Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03651-42

Combined Assessment Program Review of the El Paso VA Health Care System El Paso, Texas

January 15, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
EHR	electronic health record
EOC	environment of care
facility	El Paso VA Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PI	performance improvement
PRC	Peer Review Committee
QM	quality management
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 November 4, 2013.

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

- Environment of Care
- Continuity of Care
- Suicide Prevention Safety Plans

The facility's reported accomplishment was an audiology patient access systems redesign project.

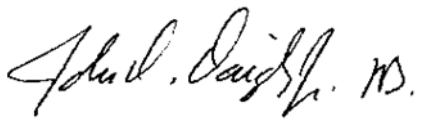
Recommendations: We made recommendations in the following two activities:

Quality Management: Ensure the Surgical Work Group meets monthly.

Moderate Sedation: Ensure pre-sedation assessment documentation includes a review of the history of any previous adverse experience with sedation. Require that any changes to informed consents are discussed with and approved by the patients prior to administration of sedation. Ensure patients who undergo moderate sedation are appropriately monitored during the procedure.

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 16–19, 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 five activities:

- QM
- EOC
- Continuity of Care
- Moderate Sedation
- Suicide Prevention Safety Plans

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

The review covered facility operations for FY 2013 and FY 2014 through October 31, 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 the El Paso VA Health Care System, El Paso, Texas,* Report No. 10-01876-252, September 21, 2010).

During this review, we presented crime awareness briefings for 177 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 124 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

Audiology Patient Access Systems Redesign

In November 2012, audiology clinic staff initiated a systems redesign project to improve patient access. At that time, 14-day access to audiology services was at 22.7 percent for new patients and at 70.5 percent for established patients. This resulted in a delay in care. The audiology team implemented the following improvements: (1) triaged appointment classifications (used staff in accordance with their level of competency for each appointment type), (2) used non-face-to-face modalities, (3) created an otoscopic check clinic, (4) redesigned vestibular clinic profiles for hearing evaluations to allow two unscheduled slots per provider per day for same day access, and (5) matched demand by initiating telephone triage and follow-ups. As a result, in May 2013, there was an increase in 14-day new patient access to 90.4 percent and in established patient access to 93.7 percent.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[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 area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/PI that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
NA	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were re-assessed timely.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met 2 times over the past 6 months.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
NA	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
NA	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in PI over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/PI program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendation

1. We recommended that the Surgical Work Group meet monthly.

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 radiology and acute MH were met.[2]

We inspected the podiatry, orthopedic/urology/gastroenterology, dermatology/neurology, endocrine/hematology/oncology/infectious disease/pulmonary, primary care, cardiology, eye, and dental specialty clinic areas and radiology. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 10 radiology employee training records. 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 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.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	

NM	Areas Reviewed for Radiology (continued)	Findings
	The facility had policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
NA	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	
NA	Locked MH unit(s) were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VHA expense was available to facility providers.[3] Such information is essential to coordination of care and optimal patient outcomes.

We reviewed the EHRs of 30 patients who had been hospitalized in the local community at VHA expense during calendar year 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.

NM	Areas Reviewed	Findings
	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the hospitalization.	
	The facility complied with any additional elements required by VHA or local policy.	

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.[4]

We reviewed relevant documents, the EHRs of 10 patients who received moderate sedation, and 7 employee training/competency records. Additionally, we conversed with key employees and observed the timeout process. 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
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.	
X	Pre-sedation documentation was complete.	• None of the EHRs included documentation of a review of the history of any previous adverse experience with sedation.
X	Informed consent was completed appropriately and performed prior to administration of sedation.	• For six patients, the provider who performed the procedure was not the same as the provider listed on the consent form, and there was no evidence in the EHRs that the change in provider was discussed with and agreed to by the patients.
	Timeouts were appropriately conducted.	
X	Monitoring during and after the procedure was appropriate.	• Two EHRs did not contain documentation of vital signs at 5-minute intervals during the procedure or documentation of an exception to the requirement.
	Moderate sedation patients were appropriately discharged.	
NA	The use of reversal agents in moderate sedation was monitored.	
NA	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.	
NA	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

2. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes a review of the history of any previous adverse experience with sedation and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that any changes to informed consents are discussed with and approved by the patients prior to administration of sedation and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that patients who undergo moderate sedation are appropriately monitored during the procedure and that compliance be monitored.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide.[5]

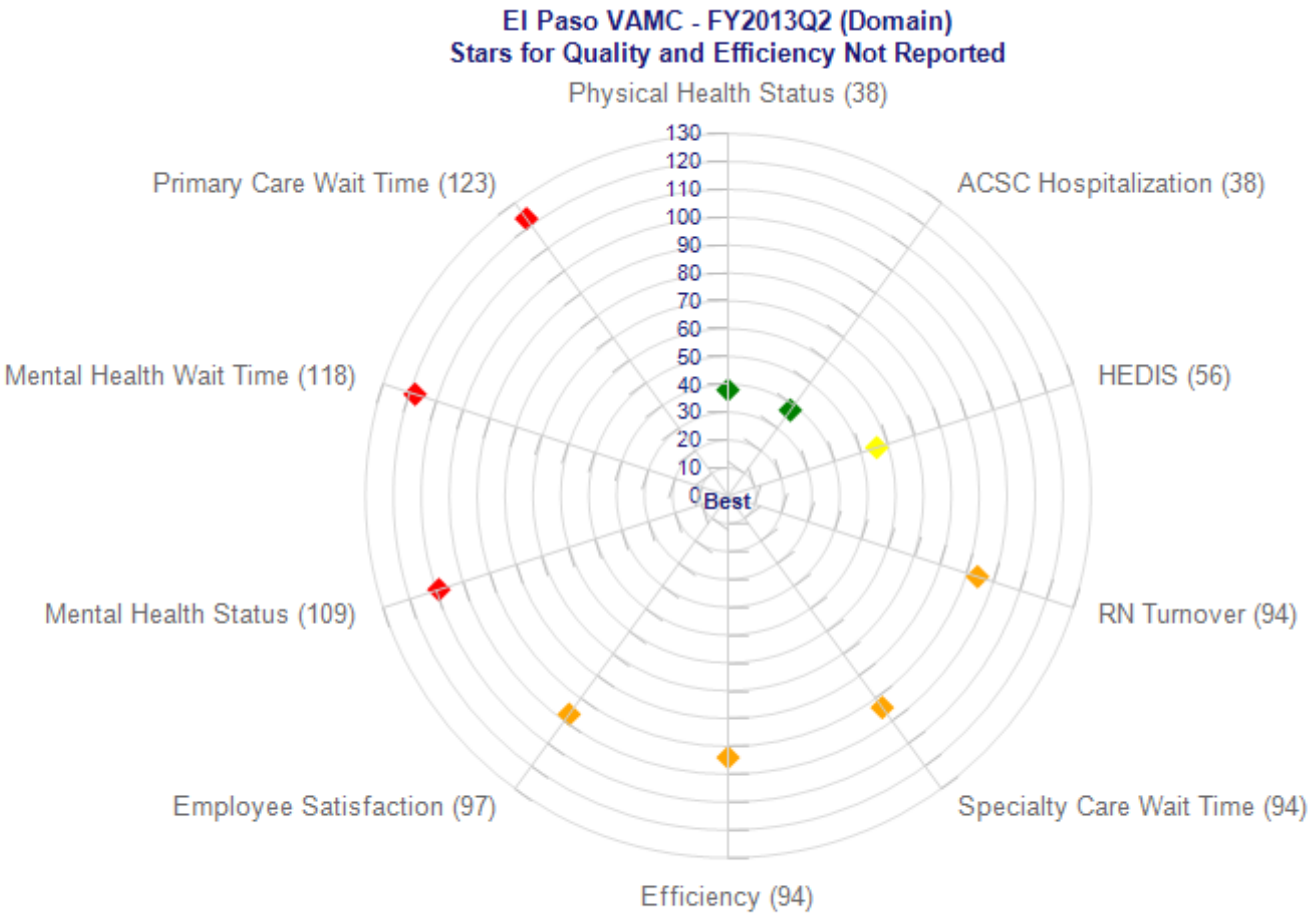
We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 10 patients assessed to be at high risk for suicide. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients had documented safety plans that specifically addressed suicidality.	
	Patients/families participated in plan development.	
	Safety plans contained all required elements.	
	There was documented evidence that the patients and/or their families received a copy of the plan.	
	Patient record flags were placed for high-risk patients.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (El Paso/756) FY 2014 through November 2013[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$111.7
Number of:	
• **Unique Patients**	15,230
• **Outpatient Visits**	43,722
• **Unique Employees**[b]	578
Type and Number of Operating Beds:	
• **Hospital**	N/A
• **Community Living Center**	N/A
• **MH**	N/A
Average Daily Census:	
• **Hospital**	N/A
• **Community Living Center**	N/A
• **MH**	N/A
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Las Cruces/756GA Eastside/756GB
VISN Number	18

[a] All data is for FY 2014 through November 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

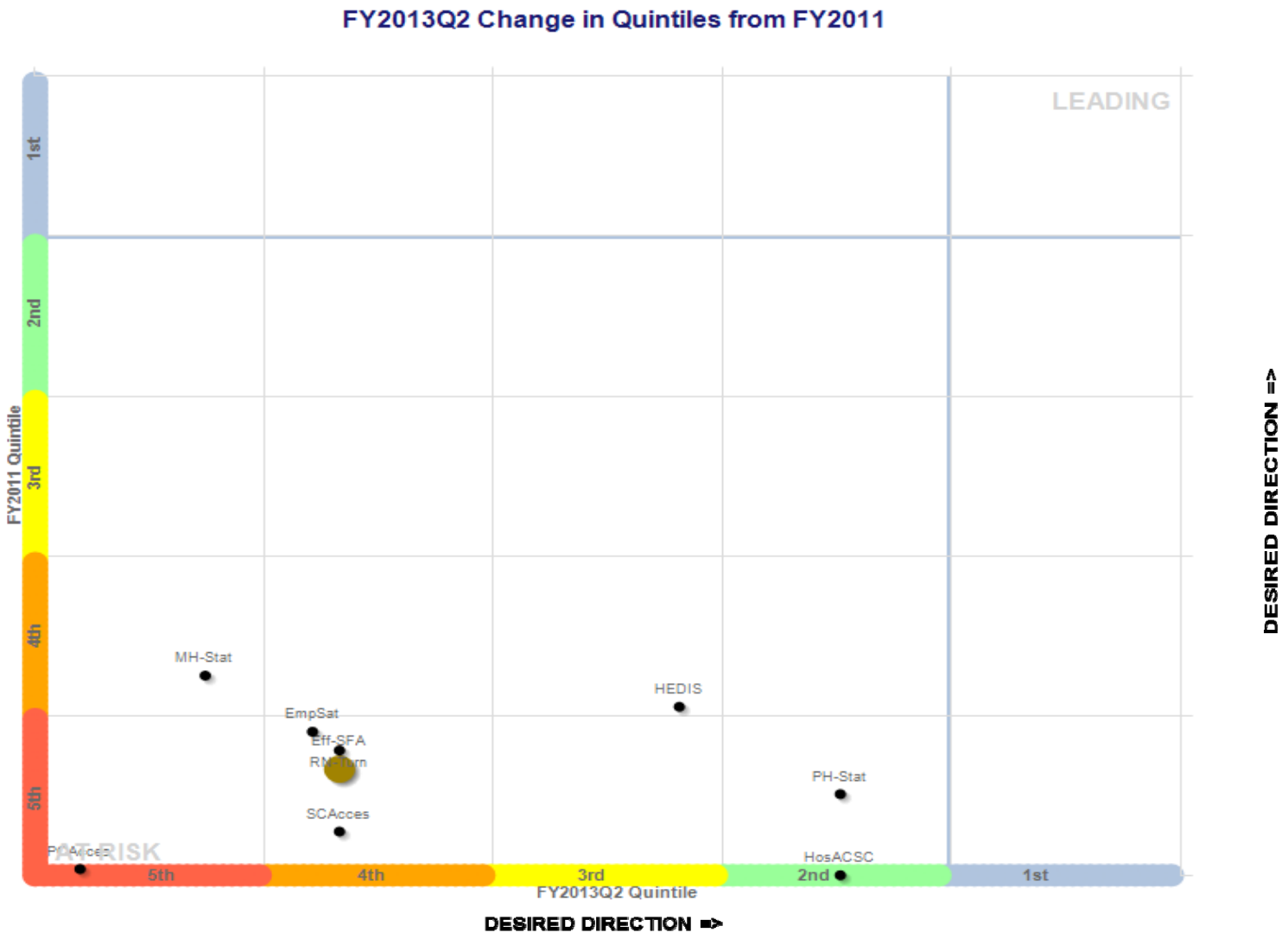
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] 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
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 Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	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)	A higher value is better than a lower value
PSI	Patient safety indicator	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)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 13, 2013

From: Director, VA Southwest Health Care Network (10N18)

Subject: **CAP Review of the El Paso VA Health Care System, El Paso, TX**

To: Director, San Diego Office of Healthcare Inspections (54SD)

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

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas.

2. If you have any questions or concerns, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at 408-397-2777.

Susan P. Bowers

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 4, 2013

From: Director, El Paso VA Health Care System (756/00)

Subject: **CAP Review of the El Paso VA Health Care System, El Paso, TX**

To: Director, VA Southwest Health Care Network (10N18)

1. I have reviewed and concur with the findings and recommendations in the draft report of the Office of the Inspector General Combined Assessment Program Review conducted the week of November 4, 2013.

2. Corrective action plans have been established, with some being already implemented, and target completion dates have been set for the remaining items as detailed in the attached report.

John A. Medoza
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: Completed

Facility response: The El Paso VAHCS chartered its facility-level Surgical Work Group in September 2013. Since its inception, the work group has met and official minutes have been recorded for September, October and November 2013. The last meeting occurred on December 3, 2013. Future meetings are scheduled for the first Tuesday of every month.

Recommendation 2. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes a review of the history of any previous adverse experience with sedation and that compliance be monitored.

Concur

Target date for completion: December 20, 2013

Facility response: The template for the pre-sedation assessment is being revised to include a review of the history and previous adverse sedation experience. This will be a required entry to complete the assessment. There is currently a monthly monitoring and trending of the moderate sedation audit data tool with monthly reporting to the VISN to ensure compliance and sustainability. The data/findings with action plans, if needed, is reported to the Surgery Workgroup.

Recommendation 3. We recommended that processes be strengthened to ensure that any changes to informed consents are discussed with and approved by the patients prior to administration of sedation and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: Surgery Staff has been instructed that any changes to informed consents are discussed with and approved by the patient prior to administration of sedation. This will be reiterated at monthly surgical staff meetings. There is currently a monthly monitoring and trending of the moderate sedation audit data tool with monthly

reporting to the VISN to ensure compliance and sustainability. The data/findings with action plans, if needed, is reported to the Surgery Workgroup.

Recommendation 4. We recommended that processes be strengthened to ensure that patients who undergo moderate sedation are appropriately monitored during the procedure and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: The findings were reviewed with assigned staff on November 12, 2013, with a follow-up completed on December 3, 2013. There is currently a monthly monitoring and trending of the moderate sedation audit data tool with monthly reporting to the VISN to ensure compliance and sustainability. The data/findings with action plans, if needed, is reported to the Surgery Workgroup.

OIG Contact and Staff Acknowledgments

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

Endnotes

[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*, October 15, 2012.
- 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.

[2] References used for this topic included:
- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- VA National Center for Patient Safety, "Privacy Curtains and Privacy Curtain Support Structures (e.g., Track and Track Supports) in Locked Mental Health Units," Patient Safety Alert 07-04, February 16, 2007.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- U.S. Pharmacopeia <797>, *Guidebook to Pharmaceutical Compounding–Sterile Preparations*, June 1, 2008.
- 10 CFR 20, Subpart F.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] The reference used for this topic was:
- VHA Handbook 1907.01.

[4] References used for this topic included:
- VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.

[5] References used for this topic included:
- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- Barbara Stanley and Gregory K. Brown, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*, August 20, 2008.
- Various requirements of The Joint Commission and the VA National Center for Patient Safety.