Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00101-300

Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System Los Angeles, California

May 11, 2016

Washington, DC 20420

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

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	VA Greater Los Angeles Healthcare 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

Table of Contents

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 January 11, 2016.

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

- Coordination of Care
- Advance Directives

The facility's reported accomplishment was receiving the VA National Center for Patient Safety's Gold Cornerstone Award for fiscal year 2015.

Recommendations: We made recommendations in the following five activities and four follow-up review areas:

Quality, Safety, and Value: Ensure the senior-level committee responsible for key quality, safety, and value functions is chaired or co-chaired by the Facility Director. Consistently review Ongoing Professional Practice Evaluation data semi-annually. Ensure Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database. Consistently follow actions taken when data analyses indicated problems or opportunities for improvement to resolution in the Inpatient Operations Council, Medical Executive Committee, and Medical Records Committee. Ensure senior managers become involved in quality, safety, and value activities.

Environment of Care: Promptly remove expired medications from patient care areas. Secure medication carts and automated dispensing machines when not in use.

Medication Management: Ensure pharmacy technicians complete all competency components annually. Monitor temperature in the compounding areas at the Sepulveda pharmacy.

Computed Tomography Radiation Monitoring: Require that a medical physicist inspects computed tomography scanners that had repairs or modifications that affected dose or image quality before return to clinical service, and document the inspection. Ensure computed tomography technologists hired prior to January 1987 have written affirmation of competencies.

Suicide Prevention Program: Ensure new non-clinical employees receive suicide prevention training and new clinical employees receive suicide risk management training. Complete required reports and reviews regarding patients who attempt or

complete suicide. Consistently place flags in the electronic health records of high-risk patients. Include in Suicide Prevention Safety Plans the contact numbers of family or friends for support and assessment of available lethal means and how to keep the environment safe. Ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan. Follow up with patients at least four times during the first 30 days after discharge.

Follow-Up on Quality Management: Require the Medical Records Committee to provide oversight and coordination of the review of the quality of entries in electronic health records. Ensure Surgery Service representatives consistently attend Blood Usage Committee meetings.

Follow-Up on Environment of Care: Ensure all designated employees complete annual N95 respirator fit testing.

Follow-Up on Medication Management – Controlled Substances Inspection Program: Initiate actions to address identified security deficiencies, and correct all deficiencies identified during annual physical security surveys.

Follow-Up on Pressure Ulcer Prevention and Management: Ensure all patients discharged with pressure ulcers receive dressing supplies prior to being discharged.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 26–34, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- Follow-Up on Quality Management
- Follow-Up on EOC

- Follow-Up on Medication Management – Controlled Substances Inspection Program

- Follow-Up on Pressure Ulcer Prevention and Management

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, FY 2015, and FY 2016 through January 14, 2016, 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 Greater Los Angeles Healthcare System, Los Angeles, California,* Report No. 13-02640-06, October 30, 2013). We made repeat recommendations in Quality Management, EOC, Medication Management – Controlled Substances Inspection Program, and Pressure Ulcer Prevention and Management.

During this review, we presented crime awareness briefings for 1,091 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 924 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

Cornerstone Recognition Program

The VA National Center for Patient Safety initiated the Cornerstone Recognition Program in 2008 to enhance the root cause analysis process and recognize the accomplishments of patient safety at the facility level. The facility received the Gold Cornerstone Award for FY 2015.

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, 5 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
X	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.	• There was no evidence that the senior-level committee responsible for key QSV functions was chaired or co-chaired by the Facility Director October 2014–October 2015.	**1.** We recommended that the senior-level committee responsible for key quality, safety, and value functions be chaired or co-chaired by the Facility Director.
X	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.	• Six profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data semi-annually.	**2.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data semi-annually and that facility managers monitor compliance.

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.	• There was no evidence Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database for any of the cases referred to them July 1, 2014, through September 30, 2015.	**3.** We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.	• The facility did not consistently follow corrective actions to resolution for the Inpatient Operations Council, Medical Executive Committee, and Medical Records Committee. This was a repeat finding from our prior CAP review.	**4.** We recommended that facility managers consistently follow actions taken when data analyses indicated problems or opportunities for improvement to resolution in the Inpatient Operations Council, Medical Executive Committee, and Medical Records Committee.
X	Overall, senior managers actively participated in QSV activities.	Quality Council, Inpatient Operations Council, Medical Executive Committee, and Medical Records Committee meeting minutes reviewed: • There was no evidence of senior managers' involvement in QSV activities over the past 12 months.	**5.** We recommended that senior managers become involved in quality, safety, and value 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]

At West Los Angeles, we inspected the general medicine, telemetry, intensive care, and community living center units; the specialty care and primary care clinics; the inpatient MH, intensive care, and subacute units; two dental clinics; the OR; and the Emergency Department. At Sepulveda, we inspected the primary care, specialty care, MH, and dental clinics and two community living center units. Additionally, we reviewed relevant documents and 27 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
X	The facility met medication safety and security requirements.	• Two of 14 patient care areas had expired medications. • Medication carts or automated dispensing machines in 3 of 14 patient care areas were unlocked and unattended.	**6.** We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance. **7.** We recommended that employees secure medication carts and automated dispensing machines when not in use and that facility managers monitor compliance.
	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.		
	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.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
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		
	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.		
	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.		
	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 15 pharmacy technicians. Additionally, we inspected four areas 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.	• Three of the 15 pharmacy technicians did not complete all competency assessment components annually.	**8.** We recommended that facility managers ensure pharmacy technicians complete all competency components annually and monitor compliance.

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.		
X	The facility met design and environmental safety controls in compounding areas.	• There was no evidence of temperature monitoring in the compounding areas at the Sepulveda pharmacy.	**9.** We recommended that employees monitor temperature in the compounding areas at the Sepulveda pharmacy and that facility managers monitor compliance.
	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.		
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	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. 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 policy that addressed patient discharge and 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.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	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.		

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 eight CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 47 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.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist 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.		
X	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.	• One of two CT scanners that had repairs or modifications that affected dose or image quality did not receive an inspection by a medical physicist before return to clinical service.	**10.** We recommended that a medical physicist inspect computed tomography scanners that had repairs or modifications that affected dose or image quality before return to clinical service and document the inspection and that facility managers monitor compliance.
	If required by local policy, 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.		
X	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.	• One CT technologist hired prior to January 1987 did not have written affirmation of competencies.	**11.** We recommended that facility managers ensure computed tomography technologists hired prior to January 1987 have written affirmation of competencies.
	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 31 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. 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.		
	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.		
	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 40 patients assessed to be at high risk for suicide during the period October 1, 2014–September 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	• There was no evidence the facility provided suicide prevention training to new non-clinical employees or suicide risk management training to new clinical employees.	**12.** We recommended that facility managers ensure new non-clinical employees receive suicide prevention training and new clinical employees receive suicide risk management training and monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
X	The facility completed required reports and reviews regarding patients who attempted or completed suicide.	• The facility did not complete all required reports and behavioral reviews for patients who attempted or completed suicide during the time period October 1, 2014–September 30, 2015.	**13.** We recommended that employees complete the required reports and reviews regarding patients who attempt or complete suicide and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians assessed patients for suicide risk at the time of admission.		
X	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.	• Clinicians had not placed flags in the EHRs of 10 of 15 high-risk patients.	**14.** We recommended that clinicians consistently place flags in the electronic health records of high-risk patients and that facility managers monitor compliance.
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	• Thirty-one of the 40 (78 percent) safety plans lacked documentation of the identification of contact numbers of family or friends for support. • Twelve of the 40 (30 percent) safety plans lacked documentation of the assessment of available lethal means and how to keep the environment safe.	**15.** We recommended that clinicians include contact numbers of family or friends for support and assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.
X	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.	• In 39 of the 40 EHRs (98 percent), clinicians did not document that they gave patients and/or caregivers a copy of the plan.	**16.** We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.
X	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	• Thirteen of the 15 applicable EHRs did not contain evidence that the treatment team followed up with patients at least four times during the first 30 days after discharge.	**17.** We recommended that treatment teams follow up with patients at least four times during the first 30 days after discharge and that facility managers monitor compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Review Activities With Previous CAP Recommendations

Follow-Up on Quality Management

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with oversight and coordination of the review of the quality of entries in EHRs and Blood Usage Committee representatives.[h]

EHR Quality Review. VHA requires results of qualitative and quantitative analysis of patient health records review to be reported to the facility Health Record Review Committee. During our previous CAP review, we found no evidence that the Medical Records Committee provided oversight and coordination of the review of the quality of entries in the EHR. During this review, we looked at 3 quarters of Medical Records Committee meeting minutes. There was no evidence that the committee provided oversight and coordination of the review of the quality of entries in the EHR.

Blood Usage Committee Representatives. VHA requires that the Blood Usage Committee include representation from all major departments or services that transfuse blood or blood products. During our previous CAP review, we found that clinical representatives from Surgery and Anesthesia Services did not attend two of the four meetings. During this review, we found that clinical representatives from Surgery Service did not attend three of the five meetings.

Recommendations

18. We recommended that the Medical Records Committee provide oversight and coordination of the review of the quality of entries in electronic health records.

19. We recommended that representatives from Surgery Service consistently attend Blood Usage Committee meetings.

Follow-Up on EOC

As a follow-up to recommendations from our two prior CAP reviews, we reassessed facility compliance with N95 respirator fit testing.[i]

N95 Respirator Fit Testing. VHA requires facilities using N95 and other types of respirators to fit test designated employees annually. During our June 21, 2010, CAP review, we reviewed annual fit testing documentation for 20 designated employees and found that 9 (45 percent) did not receive required fit testing. During our August 19, 2013, CAP review, 183 of the 912 designated employees (20 percent) were overdue for annual fit testing. During this review, 174 of the 1,284 designated employees (14 percent) were overdue for annual fit testing.

Recommendation

20. We recommended that facility managers ensure all designated employees complete annual N95 respirator fit testing and monitor compliance.

Follow-Up on Medication Management – Controlled Substances Inspection Program

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with pharmacy-related security deficiencies.[j]

Pharmacy-Related Deficiencies. VHA requires that the Chief of Police and Security follow up to ensure recommended corrective action has been taken to address pharmacy-related security deficiencies. During our previous CAP review, pharmacy-related security deficiencies identified by VA Police in 2011 and 2012 had not yet been corrected. During this review, we found that work orders were submitted in September 2014. However, the identified deficiencies still had not been corrected.

Recommendation

21. We recommended that facility managers initiate actions to address identified security deficiencies and ensure correction of all deficiencies identified during annual physical security surveys.

Follow-Up on Pressure Ulcer Prevention and Management

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with discharging patients who have pressure ulcers.[k]

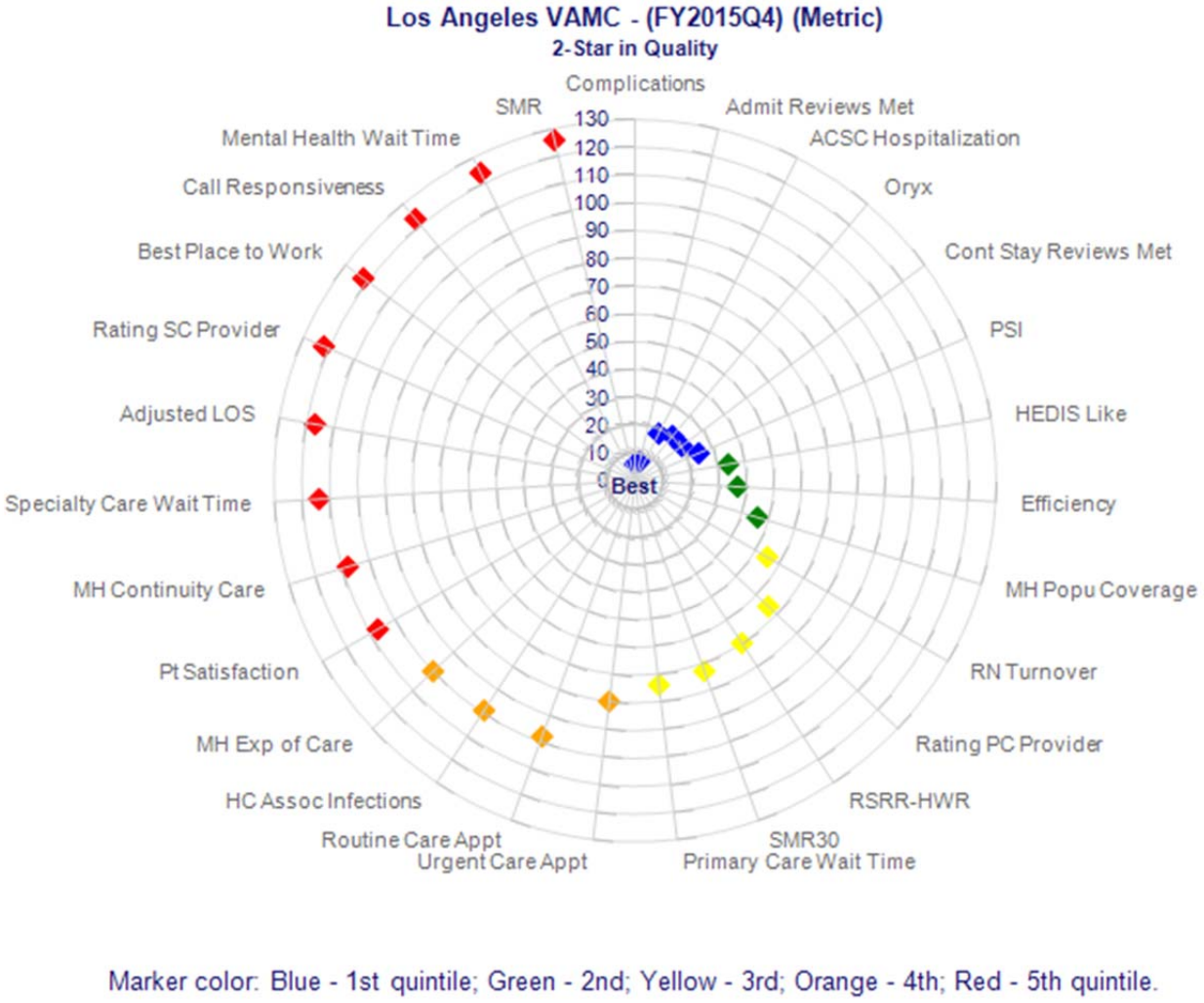
Pressure Ulcer Patient Discharge. The Joint Commission requires that prior to discharge, the facility arrange or assist in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services. During our previous review, six of eight applicable EHRs did not contain evidence that patients received dressing supplies prior to discharge. During this review, the facility provided 2 quarters of pressure ulcer discharge data showing that three of six patients did not receive pressure ulcer dressing supplies at the time of discharge. The facility modified EHR documentation templates to incorporate the discharge plan, dressing supplies, and education related to pressure ulcers.

22. We recommended that facility managers ensure all patients discharged with pressure ulcers receive dressing supplies prior to being discharged and monitor compliance.

Facility Profile (Los Angeles/691) FY 2016 through December 2015	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$265.1
Number of:	
• **Unique Patients**	57,402
• **Outpatient Visits**	330,676
• **Unique Employees**[1]	4,423
Type and Number of Operating Beds:	
• **Hospital**	316
• **Community Living Center**	372
• **Domiciliary**	296
Average Daily Census:	
• **Hospital**	225
• **Community Living Center**	182
• **Domiciliary**	208
Number of Community Based Outpatient Clinics	9[2]
Location(s)/Station Number(s)	Santa Barbara/691GB Gardena/691GC Bakersfield/691GD Los Angeles/691GE Commerce/691GF Lancaster/691GG San Luis Obispo/691GK Santa Maria/691GL Oxnard/691GM
Veterans Integrated Service Network Number	22

[1] Unique employees involved in direct medical care (cost center 8200).
[2] We have omitted Culver City (691GI) and West Hollywood (691GJ) as no workload/encounters or services were reported.

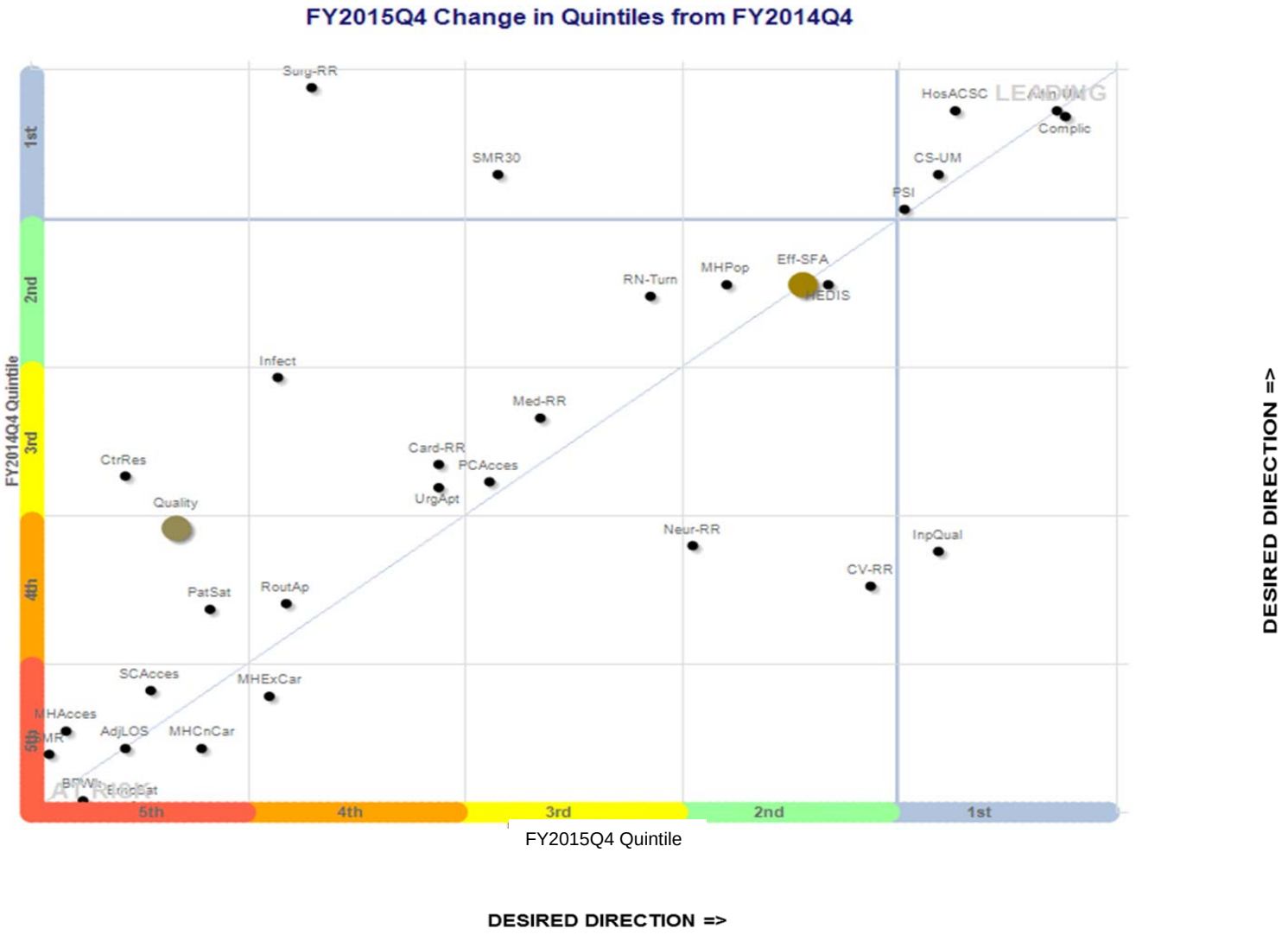
Strategic Analytics for Improvement and Learning (SAIL)[3]



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: April 5, 2016

From: Network Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the VA Greater Los Angeles Healthcare System, Los Angeles, CA**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

1. I have reviewed and concur with the findings and recommendations in the draft OIG report, entitled, "Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles."

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact Ms. Jimmie Bates, VISN 22 Quality Management Officer, at (562) 826-5963.

(original signed by:)
Marie L. Weldon, FACHE

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 1, 2016

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subject: **CAP Review of the VA Greater Los Angeles Healthcare System, Los Angeles, CA**

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. Please find VA Greater Los Angeles Healthcare System response to the Office of Inspector General Health Inspection conducted during the week of January 11, 2016, report entitled, Combined Assessment Program Review of VA Greater Los Angeles Healthcare System, Los Angeles, CA.

2. I have reviewed the document and concur with the recommendations. Relevant action plans have been established as detailed in the attached report.

3. If you have any questions or concerns, please contact Therese Cortez, MSN, Acting Chief, Quality Management at 310 478 3711 x41389.

(original signed by:)
Ann R. Brown, FACHE

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 senior-level committee responsible for key quality, safety, and value functions be chaired or co-chaired by the Facility Director.

Concur

Target date for completion: June 30, 2016

Facility response: GLA is committed to ensure that the Quality Council, which is responsible for key quality, safety and value functions, is co-chaired by the Facility Director.

Recommendation 2. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data semi-annually and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that all Ongoing Professional Practice Evaluations are reviewed semi-annually. Compliance will be monitored by Credentialing and Privileging through random selection of Ongoing Professional Practice Evaluations. A total of 20 Ongoing Professional Practice Evaluations will be reviewed per month until the target of 90% has been sustained for 3 consecutive months. Results of the audits will be reported to the Professional Standards Board for compliance.

Recommendation 3. We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: The Physician Utilization Management Advisors (PUMA) received training to document their decisions in the National Utilization Management Integration database on March 17, 2016. The report of cases not meeting the standardized criteria will be reviewed on a weekly basis beginning in April 2016 to monitor PUMA response rates until a target of 90% compliance has been sustained for 3 consecutive months.

Results of the monitoring reports will be presented to the Inpatient Operations Council to demonstrate sustained improvement in PUMA reviews.

Recommendation 4. We recommended that facility managers consistently follow actions taken when data analyses indicated problems or opportunities for improvement to resolution in the Inpatient Operations Council, Medical Executive Committee, and Medical Records Committee.

Concur

Target date for completion: September 30, 2016

Facility response: Executive Leadership Team, in conjunction with Quality Management, will ensure that actions are consistently documented for identified problems or opportunities for improvement and resolution of follow-up in the Inpatient Operations Council, Medical Executive Committee, and Medical Records Committee.

Recommendation 5. We recommended that senior managers become involved in quality, safety, and value activities.

Concur

Target date for completion: September 30, 2016

Facility response: GLA will ensure that senior managers become involved in quality, safety, and value activities. Evidence of senior management involvement in quality, safety, and value activities will be reported to Quality Council, Inpatient Operations Council, and Medical Executive Council.

Recommendation 6. We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that employees promptly remove expired medications from patient care areas. Observations for expired medications will be monitored during Environment of Care Rounds until 90% compliance is sustained for 3 consecutive months. Results will be reported to Environment of Care Committee and Nurse Executive Council to ensure compliance.

Recommendation 7. We recommended that employees secure medication carts and automated dispensing machines when not in use and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that medication carts and automated dispensing machines are secured when not in use. Observations for secured medication carts and automated dispensing machines when not in use will be monitored during Environment of Care Rounds until 90% compliance is sustained for 3 consecutive months. The results will be reported monthly to Environment of Care Committee and Nurse Executive Council to ensure compliance.

Recommendation 8. We recommended that facility managers ensure pharmacy technicians complete all competency components annually and monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that pharmacy technicians complete all competency components annually. The competencies will be submitted to Quality Management for compliance.

Recommendation 9. We recommended that employees monitor temperature in the compounding areas at the Sepulveda pharmacy and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that employees monitor temperature in the compounding areas at the Sepulveda pharmacy. The temperature logs will be submitted monthly to Quality Management to ensure compliance.

Recommendation 10. We recommended that a medical physicist inspect computed tomography scanners that had repairs or modifications that affected dose or image quality before return to clinical service and document the inspection and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA has improved the communication process between Biomedical Engineering and Radiation Safety to ensure documentation of the computed tomography scanners inspections. GLA will ensure that a medical physicist inspect computed tomography scanners that had repairs or modifications that affected dose or image quality before return to clinical service. The documentation of the inspections will be submitted to the Radiation Safety Committee for compliance.

Recommendation 11. We recommended that facility managers ensure computed tomography technologists hired prior to January 1987 have written affirmation of competencies.

Concur

Target date for completion: May 31, 2016

Facility response: GLA will ensure that computed tomography technologists hired prior to January 1987 have written affirmation of competencies. The written affirmation of competencies will be reported to Radiation Safety Committee to ensure compliance.

Recommendation 12. We recommended that facility managers ensure new non-clinical employees receive suicide prevention training and new clinical employees receive suicide risk management training and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Suicide prevention training, Operation SAVE, for all new employees was implemented in January 2016. Talent Management System (TMS) module #6201, Suicide Risk Management Training for Clinicians, was added as a mandatory training for new clinical employees in February 2016. Completion of TMS module #6201, Suicide Risk Management Training for Clinicians will be completed within 90 days of hire. Compliance with the suicide prevention training will be monitored by the Suicide Prevention Coordinators through monthly checks of TMS training. Monthly monitoring reports will be completed until the target of 90% has been sustained for 3 consecutive months. Results will be reported to the Mental Health Executive Committee and Quality Management.

Recommendation 13. We recommended that employees complete the required reports and reviews regarding patients who attempt or complete suicide and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that required reports and reviews regarding patients who attempt or complete suicide is completed. Suicide Prevention Coordinators will

monitor the completion of the reports monthly. Monthly monitoring reports will be completed until the target of 90% has been sustained for 3 consecutive months. Results will be reported to the Mental Health Executive Committee and Quality Management for compliance.

Recommendation 14. We recommended that clinicians consistently place flags in the electronic health records of high-risk patients and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that clinicians consistently place flags in the electronic health records of high risk patients. The Suicide Risk Assessment/Prevention Plan template in the electronic health record will be modified to incorporate the levels of risk. Suicide Prevention coordinators will monitor the completion of the flags for high risk patients. A total of 20 high- risk patients will be performed per month until the target of 90% has been sustained for 3 consecutive months. Results will be reported to the Mental Health Executive Committee and Quality Management for compliance.

Recommendation 15. We recommended that clinicians include contact numbers of family or friends for support and assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Suicide Safety Plan template in the electronic health record has been modified to ensure documentation of contact numbers of family or friends for support, assessment of available lethal means and how to keep the environment safe. Compliance will be monitored by the Suicide Prevention Coordinators through random selection of Suicide Safety Plans to assess for appropriate completion. A total of 20 Suicide Safety Plans will be reviewed per month until the target of 90% has been sustained for 3 consecutive months. Results of the audits will be reported to the Mental Health Executive Committee and Quality Management for compliance.

Recommendation 16. We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Suicide Safety Plan template in the electronic health record will be modified to ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan. Compliance will be monitored by the Suicide Prevention Coordinators through random selection of Suicide Safety Plans to assess for appropriate completion. A total of 20 Suicide Safety Plans will be reviewed per month until the target of 90% has been sustained for 3 consecutive months. Results of the audits will be reported to Mental Health Executive Committee and Quality Management for compliance.

Recommendation 17. We recommended that treatment teams follow up with patients at least four times during the first 30 days after discharge and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: GLA will ensure that the treatment teams follow up with patients at least 4 times during the first 30 days after discharge. Compliance will be monitored by the Suicide Prevention Coordinators through random selection of high-risk flagged patients to ensure they are seen at least 4 times within the first 30 days post discharge. Monthly chart audits will be conducted until 90% compliance has been sustained for 3 consecutive months. Results of the audits will be reported to the Mental Health Executive Committee and Quality Management for compliance.

Recommendation 18. We recommended that the Medical Records Committee provide oversight and coordination of the review of the quality of entries in electronic health records.

Concur

Target date for completion: September 30, 2016

Facility response: GLA will ensure that the Medical Records Committee (MRC) ensure oversight and coordination of the review of the quality of entries in the electronic health record. Compliance of the review will be reported to the Medical Executive Committee.

Recommendation 19. We recommended that representatives from Surgery Service consistently attend Blood Usage Committee meetings.

Concur

Target date for completion: June 30, 2016

Facility response: Surgery Service will ensure that representatives consistently attend Blood Usage Committee.

Recommendation 20. We recommended that facility managers ensure all designated employees complete annual N95 respirator fit testing and monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure all designated employees complete annual N95 respirator fit testing. Monthly monitoring reports of designated employees with completion of annual N95 respirator fit testing will be completed until the target of 90% has been sustained for 3 consecutive months. The results of the compliance will be reported monthly to the Environment of Care Committee.

Recommendation 21. We recommended that facility managers initiate actions to address identified security deficiencies and ensure correction of all deficiencies identified during annual physical security surveys.

Concur

Target date for completion: September 30, 2016

Facility response: The FY15 annual pharmacy physical security survey conducted by VA Police resulted in notification to Facility Management Service and Pharmacy Service of the continued pharmacy findings. Pharmacy Service will continue to monitor completion of the project requests to address the findings monthly. Results will be reported to the Environment of Care Committee and Executive Leadership Team for compliance.

Recommendation 22. We recommended that facility managers ensure all patients discharged with pressure ulcers receive dressing supplies prior to being discharged and monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: GLA will ensure that all discharged patients with pressure ulcers will receive dressing supplies prior to being discharged. Randomly selected chart audits of patients discharged with pressure ulcers will be conducted for 3 consecutive months until 90% compliance is sustained. The results of the audits will be reported monthly to Quality Council and Nurse Executive Council for oversight.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Alicia Castillo-Flores, MBA, MPH, Team Leader Debra Boyd-Seale, RN, PhD Sheila Cooley, GNP, MSN Wachita Haywood, RN Tanya Smith-Jeffries, LCSW, MBA Brian Kelly, Special Agent, Office of Investigations Thomas Oberhofer, Special Agent, Office of Investigations Patricia Santillan, Special Agent, Office of Investigations Thomas Walker, Special Agent, Office of Investigations
Other Contributors	Judy Brown Elizabeth Bullock Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Larry Ross, Jr., MS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Desert Pacific Healthcare Network (10N22)
Director, VA Greater Los Angeles Healthcare System (691/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Barbara Boxer, Dianne Feinstein
U.S. House of Representatives: Pete Aguilar, Karen Bass, Xavier Becerra, Julia Brownley, Ken Calvert, Lois Capps, Tony Cárdenas, Judy Chu, Paul Cook, Janice Hahn, Duncan D. Hunter, Darrell Issa, Ted Lieu, Kevin McCarthy, Steve Knight, Alan Lowenthal, Grace Napolitano, Scott Peters, Dana Rohrabacher, Lucille Roybal-Allard, Ed Royce, Raul Ruiz, Linda Sánchez, Loretta Sanchez, Adam Schiff, Brad Sherman, Mark Takano, Norma Torres, David Valadao, Mimi Walters, Maxine Waters

This report is available at **www.va.gov/oig**.

Endnotes

[a] The 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] The 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] The 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] The 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] The 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 2/3/11).
- 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.

[h] The references used for this topic were:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 1185, *Transfusion Utilization Committee and Program*, September 11, 2015.

[i] The reference used for this topic was:
- Under Secretary for Health, *Respiratory Protection Used for Infectious Disease and Annual Fit-Testing, Information Letter 10-2012-012,* August 2, 2012.

[j] The reference used for this topic was:
- VA Handbook 0730, *Security and Law Enforcement,* August 11, 2000.

[k] The reference used for this topic was:
- The Joint Commission PC.04.01.03. EP 4.