Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00597-462

Combined Assessment Program Review of the Northport VA Medical Center Northport, New York

August 18, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CPR	cardiopulmonary resuscitation
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Northport VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PTSD	post-traumatic stress disorder
QM	quality management
RRTP	residential rehabilitation treatment program
SA	substance abuse
SCI	spinal cord injury
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 May 4, 2015.

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

- Advance Directives
- Surgical Complexity
- Emergency Airway Management

The facility's reported accomplishment was the Bay Shore Community Based Outpatient Clinic Collaborative Unified Behavioral Health Center.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure licensed independent practitioners' folders do not contain non-allowed information. Reassess observation criteria and utilization when conversions from observation bed status to acute admissions are 25–30 percent or more. Ensure the CPR (cardiopulmonary resuscitation) Committee reviews each code episode. Require the Surgical Work Group to document its review of National Surgical Office reports. Keep the recipient list for the automated Critical Incident Tracking Notification e-mail current. Review the quality of entries in the electronic health record at least quarterly. Ensure the scanning quality control policy includes required elements. Revise the observation bed policy to reflect Veterans Health Administration policy and current practice.

Environment of Care: Ensure the Infection Control Committee consistently documents analysis of surveillance activities and data. Delegate responsibility for cleaning non-critical equipment. Establish a policy/procedure/guideline for the identification of individuals entering the facility. Store clean and dirty items separately. Ensure furniture in inpatient mental health patient care areas is compliant with the VA Mental Health Environment of Care Checklist. Maintain ventilation, temperature, and humidity levels in inpatient care areas according to applicable guidelines. Establish a list of resources and assets the facility may need during an emergency. Ensure the Emergency Operations Plan includes required elements.

Medication Management: Use special medication labeling or institute unique storage practices for look-alike and sound-alike medications. Develop and implement a process for managing and labeling high-alert medications. Revise the policy for safe use of automated dispensing machines to include oversight of overrides.

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

Computed Tomography Radiation Monitoring: Develop policies and procedures for managing and reviewing revised computed tomography protocols. Ensure a medical physicist reviews all revised computed tomography protocols. Include the radiation dose in all computed tomography reports.

Mental Health Residential Rehabilitation Treatment Program: Ensure that Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program employees submit timely work orders for items needing repair and that program managers ensure deficiency correction. Require that Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program employees perform and document contraband inspections. Ensure the Substance Abuse Residential Rehabilitation Treatment Program has written agreements in place acknowledging resident responsibility for medication security. Require that closed circuit television in the Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Programs does not monitor treatment activities.

Comments

The Interim Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 26–35, for the full text of the Directors' comments.) We consider recommendations 1, 5, 11, 15, 16, 21, and 27 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General for
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Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM
- MH RRTP

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2014 and FY 2015 through 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 Northport VA Medical Center, Northport, New York,* Report No. 12-04191-123, March 4, 2013). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 190 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 342 responses. We shared summarized results with facility managers.

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 Accomplishment

Bay Shore Community Based Outpatient Clinic Collaborative Unified Behavioral Health Center

The facility's Unified Behavioral Health Center and the North Shore Long Island Jewish Medical Center collaborated to facilitate seamless access to MH services for veterans and their families. Since November 2012, this unique facility includes VA MH professionals and a primary care team treating the veteran on one side of the building and the North Shore Long Island Jewish Medical Center treating the veteran's family members on the other side. VA and North Shore Long Island Jewish Medical Center health care providers can jointly meet with the veteran and family members to determine a health care plan for the entire family. The shared location provides both the veteran and family members an opportunity to discuss concerns with their health care providers. This is done with consent from all individuals.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 10 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms.	• All licensed independent practitioners' folders reviewed contained non-allowed information.	**1.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• 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.		
X	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.	Twelve months of data reviewed: • For 10 months, the facility converted more than 30 percent of observation patients to acute admissions but did not reassess observation criteria or utilization during that time.	**2.** We recommended that when conversions from observation bed status to acute admissions are 25–30 percent or more, the facility reassesses observation criteria and utilization.
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 CPR Committee meeting minutes reviewed: • The committee did not document review of any code episodes.	**3.** We recommended that the CPR Committee review each code episode.
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.	Twelve months of Surgical Work Group meeting minutes reviewed: • The group did not review National Surgical Office reports.	**4.** We recommended that the Surgical Work Group document its review of National Surgical Office reports.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
X	Clinicians appropriately reported critical incidents.	• The recipient list for the Critical Incident Tracking Notification automatic e-mail was not current.	**5.** We recommended that the facility keep the recipient list for the automated Critical Incident Tracking Notification e-mail current.
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	• A committee did not review the quality of entries in the EHR.	**6.** We recommended that the facility review the quality of entries in the electronic health record at least quarterly.
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 irretrievability of the record and quality assurance reviews on a sample of the scanned documents.	• The scanning policy did not include a complete review of scanned documents to ensure readability and retrievability. • Three of 17 applicable ADs were not current due to scanning issues such as illegibility, missing pages, and failure to link to the Clinical Warning Allergies and Directives system.	**7.** We recommended that the quality control policy for scanning include a complete review of scanned documents to ensure readability and retrievability and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
X	The facility met any additional elements required by VHA or local policy.	• The facility observation bed policy showed a timeframe for observation status that was not consistent with the facility's current practice and VHA policy.	**8.** We recommended that the facility revise the observation bed policy to reflect Veterans Health Administration policy and current practice.

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 medical/surgical (units 33 and 34), inpatient MH (unit 21), the intensive care unit, community living center 4, the Emergency Department, and primary care pod 1A. Additionally, we reviewed relevant documents, including eight employee training 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
	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.		
X	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.	Five months of Infection Control Committee meeting minutes reviewed: • Minutes did not consistently reflect analysis of surveillance activities and data.	**9.** We recommended that the Infection Control Committee consistently document analysis of surveillance activities and data.
X	The facility had established a process for cleaning equipment.	• The facility had not established responsibility for cleaning non-critical items.	**10.** We recommended that facility managers delegate responsibility for cleaning non-critical equipment and monitor compliance.
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
X	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.	• The facility did not have a policy/procedure/guideline for identification of individuals entering the facility.	**11.** We recommended that the facility establish a policy/procedure/guideline for the identification of individuals entering the facility and that facility manager's monitor compliance.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• Three of seven patient care areas had clean and dirty items stored together. This was a repeat finding from the previous Combined Assessment Program review.	**12.** We recommended that employees store clean and dirty items separately and that facility managers monitor compliance.
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	The VA National Center for Patient Safety MH EOC Checklist requires that inpatient MH units have only weighted chairs. • The facility had non-weighted chairs in two dayrooms on the inpatient MH unit. Joint Commission, Centers for Disease Control and Prevention guidelines, and VA policy reviewed, which require that ventilation, temperature, and humidity levels in patient care areas provide a safe environment for patients, staff, and visitors. • The facility did not maintain safe ventilation, temperature, and humidity levels in inpatient care areas.	**13.** We recommended that facility managers ensure that furniture in inpatient mental health patient care areas is compliant with the VA National Center for Patient Safety Mental Health Environment of Care Checklist and monitor compliance. **14.** We recommended that the facility maintain ventilation, temperature, and humidity levels in inpatient care areas according to Joint Commission and Centers for Disease Control and Prevention guidelines and VA policy to provide a safe environment for patients, staff, and visitors and that facility managers monitor compliance.
	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.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
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.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
X	The facility maintained a list of resources and assets it may need during an emergency.	• The facility did not have a documented list of resources and assets it may need during an emergency.	**15.** We recommended that the facility establish a list of resources and assets it may need during an emergency.
X	The facility had a written Emergency Operations Plan that addressed key components.	• The facility's Emergency Operations Plan did not include: o The management of a potential increase in demand for clinical services for patients who are geriatric or disabled or have serious chronic conditions or addictions o The management of MH services during an emergency	**16.** We recommended that the facility's Emergency Operations Plan include the management of a potential increase in demand for clinical services for patients who are geriatric or disabled or have serious chronic conditions or addictions and the management of mental health services during an emergency.
	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.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	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 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the Emergency Department, medical/surgical (unit 34), the post-anesthesia care unit, and community living center 1 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
X	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 did not use special medication labeling/institute unique storage practices for look-alike and sound-alike medications.	**17.** We recommended that the facility use special medication labeling or institute unique storage practices for look-alike and sound-alike medications and that facility managers monitor compliance.
X	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 did not have a documented process for managing and labeling high-alert medications.	**18.** We recommended that the facility develop and implement a process for managing and labeling high-alert medications and that facility managers monitor compliance.
	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include oversight of overrides.	**19.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and that facility managers monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

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

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 40 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	Recommendation
	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.	• Ten (25 percent) consult requests did not include "inpatient" in the title.	**20.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

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 nine CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. 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 designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
X	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	• The facility did not have policies and procedures in place for managing and reviewing revised CT protocols.	**21.** We recommended that the facility develop policies and procedures for managing and reviewing revised computed tomography protocols.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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 did not review all revised CT protocols during the past 12 months.	**22.** We recommended that a medical physicist review all revised computed tomography protocols and that facility managers monitor compliance.
	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.		
X	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.	• Six EHRs (12 percent) did not contain radiation dose information in the CT report.	**23.** We recommended that radiologists ensure all computed tomography reports contain the radiation dose and that facility managers monitor compliance.
	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.		
	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 the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 47 randomly selected patients who had an acute care admission January 1–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 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.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	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. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendation
	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.		
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 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. 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 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		
NA	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.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

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

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

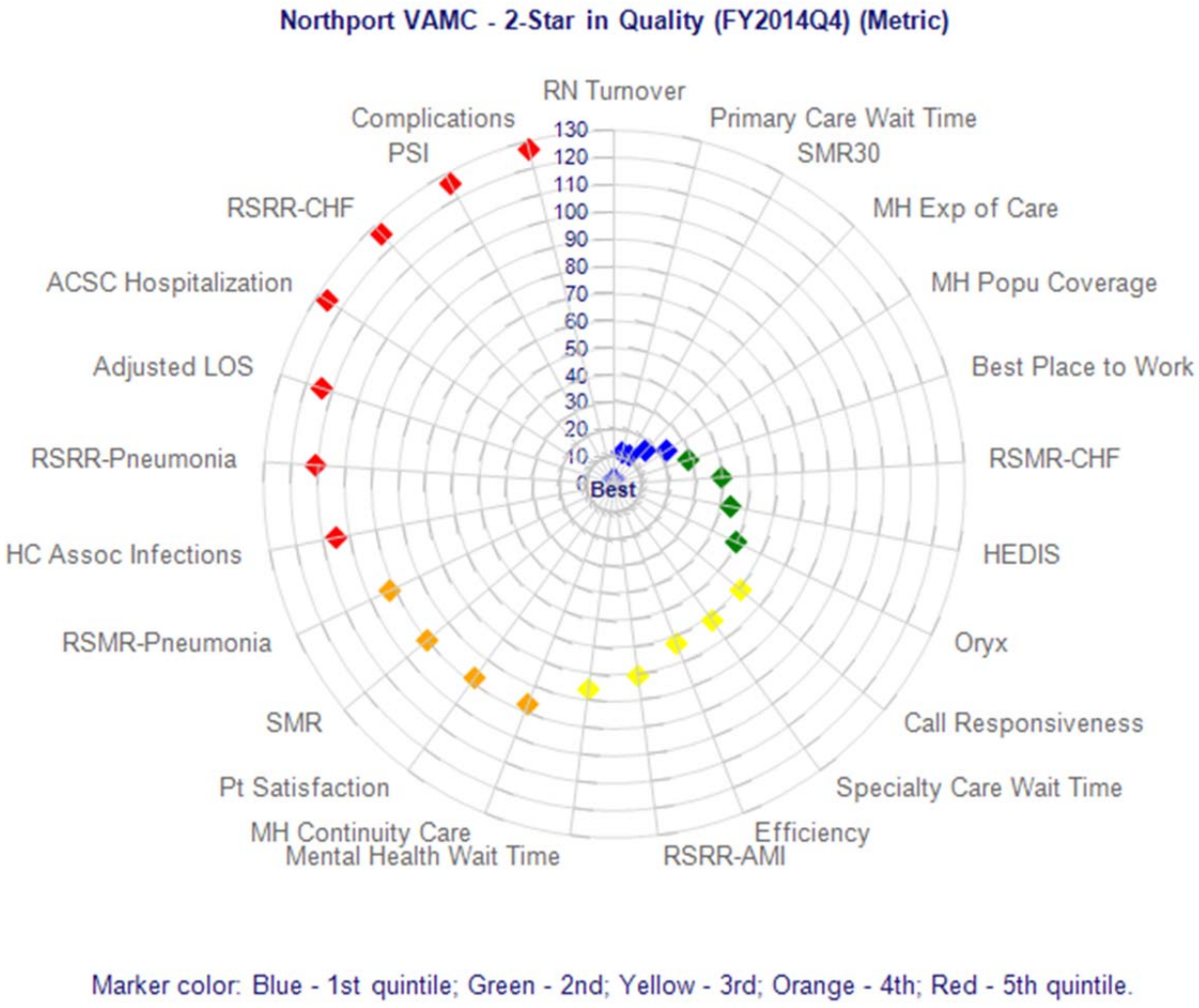
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	Six months of self-inspection documentation reviewed: • PTSD RRTP employees did not submit timely work orders for items needing repair.	**24.** We recommended that Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program employees submit timely work orders for items needing repair and that program managers ensure deficiency correction.
X	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.	Of the 5 weeks of inspection documentation reviewed: • SA RRTP employees did not complete weekly contraband inspections for 4 weeks. • PTSD RRTP employees did not complete weekly contraband inspections for 2 weeks.	**25.** We recommended that Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program employees perform and document contraband inspections and that program managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.	• The SA RRTP did not have written agreements in place for four of nine applicable residents.	**26.** We recommended that Substance Abuse Residential Rehabilitation Treatment Program managers ensure that the program has written agreements in place acknowledging resident responsibility for medication security.
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		
X	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.	We found closed circuit television monitors with recording capability in: • Two SA RRTP multipurpose rooms that were used for treatment. • Two PTSD RRTP multipurpose rooms that were used for treatment.	**27.** We recommended that Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program managers ensure that closed circuit television does not monitor treatment activities.
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Northport/632) FY 2015 through April 2015[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$288
Number (as of September 2014) of:	
• **Unique Patients**	26,427
• **Outpatient Visits**	322,586
• **Unique Employees**[2]	1,597
Type and Number of Operating Beds:	
• **Hospital**	302
• **Community Living Center**	170
• **MH**	30
Average Daily Census:	
• **Hospital**	69
• **Community Living Center**	107
• **MH**	30
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	East Meadow/632GA Valley Stream/632HA Riverhead/632HB Bay Shore/632HC Patchogue/632HD
VISN Number	3

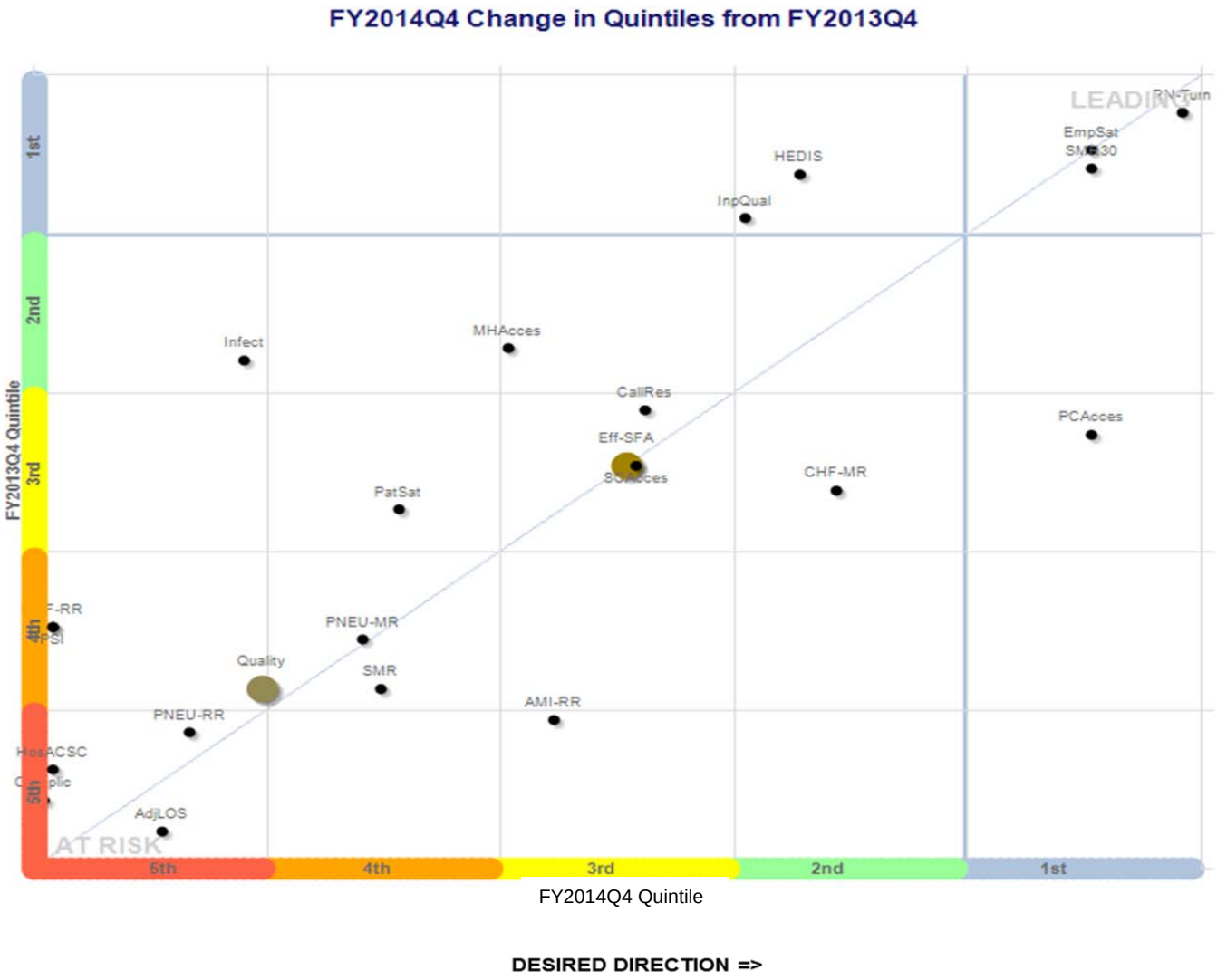
[1] All data is for FY 2015 through April 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



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

Interim VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: July 23, 2015

From: Interim Director, VA NY/NJ Veterans Healthcare Network (10N3)

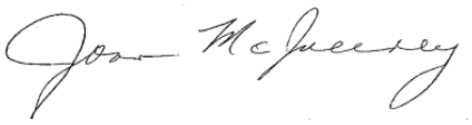
Subject: **CAP Review of the Northport VA Medical Center, Northport, NY**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

Attached please find the Combined Assessment Program (CAP) draft response from the Northport VA Medical Center. I have reviewed the draft report for the Northport VA Medical Center and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality care to Veterans at the Northport VA Medical Center.



Joan McInerney, MD, MBA, MA, FACEP

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: July 23, 2015

From: Director, Northport VA Medical Center (632/00)

Subject: **CAP Review of the Northport VA Medical Center, Northport, NY**

To: Interim Director, VA NY/NJ Veterans Healthcare Network (10N3)

1. Status Request – Combined Assessment Review of the Northport VA Medical Center, Northport, NY.

2. Should you have any questions, please do not hesitate to contact Jennifer Newburger, Chief Quality Management at 631-261-4400 extension 2768.

Patricia Burke

Acting Medical Center Director for
PHILIP C. MOSCHITTA

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur – Yes

Target date for completion: June 1st 2015

Facility response: Non allowed information was removed from all LIP folders as of 6/1/2015. Only required/allowed information will be placed in LIP files going forward.

Recommendation 2. We recommended that when conversions from observation bed status to acute admissions are 25–30 percent or more, the facility reassesses observation criteria and utilization.

Concur – Yes

Target date for completion: December 31st 2015

Facility response: ACOS of Primary Care/Emergency Room will review monthly Observation conversion rates from NUMI data. An action plan will be developed to address an observation rate greater than 25%. Quarterly this will be submitted to the VISN for review. This quarterly submission will commence July 15, 2015 and until there is an improvement to less than a 25% conversion rate.

Recommendation 3. We recommended that the CPR Committee review each code episode.

Concur – Yes

Target date for completion: September 1st 2015

Facility response: As of May 2015, the CPR minutes outline has been changed. The details of each code will be presented in the minutes as well as recommendations and actions to be taken if needed.

Recommendation 4. We recommended that the Surgical Work Group document its review of National Surgical Office reports.

Concur – Yes

Target date for completion: October 1st 2015

Facility response: Previously the Quarterly reports from the NSO were discussed at the Facility Surgical Work Group (FSWG) and/or VISN monthly call. Going forward, the NSO reports will be discussed/reviewed at the monthly FSWG and documented in our FSWG minutes. We have also added a new section in our binder where these NSO quarterly reports will be kept. The discussion of the NSO reports will be going forward as of 6/19/15.

Recommendation 5. We recommended that the facility keep the recipient list for the automated Critical Incident Tracking Notification e-mail current.

Concur – Yes

Target date for completion: June 19th 2015

Facility response: As of 5/18/15, the new Patient Safety Manager for Northport was added as an email recipient for the critical incident tracking notification (CITN). As of 6/19/15 CITN will be a standing agenda item at the FSWG.

Recommendation 6. We recommended that the facility review the quality of entries in the electronic health record at least quarterly.

Concur – Yes

Target date for completion: December 31st 2015

Facility response: The Compliance Officer will collaborate with HIM & Clinical Services to implement a Review Tool to be used in completion of Quality Medical Record Reviews. Clinical Services will complete reviews and report results quarterly to the facility Medical Record Committee as an ongoing agenda item.

Recommendation 7. We recommended that the quality control policy for scanning include a complete review of scanned documents to ensure readability and retrievability and that facility managers monitor compliance.

Concur – Yes

Target date for completion: December 31st 2015

Facility response: The facility scanning policy CM Bus-03 has been revised to ensure that all documents scanned to the medical record are legible, complete and of acceptable quality. Staff assigned to the responsibility of scanning will be educated on the updated policy. A Quality Assurance Review will be conducted by the Compliance Officer in collaboration with HIM and the Health Information Office using the Facility Scanning QA Tool with documented results showing 90% sustained compliance over 3 months.

Recommendation 8. We recommended that the facility revise the observation bed policy to reflect Veterans Health Administration policy and current practice.

Concur – Yes

Target date for completion: July 31st 2015

Facility response: The CM-147 "Observation Beds and Observation Units" has been updated formatted and sent out for Clinical Service Chief review on 5/27/2015 for review and concurrence for 7 calendar days. Will then send to Union partners for review and concurrence for 15 calendar days. Finally to Labor Relations for concurrence and routed for signature. In the interim, the Medical Center Director has temporarily signed off on this CM while undergoing review process.

Recommendation 9. We recommended that the Infection Control Committee consistently document analysis of surveillance activities and data.

Concur – Yes

Target date for completion: December 31st 2015

Facility response: The Infection Control Committee minutes will now have an analysis portion for each agenda item.

Recommendation 10. We recommended that facility managers delegate responsibility for cleaning non-critical equipment and monitor compliance.

Concur – Yes

Target date for completion: October 31st 2015

Facility response: CM 118-23 addresses reprocessing of non-critical RME. It has been revised and awaiting processing. Unit staff will be educated on the updated policy by 6/30/2015. Unit managers will round in the clean rooms on a bi-weekly basis.

Recommendation 11. We recommended that the facility establish a policy/procedure/guideline for the identification of individuals entering the facility and that facility managers monitor compliance.

Concur – Yes

Target date for completion: July 7th 2015

Facility response: Northport utilizes a Police Checkpoint at the entrance of the facility on a 24 hour/7 day a week basis. The Police Officer assigned to the checkpoint maintains presence and ensures 100% ID checks of all persons entering the facility. Only those who have a valid reason to enter the facility (employees, patients, visitors, contractors, vendors, buses, taxis, etc.) are granted access. Those without a valid

reason will be turned away. Additionally, during WHEN hours, the Police Officer at the checkpoint will ensure that all visitors sign in on VA Form 4793 "Visitor Register." The Visitors Register will be reviewed every 3 months.

Recommendation 12. We recommended that employees store clean and dirty items separately and that facility managers monitor compliance.

Concur – Yes

Target date for completion: October 31, 2015

Facility response: Unit Managers to identify and designate separate storage areas for clean and dirty storage. Unit staff will be educated on the designated areas for clean and dirty storage by July 31, 2015. Unit supervisors will round on clean and dirty storage rooms on a bi-weekly basis to ensure 100% compliance and will remain the standard of practice.

Recommendation 13. We recommended that facility managers ensure that furniture in inpatient mental health patient care areas is compliant with the VA National Center for Patient Safety Mental Health Environment of Care Checklist and monitor compliance.

Concur – Yes

Target date for completion: September 1st 2015

Facility response: All non-weighted chairs were removed from the units. Facility Planner contacted the vendor Norix for quotes on new weighted chairs and an order placed on June 1st 2015.

Recommendation 14. We recommended that the facility maintain ventilation, temperature, and humidity levels in inpatient care areas according to Joint Commission and Centers for Disease Control and Prevention guidelines and VA policy to provide a safe environment for patients, staff, and visitors and that facility managers monitor compliance.

Concur – Yes

Target date for completion: May 1st 2016

Facility response: Initial failures for the HVAC system of Units 21/22 on or about April, 2015. These failures were immediately processed as an emergency order and services were restored to full level. This will be continuously monitored through the building automation systems. As a FY16, Q1 action, the medical facility will submit a procurement package for a replacement system for Unit 22 which will complete the actions required for the failures observed.

Recommendation 15. We recommended that the facility establish a list of resources and assets it may need during an emergency.

Concur – Yes

Target date for completion: May 26th 2015

Facility response: A newly created Inventory and Inventory list has been completed.

Recommendation 16. We recommended that the facility's Emergency Operations Plan include the management of a potential increase in demand for clinical services for patients who are geriatric or disabled or have serious chronic conditions or addictions and the management of mental health services during an emergency.

Concur – Yes

Target date for completion: June 4th 2015

Facility response: A newly created SOP was developed and uploaded onto the Northport VAMC Intranet (Emergency Tab).

Recommendation 17. We recommended that the facility use special medication labeling or institute unique storage practices for look-alike and sound-alike medications and that facility managers monitor compliance.

Concur – Yes

Target date for completion: October 1st 2015

Facility response: The Look-Alike and Sound-Alike labels (LASA) were place on all LASA medications to coincide with the 2015 LASA list approved by P/T Committee for all appropriate LASA medications. Going forward, all medications approved by the P/T Committee that is added to formulary list, that are considered LASA, will be labeled as such. Pharmacy to monitor LASA medication is appropriately labeled prior to leaving pharmacy showing a 90% sustained compliance over 3 months.

Recommendation 18. We recommended that the facility develop and implement a process for managing and labeling high-alert medications and that facility managers monitor compliance.

Concur – Yes

Target date for completion: October 1st 2015

Facility response: The High Alert labels were place on all High Alert medications to coincide with the 2015 High Alert medication list approved by P/T Committee for all appropriate High Alert medications. Pharmacy to monitor High Alert medication is

appropriately labeled prior to leaving pharmacy showing a 90% sustained compliance over 3 months.

Recommendation 19. We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and that facility manager's monitor compliance.

Concur – Yes

Target date for completion: October 1st 2015

Facility response: CM 119-18 is currently being updated to include the Oversight of Overrides addendum. The Pharmacy will provide weekly reports of overrides to Nursing for 3 consecutive months to reach 90%. The findings will be reported by Nursing to Nursing/Pharmacy Committee.

Recommendation 20. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur – Yes

Target date for completion: December 31st 2015

Facility response: The facility will educate providers on appropriate use of Inpatient consults. Practitioners (LIPs) and Clinical Support Staff involved with Consult Management Oversight have been assigned TMS module 24762 "What Every VA Clinician & Resident Needs to Know About Consult." The module includes information on selection of correct location and note title. The Inpatient Consult Menu in CPRS has been updated to ensure that all consult titles include "IP" for Inpatient in the consult title to facilitate selection by provider (Example: Podiatry IP; Infectious Disease IP; etc.). Monitoring to ensure that the correct consult title has been selected will be ongoing. An Audit tool will be implemented to include correct consult title selection with results reported to Medical Record Committee.

Recommendation 21. We recommended that the facility develop policies and procedures for managing and reviewing revised computed tomography protocols.

Concur – Yes

Target date for completion: June 2nd 2015

Facility response: A policy and procedure have been established for reviewing and establishing new CT protocols.

Recommendation 22. We recommended that a medical physicist review all revised computed tomography protocols and that facility managers monitor compliance.

Concur – Yes

Target date for completion: September 1st 2015

Facility response: A medical physicist will review all CT imaging protocols annually.

Recommendation 23. We recommended that radiologists ensure all computed tomography reports contain the radiation dose and that facility managers monitor compliance.

Concur – Yes

Target date for completion: August 31st 2015

Facility response: A pre-existing 10 case quarterly monitoring program for tracking radiation dose description has been accentuated as follows: Radiation dose documentation data on PACS, VISTA IMAGING DISPLAY AND DICTATED REPORTS (CPRS) will be monitored for one quarter (APRIL–JUNE, 2015) at the rate of 90 cases/quarter. 90% compliance in PACS, VISTA IMAGING AND/OR CPRS for this quarter will be considered an appropriate end point. Collated data will be submitted for review by July 15, 2015.

Recommendation 24. We recommended that Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program employees submit timely work orders for items needing repair and that program managers ensure deficiency correction.

Concur – Yes

Target date for completion: October 1st 2015

Facility response: The Psychiatry secretary in Psychiatry office to receive monthly inspections. The secretary will put in any necessary work orders and follow-up on status. If status remains unresolved for more than 3 weeks, the office will send inquiry to Safety Officer and responsible service to ensure repairs are made. To insure consistent procedures on both RRTP's (Rehabilitation Recovery Treatment Program) a designated staff member to do the same in Psychology for SARRTP (Substance Abuse Rehabilitation Recovery Treatment Program).

Recommendation 25. We recommended that Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program employees perform and document contraband inspections and that program managers monitor compliance.

Concur – Yes

Target date for completion: October 1st 2015

Facility response: Staff was educated on VHA handbook 1162.02 on how to detect for contraband. The treatment team will randomly select 10% of the residents on contraband inspections. The nurse manager will track employee compliance on an ongoing basis to ensure 100 % compliance and will remain a standard practice.

Recommendation 26. We recommended that Substance Abuse Residential Rehabilitation Treatment Program managers ensure that the program has written agreements in place acknowledging resident responsibility for medication security.

Concur – Yes

Target date for completion: October 1st 2015

Facility response: Staff was educated on VHA handbook 1162.02. A safe management agreement will be completed by the RN at the time of admission. The nurse manager will track employee compliance on an ongoing basis to ensure 100% compliance and will remain a standard practice.

Recommendation 27. We recommended that Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program managers ensure that closed circuit television does not monitor treatment activities.

Concur – Yes

Target date for completion: May 29th 2015

Facility response: Cameras were removed in multi-purpose rooms for both programs on May 29th 2015.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: Steve Israel, Pete King, Kathleen Rice, Lee Zeldin

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, 2011 VA HVAC Design Manual, Centers for Disease Control and Prevention *Guidelines for Environmental Infection Control in Health-Care Facilities*, June 6, 2003.

[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 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[i] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.