Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00079-358

Combined Assessment Program Review of the VA Sierra Nevada Health Care System Reno, Nevada

June 2, 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	VA Sierra Nevada Health Care System
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
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 March 23, 2015.

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

- Coordination of Care
- Surgical Complexity

The facility's reported accomplishments were the Honors Escort Program, a patient safety award, improved primary care clinic access, and Joint Commission recognition.

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

Quality Management: Ensure that the Intensive Care Unit Committee reviews each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the code occurrence. Share patient handling injury data with the newly designated safe patient handling coordinator/champion. Establish an oversight committee for electronic health record quality review activities.

Environment of Care: Ensure selected employees receive chemical labeling/safety data sheet and annual bloodborne pathogens training. Require that patient care equipment items and surfaces are clean. In the construction area, change walk-off sticky mats as needed, and equip the temporary construction barrier with a self-closing door with a metal frame.

Medication Management: Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements. Educate medical and community living center unit employees that intravenous syringes are not to be used to measure oral liquid medications.

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

Acute Ischemic Stroke Care: Implement an acute ischemic stroke policy. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines in all required patient care areas, and screen patients for difficulty swallowing prior to oral intake. Provide patients with printed stroke education upon discharge, and report all required data elements to the Veterans Health Administration.

Emergency Airway Management: Ensure that a qualified physician is present in the Emergency Department at all times and that non-Emergency Department clinicians are assigned inpatient emergency airway management coverage from 9:00 p.m. to 7:00 a.m.

Follow-Up on Colorectal Cancer Screening: Ensure patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe.

Comments

The VISN Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 28–37, for the full text of the Directors' comments.) We consider recommendation 8 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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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 Colorectal Cancer Screening

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 March 23, 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 VA Sierra Nevada Health Care System, Reno, Nevada,* Report No. 12-00372-221, July 16, 2012). We made a repeat recommendation in colorectal cancer screening.

During this review, we presented crime awareness briefings for 174 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 84 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

Honors Escort Program

The facility's Honors Escort Program provides a dignified transfer of a recently deceased veteran from their hospital room to the facility morgue. A special gurney with a frame is used for transport, and an American flag is draped over the gurney. Specially trained staff and volunteers serve as escorts. Staff and visitors who are in hallways when the procession passes stand to the side and salute or place a hand over the heart. After the procession, family members are provided the opportunity to assist with folding the flag. The program has been well received by family members, and an article describing this unique way of paying tribute to veterans was featured in the October–November 2014 issue of VAnguard—a VA employee magazine.

Patient Safety Silver Cornerstone Award

In December 2014, the facility received the VA National Center for Patient Safety Silver Cornerstone Award in recognition of its enhanced root cause analysis process. The award recognizes accomplishments in patient safety and in measuring the quantity and quality of root cause analyses and aggregate reviews.

Improved Primary Care Access

The facility's "New Enrollee Onboarding" system redesign project improved primary care clinic access by reducing the wait time for veterans with no "same day" appointment from an average of 42 days to 3 days. With this project, 97 percent of veterans

presenting to the clinic as “walk-ins” (without an appointment) were seen on the same day. For veterans who cannot be seen on the same day (many times due to the veteran’s schedule), the average wait for an appointment is 3 days.

Joint Commission Recognition

The facility is one of 32 VA facilities from across the Nation to earn the distinction as a Top Performer on Key Quality Measures® for 2013. The Joint Commission recognizes facilities that are top performers in using evidence-based care processes closely linked to positive patient outcomes. The facility was recognized for attaining and sustaining excellence in accountability measures for heart attack, heart failure, pneumonia, and surgical care.

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, 12 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
	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.		
	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.	Nine months of Intensive Care Unit Committee meeting minutes reviewed: • Committee minutes did not reflect a review of each code episode. • Code reviews did not include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.	**1.** We recommended that the Intensive Care Unit Committee review each code episode and that 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.		
	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.	Twelve months of EOC Committee meeting minutes reviewed: • The committee did not share patient handling injury data with the newly designated safe patient handling coordinator/champion for 5 of the 12 months reviewed.	**2.** We recommended that the Environment of Care Committee share patient handling injury data with the newly designated safe patient handling coordinator/champion.
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.	• There was no designated committee responsible for oversight and coordination of EHR quality review activities.	**3.** We recommended that the facility establish a committee to provide oversight and coordination of electronic health record quality review activities.
	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 critical care, medical, surgical, locked MH, and CLC inpatient units; the ED; and the outpatient oncology clinic. We also performed a perimeter inspection of the B5 unit renovation construction site. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 20 employee training records (10 critical care and 10 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.		
X	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.	• Eleven of 20 employee training records did not contain evidence of chemical labeling/safety data sheet training.	**4.** We recommended that facility managers ensure employees receive training on chemical labeling/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.	• Four of five patient care areas contained dirty weight scales. • Two of five patient care areas had dusty surfaces.	**5.** We recommended that facility managers ensure patient care equipment items and surfaces are clean and monitor compliance.
	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		
X	Designated critical care employees received bloodborne pathogens training during the past 12 months.	• Three of the 10 critical care employees did not receive bloodborne pathogens training during the past 12 months.	**6.** We recommended that facility managers ensure all designated critical care employees receive annual bloodborne pathogens training and monitor compliance.
	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.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	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.		
X	The facility met environmental safety requirements in the CLC.	• One weight scale was dirty. • Cart shelves with care supplies were dirty.	See recommendation 5. .
	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
X	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.	• Walk-off sticky mats were not changed as needed to minimize dust. • The temporary construction barrier was not equipped with a self-closing door with a metal frame for worker access.	**7.** We recommended that facility managers ensure walk-off sticky mats are changed as needed to minimize dust and monitor compliance. **8.** We recommended that facility managers ensure that the temporary construction barrier is equipped with a self-closing door with a metal frame for worker access.
	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, post-anesthesia care, and CLC units and the ED 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.		
	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.	• The facility's written policy for safe use of automated dispensing machines did not include employee training and competency requirements.	**9.** We recommended that the facility revise the policy for safe use of automated dispensing machines include employee training and minimum competency requirements for users and that facility managers monitor compliance.
X	The facility employed practices to prevent wrong-route drug errors.	• On the medical and CLC units, employees stated that an intravenous syringe is used to measure liquid medications when dose amounts differed from the unit dose package supplied.	**10.** We recommended that the facility educate employees on the medical and community living center units that intravenous syringes are not to be used to measure oral liquid medications and that facility managers monitor compliance.
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 15 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 74 employees (30 randomly selected Level 1 ancillary staff and 44 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. 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.	• Twenty-five designated Level 1 ancillary staff (83 percent) 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 45 patients who experienced stroke symptoms, and 10 employee training records (five ED and five inpatient medical/surgical unit), and we conversed with key employees. We also conducted onsite inspections of the ED, the intensive critical care unit, and two acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility's stroke policy addressed all required items.	• The facility did not have a policy in place that addressed the management of acute ischemic stroke.	**12.** We recommended that the facility implement an acute ischemic stroke policy that addresses all required items.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For 26 of the 32 applicable patients (81 percent), clinicians did not document evidence of completion of stroke scales.	**13.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	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 in any of the four areas.	**14.** We recommended that facility managers post stroke guidelines in all required patient care areas.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For 25 of the 37 applicable patients (68 percent), clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**15.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 24 applicable patients' EHRs contained documentation that clinicians provided stroke education to the patients/caregivers.	**16.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	• The facility did not 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	**17.** We recommended that the facility 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 10 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	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 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 12 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 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 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		
	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		

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.		
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy reviewed, which requires a physician to be present in the ED at all times: • From 9:00 p.m. to 7:00 a.m., the ED physician was the sole provider covering the ED and was also assigned inpatient EAM coverage, which required the physician to leave the ED.	**18.** We recommended that the facility ensure that a qualified physician is present in the Emergency Department at all times, that non-Emergency Department clinicians are assigned inpatient emergency airway management coverage from 9:00 p.m. to 7:00 a.m., and that facility managers monitor compliance.

Review Activity with Previous CAP Recommendations

Follow-Up on Colorectal Cancer Screening

As a follow-up to a recommendation from our previous CAP review, we reassessed facility compliance with colorectal cancer screening.[i]

Diagnostic Testing Timeliness. VHA requires that if a diagnostic colonoscopy is indicated, it must be performed within 60 calendar days of the positive screening test results. In FY 2014, the facility reported completing 149 colonoscopies. The facility monitored timeliness of colorectal cancer screening and diagnostic testing and reported that it did not complete 99 colonoscopies (66 percent) within 60 days.

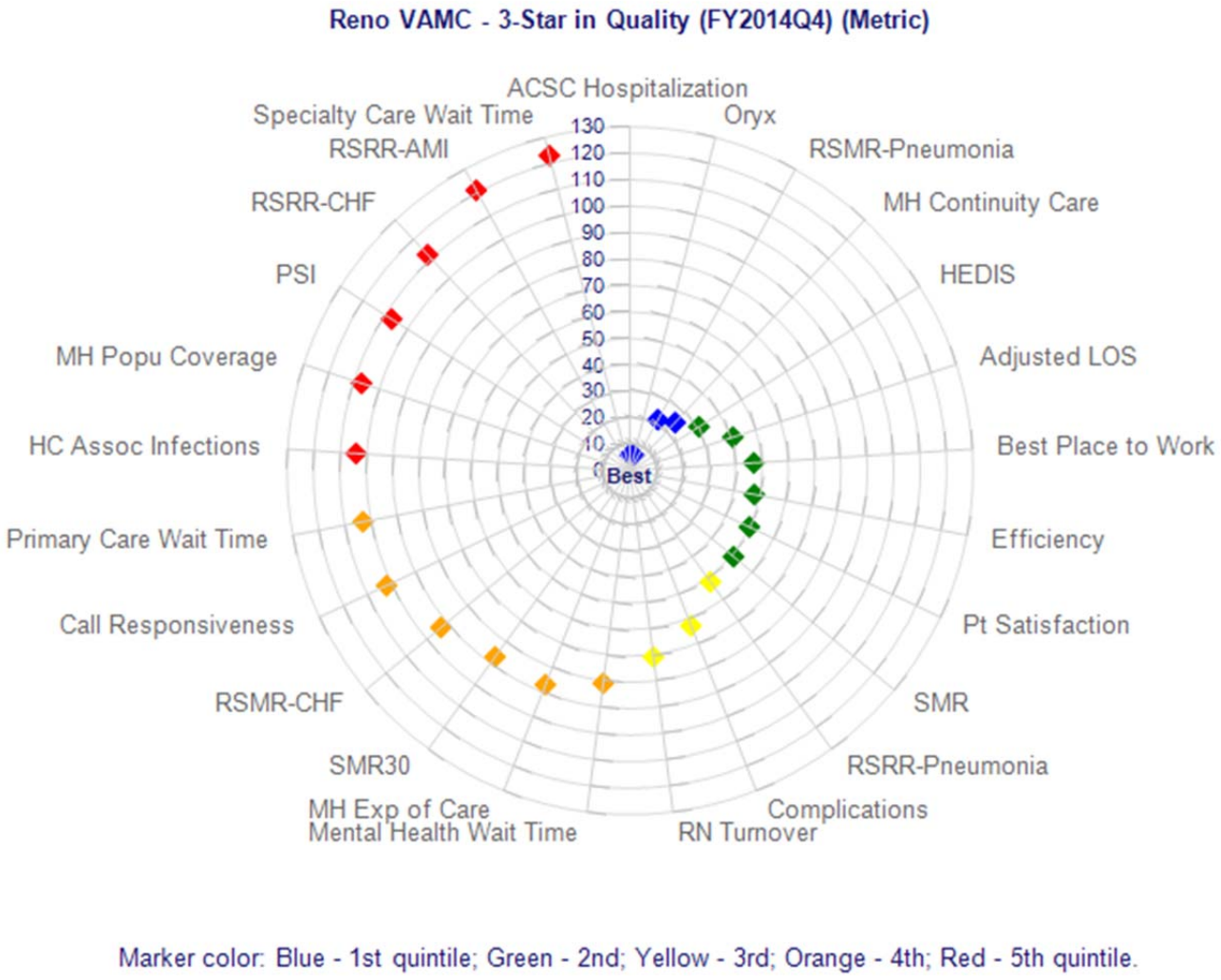
Recommendation

19. We recommended that the facility ensure patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe and that facility managers monitor compliance.

Facility Profile (Reno/654) FY 2015 through February 2015[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$239.5
Number (as of March 17, 2015) of:	
• **Unique Patients**	26,119
• **Outpatient Visits**	177,521
• **Unique Employees**[2]	1,125
Type and Number of Operating Beds:	
• **Hospital**	64
• **CLC**	60
• **MH**	NA
Average Daily Census:	
• **Hospital**	49
• **CLC**	46
• **MH**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Sierra Foothills/654GA Carson Valley/654GB Lahontan Valley/654GC Diamond View/654GD
VISN Number	21

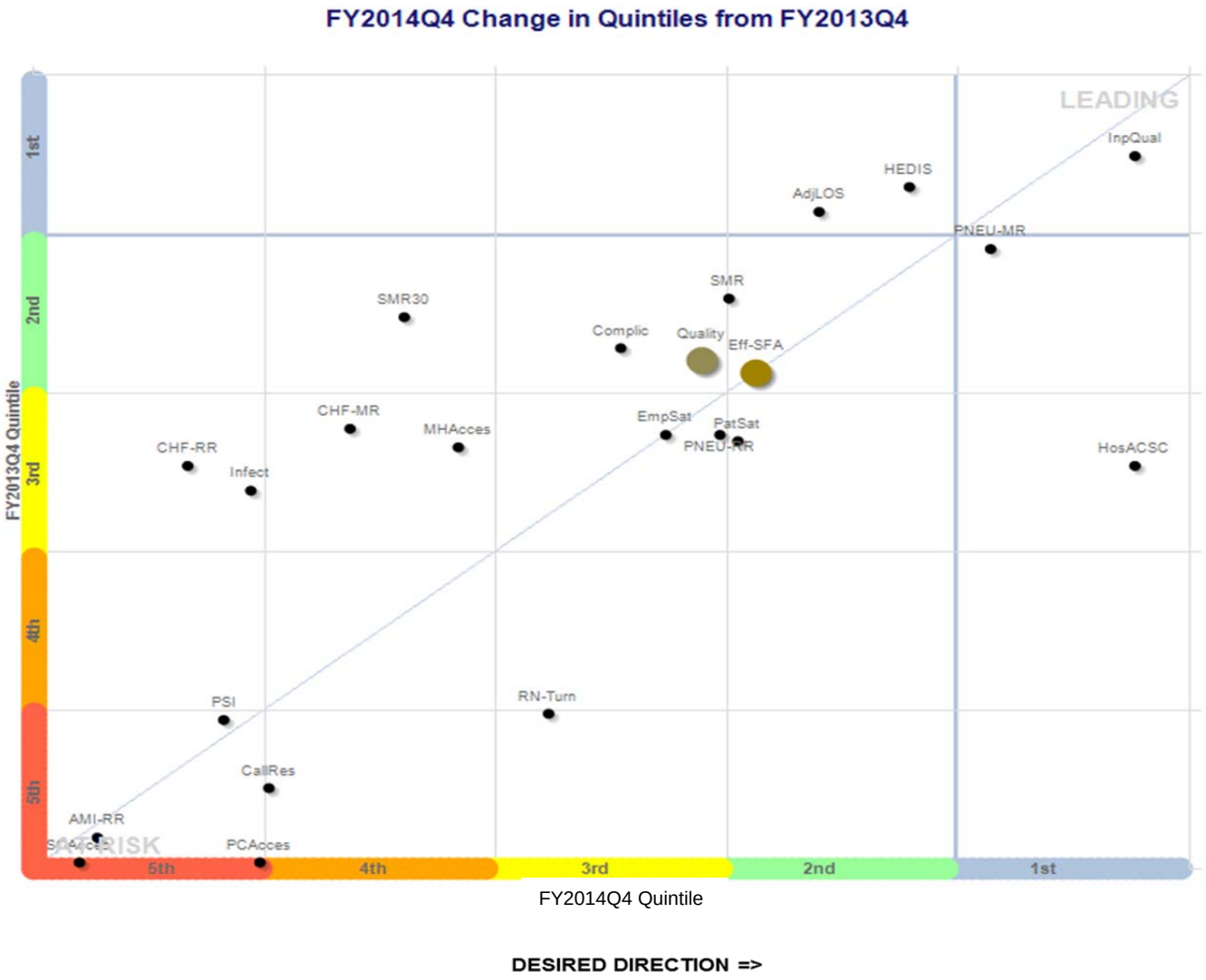
[1] All data is for FY 2015 through February 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



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 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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: May 1, 2015

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Sierra Nevada Health Care System, Reno, NV**

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

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

1. Thank you for the opportunity to review the draft report from the recent OIG site visit. Attached is the action plan developed by the facility.

2. Should you have any questions regarding the plan, please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8370.

Sheila M. Cullen

Attachments

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 29, 2015

From: Acting Director, VA Sierra Nevada Health Care System (654/00)

Subject: **CAP Review of the VA Sierra Pacific Health Care System, Reno, NV**

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations for the OIG CAP Review conducted at the VA Sierra Nevada Health Care System March 23–27, 2015.

2. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing, actions to resolve these issues.

Lisa Howard
Acting 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 Intensive Care Unit Committee review each code episode and that 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: September 1, 2015

Facility response: The ICU Medical Director/designee and Nurse Manager/designee will review all events within 72 hours. The Code Blue Sub-Committee of the ICU Committee will review each code to detect problems, analyze trends and identify opportunities for improvement. A written report of this review will be presented at the ICU Committee's monthly meeting for discussion and action as necessary effective June 5, 2015. Target for compliance is 100%. This will be audited for three consecutive months for compliance and reported to Quality Executive Council in the ICU Committee Executive Summary.

Recommendation 2. We recommended that the Environment of Care Committee share patient handling injury data with the newly designated safe patient handling coordinator/champion.

Concur

Target date for completion: May 6, 2015

Facility response: The previous Safe Patient Handling Coordinator left the facility in the summer of 2014. A new Coordinator, as collateral duty, was officially identified at the January 2015 Environment of Care Council Meeting. All reported Lifting/Repositioning Patient incidents are discussed in Accident Review Board (ARB) Meetings. Since being appointed, the new Safe Patient Handling Coordinator regularly attends monthly Accident Review Board meetings. The new Safe Patient Handling Coordinator will work with the Safety Specialist and Occupational Health on the topic of employee injuries related to lifting/repositioning patients. The new Safe Patient Handling Coordinator will provide quarterly reports to the Environment of Care Council beginning May 6, 2015, for Quarter 2 of FY 2015.

Recommendation 3. We recommended that the facility establish a committee to provide oversight and coordination of electronic health record quality review activities.

Concur

Target date for completion: June 15, 2015

Facility response: The Medical Records Committee charter has been developed and the committee will provide oversight and coordination of the electronic health record quality review activities, in accordance with VHA Handbook 1907.01, "Health Information Management and Health Records", issued on March 19, 2015. The committee will meet a minimum of six times per year, with the first meeting scheduled for May 29, 2015. Medical Records Committee will be chaired by the Chief of HIMS and meeting minutes will be kept. Members of the Medical Records Committee will include the HIMS Chief, the coding supervisor, the VERA coordinator, the administrative officers of Medicine, Surgery, Mental Health, Geriatrics and Extended Care, and Ambulatory Care. The service chiefs will attend when their service reviews are presented.

Recommendation 4. We recommended that facility managers ensure employees receive training on chemical labeling/safety data sheets.

Concur

Target date for completion: July 31, 2015

Facility response: All Health Care System employees have been assigned the Globally Harmonized System for Hazard Communications TMS module. As of 4/22/2015, 1227/1341 (91%) of employees have completed the TMS module. The target is for 95% of current paid employees to complete the training by 7/31/2015. Additionally, hazardous material inventories are available on the VA Sierra Nevada Health Care System Safety and Occupational Health SharePoint site and Safety Data Sheets are available through a link on the VA Sierra Nevada Health Care System intranet home page. Monitoring for compliance with the TMS training requirement will be performed by the Industrial Hygienist, and reported in June 2015 and then quarterly to the Environment of Care Council with the Quarterly Hazardous Materials and Waste Management Plan Report.

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

Concur

Target date for completion: August 20, 2015

Facility response: Starting May 4, 2015, Environmental Services work leaders on 1st shift and 2nd shift will both conduct weekly inspections using the VA Central Office Housekeeping "2 step Cleaning Checklist." Environmental Management Service work leaders will convey to their personnel to pay particular attention to discrepancies noted

in the inspections. The Environmental Management Service supervisors will perform weekly inspections of designated areas and ensure any discrepancies are corrected on the spot by the respective housekeeper assigned to that area. The facility's newly hired Non Critical Reusable Medical Equipment (NC-RME) housekeepers will perform bi weekly (once every 2 weeks) cleaning of weight scales, cart shelves, computers on wheels, isolation and crash carts. Additionally, housekeepers assigned to wards with the latter equipment will inspect and clean as needed. During Environment of Care rounds, the patient care equipment items and surfaces as well as the care environment will be noted and inspected for cleanliness. Any discrepancies found will be documented on the Environment of Care tablets and tracked for completion. The Chief, Environmental Services, will report out quarterly to the Environment of Care Council starting May 6, 2015, on the status of these findings.

Recommendation 6. We recommended that facility managers ensure all designated critical care employees receive annual bloodborne pathogens training and monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: Patient Care and Environmental Service employees who work in critical care (Emergency Department, ICU, Perioperative care) are expected to receive (and have documented) blood borne pathogen training at start of employment and annually. Nurse Managers and Environmental Service will monitor all new staff for evidence of training documentation upon initial arrival to their service and annually thereafter, with the target of 95% compliance. Audit results will be reported by the nurse managers to the Chief Nurse of Acute Care Nursing Service, who will report to Infection Control monthly until three consecutive months of 95% compliance is achieved. Environmental Service will report monthly to Chief, Facility Management Service who will report to Infection Control until three consecutive months of 95% compliance is achieved.

Recommendation 7. We recommended that facility managers ensure walk-off sticky mats are changed as needed to minimize dust and monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: The contractor on the project for which the referenced observation was made immediately changed the walk-off mat in question on March 24, 2015. To assure that future similar events do not occur, project CORs have begun daily checks of the walk-off mats as they enter each construction zone they have been assigned to. Additionally this is a weekly item for inspection on the safety walks. Any instance of mats not being changed will result in both verbal and written (emails) direction to the contractor for action, with copies sent to NCO for appropriate notification up the

contractor chain as the situation warrants, as well as quarterly reports to Environment of Care Council.

Recommendation 8. We recommended that facility managers ensure that the temporary construction barrier is equipped with a self-closing door with a metal frame for worker access.

Concur

Target date for completion: March 31, 2015

Facility response: Subject door now has a metal frame and is self-closing; these changes were completed by March 27, 2015. All other ongoing construction projects on site were also checked for proper door and frame and were determined to be in compliance. Additionally, for all future construction projects immediately upon installation of the construction barrier, the project COR will check the barrier to ensure they are properly installed and are in compliance.

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: June 30, 2015

Facility response: Training on the use of automated dispensing machines is done during initial nursing orientation as employees use this equipment on a routine basis. The policy for automated dispensing has been amended to reflect current practice and define minimal competencies; it has been sent out for review and it is anticipated it will be signed by June 1, 2015. Nurse Educators validate competency of all new nurses who utilize the automated dispensing machines. Patient Care Service will ensure current staff have documented competencies on the use of automated dispensing machines on file by June 20, 2015. Target for compliance is 95%. Results will be monitored by pharmacy and reported to the Chief Nurses of Acute Care, Nursing Service and Extended Care and Mental Health Nursing Service and to Quality Executive Council for three consecutive months of 95% compliance.

Recommendation 10. We recommended that the facility educate employees on the medical and community living center units that intravenous syringes are not to be used to measure oral liquid medications and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: Inpatient and Community Living Center nursing staff were educated, by email and unit huddles by their Nurse Managers regarding the importance of utilizing

oral syringes for administration of liquid medications. Pharmacy supplied the oral syringes to each unit. Nurse Managers/designee will do random audits of liquid partial dose medication administration monthly. Target for compliance is 95%. Results will be reported to the Chief Nurses of Acute Care Nursing Service and Extended Care and Mental Health Nursing Service.

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: September 1, 2015

Facility response: Diagnostic Imaging Service will require Medical Service, Surgical Service, Patient Care Service, Police Service and Environmental Management Service to identify by May 15, 2015, the specific staff, by name, in their service who qualify for Level-1 MRI training in accordance with VHA Handbook 1105.05. The Services will need to identify the date each of these individuals has completed the TMS Training #9696 on the topic of Ancillary Staff Level 1 Magnetic Resonance Imaging Safety Training. Diagnostic Imaging Service Administrative Officer and/or Administrative Assistant will obtain this information from services on a quarterly basis. Target compliance is 90% (total combination of all who have completed the training divided by total of all who are identified for training). Diagnostic Imaging will report compliance for four consecutive quarters of 90% of higher compliance to Quality Executive Council.

Recommendation 12. We recommended that the facility implement an acute ischemic stroke policy that addresses all required items.

Concur

Target date for completion: June 30, 2015

Facility response: Medical Service has revised facility directive 111-14, entitled "Treatment of Acute Ischemic Stroke," to comply with VHA Directive 2011-038. The revised directive was routed for approval on April 22, 2015. The Chief of Staff and Chief Nurse Executive will ensure clinical staff receive education on the revised directive by June 30, 2015.

Recommendation 13. 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: September 30, 2015

Facility response: National Institutes of Health stroke scale *will* be placed in the Emergency Department physician/provider note and in the Emergency Department resident summary note templates. There is a National Institutes of Health stroke scale note template for all providers to use should a patient exhibit stroke symptoms while an in-patient. Education will be completed by May 30, 2015, to Emergency Department providers/physicians, attending physicians, residents, at staff meeting(s). A minimum of 30 charts per month (or 100% of applicable charts if the number of suspected stroke patients is less than 30) will be reviewed by Medical Service until 90% compliance is met for three consecutive months. Quarterly audits will be conducted for a year to ensure sustained compliance. Findings of the audits will be reported monthly to staff, and quarterly to Quality Executive Council.

Recommendation 14. We recommended that facility managers post stroke guidelines in all required patient care areas.

Concur

Target date for completion: July 1, 2015

Facility response: An algorithm was developed and included as an attachment to the revised facility directive 111-14, entitled "Treatment of Acute Ischemic Stroke" which is being routed for approval. A copy of the algorithm will be sent to Interior Designer for framing and signage posting by July 1, 2015, at the nursing stations for inpatient units B3, B4, ICU and the Emergency Department, in compliance with VHA directive 2011-038 "Treatment of Acute Ischemic Stroke."

Recommendation 15. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Education will be completed by May 30, 2015, to Emergency Department providers/physicians, attending physicians, residents, at staff meeting(s) on the need to screen patients prior to ordering a diet or oral medication administration. Based on stroke codes, HIMS pulls a list of inpatient and Emergency Department patients for Medical Service Administrative Nurse to audit. Fall outs for Emergency Department patients are sent to both the Emergency Department providers meeting and the Emergency Department multidisciplinary meeting for review and action on a monthly basis. Medical Service Administrative Nurse will report quarterly to Quality Executive Council for two consecutive quarters of 90% compliance.

Recommendation 16. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: Inpatient nursing staff was educated, during unit huddles and email, regarding the importance of patient education throughout the hospital stay for patients admitted for post-stroke care. Nursing education templates for Nursing Inpatient Note and Nursing Discharge Summary Note were modified to include selections for specific written stroke education and instructions so that nursing documentation of the patient education is provided and documented during the patient's hospitalization and upon discharge. All medical records of patients admitted to the acute inpatient care unit for post-stroke care will be audited for three months by the Nurse Manager/designee, for documentation of written discharge stroke education. Target for compliance is 95%. Audit results will be reported to the Chief Nurses of Acute Care Nursing Service and Extended Care and Mental Health Nursing Service.

Recommendation 17. We recommended that the facility 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: September 1, 2015

Facility response: Based on stroke codes, HIMS pulls a list of inpatient and Emergency Department patients for Medical Service Administrative Nurse to audit. Fall outs for Emergency Department patients are sent to both the Emergency Department providers meeting and the Emergency Department multidisciplinary meeting for review and action on a monthly basis. The Medical Service Administrative Nurse will begin sending the inpatient fall outs to the Chief of Medical Service and the Chief Nurse of Acute Care Nursing Service on a monthly basis for their respective review and submission of action plans. Medical Service Administrative Nurse will report quarterly to Quality Executive Council for two consecutive quarters of 90% compliance.

Recommendation 18. We recommended that the facility ensure that a qualified physician is present in the Emergency Department at all times, that non-Emergency Department clinicians are assigned inpatient emergency airway management coverage from 9:00 p.m. to 7:00 a.m., and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: VA Sierra Nevada Health Care System Out of Operating Room Airway Management directive will be revised by May 15, 2015 to address coverage in the Emergency Department during times where the Emergency Department physician is needed for intubations outside of the Emergency Department. Emergency Department physician coverage will be provided by the in house Resident physician for the time the Emergency Department physician is not in the Emergency Department. This process will be implemented by May 22, 2015. The Emergency Department Director will monitor monthly the frequency and compliance with the revised policy, providing monthly reports to the Chief of Staff, who will report to Medical Executive Council on a monthly basis.

Recommendation 19. We recommended that the facility ensure patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: September 1, 2015

Facility response: Medical Service has hired a GI RN Coordinator who will coordinate schedules, procedures, consults, and follow-ups, and track no-shows. This RN coordinator will track positive FIT tests from test date to completed colonoscopy and will coordinate GI appointments and procedure schedules with veterans and staff to ensure timeliness of colonoscopy. A search for positive FIT lab tests will be conducted weekly. A monthly report of timeliness (and identification of any barriers) will be reported to the Quality Executive Council and Medical Executive Council until four consecutive months of compliance have been achieved (target September 1, 2015), then quarterly reports will be presented for a year to reflect sustained compliance.

Office of Inspector General
Contact and Staff Acknowledgments

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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.

[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 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.
- 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] The reference used for this topic was:

- VHA Directive 1015, *Colorectal Cancer Screening*, December 30, 2014.