Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04707-111

Combined Assessment Program Review of the VA Central California Health Care System Fresno, California

February 11, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Central California VA Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of November 30, 2015.

Review Results: The review covered seven activities. The facility's reported accomplishments were the Specialty Care Neighborhood initiative, the newly implemented total joint replacement program, and surgical care delivery improvements.

Recommendations: We made recommendations in all seven of the following activities:

Quality, Safety, and Value: Complete at least 75 percent of all utilization management reviews. Ensure the Patient Safety Manager consistently enters all reported patient incidents into the WEBSPOT database and provides feedback about root cause analysis findings to the individual or department who reported the incident.

Environment of Care: Ensure Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, include corrective actions to address those deficiencies, and track corrective actions to closure. Require that Hospital Epidemiology Committee meeting minutes consistently reflect discussion of identified high-risk areas and implementation of actions to address those areas and document follow-up actions implemented to address identified problems. Revise the policy and protocol for the identification of individuals entering the facility to include specialty/restricted areas and instructions regarding visitors who enter the facility during business hours. Revise operating room emergency fire policy and procedures to include alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.

Medication Management: Ensure competency assessment for employees who prepare compounded sterile products includes visual observation/"hands-on" skill assessment of aseptic technique and gloved fingertip sampling. Require that an emergency eyewash station is readily accessible to the chemotherapy compounding area and that all hoods are certified at least every 6 months.

Coordination of Care: Revise the policy for patient discharge to include scheduling discharges early in the day. Ensure that physicians consistently document discharge progress notes or instructions that include patient diagnoses and that special care unit sending nurses document transfer assessments.

Computed Tomography Radiation Monitoring: Review the organizational alignment for the Radiation Safety Officer position to ensure compliance with Veterans Health Administration policy. Develop and implement a comprehensive computed tomography quality assurance policy that includes a quality control program and procedures to follow

when revising computed tomography protocols. Ensure that computed tomography technologists perform and document daily quality control checks and that a supervisory employee conducts periodic review to verify that the checks were done.

Advance Directives: Implement a plan for transition to the allowed note titles. Screen inpatients to determine whether they have advance directives, and document the screening. Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Suicide Prevention Program: Ensure that new employees complete suicide prevention training and that new clinical employees complete suicide risk management training within the required timeframe. Include in Suicide Prevention Safety Plans contact numbers of family or friends for support.

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 will follow up on the planned actions 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 seven activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program

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 2015 and FY 2016 through December 3, 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 VA Central California Health Care System, Fresno, California,* Report No. 13-01975-292, August 27, 2013). We had a repeat finding in QSV, which was a component of quality management during the previous CAP review.

During this review, we presented crime awareness briefings for 198 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 318 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 Accomplishments

Specialty Care Neighborhood Initiative

In 2015, the facility implemented the Specialty Care Neighborhood initiative under the Medicine and Surgery Services by employing numerous Systems Redesign and Lean methodologies. This team-based specialty care model resulted in the creation of clinic-based standard operating procedures and the reassignment of nursing employees to use resources more efficiently.

Using Veterans Access, Choice, and Accountability Act of 2014 funding augmented the teams with additional staff—registered nurse care coordinators, licensed practical nurses, and medical support assistants—to provide coordinated and improved continuity of care for veterans with the greatest specialty care needs. Under this model, interdisciplinary team members were better positioned to provide the clinical support necessary for integrating new types of specialty services into the facility. Since implementation, the facility has reported higher employee morale and more timely and personalized access to specialty care for veterans.

Total Joint Replacement Program

In July 2015, the facility activated its total joint replacement program. The surgical team developed and implemented an extensive employee education program, enabling other clinical employees to render specialized pre- and post-operative joint care. A registered nurse care coordinator assisted in developing and implementing a new patient education program for veterans undergoing joint replacement procedures. A re-organized physical therapy department provided focused post-operative support and rehabilitation.

By early December 2015, the facility reported completing more than 20 joint surgeries. This program has been of great benefit to veterans who previously had to travel 3–4 hours to a VA referral hospital to obtain such care.

Surgical Care Improvements

In its effort to improve surgical care delivery, the facility's surgical team implemented the anesthesia pre-operative clinic. This clinic has helped decrease overall patient risk by optimizing the probability for good patient outcome in the OR with an interdisciplinary team approach.

Additionally, the surgical team adopted the Patient Aligned Care Team model of care within the Specialty Care Neighborhood concept, providing each veteran with a registered nurse care coordinator as a single point of contact for patient education and pre- and post-operative care management. Weekly team huddles were established between OR, recovery room, anesthesia, and care coordination employees to review and coordinate the care of all surgical cases scheduled for the coming week.

During the 4th quarter of FY 2014, VHA's National Surgery Office selected the facility's Surgical Service to participate in the VA Center for Applied Systems Engineering Surgical Improvement Project. Through rapid process improvement workshops and other process improvement and Lean methodologies, the facility improved OR start times and decreased surgical cancellation rates.

Improvement Projects	4th quarter FY 2013	3rd quarter FY 2015
Percent of surgeries that started on time (OR start time)	71 percent	81 percent
Surgery cancellation rate	21.2 percent	8.9 percent.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 4 root cause analyses, 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 QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.	• For the timeframe October 1, 2014–September 30, 2015, the facility completed only 62 percent of all required reviews. This was a repeat finding from our previous CAP review.	**1.** We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance.
X	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.	• The Patient Safety Manager did not enter all patient incidents reported in FY 2015 into the WEBSPOT database. • The Patient Safety Manager did not provide feedback about the findings to the individual or department who reported the incident for any of the four root cause analyses.	**2.** We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance. **3.** We recommended that the Patient Safety Manager provide feedback about root cause analysis findings to the individual or department who reported the incident and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	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 the dental clinic and the OR.[b]

We inspected the intensive care, MH (6E), and medical/surgical (5E) units; the community living center; the Emergency Department; the OR; and the dental and women's clinics. Additionally, we reviewed relevant documents and 40 employee training records, and we 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.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not include consistent discussion of EOC rounds deficiencies. • Minutes did not consistently include corrective actions taken to address rounds deficiencies or track corrective actions to closure.	**4.** We recommended that Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, include corrective actions to address those deficiencies, and track corrective actions to closure.
	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 Hospital Epidemiology Committee meeting minutes reviewed: • Minutes did not consistently include discussion of the facility's high-risk areas identified in the infection prevention risk assessment. • Minutes did not reflect implementation of actions to address all high-risk areas. • Minutes did not reflect follow-up on actions implemented to address identified problems.	**5.** We recommended that Hospital Epidemiology Committee meeting minutes consistently reflect discussion of identified high-risk areas and implementation of actions to address those areas and document follow-up on actions implemented to address identified problems.
	The facility had established a process for cleaning equipment between patients.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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.	Facility policy and protocol for identification of individuals entering the facility reviewed: • Policy did not include specific protocols for persons entering all specialty/restricted areas such as the OR, intensive care unit, Sterile Processing Service, MH unit, or community living center. • Protocol for visitors only included instructions regarding those entering the facility after hours.	**6.** We recommended that the facility revise the policy and protocol for the identification of individuals entering the facility to include specialty/restricted areas and instructions regarding visitors who enter the facility during business hours and that facility managers monitor compliance.
	The facility met fire safety requirements.		
	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 Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
X	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.	• OR emergency fire policy and procedures did not include alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.	**7.** We recommended that the facility revise operating room emergency fire policy and procedures to include alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		

NM	Areas Reviewed for the OR (continued)	Findings	Recommendations
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees (3 pharmacists and 7 technicians). Additionally, we inspected one area where sterile products are compounded. 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 policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
X	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.	• Facility competency assessment for employees who prepare CSPs did not include visual observation/"hands-on" skill assessment of aseptic technique and gloved fingertip sampling.	**8.** We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes visual observation/"hands-on" skill assessment of aseptic technique and gloved fingertip sampling.

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
X	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.	• An emergency eyewash station was not readily accessible in or near the chemotherapy compounding area where employees compounded hazardous medications.	**9.** We recommended that facility managers ensure an emergency eyewash station is readily accessible to the chemotherapy compounding area where employees compound hazardous medications.
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
X	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.	• For three hoods, there was no documented evidence of certifications at least every 6 months during the past 12-month period.	**10.** We recommended that facility managers ensure all hoods are certified at least every 6 months and monitor compliance.
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. 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	Opportunities for Improvements
X	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.	• The facility did not have a policy that addressed scheduling patient discharges early in the day.	**11.** We recommended that the facility revise its policy for patient discharge to include scheduling discharges early in the day.
	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
X	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.	• For two of the six applicable EHRs, special care unit sending nurses did not document transfer assessments.	**12.** We recommended that special care unit sending nurses document transfer assessments and that facility managers monitor compliance.
X	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.	• For 4 of the 27 applicable EHRs, physician documented discharge progress notes or instructions did not include patient diagnoses.	**13.** We recommended physicians consistently document discharge progress notes or instructions that include patient diagnoses and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with 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 seven CT technologists and CT scanner inspection reports, and we 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
X	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.	VHA policy reviewed, which requires the Radiation Safety Officer to report directly to executive management or a member of facility senior leadership such as the Chief of Staff or the Associate Director to ensure independence and avoid possible conflict of interest: • At the time of our review, the Radiation Safety Officer reported to the Chief of Radiology.	**14.** We recommended that facility managers review the organizational alignment for the Radiation Safety Officer position to ensure compliance with Veterans Health Administration policy.
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	• The facility's Radiology Service did not have a written policy or procedure that included a CT quality control program and procedures to follow when revising CT protocols.	**15.** We recommended that facility managers develop and implement a comprehensive computed tomography policy that includes a quality control program and procedures to follow when revising computed tomography protocols.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	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.		
	If required by local policy or if a California facility, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), 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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy requires daily quality control checks of the CT scanner prior to use on patients. We reviewed 49 selected dates for documentation of quality control checks: • Technologists did not document 10 of 49 required quality control checks (20 percent).	**16.** We recommended that computed tomography technologists perform and document daily quality control checks, that a supervisory employee conducts periodic review to verify the checks were done, and that facility managers monitor compliance.

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 32 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles	• Non-allowed note titles were in common use, and there was no plan for transition to the allowed note titles.	**17.** We recommended that the facility implement a plan for transition to the allowed note titles and that facility managers monitor compliance.
X	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.	• Four of the 32 EHRs (13 percent) did not contain documentation that employees screened inpatients to determine whether they had ADs.	**18.** We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance.
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Fifteen of the 28 applicable EHRs did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**19.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 39 patients assessed to be at high risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new 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.

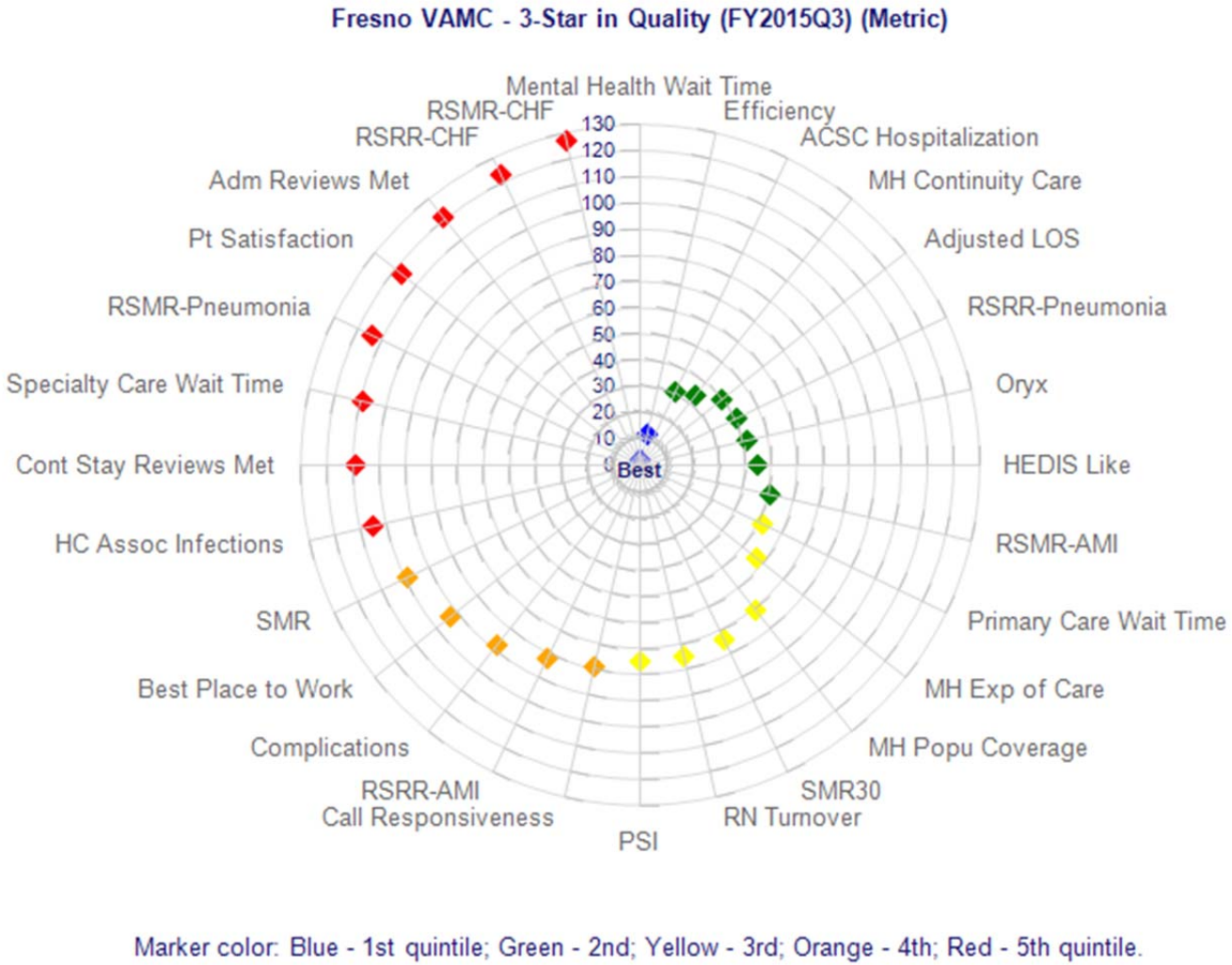
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Five of the 15 training records contained no evidence of suicide prevention training within 12 months of being hired. • Seven of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**20.** We recommended that the facility ensure new employees complete suicide prevention training and new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians assessed patients for suicide risk at the time of admission.		
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
X	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe	• Sixteen of 20 safety plans lacked documentation of the identification of contact numbers of family or friends for support.	**21.** We recommended that clinicians include contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge. • Every 90 days to review Patient Record Flags.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Fresno/570) FY 2016 through December 2015	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$50.7
Number of:	
• **Unique Patients**	17,935
• **Outpatient Visits**	68,219
• **Unique Employees**[1]	1,123
Type and Number of Operating Beds:	
• **Hospital**	57
• **Community Living Center**	54
• **MH**	12
Average Daily Census:	
• **Hospital**	37
• **Community Living Center**	41
• **MH**	7.4
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Merced/570GA Tulare/570GB Oakhurst/570GC
Veterans Integrated Service Network Number	21

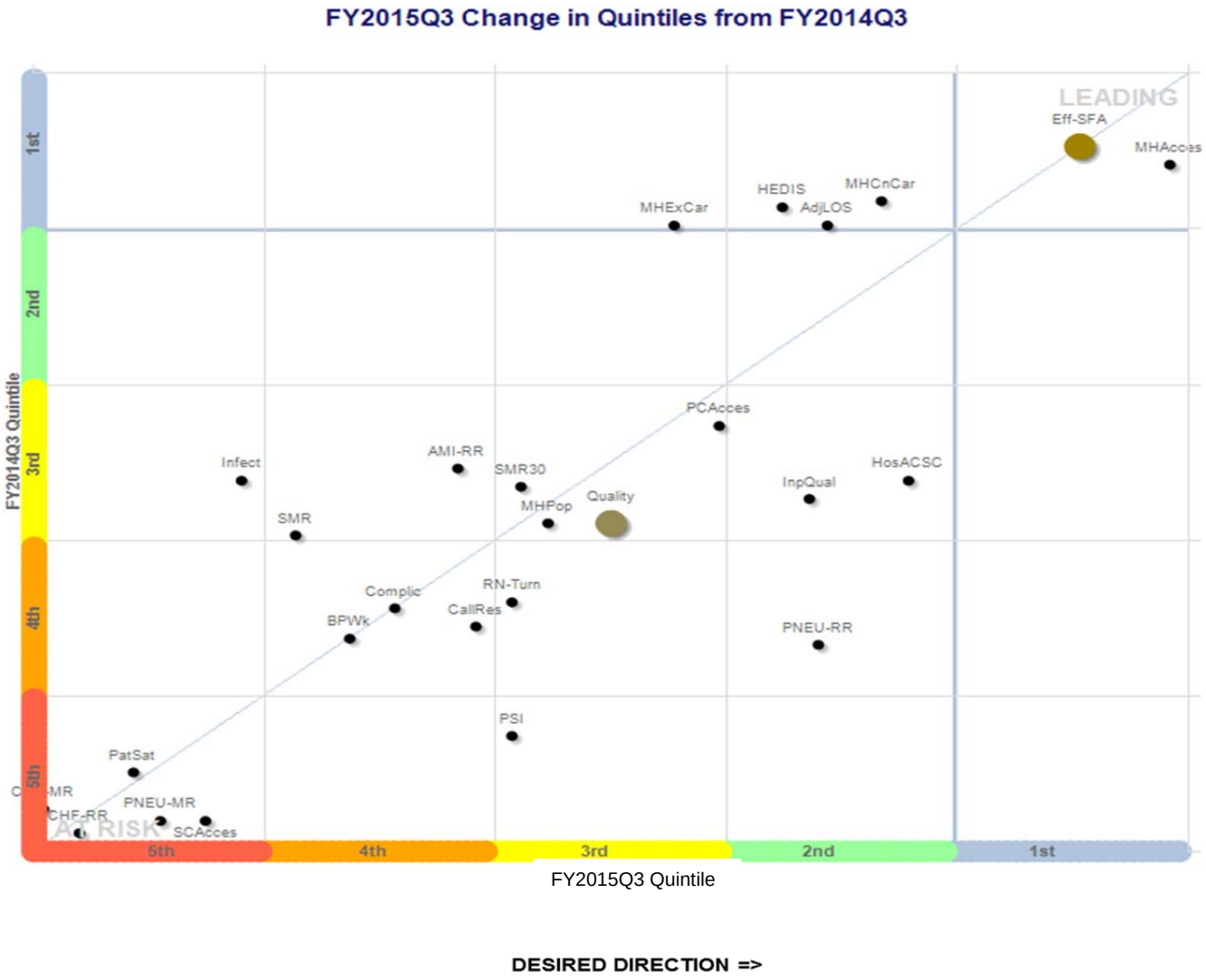
[1] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[2]



[2] 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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: January 15, 2016

From: Director, Sierra Pacific Network (10N21)

Subject: CAP Review of the VA Central California Health Care System, Fresno, CA

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

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

1. Thank you for the opportunity to review your draft findings. The facility has developed an action plan for each of the recommendations.

2. Should you have any questions regarding the plan, please contact the Deputy Quality Manager for Network 21, Terry Sanders at (707) 562-8350.

Sheila M. Cullen

Attachments

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 14, 2016

From: Director, VA Central California Health Care System (570/00)

Subject: CAP Review of the VA Central California Health Care System, Fresno, CA

To: Director, Sierra Pacific Network (10N21)

1. I appreciate the opportunity to provide our input to the VA-OIG Combined Assessment Program (CAP) review of our health care system which took place during the week of November 30, 2015.

2. I concur with all the findings and suggested improvement actions.

3. On behalf of our health care system, I would like to express my thanks to the OIG-CAP review team which visited our facility. We found the team members not only fair in their assessments, but very helpful throughout our preparatory activities and during the review itself.

4. We appreciate the important feedback we received from this review and will use information to further strengthen our administrative and clinical operations.

Sincerely,

Stephen R. Bauman
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 clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility manager's monitor compliance.

Concur

Target date for completion: 4/30/16

Facility response: The UM team met the goal of 75% review completion in October 2015. To promote sustainment of this goal, the facility is in the process of hiring one nurse (1.0 FTEE) which will bring the UM team to an appropriate staffing level. In the interim, additional reviews will be completed through use of staff overtime. The UM team is also completing a Systems Redesign Rapid Process Improvement project which is aimed at improving program efficiencies.

Recommendation 2. We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.

Concur

Target date for completion: completed

Facility response: All (100%) patient incidents are currently being entered into WEBSPOT and the Quality Manager is monitoring compliance through verbal confirmation.

Recommendation 3. We recommended that the Patient Safety Manager provide feedback about root cause analysis findings to the individual or department who reported the incident and that facility managers monitor compliance.

Concur

Target date for completion: 2/29/16

Facility response: An expanded Patient Safety Team is being developed. The members of that team will be instructed that the individual or department who reported the incident that triggered an RCA is to receive notification of findings once the RCA has been completed. Current staff members who complete RCAs have been educated

regarding this expectation. The Quality Manager will monitor the completion of this education and the tracking of notifications.

Recommendation 4. We recommended that Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, include corrective actions to address those deficiencies, and track corrective actions to closure.

Concur

Target date for completion: 2/1/2016

Facility response: Safety Service will employ means within Performance Logic (an Environment of Care (EOC) Assessment & Compliance Tool) to produce reports on EOC rounds deficiencies, EOC rounds deficiencies that require corrective actions and EOC rounds deficiency closure dates. Trending reports indicating repeat findings will be included. Initial EOC rounds reporting will commence with the February 2016 Environment of Care Board meeting.

Recommendation 5. We recommended that Hospital Epidemiology Committee meeting minutes consistently reflect discussion of identified high-risk areas and implementation of actions to address those areas and document follow-up on actions implemented to address identified problems.

Concur

Target date for completion: Completed and on-going

Facility response: FY16 Hospital Epidemiology Committee (HEC) Calendar Report is revised to ensure FY16 high-risk areas action plan implemented and outcomes are routinely discussed and monitored during the HEC meeting.

Recommendation 6. We recommended that the facility revise the policy and protocol for the identification of individuals entering the facility to include specialty/restricted areas and instructions regarding visitors who enter the facility during business hours and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: The Health Care System Policy on Visiting Hours has been revised to reflect individuals entering the facility to include specialty/restricted areas and instructions regarding visitors who enter the facility during business hours. Visiting hours are posted at the main entrances to the hospitals. All staff have been educated regarding the above statement.

Monitoring will be completed by the Chief of Police with a report annually to the Environment of Care Board. Additionally, the Office of Security and Law Enforcement (VACO) does a bi-annual program inspection of the VA Police program which includes a checklist and a report back to the facility concerning any security issues. If the police management plan were not being met, it would be brought to the Facility Director's attention. Any issues brought up are included in the inspection report.

Recommendation 7. We recommended that the facility revise operating room emergency fire policy and procedures to include alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.

Concur

Target date for completion: 1/15/16

Facility response: VACCHCS is in the process of rewriting Operating Room (OR) fire response Standard Operating Procedure (SOP) to clearly identify alarm activation, evacuation, and equipment shutdown and responsibility for shutting off oxygen. The revised policy reflects the training that occurred and those trained are competent with the revised policy.

Recommendation 8. We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes visual observation/"hands-on" skill assessment of aseptic technique and gloved fingertip sampling.

Concur

Target date for completion: Employee testing will be completed by 2/29/16

Facility response: The process in the pharmacy for IV 797 competency assessment was revised 9/29/2015 to outline competency assessment for all employees who prepare compounded sterile products. The competency assessment includes visual observation/"hands-on" skill assessment of aseptic technique and gloved fingertip sampling. Competency assessments for all employees working in this area will be completed by the date above and annually thereafter.

Recommendation 9. We recommended that facility managers ensure an emergency eyewash station is readily accessible to the chemotherapy compounding area where employees compound hazardous medications.

Concur

Target date for completion: 1/18/16

Facility response: Safety Service will conduct a risk assessment of the chemotherapy compounding area that reflects type of hazardous medication and type of personal protective equipment (PPE) provided to/utilized by staff.

Recommendation 10. We recommended that facility managers ensure all hoods are certified at least every 6 months and monitor compliance.

Concur

Target date for completion: 3/31/16

Facility response: Responsibility for the maintenance and testing of both the sterile compounding suite and the clean tables/hood within the sterile compounding suite have been transferred to the Operations Supervisor with very close monitoring by the Chief, Maintenance and Repair Section. The facility will also enter into a contract with a certification agency to assure timely certifications and testing. Engineering will create a calendar reminder for testing before testing is due. Engineering will use equipment sticker to track room and hood certification status to include last certification date and next due date certification. This information will be reported to the Chief of Pharmacy for review every 6 months.

Recommendation 11. We recommended that the facility revise its policy for patient discharge to include scheduling discharges early in the day.

Concur

Target date for completion: Completed

Facility response: Policy revised and staff were educated on the revisions of the policy.

Recommendation 12. We recommended that special care unit sending nurses document transfer assessments and that facility managers monitor compliance.

Concur

Target date for completion: 3/31/16

Facility response: Bedside nurse to inform Charge Nurse of any patient transferring to floor to double check the transfer note was completed and vice-versa. Unit will develop a tracking tool and report on a monthly basis.

ICU-SD unit will demonstrate an improvement on the transfer note compliance for three month period (Target 90%).

Recommendation 13. We recommended physicians consistently document discharge progress notes or instructions that include patient diagnoses and that facility managers monitor compliance.

Concur

Target date for completion: 3/31/16

Facility response: During the week of OIG the Clinical Application Coordinator (CAC) and Chief of Medicine reviewed the discharge instruction template and reconfigured the template to not allow residents to bypass this field. Instructions were placed into the template and CAC changed programing so that this field would become mandatory and therefore would not allow for this to be bypassed.

All resident training was complete during a mandatory meeting and in addition, an informational email was sent out. Faculty staff were included on the email which reviewed the importance of ensuring plain language discharge diagnosis documented. Reviewing sampling of discharge instructions with chart audits of 5 a month to be done by Residency Program Director (or designee) and reported weekly to Chief of Medicine Process Improvement meeting.

Recommendation 14. We recommended that facility managers review the organizational alignment for the Radiation Safety Officer position to ensure compliance with Veterans Health Administration policy.

Concur

Target date for completion: Completed

Facility response: The Radiation Safety Officer (RSO) reporting alignment has been changed from the chief of Radiology to the Facility Safety Officer.

Recommendation 15. We recommended that facility managers develop and implement a comprehensive computed tomography policy that includes a quality control program and procedures to follow when revising computed tomography protocols.

Concur

Target date for completion: Completed 1/13/16 and on-going

Facility response: Quality Control (QC) Program plan has been revised. Weekly meetings with all parties involved are scheduled until the plan and implementation are completed. A comprehensive computed tomography policy has been developed and implemented that includes the revised quality control program and procedures to follow when revising computed tomography protocols.

Recommendation 16. We recommended that computed tomography technologists perform and document quality control checks, that a supervisory employee conducts periodic review to verify the checks were done, and that facility managers monitor compliance.

Concur

Target date for completion: Completed and on-going

Facility response: All Diagnostic Radiologic Technician (DRT's) were verbally reminded to update the Imaging Service Quality Control (QC) CT log by the DRT Supervisor on 12/24/2015. The DRT Supervisor will be performing daily checks on this log for one week to ensure compliance. With accurate compliance, the DRT Supervisor will start checking the CT QC log one time per week and continue for 3 months and reported to imaging leadership weekly with a target of 90%.

Recommendation 17. We recommended that the facility implement a plan for transition to the allowed note titles and that facility managers monitor compliance.

Concur

Target date for completion: 3/31/16

Facility response: Informatics have renamed the note title "Advance Directive Consult" to "Advance Directive Discussion" The Advance Directive (AD) Discussions note title is utilized for documentation of Advance Directive discussions with each Veteran. All AD consults will be closed administratively by the Advance Directive Social Worker. Only 3 note titles will be utilized: Advance Directive Consult, Advance Directive and Rescinded Advance Directive. The Advance Directive Policy will be updated to reflect changes. The AD Social Worker pulls the VISTA reports daily to check AD's entered and completed. Social Work admin runs the VSSC report for consults outstanding every Thursday. This will be reported to Chief of Social Work at a minimum weekly with a target of 90%.

Recommendation 18. We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance.

Concur

Target date for completion: 3/31/16

Facility response: The note has been revised and is complete. Education to the Medical/Surgical Unit to the change made in the "Nursing Admission/Initial Treatment Plan." The change will automatically create a prompt to a social work consult if the patient is unable to respond to questions about his/her advanced directives.

Will evaluate charts to make sure that documentation shows that yes they have been screened or no they have not been screened and a consult has been generated to social services. This will be reported to Chief of Social Work at a minimum weekly with a target of 90% within 3 months.

Recommendation 19. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: Completed and on-going

Facility response: The Advance Directive (AD) policy was revised that incorporates employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives. Compliance will be monitored by Practitioners placing AD Consults-as evidenced that Advance Directives are being offered to Veterans. Will monitor Daily Advance Directive Consults placed by practitioners as well as Advance Directives completed each day. This will illustrate how frequently Practitioners are proposing to Veterans the Advance Directive update option and which particular discipline has completed/updated the Advance Directive and the Advance Directives that have been updated utilizing an Advance Directive Discussion Note. This will be reported to the Chief of Social Work at a minimum weekly with a target of 90%.

Recommendation 20. We recommended that the facility ensure new employees complete suicide prevention training and new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: 2/1/16

Facility response: The Human Resources (HR) department will provide electronic verification of all new hires completing Suicide Prevention (Operation S.A.V.E) training to the Mental Health Department Leadership team. All staff were compliant. Operation S.A.V.E. was provided for all New Employee Orientations over the last 4 years and continues to be provided. The Mental Health Department Leadership team will communicate with the Chief of the department of Education and or the TMS Administrator, and will provide a monthly report displaying which clinicians have completed the training.

Recommendation 21. We recommended that clinicians include contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: 2/1/16

Facility response: The Clinicians completing the Safety Plans will obtain contact numbers of family and friends for Veteran. If the Veteran is unable to provide family or friends' contact numbers, the clinicians will document that information. The clinician will

then place the Mental Health's Suicide Prevention team's contact numbers on the Safety Plan as support for the High-Risk Veteran. When a Provider speaks with a High-Risk for Suicide Veteran they are reminded of their Safety Plan. During the encounters (phone or face-to-face) the Providers will request updated phone contact information from the High-Risk Veteran. Monitoring of compliance for suicide safety plans will be completed weekly by the suicide prevention coordinator and reported to the Mental Health Executive Board bi-monthly with a target of 90%.

Office of Inspector General
Contact and Staff Acknowledgments

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

Endnotes

[a] References used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- 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, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[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 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected February 3, 2011).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.