ensures systems are in place to continuously improve and sustain organizational performance. The board is multidisciplinary with leadership and oversight for continuous quality improvement, promoting a culture of safety, incorporating robust process improvement tools, and ensuring processes are integrated throughout the facility and sustained over time. Together, the Executive Leadership Council and Quality Improvement Board establish a foundation that facilitates a culture of safety and provides an organizational framework that integrates quality, safety, and high reliability to achieve value for Veterans. This framework is further supported by the Medical Executive Board, Nurse Executive Board, and Resource Management Board as collaborative and coordinating committees integrating key quality management processes horizontally and vertically throughout the Medical Center. This enables the Facility Director, through the committee structure, to guide a coordinated process to ensure that quality management components are implemented, integrated, and communicated; thereby promoting a culture conducive to patient safety and continuous quality improvement. Medical Executive Board subordinate committee policies will be updated to reflect the new reporting structure.

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.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.