Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02445-44

Combined Assessment Program Review of the San Francisco VA Medical Center San Francisco, California

December 15, 2008

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Table of Contents

Executive Summary

Introduction

During the week of September 29–October 3, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the San Francisco VA Medical Center (SFVAMC), San Francisco, CA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 183 employees. The SFVAMC is part of Veterans Integrated Service Network (VISN) 21.

Results of the Review

The CAP review covered nine operational activities. We identified the following organizational strengths and reported accomplishments:

- Adverse event disclosure log.
- Simulation center.
- Three-dimensional (3D) imaging laboratory.
- Ethanol fueling station.

We made recommendations in six of the activities reviewed. For these activities, the SFVAMC needed to:

- Ensure that discussions about QM data analyses are documented and that actions to address problems or trends are implemented and evaluated.
- Expand monitoring of medication reconciliation to include admission and transfer and improve compliance.
- Require that individual restraint and seclusion uses are monitored for compliance and that aggregate data are analyzed to determine trends.
- Ensure that controlled substances (CS) inspectors assigned to the research laboratories receive the required annual training and that competency assessments are completed for all CS inspectors.
- Address identified fire safety, security, and infection control (IC) issues.
- Ensure that Multidisciplinary Safety Inspection Team (MSIT) members complete the required training and clarify the expectations and responsibilities of MSIT and environment of care (EOC) inspections.

- Correct identified cleanliness and security deficiencies in the Emergency Department (ED).
- Require compliance with Veterans Health Administration (VHA) inter-facility transfer regulations.
- Ensure that nurses consistently document the effectiveness of all pain medications within the required timeframes.
- Ensure timely dictation and posting of discharge summaries and documentation of discharge orders.

The SFVAMC complied with selected standards in the following three activities:

- Patient Satisfaction Survey Scores.
- Physician Privileges.
- Staffing.

This report was prepared under the direction of Julie Watrous, Director, Los Angeles Office of Healthcare Inspections.

Comments

The VISN and Acting SFVAMC Directors concurred with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 16–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The SFVAMC is a tertiary care teaching facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in San Francisco, Eureka, San Bruno, Santa Rosa, and Ukiah, CA. The SFVAMC is part of VISN 21 and serves a veteran population of about 300,000 throughout San Francisco, San Mateo, Marin, Napa, Sonoma, Lake, Mendocino, and Humboldt counties in California.

Programs. The SFVAMC provides medical, surgical, primary, mental health, long-term, and rehabilitation care. It has 124 hospital beds and 120 long-term care beds.

Affiliations and Research. The SFVAMC is affiliated with the University of California's San Francisco Schools of Medicine, Nursing, Pharmacy, and Dentistry. It supports 153 medical resident positions. In fiscal year (FY) 2007, the SFVAMC's research program had 960 projects and a budget of $78 million. Important areas of research include prostate cancer, post-traumatic stress disorder, and hepatitis.

Resources. In FY 2008, medical care expenditures totaled $339 million. FY 2008 staffing was 1,856 full-time employee equivalents (FTE), including 218 physician and 490 nursing FTE.

Workload. In FY 2008, the SFVAMC treated 51,151 unique patients. The inpatient care workload totaled 5,311 discharges, and the average daily census, including extended care patients, was 193.6. Outpatient workload totaled 419,781 visits.

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 administration and QM.
- Provide fraud and integrity awareness training 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 the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following nine activities:

- Coordination of Care.
- ED and Urgent Care Center (UCC) Operations.
- EOC.
- Medication Management.
- Patient Satisfaction Survey Scores.
- Pharmacy Operations and CS Inspections.
- Physician Privileges.
- QM.
- Staffing.

The review covered SFVAMC operations for FY 2008 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the SFVAMC (*Combined Assessment Program Review of the San Francisco VA Medical Center, San Francisco, California,* Report No. 05-02361-50, January 6, 2006). The SFVAMC had addressed all findings related to patient complaints management from our prior CAP review, and we consider the report closed.

During this review, we also presented fraud and integrity awareness briefings for 183 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.

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. The activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Adverse Event Disclosure Log

The Adverse Event Disclosure Log was developed in response to the previous OIG CAP review. At that time, it was difficult to locate disclosure notes, and the facility had no way to track and trend disclosures. The log is an Excel spreadsheet used for documenting the date and type of disclosure and includes a comment field for adverse events that are outside the facility's control, such as when the manufacturer is responsible. QM staff screen all patient incidents for the possible need for disclosure. At the end of each month, QM staff search for any new disclosure notes that may have been entered without notifying QM.

Simulation Center

In 2008, the SFVAMC opened a new high-tech Simulation Center that creates realistic medical scenarios to allow clinicians to improve and refine their medical skills and techniques. The center includes a simulation lab as well as a classroom and communication room. Clinicians participate in hands-on educational programs with a focus on health care team training. The exercises take place in a simulated environment that imitates a real life patient care setting where staff can practice and master skills in a non-threatening environment.

Three-Dimensional Imaging Laboratory

In 2008, the SFVAMC opened its newly remodeled imaging laboratory that offers 3D visualization methods. The new laboratory houses workstations with the multiple computer platforms needed to address the expanding use of 3D imaging in everyday patient care. This imaging is used for several applications, including coronary angiography, aneurysm evaluation, and brain-body perfusion techniques.

Ethanol Fueling Station

The Energy Policy Act of 2005 mandated a reduction in the amount of petroleum consumption for transportation. In 2008, the SFVAMC took a major step to reduce petroleum consumption by installing an ethanol fueling station. Ethanol is commonly referred to as E-85. The SFVAMC is one of

only six VA medical centers to construct an E-85 fueling station on campus for fueling government vehicles.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the SFVAMC's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the SFVAMC's Acting Director, Chief of Staff, and Chief of QM. We also interviewed QM personnel and several other service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the SFVAMC's quality of care. Appropriate review structures were in place for 12 of the 15 program activities reviewed. However, we identified three areas that needed improvement.

Documentation of Action Items. Improvement was needed in documenting discussions about data analyses that were presented in committee meetings. Discussions and actions from QM data analyses were inconsistently documented in the meeting minutes. Although the Medical Executive Committee minutes documented discussions and actions needed for improvement, other high level committees' minutes did not.

For example, although data regarding patient complaints were gathered and analyzed, we did not find documentation in the Leadership Committee meeting minutes indicating that identified problems were discussed and that actions were taken. We were told that a detailed discussion took place at the meeting, but it was not documented in the minutes.

Recommendation 1 We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that committee chairpersons assure consistent documentation of discussions about QM data analyses and that they implement and evaluate actions to address problems or trends.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. A template for meeting minutes will be implemented by January 30, 2009. The

template will be used by all chartered committees to document discussion of data analysis and to track follow-up. Committee minutes will be reviewed by QM staff to ensure compliance. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Medication Reconciliation. This topic is a national patient safety goal that requires the facility to maintain a list of all medications each patient takes. This list must be reviewed at key points during each patient's care, including admission, transfer, and discharge. Any medication duplications, omissions, or potentially hazardous combinations must be addressed or reconciled.

Although clinicians monitored medication reconciliation at discharge, we did not find evidence of medication reconciliation monitoring at admission or transfer. The discharge medication reconciliation reviews had identified several problems that were being addressed. However, compliance was below expectations. Managers needed to ensure that a process for comprehensive monitoring is in place and that actions are taken to improve compliance.

Recommendation 2 We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that a process for comprehensive monitoring of medication reconciliation is maintained and that actions are taken to improve compliance.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. Each provider note will have a mandatory box to be checked indicating that medication reconciliation was completed and that the patient provided input. Monthly reports will be generated, and compliance with documentation will be reported to service chiefs and the Medical Executive Committee. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Restraints and Seclusion Monitoring. When patients' freedom is restricted through the use of physical restraints or seclusion, several processes are required, including that alternatives are considered, appropriate orders are written, and comfort measures are ensured. We did not find evidence that the individual use of restraints was monitored for compliance with required processes. In addition, we did

not find that restraint use had been analyzed across the organization to determine if there were trends that needed to be addressed.

Recommendation 3 We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that individual restraint and seclusion use be monitored and that aggregate restraint data be analyzed to determine trends.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. On October 31, 2008, a new progress note template was implemented. Nursing management will review all episodes of restraint and seclusion use, and results will be presented to the Medical Executive Committee and the Leadership Committee. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Operations and Controlled Substances Inspections

The purpose of this review was to evaluate whether VHA facilities had adequate controls to ensure the pharmacies' security and proper management of CS. We also assessed whether processes were in place to monitor polypharmacy (patients prescribed multiple medications), especially in vulnerable populations.

We reviewed VHA regulations governing pharmacy and CS security, and we assessed whether the facility's policies and practices were consistent with VHA regulations. We inspected the inpatient and outpatient pharmacies for security, EOC, and IC issues.

The SFVAMC had appropriate policies to ensure the security of the pharmacies and CS. Managers had developed effective processes to ensure that clinical pharmacists identified patients who were receiving multiple prescription medications, reviewed their medication regimens to avoid polypharmacy, and appropriately advised providers.

The pharmacies' internal environments were generally clean and well maintained. The annual physical security surveys had been conducted, as required, and all but two of the surveys' recommendations had been corrected. The dispensing window in the methadone clinic and the windows inside the inpatient pharmacy did not meet VHA security requirements. Managers assured us that the dispensing window had been purchased and will be installed upon receipt and that the windows in the inpatient pharmacy will be

secured. Therefore, we did not make recommendations in these areas.

The CS Inspection Program Coordinator and the Chief Inspector provided effective oversight of the program. Monthly unannounced inspections and rotation of inspectors complied with VHA policy. Inspection findings were trended, analyzed, and appropriately followed up. We identified the following improvement opportunities.

Training and Competency Assessments. Facility policy requires that individuals assigned to inspect CS in the research laboratories receive the required annual Biosafety Level 2 (BSL2) refresher training. Because research laboratories may contain hazardous materials, it is important that inspectors receive training about safety measures to prevent potential injuries. Two of the three assigned inspectors had not received the required annual training. Program managers assured us that all three inspectors had received the initial BSL2 training and that the annual training will be completed.

Program managers had developed a comprehensive competency assessment checklist to ensure that inspectors have received the appropriate orientation and training to successfully perform their duties. We found that the annual competency assessments for several inspectors had not been completed. Without documentation of demonstrated competencies, managers could not be sure that these inspectors have the necessary skills or training to successfully complete their inspection responsibilities.

Recommendation 4 We recommended that the VISN Director ensure that the Acting SFVAMC Director requires the CS Inspection Program Coordinator to ensure that the required annual training for inspectors assigned to research laboratories is completed and that competency assessments for all CS inspectors are completed.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. The two employees who alternate inspecting research laboratories received BSL2 training, and managers will ensure that BSL2 refresher training is scheduled annually. Inspectors without current competencies will be assessed during their next inspection. The target completion date for this is January 31, 2009. The SFVAMC will ensure that each inspector's competency is

assessed annually. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the SFVAMC complied with selected IC standards and maintained a clean, safe, and secure environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff.

We inspected primary care, dermatology, radiology, methadone, and mental health clinics and all inpatient units. We also inspected the laboratory, the hemodialysis area, and the gastroenterology laboratory. Overall, we found the areas we inspected to be generally clean and well maintained.

We identified several items that required managers' attention, such as construction zone infractions, uncovered biohazard trash bins, and unprotected patient information. Managers took immediate actions to correct these deficiencies. Therefore, we did not make any recommendations related to these items.

However, we identified additional conditions related to fire safety, security, and IC that needed improvement. Also, in the locked psychiatric intensive care unit (PICU), we identified deficiencies related to training and safety inspections.

Fire Safety, Security, and Infection Control. Facility policy requires quarterly fire drills on all shifts (day, night, and swing). We found that responsible personnel did not consistently conduct fire drills on all shifts in Building 200 for 3 of the 4 quarters of FY 2008. Facility policy also requires monthly alarm checks. We found that police officers did not consistently record the date and results of each alarm test. The Police Chief developed a standard operating procedure (SOP) for monthly alarm checks while we were onsite. Compliance with this SOP needs to be monitored.

During our tour of inpatient units, we found several areas with call light pull cords that were made of cloth material. Managers needed to conduct a comprehensive assessment of all pull cords and replace those that do not meet safety and IC requirements.

Recommendation 5 We recommended that the VISN Director ensure that the Acting SFVAMC Director takes action to address identified fire safety, security, and IC deficiencies.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. The fire drill schedule was revised to include all areas. Documentation of drills is now maintained in the Safety Office, and quarterly reports are presented to the EOC Functional Team and the Research Safety Committee. IC staff did a comprehensive assessment, and new pull cords were installed in all areas identified as needing them. The corrective actions are acceptable, and we consider this recommendation closed.

Locked Mental Health Unit. VHA developed the mental health EOC checklist along with the protocol to identify safety concerns on locked mental health units. The protocol specifies the establishment of a specially trained MSIT for identification of environmental hazards. We found that PICU staff and the MSIT have implemented changes to protect their patient population. However, not all members of the MSIT had received the required annual training.

The PICU undergoes two separate safety inspections. One inspection is conducted by the MSIT specifically to identify suicide risks. The MSIT is responsible for ensuring that the suicide risk level classification is assigned correctly. The second inspection is an EOC inspection, which also identifies and rates risks. We found confusion with risk level classification and the responsibilities of the two teams. Managers needed to reassess the process for each team, including the documentation and follow-up actions required.

Recommendation 6 We recommended that the VISN Director ensure that the Acting SFVAMC Director takes action to ensure that all MSIT members comply with the annual training requirement and to clarify the expectations and responsibilities of MSIT and EOC inspections.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. As of October 10, 2008, all

existing MSIT members had completed the required training. Two new MSIT members from Engineering Service were trained and will provide consultation to the MSIT to determine appropriate risk scoring that is in line with the current EOC scoring guidelines. The new process will provide both an MSIT risk score and an associated EOC risk score for each item on the checklist. The corrective actions are acceptable, and we consider this recommendation closed.

Emergency Department and Urgent Care Center Operations

The purpose of this review was to evaluate selected aspects of care and operations in VHA EDs and UCCs, such as clinical services, consults, inter-facility transfers, staffing, and staff competencies. We also assessed the physical environment and equipment maintenance.

We interviewed program managers and transfer coordinators and reviewed documents, including competency files, credentialing and privileging (C&P) folders, and medical records of patients who were transferred to other medical facilities or admitted to inpatient units within the SFVAMC.

Our review showed that clinical services, consults, staffing, and nursing staff competencies were appropriate. The ED is open 24 hours per day, 7 days per week. Emergency services provided are within the facility's patient care capabilities. In addition, we found appropriate policies for managing patients whose care may exceed the SFVAMC's capability. However, we found two areas that needed management attention.

Environment of Care. We identified a number of EOC deficiencies that needed to be addressed in general maintenance (torn mattresses), IC (availability of sinks for hand washing) and security (computer screens visible to unauthorized individuals). Also, the ED must be a controlled access area, yet we found several entry and exit doors within the ED that were not secured.

Recommendation 7 We recommended that the VISN Director ensure that the Acting SFVAMC Director takes actions to correct identified EOC deficiencies in the ED.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. Torn mattresses were replaced, a new sink was installed, privacy screens were mounted on all computers in public areas within the ED, and new locks were installed at all ED access points. The

corrective actions are acceptable, and we consider this recommendation closed.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred to and from the ED. We found incomplete documentation of inter-facility transfer information. Staff did not consistently use the required inter-facility transfer form (VA Form 10-2649A) or the appropriate electronic medical record template note. Lack of complete information upon transfer can result in decreased continuity of care.

Recommendation 8 We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that all inter-facility transfer documentation comply with VHA policy and that patient transfers are monitored and evaluated to ensure compliance.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. The inter-facility transfer template that was already in use in the inpatient setting has been implemented in the ED. The corrective action is acceptable, and we consider this recommendation closed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed selected medication management processes in the inpatient medicine, surgery, mental health, and community living center[1] units. We found adequate management of medications brought into the facility by patients or their families and appropriate use of patient armbands to correctly identify patients prior to medication administration. We identified one area that needed improvement.

Timeliness of Pain Medication Effectiveness Documentation. In all of the inpatient units we reviewed, nurses consistently documented the effectiveness of pain medications administered to patients. However, nurses did not consistently document medication effectiveness within the timeframes specified in local policy. During the week of August 10–16, nurses administered more than 1,300 doses of pain medications. The SFVAMC's average compliance rate for timeliness of documentation was 62 percent

[1] A community living center (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

(831/1,338). The range was 37–72 percent. We reviewed the medical records of 42 patients who received a total of 119 pain medication doses and found a compliance rate of 77 percent. Managers agreed that timeliness of documentation is important, and they will monitor to ensure that pain medication effectiveness is appropriately recorded in patient records.

Recommendation 9 We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that nurses consistently document pain medication effectiveness within the required timeframes.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. The SFVAMC took actions, including standardizing timeframes to chart pain medication effectiveness, performing spot checks, counseling nurses as needed, and providing weekly reports to the Chief Nurse Executive. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Coordination of Care

The purpose of this review was to evaluate whether consultations, intra-facility transfers, and discharges were coordinated appropriately. Well-coordinated consultations, patient transfers, and discharges are essential to continuity of care and optimal patient outcomes.

We reviewed the medical records of 21 patients who had consultations ordered and performed at the SFVAMC. In general, we found timely responses to the consultation requests and consistent communication between requesting and consulting providers.

We reviewed the medical records of 20 patients who transferred between units. Although the handoff policy did not require documentation of nursing reports for patient transfers, we found consistent and timely patient assessments by receiving unit nursing staff. In addition, physicians consistently documented patients' conditions and needs prior to transfer. We identified one area that needed management attention.

Discharge Documentation. We reviewed the medical records of 21 patients who were discharged from the SFVAMC. In all cases, the patients received discharge instructions, and clinicians documented that the patients understood the instructions. However, 6 (29 percent) of the 21 records

reviewed had no discharge summaries dictated within 30 days of discharge or had no discharge orders documented.

Recommendation 10 We recommended that the VISN Director ensure that the Acting SFVAMC Director requires timely dictation and posting of discharge summaries and consistent recording of discharge orders in medical records.

The VISN and Acting SFVAMC Directors concurred with the findings and recommendation. The SFVAMC implemented several actions, including providing training for staff regarding deficiency analysis, providing training for administrative officers regarding tracking the physicians within their services, and following up with individual providers who have deficient documents nearing delinquency. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent that VHA medical centers use the quarterly survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients.

Figures 1 and 2 on the next page show the SFVAMC's patient satisfaction performance measure results for inpatients and outpatients, respectively.

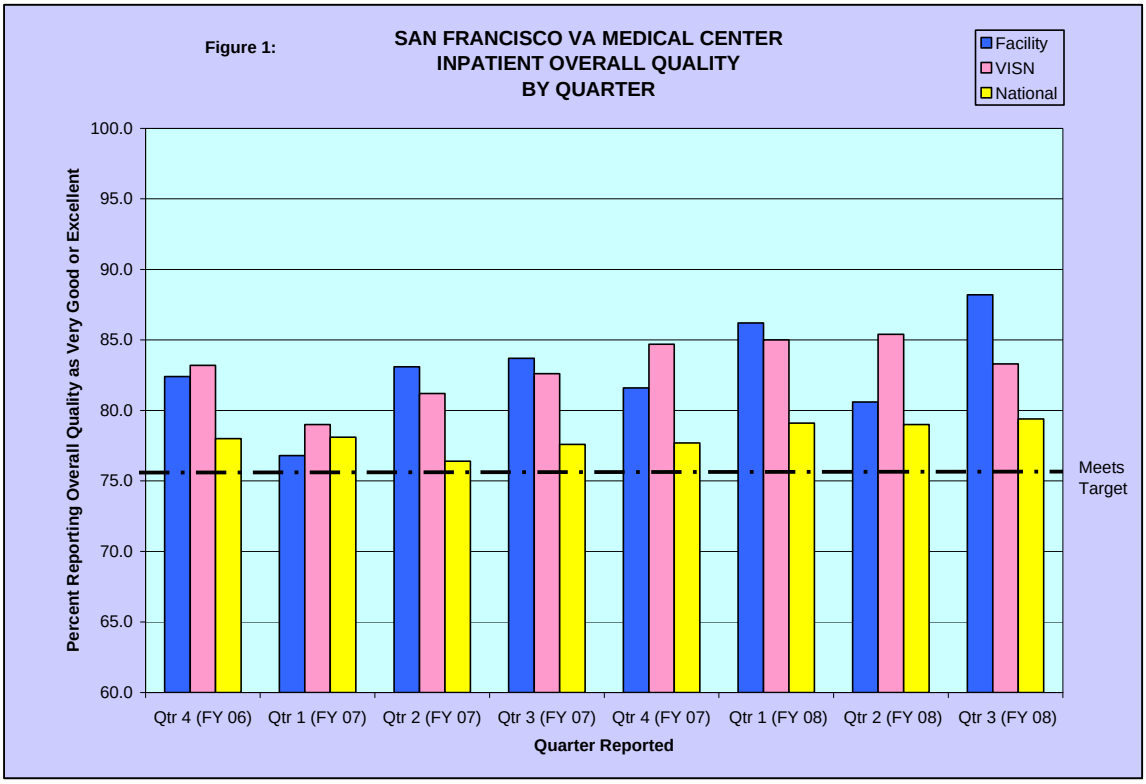
Figure 1:
SAN FRANCISCO VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100.0
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

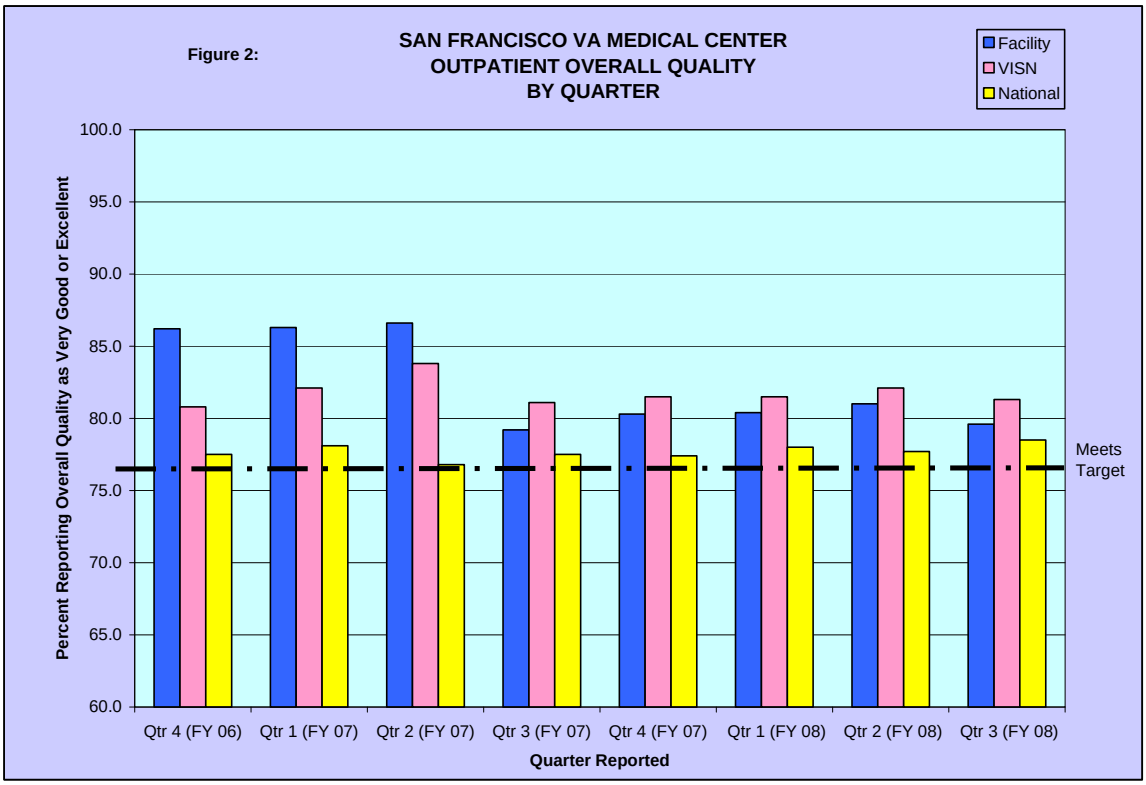
Figure 2:
SAN FRANCISCO VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100.0
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

The SFVAMC's inpatient and outpatient scores exceeded the target in all 8 quarters. We made no recommendations.

Physician Privileges

The purpose of this review was to determine whether VHA facilities have processes to ensure that physicians are granted only those privileges for which they have demonstrated competence.

We reviewed a sample of physicians' C&P files, along with provider profiles and performance data. We also reviewed meeting minutes during which discussions about the physicians took place.

We found that service-specific criteria and performance targets had been developed and that continuous monitoring had begun, as required. It was not clear what actions would be taken if the performance targets were not met. We were told that provider-specific procedure complication rates were very difficult to compile for use in reprivileging. Although competency data could be improved to better relate to physicians' specific privileges, sufficient data were present to meet current accreditation standards. Therefore, we made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the SFVAMC had developed staffing guidelines for nursing staff, and we found them to be adequate.

The SFVAMC uses hours per patient day as the primary staffing methodology. We reviewed staffing for 8 inpatient units for a total of 115 shifts. We found that nurse staffing requirements were met 95 percent of the time in all areas reviewed and that specific actions had been taken to ensure safe patient care, including the use of supplemental staff and one-to-one staffing, when needed. Overall, we found that the SFVAMC had adequate nursing staff. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 13, 2008

From: VISN Director (10N21)

Subject: Combined Assessment Program Review of the San Francisco VA Medical Center, San Francisco, California (Project No. 2008-02445-HI-0155)

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

Director, Management Review Service (10B5)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the San Francisco VA Medical Center (662), September 29–October 3, 2008. We concur with the recommendations and will ensure that they are completed as described in the attached plan by the established target dates.

2. If you have any questions regarding the attached response or actions to the recommendations in the draft report, please contact Ms. Judy Daley, VISN 21 Quality Management Officer, at (775) 328-1461.

(original signed by Cassandra M. Law for:)
Sheila M. Cullen

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 7, 2008

From: Acting San Francisco VA Medical Center Director (662/00)

Subject: Combined Assessment Program Review of the San Francisco VA Medical Center, San Francisco, California

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

1. We appreciate the opportunity to comment on the draft report of the Combined Assessment Program (CAP) review of the San Francisco VA Medical Center (SFVAMC). In brief, we concur with the findings and suggested improvement actions, which are already in progress. The action plans are targeted for completion in the next few months.

2. We are pleased that there are limited findings related to environment of care, that patient interviews indicated a high level of patient satisfaction, and that clinical processes were found to be timely and appropriate in various clinical areas.

3. In closing, we express thanks to the CAP review team. The team members were professional, comprehensive, and focused. We especially appreciated that the survey team openly discussed issues and listened to our input. The educational sessions regarding fraud and abuse awareness were also helpful and very well received. The collective interest and efforts of the CAP review team have helped improve our clinical practices at VAMC San Francisco.

(original signed by:)
Ezra R. Safdie, P.E.

SAN FRANCISCO VA MEDICAL CENTER
Response to the Office of Inspector General Combined Assessment Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Quality Management

Recommendation 1. We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that committee chairpersons assure consistent documentation of discussions about QM data analyses and that they implement and evaluate actions to address problems or trends.

Concur with recommendation. Target Date of Completion: Jan. 30, 2009

Planned Actions: The template used for MEC minutes will now be used for all chartered committees to document discussion of data analysis and to track follow-up. All committees will be required to implement the template by January 30, 2009. Committee minutes will be reviewed by QM to ensure compliance.

Recommendation 2. We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that a process for comprehensive monitoring of medication reconciliation is maintained and that actions are taken to improve compliance.

Concur with recommendation. Target Date of Completion: Dec. 31, 2008

Planned Actions: Currently, medication reconciliation is completed by the providers at the time of admission to, and discharge from, the hospital and at each clinic or ED visit where medications are changed. By Nov. 30, 2008, each provider note will have a mandatory radio box to be checked indicating that: medication reconciliation has been completed, there has been input from the patient (and /or family) in the process, and patient education has been provided. Monthly reports will be generated from these notes starting Dec. 31, 2008, and compliance with documentation will be reported to the service chiefs monthly and to the MEC quarterly. Pharmacy reviews of the accuracy of medication reconciliation will also be reported to the MEC quarterly. It should be

noted that studies both at our facility and in the literature have demonstrated that the accuracy of medication reconciliation, which is the assurance that the patient receives the correct medication, is much improved when pharmacists are actively involved in the medication reconciliation process. Therefore, a request for additional pharmacists has been submitted to provide a second layer of safety in medication reconciliation for inpatient areas. In the meantime, pharmacists are actively involved in performing medication reconciliation for high-risk areas as well as high risk medications, and the results of pharmacist medication reconciliation are being monitored through the pharmacy QM program.

Recommendation 3. We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that individual restraint and seclusion use be monitored and that aggregate restraint data be analyzed to determine trends.

Concur with recommendation. Target Date of Completion: Nov. 30, 2008

Planned Actions: A restraint and seclusion review template has been developed utilizing the criteria contained in the standards. The new template was presented to Nursing Service on October 31, 2008. Each month, nursing management and nursing quality improvement staff will review all episodes of restraints and seclusion utilizing the new template. Completed monthly review records will be forwarded to QM for aggregation and analysis. Results will be presented to the MEC and Nursing Leadership on a quarterly basis. Any opportunities for improvement identified will be analyzed with corrective actions identified to the Leadership Committee.

Pharmacy Operations and Controlled Substances Inspections

Recommendation 4. We recommended that the VISN Director ensure that the Acting SFVAMC Director requires the CS Inspection Program Coordinator to ensure that the required annual training for inspectors assigned to research laboratories is completed and that competency assessments for all CS inspectors are completed.

Concur with recommendation. Target Date of Completion: Jan. 31, 2009

Planned Actions:

Employees who inspect research narcotic areas of use did not receive annual BSL2 training: Of note, all inspectors received annual orientation and training. The two employees who alternate inspecting research labs

have received BSL2 training this year (2008), and we will ensure annual BSL2 refresher training is scheduled in August or September of each year hereafter.

Inspectors' competencies were not annually assessed: All inspectors' competencies were assessed during their initial inspections; however, three inspectors appointed in 2007 were not reassessed as of the CAP OIG visit, and two inspectors appointed on August 1, 2008, have not undergone initial competency assessment. The five inspectors' competencies will be assessed during their next inspection, and the projected completion date is January 31, 2009. Furthermore, we will ensure all inspectors competency is assessed annually.

Environment of Care

Recommendation 5. We recommended that the VISN Director ensure that the Acting SFVAMC Director takes action to address identified fire safety, security, and IC deficiencies.

Concur with recommendation. Target Date of Completion: Complete

Planned Actions: The fire drill schedule has been approved by the Safety Officer to ensure all areas conduct drills in accordance with Joint Commission standards and NFPA regulations. The new schedule will be presented to the EOC Functional Team (ECFT) on November 24, 2008. The schedule has also been presented to the Research Safety Committee. Documentation of drills will be kept in the Safety Office. A copy of the fire drill critique and report is now sent to the service chief of the area affected by the fire drill. The fire drill compliance report has been added to the ECFT agenda. The first report was presented on October 27, 2008. Future reports will occur on a quarterly basis. This same report will also be presented to the Research Safety Committee on a quarterly basis.

IC did a comprehensive assessment of the entire hospital and the CLC and installed new pull cords in all areas identified as needing them.

Recommendation 6. We recommended that the VISN Director ensure that the Acting SFVAMC Director takes action to ensure that MSIT members comply with the annual training requirement and to clarify the expectations and responsibilities of MSIT and EOC inspections.

Concur with recommendation. Target Date of Completion: Complete

Planned Actions: The team leader identified one MSIT team member who had not had the required training. That team member has completed the required online training as of October 10, 2008. The remaining team members were current at the time of the inspection. The Chief of Engineering has selected a representative and alternate from his service to become a member of the MSIT team. The two individuals completed their required training. The new team members will provide consultant services to the MSIT team to determine appropriate risk scoring in line with the current EOC scoring guidelines. The new process will provide both an MSIT risk score and an associated EOC risk score for each item on the checklist.

Emergency Department and Urgent Care Center Operations

Recommendation 7. We recommended that the VISN Director ensure that the Acting SFVAMC Director takes actions to correct identified EOC deficiencies in the ED.

Concur with recommendation. Target Date of Completion: Nov. 20, 2008

Planned Actions: New mattresses were purchased and delivered to the ED on October 31, 2008. Two new exam tables were obtained from GSA overstock. They are scheduled to arrive the week of November 17, 2008; they will be installed immediately upon arrival.

The new ED sink has been installed and is currently in use.

The privacy screens have arrived and have been installed on all public area computers within the Emergency Department.

New locks have been installed at all access points to the Emergency Department.

Recommendation 8. We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that all inter-facility transfer documentation comply with VHA policy and that patient transfers are monitored and evaluated to ensure compliance.

Concur with recommendation. Target Date of Completion: Complete

Planned Actions: A transfer task force has been meeting over the past 6 months to ensure implementation of the VHA Directive on inter-facility transfers. The required template has been in use in the inpatient setting

for several months. It has now been implemented in the ED, the identified non-compliant area during the inspection.

A data extraction tool for monitoring transfers out of the SFVAMC is being tested by the program writer. The tool looks at compliance with the VHA Directive, the clinical appropriateness of the transfer, and the reason for transfers by extracting the data from the computerized patient record. The data results will be reported to the MEC on a quarterly basis.

Medication Management

Recommendation 9. We recommended that the VISN Director ensure that the Acting SFVAMC Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframes.

Concur with recommendation. Target Date of Completion: Nov. 30, 2008

Planned Actions:

1. Standardize times to chart prn effectiveness:
   a) Chart effectiveness within 45 min. to 2.5 hours for PO/PR/IM/IV pain meds (per input from nursing staff).
   b) Set target goal at 85% of pain prn charted in proper timeframe (to be in line with other hospitals as reported by OIG).
   c) Obtain approval from pain committee and Chief Nurse Executive of standardized times and target goal from nursing administration.
   d) Managers will assign one-two champions as prn rep. from each unit.
   e) Prn champions to attend PRN group meetings.

2. Advertise standard times once agreed upon:
   a) Vista email to all nursing staff.
   b) Fliers to be distributed to all unit staff about standard times.
   c) Post standard times in units and near computers.
   d) Unit prn champions and educators to give in service to all staff on all tours.

3. Spot checks once a week by unit prn pain champion:
   a) Unit champion to report to manager/BCMA Coordinator.
   b) A weekly report will be sent to Chief Nurse Executive and associate chiefs and nurse managers of the results of weekly spot checks.
   c) BCMA coordinator to send emails to nurses and their managers of prn pain meds not charted (currently sent 5X/week).

d) Manager to counsel nurses who fail spot checks and 5X/week check from BCMA coordinator

4. Bi-Quarterly check of prn pain effectiveness charted for entire facility by BCMA Coordinator:
   a) Results reported to Chief Nurse Executive and Assoc. Chiefs, Nurse managers, QM, and unit prn champions.
   b) Results displayed to staff via VISTA email.
   c) Graph of prn effectiveness charted in proper timeframe per unit and will be a part of the medication management QI for Nursing Service.
   d) Nurse managers to disseminate results to staff during staff meetings.

5. In January 2009, BCMA Coordinator to have prn units contest:
   a) Stimulate competition, keep prn pain charting in forefront of nursing, and encourage staff participation.
   b) Reward offered (to be determined) by BCMA Coordinator.

Coordination of Care

Recommendation 10. We recommended that the VISN Director ensure that the Acting SFVAMC Director requires timely dictation and posting of discharge summaries and consistent recording of discharge orders in medical records.

Concur with recommendation. Target Date of Completion: Dec. 1, 2008

Planned Actions:

Additional staff have been added to the HIMS department; the staff have been provided new guidance relative to reviewing records for deficiency analysis. With improved analysis, deficiencies are already being better identified and attributed to the correct medical staff. (Analysis includes reviewing for discharge orders.)

The IRT report is again being published weekly, and new training will be provided to administrative officers so that they can better track the physicians within their services. We also have established new monitors (mostly manual) with our transcription contractor to know the status of pending documents.

The above actions comprise the heart of our HIMS efforts to produce timely reports that accurately reflect record status. We have also implemented phone follow-ups to individual providers who have deficient

documents nearing delinquency. Currently, there are electronic alerts in CPRS, but the problem has been individual provider compliance.

OIG Contact and Staff Acknowledgments

Contact	Julie Watrous, Director Los Angeles Office of Healthcare Inspections (213) 253-5134
Contributors	Daisy Arugay Gail Bozzelli Toni Woodard Mike Seitler, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Sierra Pacific Network (10N21)
Acting Director, San Francisco VA Medical Center (662/00)

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: Nancy Pelosi, Jackie Speier, Mike Thompson, Lynn Woolsey

This report is available at http://www.va.gov/oig/publications/reports-list.asp.