Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00599-438

Combined Assessment Program Review of the Mann-Grandstaff VA Medical Center Spokane, Washington

July 28, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Mann-Grandstaff VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

	Page
Executive Summary	i
Objectives and Scope	1
Objectives	1
Scope	1
Reported Accomplishments	2
Results and Recommendations	4
QM	4
EOC	8
Medication Management	11
Coordination of Care	14
CT Radiation Monitoring	15
ADs	17
Surgical Complexity	18
EAM	19
Review Activities with Previous CAP Recommendations	22
Follow-Up on QM	22
Appendixes	
A. Facility Profile	23
B. Strategic Analytics for Improvement and Learning	24
C. VISN Director Comments	27
D. Interim Facility Director Comments	28
E. Office of Inspector General Contact and Staff Acknowledgments	37
F. Report Distribution	38
G. Endnotes	39

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 May 4, 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 activity:

- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were a pharmacist managed Hepatitis C clinic to augment clinic capacity and initiation of an audiology progressive tinnitus management program.

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

Quality Management: Require that licensed independent practitioners who perform emergency airway management have the appropriate privileges. Ensure that the Critical/Acute Care and Transfusion Committee reviews each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the code occurrence, and that the committee consistently collects code data. Require the Surgical Quality Committee to meet monthly, document its review of National Surgical Office reports, and review all surgical deaths with identified problems or opportunities for improvement. Keep the recipient list for the critical incident automated e-mail notification current. Ensure the recently initiated Accident Review Board provide oversight of the safe patient handling program and gathers, tracks, and shares patient handling injury data. Include required elements in the quality control policy for scanning.

Environment of Care: Ensure that Environment of Care Committee meeting minutes track actions taken in response to identified deficiencies to closure. Require fire extinguishers in all patient care areas to have documented monthly safety checks. Complete and document an annual review of the Hazard Vulnerability Assessment.

Medication Management: Ensure that oral syringes are available for liquid medications on all nursing units and that they are stored separately from parenteral syringes. Require nursing reviewers to sign the monthly medication inspection forms.

Coordination of Care: Ensure requestors consistently select the proper consult title. Ensure consultants consistently complete inpatient consults within the specified timeframe.

Advance Directives: Ensure consistent correct posting of patients' advance directives status.

Surgical Complexity: Ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the intensive care unit.

Emergency Airway Management: Revise the emergency airway management policy to include the type of clinical staff whose expected duties would include emergency airway management. Ensure initial clinician emergency airway management competency assessment includes all required components and that facility managers monitor compliance. Ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care. Ensure video laryngoscopes are available for immediate clinician use.

Follow-up on Quality Management: Consistently complete actions from peer reviews, and report them to the Peer Review Committee.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–36, for the full text of the Directors' comments.) We consider recommendations 4 and 9 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities and follow-up review area:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- 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 FY 2013, FY 2014, and FY 2015 through May 7, 2015, and inspectors conducted the review 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 Spokane VA Medical Center, Spokane, Washington,* Report No. 13-00432-217, June 12, 2013). We made repeat recommendations in QM.

During this review, we presented crime awareness briefings for 120 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. We distributed an electronic survey to all facility employees and received 289 responses. We shared summarized results with the Facility Director.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Pharmacist-Managed Hepatitis C Clinic to Augment Clinic Capacity

The vacating of the facility's infectious disease position in FY 2015 impacted access to care for hepatitis C patients. In response, Pharmacy and Medicine Service leadership devised an interim solution to team a clinical pharmacy specialist with infectious disease training and a gastroenterology advanced registered nurse practitioner to maintain support for the hepatitis C treatment program. The team uses the VISN 20 SCAN-ECHO (Specialty Care Access Network – Extension for Community Healthcare Outcomes) Liver Program to obtain treatment guidance and patient prioritization from VISN 20 specialists. The SCAN-ECHO program leverages cutting-edge telehealth technology to provide specialty comprehensive care to veterans nationwide, regardless of where they live. This partnership with the VISN enables the facility team to provide improved access to care, individualized counseling, successful treatment planning, and follow-up for veterans with hepatitis C. Through efficient use of personnel and resources, the facility has increased clinic capacity in FY 2015 from 26 to 50 veterans. This creative approach continues to provide access to care for veterans diagnosed with hepatitis C.

Initiation of an Audiology Progressive Tinnitus Management Program

Tinnitus (commonly described as a ringing in the ears that affects nearly 25 million Americans) has a high prevalence in the veteran population and is the third highest rated service-connected disability. Progressive Tinnitus Management is a nationally endorsed program sponsored and supported by the VA National Center for

Rehabilitative Auditory Research in Portland, OR. The facility adopted the program in 2013 and fully implemented it in 2014. The Progressive Tinnitus Management Program is locally co-managed by Audiology and Behavioral Health Services and includes a comprehensive audiological evaluation, individual counseling, hearing aids, group education, assessment, and use of tinnitus sound devices. Patients work with a team of clinicians to create a personalized action plan to aid in management of symptoms and to improve quality of life. Group education provides an environment of supportive and encouraging peers.

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 PRC reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final PRC 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.	• None of the folders of the seven licensed independent practitioners' who were designated to cover out of operating room airway management had an appropriate EAM privilege.	**1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate privileges.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.	Twelve months of Critical/Acute Care and Transfusion Committee meeting minutes reviewed: • The committee did not review each episode. • Code reviews did not include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. • The facility did not collect data that measured performance in responding to events. This was a repeat finding from the previous CAP review.	**2.** We recommended that the Critical/Acute Care and Transfusion Committee review each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that the committee collects code data.

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.	• The Surgical Quality Committee only met nine times over the past 12 months. Nine months of Surgical Quality Committee meeting minutes reviewed: • The committee did not review National Surgical Office reports. A surgical death that occurred May 1, 2013–April 30, 2014, had identified problems or opportunities for improvement: • The Surgical Quality Committee did not review this death.	**3.** We recommended that the Surgical Quality Committee meet monthly, document its review of National Surgical Office reports, and review all surgical deaths with identified problems or opportunities for improvement.
X	Clinicians appropriately reported critical incidents.	• The recipient list for the critical incident automatic e-mail notification was not current.	**4.** We recommended that the facility keep the recipient list for the critical incident automated e-mail notification current.
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The facility did not have a committee that provided oversight of the safe patient handling program prior to March 2015.	**5.** We recommended that the recently initiated Accident Review Board provide oversight of the safe patient handling program and gather, track, and share patient handling injury data.
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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. • 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.	• The scanning policy did not include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability.	**6.** We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability.
	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 emergency management.[b]

We inspected the community living center, intensive care unit, urgent care center, inpatient behavioral health unit; inpatient general medicine unit and oncology, gastroenterology, urology, neurology, pulmonary, rheumatology, cardiology, podiatry, dermatology, orthopedics, and the wound care outpatient clinics. Additionally, we reviewed relevant documents, including 10 employee training and competency records, 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
X	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.	Three months of EOC Committee meeting minutes reviewed: • The EOC Committee did not track corrective actions to closure.	**7.** We recommended that Environment of Care Committee meeting minutes track actions taken in response to identified deficiencies to closure.
	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.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
X	The facility met fire safety requirements.	• In two of the 16 patient care areas, fire extinguishers were missing documented monthly safety checks.	**8.** We recommended that facility managers ensure fire extinguishers in all patient care areas have documented monthly safety checks and monitor compliance.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met environmental safety requirements.		
	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 SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for Emergency Management	Findings	Recommendations
X	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.	• The facility did not have documented evidence of an annual review of the Hazard Vulnerability Assessment.	**9.** We recommended the facility complete and document an annual review of the Hazard Vulnerability Assessment.
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
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 18 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the inpatient general medicine, intensive care, and post-anesthesia care units and the community living center 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.		
	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.		
X	The facility employed practices to prevent wrong-route drug errors.	• None of the units/areas inspected had oral syringes available for staff to administer liquid medications when dose amounts differed from the unit dose packages supplied, and employees reported they were using parenteral syringes instead.	**10.** We recommended that facility managers ensure that oral syringes are available for liquid medications on all nursing units and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.	Facility policy on drug distribution and accountability reviewed, which required signatures by both the nursing and pharmacy reviewer on the designated monthly medication inspection form: • Inspection forms for the intensive care and inpatient general medicine units did not contain signatures of the nursing reviewer.	**11.** We recommended that nursing reviewers sign the monthly medication inspection forms for the intensive care and inpatient general medicine units and that facility managers monitor compliance.

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 44 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.	• Sixteen of the 44 consult requests (36 percent) did not include "inpatient" in the title. • Consultants did not complete six of the applicable 43 consult requests (14 percent) within the specified timeframe.	**12.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. **13.** We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for four CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 49 randomly selected patients who had a CT scan January 1 through December 31, 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
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist, technologist expert in CT, and medical physicist reviewed all CT protocols revised during the past 12 months, and a medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
NA	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review, and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
NA	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether VHA facilities complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1 through December 31, 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
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
X	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.	• For 7 of the 27 applicable EHRs (26 percent), employees did not correctly post patients' AD status.	**14.** We recommended that employees consistently post patients' advance directives status correctly and that facility managers monitor compliance..
	When inpatients requested a discussion about ADs (create, change, and/or revoke), employees: • Documented the discussion • Used the required AD note titles		
	The facility met 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
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• None of the 10 employees on the intensive care unit had post-anesthesia care competency assessment and validation included in their competency checklist. • None of the 10 employees on the intensive care unit had post-anesthesia care competency assessment and validation documentation completed.	**15.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the intensive care unit.
NA	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 nine clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
X	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	• Facility policy did not address the type of clinical staff whose expected duties would include EAM.	**16.** We recommended that the facility revise the emergency airway management policy to include the type of clinical staff whose expected duties would include emergency airway management.

NM	Areas Reviewed (continued)	Findings	Recommendations
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	• Seven of nine clinicians with initial EAM competency assessment did not have: o Documentation of all required subject matter content elements o Evidence of a completed written test o Evidence of successful demonstration of all required procedural skills on airway simulators or mannequins o Evidence of successful demonstration of all required procedural skills on patients	**17.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required components and that facility managers monitor compliance.
	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		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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.	• None of the 30 sampled days had EAM coverage during all hours the facility provided patient care.	**18.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.
X	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.	• The facility did not have video laryngoscopes available for immediate clinician use in 19 of 24 designated locations.	**19.** We recommended that facility managers ensure video laryngoscopes are available for immediate clinician use and monitor compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Review Activities with Previous CAP Recommendations

Follow-Up on QM

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

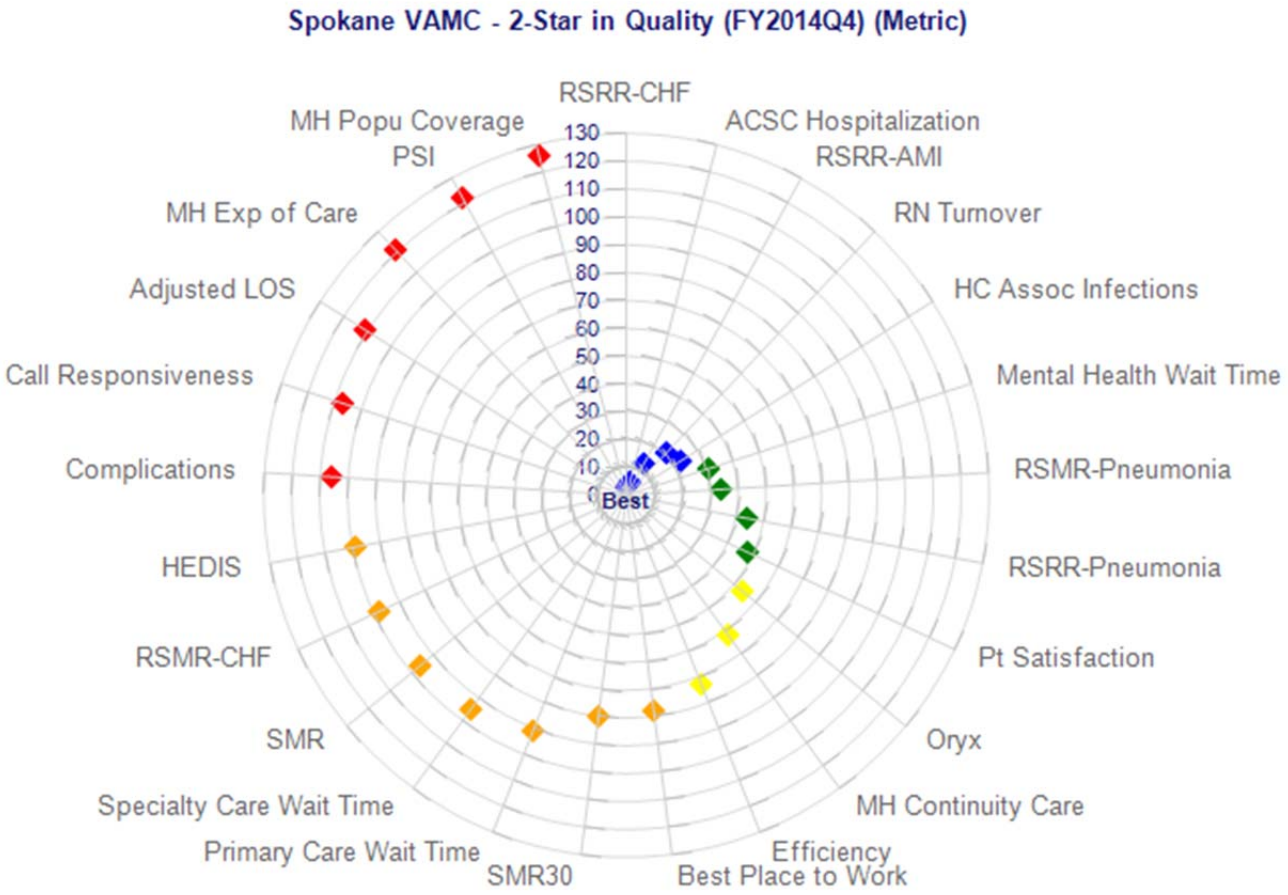
Peer Review. VHA requires the reporting of completed corrective actions from the protected peer review process to the PRC. We reviewed PRC minutes from June 2013 to December 2014 and identified corrective actions; however, minutes lacked evidence of action completion being reported to the PRC.

Recommendation 20. We recommended that the facility ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

Facility Profile (Spokane/668) FY 2015 through April 2015[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$172
Number (as of September 2014) of:	
• **Unique Patients**	26,053
• **Outpatient Visits**	255,721
• **Unique Employees**[2]	785
Type and Number of Operating Beds:	
• **Hospital**	36
• **Community Living Center**	34
• **MH**	NA
Average Daily Census:	
• **Hospital**	19
• **Community Living Center**	27
• **MH**	NA
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Wenatchee\668GA North Idaho\668GB
VISN Number	20

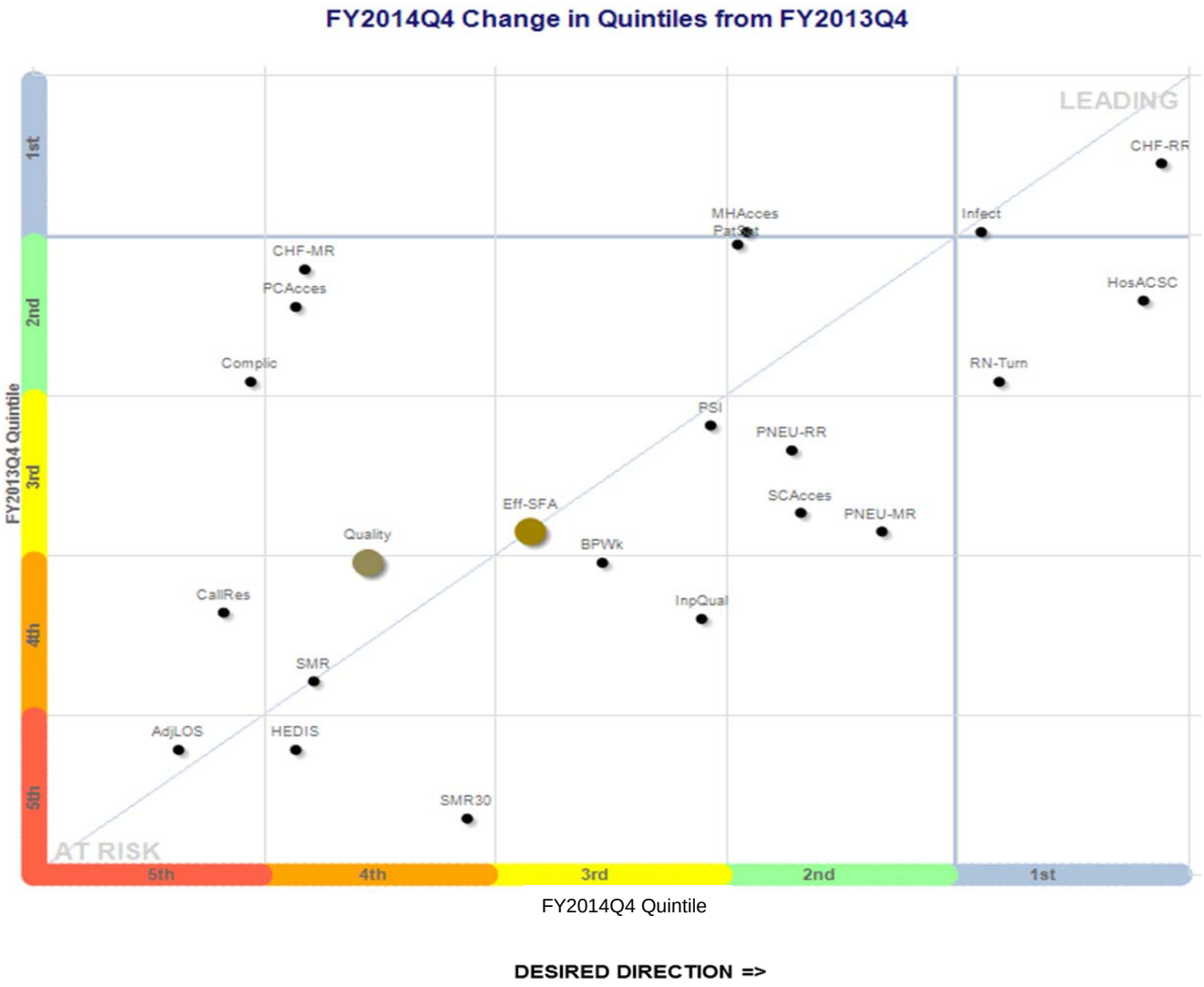
[1] All data is for FY 2015 through April 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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: June 23, 2015

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Mann-Grandstaff VA Medical Center, Spokane, WA**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

1. Thank you for the opportunity to provide responses to the findings from the Combined Assessment Program Review of the Mann-Grandstaff VA Medical Center, Spokane, Washington.

2. Attached please find the facility concurrences and responses to the findings from the review.

3. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

Lawrence H. Carroll

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 16, 2015

From: Interim Medical Center Director, Mann-Grandstaff VA Medical Center (668/00)

Subject: CAP Review of the Mann-Grandstaff VA Medical Center, Spokane, WA

To: Director, Northwest Network (10N20)

1. Please find attached the Mann-Grandstaff VAMC response to the CAP Review at the Mann-Grandstaff VAMC, Spokane, Washington, during the week of May 4, 2015.

2. The Mann-Grandstaff VAMC staff is committed to continuously improving processes and care provided to our Veterans. We are submitting a plan to implement each recommendation made by the CAP Team.

3. If you have additional questions, or need additional information, please contact Betty Braddock at 509-434-7300

J. Ronald Johnson, FACHE
Interim 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: September 2015

Facility response: Credentialing staff will ensure providers requesting Emergency Airway Management (EAM) privileges are approved through the Executive Committee of the Medical Staff (ECMS).

Credentialing staff will ensure that all providers with approved EAM privileges have the appropriate privileges documented in the provider folders.

Credentialing will audit all EAM approved providers for appropriate privileges in their folders for three consecutive months of compliance. Compliance goal has been set at 100%.

Recommendation 2. We recommended that the Critical/Acute Care and Transfusion Committee review each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that the committee collects code data.

Concur

Target date for completion: September 2015

Facility response: Each code since February of 2014 has been reviewed in the Critical/Acute Care and Transfusion Committee. Moving forward, the Associate Chief Nurse Executive, Accreditation Manager, and Chief of Anesthesia will be added as co-signers on all code notes. Additionally, the Accreditation Manager will monitor morning report documents and identify all codes that occurred. Codes identified through the co-sign process and morning reports will be communicated to the Chief of Anesthesia to include in the code reviews by the committee. Code reviews are a standing agenda item on the committee minutes.

The Chief of Anesthesia developed a new Code Blue event form to be used in documenting code events. This form includes screening for clinical issues prior to the

code that may have contributed to the occurrence of the code. This form is reviewed by the committee and documented.

A semi-annual (July and December) code blue review will be conducted during the committee meeting to review and discuss trended data. Data will come from the code blue reports above. This will be a standing semi-annual agenda item in the minutes.

Continuous Quality Improvement (CQI) will audit Critical/Acute Care and Transfusion Minutes to ensure that all codes are reviewed each month. This review will occur until three consecutive months of compliance is met. A goal of 100% has been set.

Recommendation 3. We recommended that the Surgical Quality Committee meet monthly, document its review of National Surgical Office reports, and review all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: September 2015

Facility response: The Surgical Quality Charter will be updated to state meetings will be held monthly.

Veterans Affairs Surgical Quality Improvement Program (VASQIP) and National Surgery Office (NSO) reports are routinely reviewed in Surgery Staff meetings. Beginning 6/26/2015, the VASQIP and NSO reports/findings will be reviewed and discussed in Surgical Quality meetings quarterly. VASQIP and NSO reports are a standing agenda item on the Surgical Quality minutes.

As of 5/22/2015, all surgical deaths are reviewed and discussed in Surgical Quality meetings monthly. Surgical Death Review is a standing agenda item for each meeting.

Surgical Quality minutes will be reviewed monthly by CQI staff to ensure all surgical deaths are reviewed and that the NSO report is reviewed quarterly. This review will continue until three consecutive months of compliance has been met. A goal of 100% has been set.

Recommendation 4. We recommended that the facility keep the recipient list for the critical incident automated e-mail notification current.

Concur

Target date for completion: May 2015 – completed.

Facility response: This recommendation is complete. The Recipient List was updated while the OIG was still on site. Moving forward, the VASQIP Nurse will update the Recipient List when there are changes to appropriate staff.

Recommendation 5. We recommended that the recently initiated 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 2015

Facility response: Safe Patient Handling has been added as a standing agenda item in the Accident Review Board (ARB) minutes.

Safe Patient Handling data and action items are reviewed in the ARB minutes.

Recommendation 6. We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability.

Concur

Target date for completion: September 2015

Facility response: The local policy, "Document Scanning" (Numbered Memorandum 136-31-14) is being rewritten to include the following concerns:

- Quality of source document
- Alternative means of capturing data when the quality of the source document does not meet image quality controls
- A correction process if scanned items have errors
- A complete review of scanned documents to ensure readability and retrievability.

Once the policy has been through the approval process, education will be conducted with all staff responsible for scanning of documents. This education will be documented.

Recommendation 7. We recommended that Environment of Care Committee meeting minutes track actions taken in response to identified deficiencies to closure.

Concur

Target date for completion: September 2015

Facility response: The Emergency Manager now utilizes the Performance Logic Database tracking system for all deficiencies noted through the Environment of Care (EOC) inspection process.

The EOC Deficiency List has been added to the minutes as a standing agenda item. Deficiencies will be reviewed and discussed until closure.

Review of monthly EOC minutes will occur to ensure EOC deficiencies are being tracked monthly to closure. Review will occur until three consecutive months of compliance are met. A 90% compliance goal has been set.

Recommendation 8. We recommended that facility managers ensure fire extinguishers in all patient care areas have documented monthly safety checks and monitor compliance.

Concur

Target date for completion: September 2015

Facility response: Engineering Service has begun utilizing the Life Safety Intern to complete fire extinguisher checks. The Intern has received training on how to use the tablet based inspection list. The Intern now completes scheduled checks until a new Life Safety Specialist is hired.

Currently, all fire extinguisher checks have been completed for the medical facility.

Engineering Service will randomly audit 10 patient care areas monthly to ensure compliance with fire extinguisher checks. This audit will continue until three consecutive months of compliance has been met. A goal of 90% compliance is set.

Recommendation 9. We recommended the facility complete and document an annual review of the Hazard Vulnerability Assessment.

Concur

Target date for completion: June 2015 – completed.

Facility response: This recommendation is complete. The Emergency Manager completed and documented a Hazard and Vulnerability Assessment (HVA) for FY 2015.

Recommendation 10. We recommended that facility managers ensure that oral syringes are available for liquid medications on all nursing units and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

Concur

Target date for completion: September 2015

Facility response: On 5/14/2015, oral syringes were ordered for all clinical areas at Mann-Grandstaff VA Medical Center**.**

Oral syringes have been received and distributed to all clinical areas.

CQI will randomly audit ten patient care Omnicell cabinets to ensure oral syringes are present and stored separately from parenteral syringes. This audit will continue until three consecutive months of compliance are met. A goal of 90% compliance has been set.

Recommendation 11. We recommended that nursing reviewers sign the monthly medication inspection forms for the intensive care and inpatient general medicine units and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility Response: Pharmacy staff has reviewed the "Drug Distribution and Accountability" Standard Operating Procedure to ensure they are aware that nursing staff must sign the inspection sheets monthly.

Pharmacy staff will ensure nurses co-sign the inspection sheet prior to leaving the unit/department.

Pharmacy will email copies of the monthly inspection sheets to CQI until three consecutive months of compliance are met. A 90% compliance goal has been set.

Recommendation 12. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility response: All inpatient consult templates have been edited to contain the word "Inpatient" in the title.

CQI will randomly audit 10 consults every month to ensure proper "inpatient" titles are utilized for inpatient consults. Audits will continue until three consecutive months of compliance are met. A goal of 90% compliance has been set.

Recommendation 13. We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility response: Training will be conducted with all services to ensure all consultants are aware of the timeframe required to complete consults. This training will be documented.

CQI will conduct audits of 30 consults each month to ensure that they are completed within specified timeframes. These audits will continue until three consecutive months of compliance are met. A goal of 90% compliance has been set.

Recommendation 14. We recommended that employees consistently post patients' advance directives status correctly and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility response: The Clinical Applications Coordinator has edited the Advance Directive template to allow staff to check past directives for accuracy or whether an Advance Directive is documented during the admission assessment.

Social Worker staff has received refresher training to ensure they document Advance Directive status for Veterans.

Medical Record staff will conduct 10 random patient chart reviews each month to ensure completion of Advanced Directives and that the document is posted correctly in the medical record. Reviews will occur until three consecutive months of compliance are met. A goal of 90% compliance has been set.

Recommendation 15. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the intensive care unit.

Concur

Target date for completion: July 2015

Facility response: The Intensive Care Unit (ICU)-Advanced Care Unit (ACU) Nurse Manager will ensure all ICU Registered Nurses (RNs) rotate through Post Anesthesia Care Unit (PACU) and receive Simulator Training for post-anesthesia care competencies.

The ICU/ACU Nurse Manager will ensure all ICU RNS have post-anesthesia competency assessment validations documented in their competency folders.

The ICU/ACU Nurse Manager will audit all ICU RN competency folders to ensure post-anesthesia competencies are current and documented. A goal of 90% has been set.

Recommendation 16. We recommended that the facility revise the emergency airway management policy to include the type of clinical staff whose expected duties would include emergency airway management.

Concur

Target date for completion: August 2015

Facility response: The Chief of Anesthesia will revise the "Out of Operating Room Airway Management" (OORAM) policy to include the type of clinical staff whose expected duties include emergency airway management.

Recommendation 17. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required components and that facility managers monitor compliance.

Concur

Target date for completion: July 2016

Facility response: A new process was implemented in November 2014. Documentation of OORAM competencies has been completed since November of 2014.

Documentation of the written test results has been included in the employee Talent Management System since November 2014.

Evidence of successful demonstration of required procedural skills on mannequins have been documented since November 2014.

Evidence of successful demonstration of required procedural skills on patients have been documented since November 2014.

As this new process was implemented in November 2014 monitoring will continue through July 2016 to ensure compliance with the goal of 100%.

Recommendation 18. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility response: Currently, the medical facility has 24/7 coverage for OORAM coverage. Coverage is provided by Respiratory Therapist and/or Anesthesia staff.

This process has been in place since November of 2014.

CQI will randomly audit ten days each month to ensure appropriate staff with emergency airway management privileges or scope of practice is available during all hours of patient care. Audits will continue for 12 months through September 2015 to ensure compliance of a goal of 100%.

Recommendation 19. We recommended that facility managers ensure video laryngoscopes are available for immediate clinician use and monitor compliance.

Concur

Target date for completion: August 2015

Facility response: The Chief of Anesthesia entered an Equipment Procurement PIN request for 17 Glidescopes.

Once the Glidescopes are received, one Glidescope will be placed in each code cart throughout the medical facility.

Until Glidescopes are in each code cart, the ICU nurse bringing the "Orange Box" of additional code drugs will also bring the Glidescope from the ICU.

Recommendation 20. We recommended that the facility ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

Concur

Target date for completion: September 2015

Facility response: Corrective actions from the peer review process are documented in the "Peer Review Action Item Log". This log is reviewed and discussed by the Protected Peer Review Committee at every meeting. This review and discussion is documented in the Protected Peer Review minutes as a standing agenda item.

Minutes will be audited for three consecutive months to ensure all peer review actions are tracked and monitored to closure in the Protected Peer Review minutes. A goal of 100% has been set.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Mary Noel Rees, MPA, Team Leader Craig Byer, MS, R.R.A. Carol Lukasewicz, RN, BSN Sarah Mainzer, RN, JD Sami O'Neill, MA Monika Spinks, RN, BSN Robert Sproull, Resident Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Marc Lainhart, BS Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Northwest Network (10N20)
Acting Director, Mann-Grandstaff VA Medical Center (668/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Maria Cantwell, Mike Crapo, Steve Daines, Patty Murray, James E. Risch, Jon Tester
U.S. House of Representatives: Raul R. Labrador, Cathy McMorris Rodgers, Ryan Zinke

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 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, 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 Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[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 2010-025, *Peer Review for Quality Management*, June 3, 2010.