Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01672-260

Combined Assessment Program Review of VA Butler Healthcare Butler, Pennsylvania

July 25, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
DCHV	Domiciliary Care for Homeless Veterans
EHR	electronic health record
EOC	environment of care
facility	VA Butler Healthcare
FY	fiscal year
HPC	hospice and palliative care
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
QM	quality management
RME	reusable medical equipment
SA	substance abuse
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of May 13, 2013.

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

- Environment of Care
- Medication Management – Controlled Substances Inspections
- Nurse Staffing

The facility's reported accomplishment was the domiciliary recovery model, which emphasizes enhancing life skills training.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure actions from peer reviews are consistently completed and reported to the Peer Review Committee. Consistently scan results of non-VA purchased diagnostic tests into electronic health records.

Coordination of Care – Hospice and Palliative Care: Establish a process to track hospice and palliative care consults that are not acted upon within 4 days of the request. Complete interdisciplinary care plans for all hospice and palliative care inpatients. Consistently reassess hospice and palliative care inpatients' pain, and timely document results in electronic health records.

Mental Health Residential Rehabilitation Treatment Program: Ensure monthly Domiciliary Care for Homeless Veterans Program and substance abuse domiciliary self-inspection documentation includes all required elements.

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 15–18, 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

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Nurse Staffing
- MH RRTP

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

The review covered facility operations for FY 2012 and FY 2013 through May 16, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of VA Butler Healthcare, Butler, Pennsylvania*, Report No. 11-02083-06, October 19, 2011).

During this review, we presented crime awareness briefings for 125 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 133 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

Domiciliary Recovery Model – Life Skills Training

The facility's domiciliary recovery model emphasizes enhancing life skills training. The residents take ownership responsibility of the new, state-of-the-art domiciliary by learning skills such as cleaning and cooking. The residents' sense of pride in their physical environment has motivated them to keep all five domiciliary buildings in pristine condition. This sense of accountability for the condition of their surroundings has improved the residents' chances of successfully integrating into their communities after they leave the domiciliary.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

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

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
NA	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
X	Corrective actions from the protected peer review process were reported to the PRC.	Six months of PRC meeting minutes reviewed: • Of the 13 actions expected to be completed, 3 were not reported to the PRC.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
NA	Local policy for the use of observation beds complied with selected requirements.	
NA	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Twenty-eight EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Nine test results were not scanned into the EHRs.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

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 and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected the primary care, ophthalmology, podiatry, and wound care clinics; the physical rehabilitation and restorative medicine department; both CLC units; and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed three SPS employee training and competency files. 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.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Hemodialysis	
NA	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
NA	Monthly biological water and dialysate testing were conducted and included required components, and identified problems were corrected.	
NA	Employees received training on bloodborne pathogens.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
NA	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
NA	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
	Selected infection prevention/environmental safety requirements were met.	
	Selected requirements for SPS decontamination and sterile storage areas were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of all CS Coordinators and eight CS inspectors and inspection documentation from two CS areas, the outpatient pharmacy, and the emergency drug cache. 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.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 24 employee training records (10 HPC staff records and 14 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
X	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	• Four consults were not acted upon within 4 days of the request and had not been tracked.
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
X	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	• Four of eight hospice care plans were not completed.
X	HPC inpatients were assessed for pain with the frequency required by local policy.	• Six of the 10 applicable EHRs did not contain timely documentation of pain reassessments.
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

3. We recommended that a process be established to track HPC consults that are not acted upon within 4 days of the request.

4. We recommended that processes be strengthened to ensure that interdisciplinary care plans are completed for all HPC inpatients.

5. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently reassessed and that results are documented timely in EHRs.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected long-term care unit.

We reviewed relevant documents and 12 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for the Halls of Honor CLC unit for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. 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.

NC	Areas Reviewed	Findings
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
	The unit-based expert panels followed the required processes and included all required members.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

MH RRTP

The purpose of this review was to determine whether the facility's SA domiciliary and DCHV Program complied with selected EOC requirements.[5]

We reviewed relevant documents, inspected the SA domiciliary and DCHV Program, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The residential environment was clean and in good repair.	
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
X	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	Six months of self-inspection documentation reviewed: • Documentation did not include all required elements.
	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	
	Written agreements acknowledging resident responsibility for medication security were in place.	
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es).	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	
	Medications in resident rooms were secured.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

6. We recommended that processes be strengthened to ensure that monthly DCHV Program and SA domiciliary self-inspection documentation includes all required elements.

Facility Profile (Butler/529) FY 2013 through March 2013[a]	
Type of Organization	Secondary
Complexity Level	3
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$86.5
Number (through April 2013) of:	
• **Unique Patients**	14,814
• **Outpatient Visits**	91,075
• **Unique Employees**[b]	403
Type and Number of Operating Beds:	
• **Hospital**	0
• **CLC**	97
• **Mental Health**	56
Average Daily Census:	
• **Hospital**	NA
• **CLC**	58
• **Mental Health**	51
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Mercer County/529GA Lawrence County/529GB Armstrong County/529GC Clarion County/529GD Cranberry Township/529GF
VISN Number	4

[a] All data is for FY 2013 through March 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	*	*	56.7	65.8	60.2	65.1
VISN	66.9	65.4	59.5	60.5	59.3	60.8
VHA	63.9	65.0	55.0	54.7	54.3	55.0

* The facility does not have inpatient hospital beds.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 15, 2013

From: Director, VA Healthcare (10N4)

Subject: **CAP Review of VA Butler Healthcare, Butler, PA**

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

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

I have reviewed the information provided by VA Butler Healthcare and I am submitting it to your office as requested. I concur with all responses and target dates.

If you have any questions or require additional information, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

Barbara Forsha

for **Michael E. Moreland, FACHE**

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 3, 2013

From: Director, VA Butler Healthcare (529/00)

Subject: **CAP Review of VA Butler Healthcare, Butler, PA**

To: Director, VA Healthcare (10N4)

The findings from the VA Butler Healthcare Office of the Inspector General/Combined Assessment Program Review, conducted during the week of May 13, 2013, have been reviewed.

Attached is the facility's response addressing all recommendations that have been completed.

JOHN A. GENNARO

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 processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

Concur

Target date for completion: Implemented: May 17, 2013
Target completion: September 30, 2013

Facility response: Actions for level two and level three peer reviews are documented on a tracking sheet that is attached to the monthly minutes. This tracking sheet includes the name of the assigned service chief and date of closure. The peer review form now includes a signature area so that the service chief and staff member verify by signature when the final peer review findings are reviewed.

Recommendation 2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: Implemented: June 21, 2013
Target completion: September 30, 2013

Facility response: The entire hospital episode for non-VA admissions is now scanned into the Electronic Health Record (EHR).

Recommendation 3. We recommended that a process be established to track HPC consults that are not acted upon within 4 days of the request.

Concur

Target date for completion: Implemented: June 21, 2013
Target completion: September 30, 2013

Facility response: The Hospice/Palliative Care Committee members have been educated on the timeframe for responding to Hospice/Palliative Care Consults as defined in MCM PC 79. The Hospice/Palliative Care Coordinator utilizes an open consult report twice weekly in order to ensure that all Hospice/Palliative Care Consults are acted upon according to the defined timeframes. The results of this monitor are reported quarterly to Patient Care Services Committee for further actions if needed.

Recommendation 4. We recommended that processes be strengthened to ensure that interdisciplinary care plans are completed for all HPC inpatients.

Concur

Target date for completion: Implemented: June 21, 2013
Target completion: September 30, 2013

Facility response: The Community Living Center nursing staff has been educated on the completion of interdisciplinary care plans for Hospice/Palliative Care Residents. In addition to weekly Hospice Rounds, the Hospice/Palliative Care Coordinator meets with each Hospice Veteran in order to assure that the plan of care includes all interventions specific to the Veteran. The Hospice/Palliative Care Coordinator is monitoring the completion of all Interdisciplinary care plans on all Hospice Veterans residing in the Community Living Center. The results of this monitor are reported quarterly to Patient Care Services Committee for further action as needed.

Recommendation 5. We recommended that processes be strengthened to ensure that HPC inpatients' pain is consistently reassessed and that results are documented timely in EHRs.

Concur

Target date for completion: Implemented: June 21, 2013
Target completion: September 30 2013

Facility response: All Community Living Center staff have been re-educated on the importance of pain assessment, re-assessment and timely documentation of effectiveness of interventions. The Hospice/Palliative Care Coordinator is monitoring the completion of pain assessments, re-assessments and medication effectiveness daily to assure that the results are documented and that the provider is notified when pain interventions are not effective. The results of this monitor are reported quarterly to Patient Care Services Committee for further actions if needed.

Recommendation 6. We recommended that processes be strengthened to ensure that monthly DCHV Program and SA domiciliary self-inspection documentation includes all required elements.

Concur

Target date for completion: Implemented: May 17, 2013
Target completion: September 30, 2013

Facility response: The self-assessment tool used for monthly inspections in the Domiciliary has been revised to include all required elements.

OIG Contact and Staff Acknowledgments

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National Veterans Service Organizations
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U.S. Senate: Robert P. Casey, Jr.; Patrick J. Toomey
U.S. House of Representatives: Mike Kelly, Keith Rothfus, Glenn W. Thompson

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

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Materiel Management, the Association for Professionals in Infection Control and Epidemiology.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

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