Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03085-57

Combined Assessment Program Review of the VA San Diego Healthcare System San Diego, California

January 23, 2009

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.

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Executive Summary

Introduction

During the week of November 17–21, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA San Diego Healthcare System (VASDHS), San Diego, 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 328 employees. The VASDHS is part of Veterans Integrated Service Network (VISN) 22.

Results of the Review

The CAP review covered eight operational activities and a follow-up review area from the prior CAP review. We identified the following organizational strengths and reported accomplishments:

- Computerized patient event reporting (PER).
- Emergency response to wildfires.
- Acute coronary syndrome (ACS) ordering and documentation system.

We made recommendations in five of the activities reviewed and in the follow-up review area. For these activities and the follow-up review area, the VASDHS needed to:

- Ensure that clinicians complete all assigned peer reviews within the designated timeframes.
- Require that all procedure areas consistently report procedures volume and complications data, including moderate sedation events, to the Procedures and Anesthesia Care Council (PACC) and that the PACC identify and address trends.
- Ensure that the patient advocate provides detailed patient complaint analyses and that the Veterans Employee Service Council (VESC) thoroughly discusses the trend analyses and takes appropriate actions.
- Revise the local policy to include processes to be followed when training certificates expire and ensure that the tracking mechanism includes all employees who require the training and actions taken when the certificates expire.
- Address the identified pharmacy physical security deficiency.

- Correct identified environment of care (EOC) deficiencies.
- Ensure that mental health patients discharged from the emergency department (ED) receive written discharge instructions and that clinicians document in the medical record that patients verbalized understanding.
- Ensure that nurses consistently document the effectiveness of pain medications within the required timeframe.
- Require pharmacists to improve compliance with self-medication program (SMP) documentation requirements.
- Take action to improve compliance with the Veterans Health Administration's (VHA) breast cancer (BC) screening performance measure and timeliness of mammogram reports.

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

- Coordination of Care.
- Nurse Staffing.
- Patient Satisfaction Survey Scores.

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

Comments

The VISN and VASDHS Directors concurred with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 17–24, 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 VASDHS is a tertiary facility located in San Diego, CA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Chula Vista, Escondido, El Centro, San Diego, and Vista, CA. The VASDHS is part of VISN 22 and serves a veteran population of about 267,000 throughout parts of northern, eastern (urban), and southern San Diego County.

Programs. The VASDHS provides primary care and inpatient services. It has 232 operating hospital beds and 43 long-term care beds.

Affiliations and Research. The VASDHS is affiliated with the University of California, San Diego's School of Medicine and provides training for 1,479 medical interns, residents, and fellows. It has 64 additional affiliations for other disciplines, including nursing and pharmacy. In FY 2007, the VASDHS research program had 1,068 projects and a budget of $54 million. (FY 2008 research data was not available at the time of this report.) Important areas of research include post-traumatic stress disorder, traumatic brain injury, cancer, Alzheimer's disease, hearing loss, and magnetic resonance imaging.

Resources. In FY 2008, medical care expenditures totaled more than $414 million. FY 2008 staffing was 2,218 full-time employee equivalents (FTE), including 182 physician and 650 nursing FTE.

Workload. For FY 2008 through July 31, 2008, the VASDHS treated 58,278 unique patients and provided 45,051 inpatient days in the hospital and 8,399 inpatient days in the community living center (CLC).[1] The inpatient care workload totaled 5,837 discharges, and the average daily census, including CLC patients, was 176. Outpatient workload totaled 478,468 visits.

[1] A CLC (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.

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 eight activities and follow-up review area:

- Breast Cancer Management.
- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Nurse Staffing.
- Patient Satisfaction Survey Scores.
- Pharmacy Operations.
- QM.

The review covered VASDHS 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 VASDHS (*Combined Assessment Program Review of the VA San Diego Healthcare System, San Diego, California,* Report No. 06-00372-142, May 12, 2006). We had identified

improvement opportunities in the following review areas: (1) patient complaint analyses, (2) controlled substances (CS) accountability, and (3) BC management. During our follow-up review, we found sufficient evidence that program managers had implemented the appropriate actions in the area of CS accountability, and we consider that issue closed. However, since desired outcomes for patient complaints analyses and BC management had not yet been achieved at the time of this CAP review, we reissued recommendations for these areas (see pages 6 and 13).

During this review, we also presented fraud and integrity awareness briefings for 328 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

Computerized Patient Event Reporting

In 2000, VASDHS staff developed the computerized PER software program in order to provide an efficient and user-friendly method of entering incident reports and managing data related to them. The reports are anonymous and can be used by any staff member who has computer access. Since implementation in 2005, the number of patient events submitted has tripled. The PER software program has been selected to be implemented VHA wide and is in the process of moving from a Class 3 (local) to a Class 1 (national) application information system.

Emergency Response to Wildfires

On October 21, 2007, the VASDHS executed emergency response activities in reaction to multiple wildfires in San Diego County. The VASDHS established a command post; activated a shelter-in-place; and immediately canceled elective surgeries, procedures, and clinics in the main hospital. All employees were provided with updates on the status of the VASDHS and the wildfires. The VASDHS's command post remained operational for 7 days.

The VASDHS's emergency response efforts have been recognized by several reviewers, including the VA Under Secretary for Health. Several exemplary capabilities used during the wildfires were noted. These included a strong leadership commitment, an excellent home-based specialty patient outreach program, a well-developed shelter-in-place plan, and a strong commitment to employee welfare and safety. The VASDHS received an award for use of the internet in disseminating timely information to staff.

Acute Coronary Syndrome Ordering and Documentation System

The VASDHS's ACS performance improvement team has created a computerized ordering and documentation system for the treatment of patients who present with ACS. This user-friendly electronic ordering system works within VHA's electronic medical record computer system and is designed to guide the treating physician through the appropriate ACS treatment pathway based on the patient's signs and symptoms, laboratory tests, electrocardiogram (test that records the heart's electrical activity) result, and response to treatment.

The ACS computerized treatment guidelines were created for local use but were presented to VISN 22 as a best practice and model for other sites to use. The national VHA Coronary Care Unit Director showcased the system at a national ACS conference in Washington, DC, and an article entitled "Acute Coronary Syndrome: The Time is Life Campaign at the Veterans Administration Medical Center San Diego" was published in *Critical Pathways in Cardiology* in March 2006. Through the use of the ACS computerized order sets, the VASDHS currently achieves a performance level above most Joint Commission accredited organizations and in many areas achieves the best possible results when compared to the top 10 percent of hospitals in the Nation.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the VASDHS's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the VASDHS's Director, Chief of Staff, and Chief of Performance Improvement Management Service (PIMS). We also

interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the VASDHS's quality of care. Appropriate review structures were in place for 11 of the 15 program activities reviewed. However, we identified four areas that needed improvement.

Timeliness of Peer Reviews. The peer review process was comprehensive and generally in compliance with the requirements. However, improvement was needed in completing peer reviews within the designated timeframes. For FY 2008, an average of 77 percent of initial peer reviews were completed within the 45-day timeframe, and the entire committee review process was completed within the 120-day timeframe an average of 74 percent of the time. The Chief of PIMS agreed with our findings and has analyzed the timeliness data to target efforts toward those clinical services that have not met the timeframes.

Recommendation 1 We recommended that the VISN Director ensure that the VASDHS Director requires that all clinicians complete all assigned peer reviews within the designated timeframes.

The VISN and VASDHS Directors concurred with the findings and recommendation. After the CAP review, the Chief of Staff mandated that reviews delinquent 45 days or greater were to be completed by the end of calendar year 2008. A report is expected to be available no later than January 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Invasive Procedures Monitoring. Invasive procedures monitoring and trending were not consistently performed organization wide over the past 12 months, as required. Some, but not all, procedure areas reported procedures volume and complications data semi-annually to the PACC. For example, moderate sedation events should be reported to the PACC. However, although at least 13 events occurred in the past 12 months, we found no documentation to support that any of these events had been reported to the PACC. All procedure areas needed to report volume and complications data frequently enough to provide assurance that any adverse trends will be identified and addressed timely. Reviews and analyses needed to include sufficient

information to determine if any trends occurred. Committee co-chairpersons agreed that improvement is needed in this high-risk, vulnerable organization-wide function.

Recommendation 2 We recommended that the VISN Director ensure that the VASDHS Director requires that all procedure areas consistently report procedures volume and complications data, including moderate sedation events, to the PACC and that the PACC identify and address trends.

The VISN and VASDHS Directors concurred with the findings and recommendation. Managers have started collecting provider-specific data related to out-of-operating room airway management and have implemented the use of a specialized procedure note. The PACC will be responsible for reviewing and discussing results, monitoring data trends, and reporting information to the Medical Executive Committee. Target date for completion is June 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Patient Complaint Analyses. Data regarding patient satisfaction was gathered and analyzed, as required. However, reports presented to the VESC discussed only broad topic areas, such as access to and timeliness of care. VESC meeting minutes documented little discussion and no actions resulting from the reports. Joint Commission standards require that patient complaints be analyzed for trends and incorporated into performance improvement efforts. We had a similar finding during our prior CAP review and recommended that the patient advocate provide more detailed patient complaint analyses and present actionable, trended reports to senior managers. The VASDHS Director agreed with the recommendation and implemented improvement actions. However, it appears that turnover in the patient advocate office resulted in decreased analyses and reporting.

Recommendation 3 We recommended that the VISN Director ensure that the VASDHS Director requires that the patient advocate provide detailed patient complaint analyses and that the VESC thoroughly discuss the trend analyses and take appropriate actions.

The VISN and VASDHS Directors concurred with the findings and recommendation. The patient advocate will review the

patient advocate tracking system at the end of each quarter, identify trends, and provide detailed reports of complaints to service chiefs. The VESC will discuss findings and provide guidance to the service chiefs. Target date for completion is May 1, 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Life Support Training. Local policy defines the life support training required for the different levels of staff. The training software package showed lists of employees who had completed the training and lists of employees whose training certificates had expired. However, we were not confident that all employees who required the training were on either list. Also, the tracking process does not include actions taken when training certificates expire. We were told that e-mail messages or letters are sent to employees prior to certificate expiration, but the policy does not specify what processes are to be followed once the certificates have expired. The training coordinator agreed that the policy needed to be revised and that the tracking process needed to be improved.

Recommendation 4 We recommended that the VISN Director ensure that the VASDHS Director requires that the local policy be revised to include processes to be followed when training certificates expire and that the tracking mechanism include all employees who require the training and actions taken when the certificates expire.

The VISN and VASDHS Directors concurred with the findings and recommendation. The local policy will be revised to clarify training requirements. Target date for completion is March 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Operations

The purpose of this review was to evaluate whether VHA facilities had adequate controls to ensure pharmacy security and proper management of CS. 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 infection control (IC) issues.

The VASDHS 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 CS inspection program coordinator provided effective oversight of the program. Monthly inspections complied with VHA policy, and inspection findings were trended, analyzed, and appropriately followed up. Monthly and quarterly inspection reports were comprehensive and timely.

Although lacking in adequate space, the pharmacies' internal environments were generally clean and well maintained. Appropriate IC precautions were in place. The annual physical security survey had been conducted, as required, but one recurring recommendation had not been addressed. We identified the following improvement opportunity.

Annual Physical Security Survey. VA policy[2] requires that any area or room with an intrusion detection alarm system have a remote, key-operated on/off switch installed outside the area or room adjacent to the entrance doorframe and/or a central alarm on/off control in the police office. Our review of the FY 2008 security survey reports showed that several pharmacy areas equipped with this system did not meet this requirement. VASDHS police managers and surveying officers confirmed that this has been a recurring deficiency and that a remote on/off switch is necessary to ensure access to the area in the event of an emergency.

Recommendation 5 We recommended that the VISN Director ensure that the VASDHS Director takes action to address the identified pharmacy physical security deficiency.

The VISN and VASDHS Directors concurred with the finding and recommendation. Managers have requested clarification and guidance from VA Central Office regarding this requirement. Until clear guidance is received, managers will implement an interim process. Target date for correction is March 31, 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

[2] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Environment of Care

The purpose of this review was to determine if the VASDHS 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 and dental clinics and all inpatient units. We also inspected the main laboratory, the infusion center, nuclear medicine, the hemodialysis area, and the gastroenterology laboratory. Overall, we found the areas we inspected to be generally clean, and nurse managers expressed satisfaction with the housekeeping staff assigned to their units.

We identified several items that required managers' attention, such as unprotected patient information and security and general maintenance issues. Managers took immediate actions to correct these deficiencies. Therefore, we did not make any recommendations related to these items. However, we identified the following additional conditions that needed improvement.

Equipment Maintenance and Infection Control. One defibrillator (a machine that administers a controlled electric shock to the chest or heart) in the intensive care unit and several defibrillators in other inpatient units had expired preventive maintenance (PM) inspections. Managers told us that the replacement coin batteries for some of these defibrillators had not yet arrived, delaying the completion of the PM inspections.

In addition, we found instances of missing medication refrigerator alarm sheets in three of the seven inpatient units inspected. These sheets are used to monitor refrigerator temperatures to ensure that contents are properly stored. Without these monitoring sheets, staff cannot be assured that medications are stored within acceptable temperature ranges at all times.

In several areas, we found uncovered clean and dirty linens, clean linens stored on the floor, and clean linens stored in multi-purpose rooms. Clean linens should be kept covered to avoid dust and contamination and should be stored in suitable environments with limited access.

Recommendation 6 We recommended that the VISN Director ensure that the VASDHS Director takes action to address identified equipment maintenance and IC deficiencies.

The VISN and VASDHS Directors concurred with the findings and recommendation. The VASDHS plans to implement a new medication refrigerator monitoring system and has established a new PM process for all equipment. Environmental Services personnel will conduct monthly inspections of all linen rooms. Target date for completion is March 31, 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations in VHA EDs and/or urgent care clinics, 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. We also reviewed documents, including competency files; credentialing and privileging (C&P) folders; and medical records of patients who were seen in the ED and subsequently transferred to other medical facilities, admitted to inpatient units within the VASDHS, or discharged home.

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 VASDHS's capability. However, we identified one area that needed management attention.

Discharge Instructions. We reviewed the medical records of three mental health patients discharged from the ED. We did not find documentation that these patients received written discharge instructions, as required by local policy. Managers

acknowledged that mental health providers did not consistently use the locally developed "Urgent Care Center/Emergency Room" discharge instructions form for these patients.

Recommendation 7 We recommended that the VISN Director ensure that the VASDHS Director takes action to ensure that mental health patients discharged from the ED receive written discharge instructions and that clinicians document in the medical record that patients verbalized understanding.

The VISN and VASDHS Directors concurred with the finding and recommendation. The Mental Health Executive Committee will develop ED discharge instructions tailored to the needs of mental health patients. Target date for completion is March 1, 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

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, spinal cord, and CLC 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 two areas that needed improvement.

Pain Medication Effectiveness Documentation. On all inpatient units we reviewed, nurses generally assessed the effectiveness of pain medications administered to patients (96 percent compliance rate). However, nurses did not consistently document the effectiveness within 30–60 minutes after each pain medication administration, as specified by local policy.

During the week of August 31–September 6, nurses administered 1,502 doses of pain medications to 171 patients. We reviewed the medical records of 42 patients who received a total of 115 doses of pain medications. The effectiveness of 46 (40 percent) of the 115 doses of pain medications was documented within the timeframe specified by local policy. The range of compliance

with timely documentation was 21–69 percent. Additionally, we found that in 6 (46 percent) of the 13 doses administered where pain medications proved ineffective, nurses did not consistently document appropriate actions taken. Managers agreed that timeliness of documentation is important, and they will monitor to ensure that pain medication effectiveness and any additional interventions are appropriately recorded.

Recommendation 8 We recommended that the VISN Director ensure that the VASDHS Director requires that nurses consistently document pain medication effectiveness within the required timeframe.

The VISN and VASDHS Directors concurred with the findings and recommendation. Nursing leadership has implemented corrective actions, such as providing additional staff education, conducting daily audits of effectiveness documentation, and forming a team to address documentation of actions taken when pain medications proved ineffective. Target date for completion is April 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Self-Medication Program. The SMP is designed to promote patient independence prior to discharge. The intended outcome is to instill in patients the ability to understand, participate in, and accept responsibility for their own health care. Local policy requires that pharmacists counsel program participants, conduct an initial assessment of the patient's understanding of the information provided, and document results in the medical record. Of the six patients in the SMP in FY 2008, two had no documentation of counseling. Pharmacy managers were confident that these patients had received the required counseling but acknowledged that the current system of tracking SMP patients and documentation needed improvement.

Recommendation 9 We recommended that the VISN Director ensure that the VASDHS Director requires pharmacists to improve compliance with SMP documentation requirements.

The VISN and VASDHS Directors concurred with the finding and recommendation. The VASDHS will develop a standardized template note for patients in the SMP. Staff will be trained in the use of this note and in documentation of patient education. Target date for completion is

February 29, 2009. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Breast Cancer Management

We followed up on BC management recommendations from our prior CAP review. We reviewed VASDHS performance measure results for BC screening (mammography) and for timeliness of mammogram reports. Since early 2005, mammograms have been performed through a sharing agreement with the Naval Medical Center San Diego (NMCSD). Mammogram reports are faxed weekly from the NMCSD to the VASDHS's women's program support assistant (WPSA).

For 2 of the 4 quarters of FY 2008, the VASDHS did not meet VHA's established performance measure target of 75 percent for BC screening. In addition, the length of time it took the NMCSD to fax mammogram reports to the WPSA appeared excessive. On November 17, the WPSA received 32 mammogram reports from the NMCSD. The average length of time from examination date to the date that the reports were faxed was 60 days. The range was 22–119 days. Managers acknowledged that the BC screening scores could be improved and that mammogram reports were not always timely. We determined that the proposed corrective actions in response to the recommendations in our prior CAP report had not been fully implemented. Therefore, we are reissuing a recommendation in this area.

Recommendation 10 We recommended that the VISN Director ensure that the VASDHS Director takes action to improve compliance with VHA's BC screening performance measure and timeliness of mammogram reports.

The VISN and VASDHS Directors concurred with the findings and recommendation. Mammograms are now offered onsite, and results are reported within 48 to 72 hours. Managers are optimistic that this will improve compliance with the BC screening performance measure and timeliness of reports. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

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 41 patients who had consultations ordered and performed at the VASDHS. In all cases, we found timely responses to the consultation requests and consistent communication between requesting and consulting providers.

We reviewed the medical records of 37 patients who transferred between units. In 34 (92 percent) of the 37 records reviewed, we found consistent and timely patient assessments by receiving unit nursing staff. Additionally, in all cases, physicians consistently documented patients' conditions and needs prior to transfer.

We also reviewed the medical records of 45 patients who were discharged from the VASDHS. In all cases, the patients received discharge instructions, and clinicians documented that the patients understood the instructions. We also found discharge summaries dictated within 30 days of discharge, as required by local policy.

Overall, we found that consults, intra-facility transfers, and discharges were managed and coordinated appropriately. Therefore, we made no recommendations.

Nurse Staffing

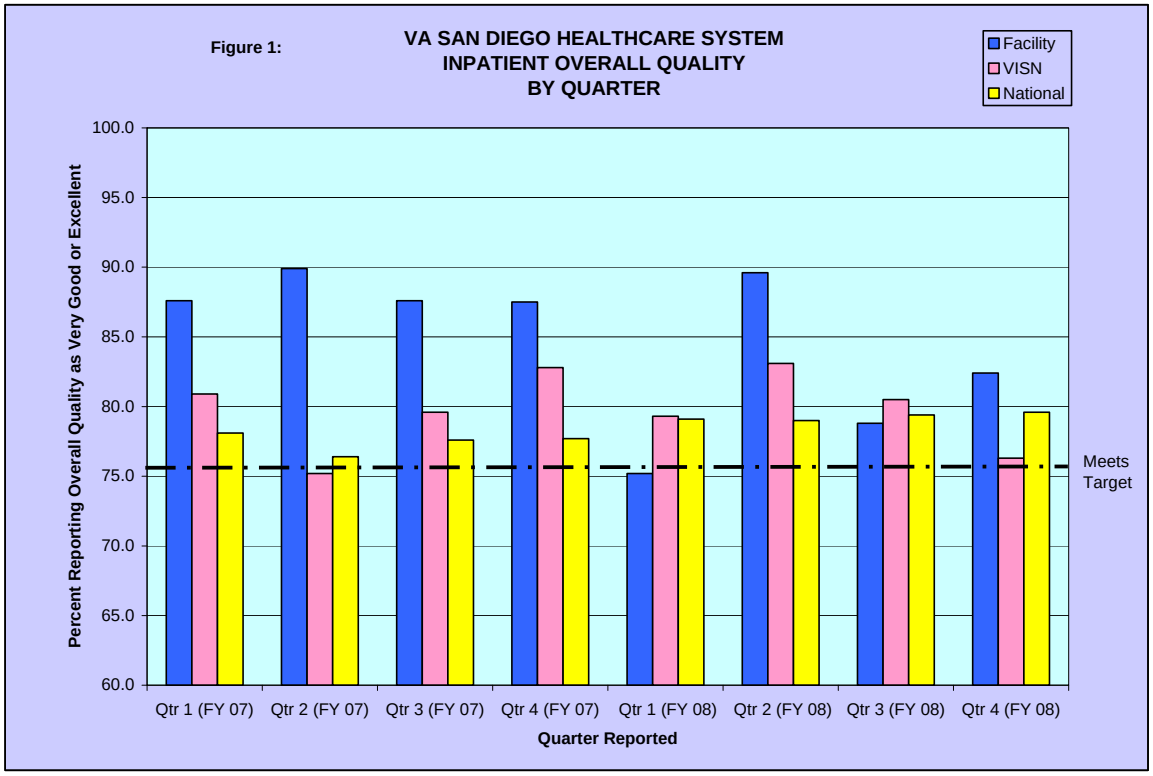
The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the VASDHS had developed staffing guidelines for nurses, and we found them to be adequate.

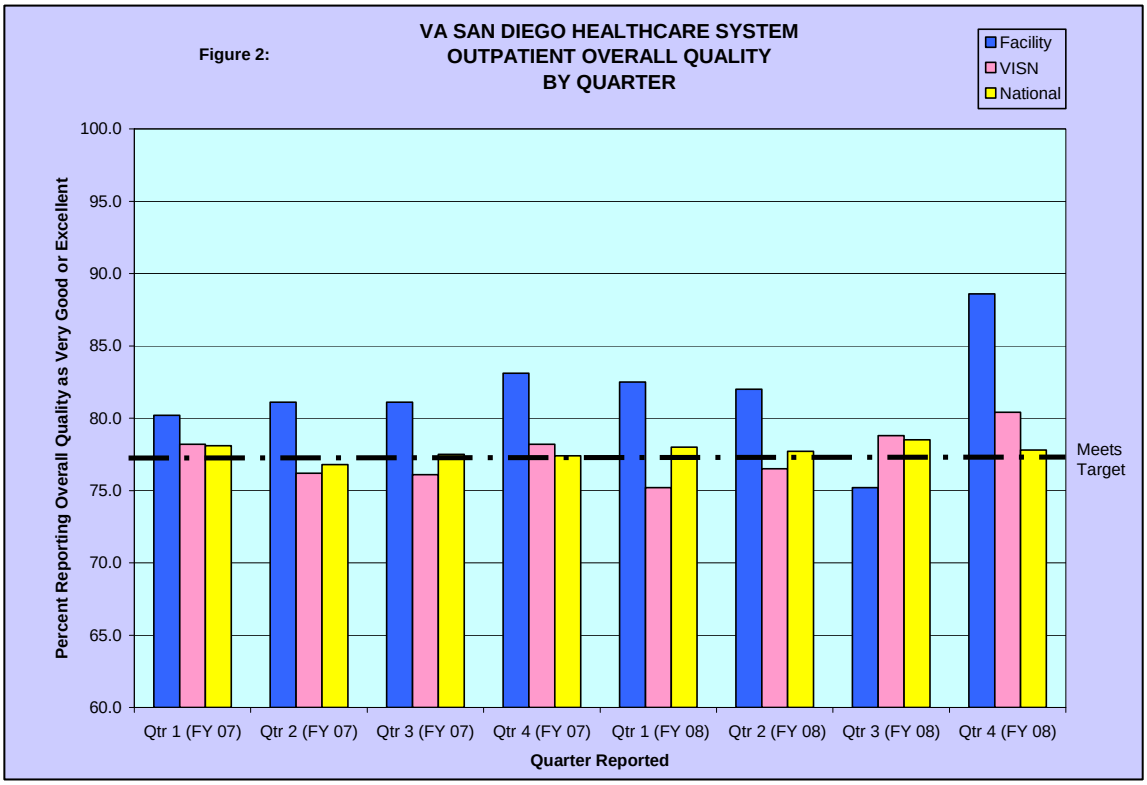
The VASDHS uses expert panel as the primary staffing methodology. We reviewed staffing for eight inpatient units for more than 80 shifts. We found that nurse staffing requirements had been met in all areas reviewed and that specific actions had been taken, when needed, to ensure safe patient care. Overall, we found that the VASDHS had adequate nursing staff. Therefore, we made no 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 percent for outpatients.

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





The VASDHS's inpatient and outpatient scores exceeded the target in all but one quarter. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 22, 2008

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

Subject: Combined Assessment Program Review of the VA San Diego Healthcare System, San Diego, California

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

Director, Management Review Service (10B5)

1. Attached for your review are concurrences and responses to each of the findings from the CAP review of the VA San Diego Healthcare System.

2. Should you have any questions or need further information, please contact John Tryboski, MSN, Network 22 Quality Management Officer, at 562-826-5963.

(original signed by William C. Raymer, Deputy Network Director for Finance, for:)

Ronald Norby

Healthcare System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 16, 2008

From: VA San Diego Healthcare System Director (664/00)

Subject: Combined Assessment Program Review of the VA San Diego Healthcare System, San Diego, California

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

Director, Management Review Service (10B5)

Thru: Network Director, VA Desert Pacific Healthcare Network (10N/22)

1. In response to the report received as a result of the CAP site visit conducted at VA San Diego Healthcare System (VASDHS) by Ms. Julie Watrous, OIG, November 17–21, 2008, the attached response is provided which addresses the inspection results and recommendations.

2. Should additional review and information be requested, the point of contact will be Cynthia Abair, Associate Director, VASDHS, at (858) 642-3205 or at e-mail address Cynthia.Abair@va.gov.

Gary J. Rossio, FACHE

Attachment

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the VASDHS Director requires that all clinicians complete all assigned peer reviews within the designated timeframes.

Concur.

Target date of completion: December 31, 2008, with report NLT Jan. 15, 2009

Action: After the OIG visit, the Chief of Staff mandated that all Morbidity and Mortality reviews that are delinquent 45 days or greater must be completed by the end of the calendar year. Completion of the 45-day backlog will permit timely completion of the 120-day Peer Review backlog. A report will be available no later than January 15, 2009.

Recommendation 2. We recommended that the VISN Director ensure that the VASDHS Director requires that all procedure areas consistently report procedures volume and complications data, including moderate sedation events, to the PACC and that the PACC identify and address trends.

Concur.

Date of implementation: November 2008

Action: We have expanded our efforts to collect provider specific and aggregate data regarding out of operating room airway management, and this information is to be discussed at the Procedure and Anesthesia Care Committee (PACC). We have implemented the use of the Endotracheal Intubation Procedure Note, and we now document provider data related to out of operating room airway management. The VA San Diego Healthcare System is using the template to collect aggregate data and also employ the code blue template, telephone operator logs, code blue committee logs, pulmonary ICU logs, and Emergency Department logs. PACC is responsible for reviewing and discussing the results. PACC will monitor data trends and ensure that corrective actions are implemented and evaluated for effectiveness when problems are identified.

PACC will include this information in their annual report to the MEC. The first report was given to PACC in late November 2008. The yearly (FY09Q1) report will be provided to MEC at its scheduled meeting in June 2009.

Recommendation 3. We recommended that the VISN Director ensure that the VASDHS Director requires that the patient advocate provide detailed patient complaint analyses and that the VESC thoroughly discuss the trend analyses and take appropriate actions.

Concur.

Target date of implementation: May 1, 2009

Planned Action: We will review the Patient Advocate Tracking System database at the end of each quarter. We will include reports identifying trends pertaining to Service standard issues in order to isolate the top three areas of complaints and discuss recent trends. We will generate drill down reports on the sub-categories of each of these areas to determine the two primary complaints in each area which contribute to the highest scores. We will provide detailed reports by hospital section and Service Chief, of all complaints within these sub-categories which occurred in their sections. The detailed reports will include patient name, employee involved, date-of-incident, issue description, and corrective action taken through the Patient Advocate's Office. The reports will be presented to the Veteran & Employee Satisfaction Council (VESC) and the Service Chiefs beginning with the VESC meeting on February 2, 2009.

The VESC members will thoroughly discuss these analyses and provide initial suggestions for action by the Service Chiefs. The VESC will request that the Service Chiefs review the reports and formulate corrective actions within their sections. The Service Chiefs will be asked to provide a report to the VESC on the success of these actions at the next monthly VESC meeting. Further discussion and suggestions of other appropriate actions at that meeting will help direct additional activity to reduce occurrences of these issues. The cycle will continue monthly at the VESC meetings until a new set of reports is presented for the next quarter. The timeframe for this action will extend continuously since each set of reports will generate more activities. However, if the monthly review cycle is regularly executed, the finding will be considered completed by May 1, 2009, when the next quarterly reports are presented to the VESC.

Recommendation 4. We recommended that the VISN Director ensure that the VASDHS Director requires that the local policy be revised to

include processes to be followed when training certificates expire and that the tracking mechanism include all employees who require the training and actions taken when the certificates expire.

Concur

Target date of completion: March 2009

Planned Action: The local policy that addresses ACLS/BLS or equivalent training will be rewritten by March 2009 and will define the period during which such training is valid, for all employees that require training, (given that certification is no longer provided by AHA or other guidance), as well as the steps that will be taken when the period of time expires for which training is considered adequate.

Recommendation 5. We recommended that the VISN Director ensure that the VASDHS Director takes action to address the identified pharmacy physical security deficiency.

Concur

Target date of completion: March 31, 2009

Planned Action: Pharmacy Service is in the process of requesting clarification from VACO Pharmacy and Central Office Police & Security, regarding the specific intention and goals of the standard. Pharmacy Service believes that complying with the standard in the absence of the inquiry would create a situation in which Police Service would have excess, untraceable, access to Pharmacy Medication spaces and would increase the potential for medication diversion. Complying without this inquiry will likely lead to a significant waste of VA funds and result in decreased security. Once a clear direction is given by VACO, a permanent corrective action will be initiated. In the interim, a temporary process will be established by 01-15-09, to meet the intent of the standard without compromising the security of the pharmacy.

Recommendation 6. We recommended that the VISN Director ensure that the VASDHS Director takes action to address identified equipment maintenance and IC deficiencies.

Concur

Target date of completion: March 31, 2009

Planned Action: A new medication refrigerator monitoring system will be implemented to ensure consistent refrigerator temperatures are

maintained, and to ensure that contents are properly stored. A process is established to ensure Preventive Maintenance (PM) is conducted in a timely manner on defibrillators and all equipment. The PM process is to be monitored for a 6 month timeframe to ensure compliance. Re-training will be provided to all appropriate Nursing and Environmental Services (ES) staff. ES will begin monthly inspections of all linen rooms; non-compliant rooms will be noted and action taken immediately to correct deficiencies. Data from inspections will be trended and reported to ES and Nursing leadership to ensure continued improvement and compliance.

Recommendation 7. We recommended that the VISN Director ensure that the VASDHS Director takes action to ensure that mental health patients discharged from the ED receive written discharge instructions and that clinicians document in the medical record that patients verbalized understanding.

Concur

Target date of implementation: March 1, 2009

Planned Action: The Mental Health Executive Committee (MHEC) concurs with the OIG CAP recommendation to develop Discharge Instructions for mental health patients seen in the Emergency Department. Such instructions have the potential to improve care, enhance the recovery focus inherent in modern treatment of mental health patients, and emphasize the integration of mental health and primary care medicine.

The MHEC will develop a set of instructions in collaboration with key personnel responsible for urgent evaluation of mental health patients, including the Director of the Psychiatric Emergency Clinic, the Director of Urgent Care, the Facility Recovery Coordinator, and the Medicine Service liaison to this facility's program on Integration of Primary Care and Mental Health. We anticipate adapting and tailoring the current ED discharge instructions to the needs of mental health patients. These instructions will be integrated into CPRS as a component of a revised mental health Emergency Department Progress Note template.

Recommendation 8. We recommended that the VISN Director ensure that the VASDHS Director requires that nurses consistently document pain medication effectiveness within the required timeframe.

Concur

Target date of implementation/completion: April 2009

Planned Action: The Associate Chief for Nursing and Patient Care Services (ACNS) concurs with the OIG/CAP recommendation to develop a process to ensure compliance with timely PRN effectiveness documentation as outlined in the Nursing Pain Management Policy. According to this policy, PRN effectiveness must be documented 30-60 minutes post-medication administration. Additionally, the ACNS concurs with the recommendation to develop a process to ensure documentation of appropriate actions when pain medications prove ineffective.

The Inpatient Services Nursing Leadership has developed the following plan to remedy the recommendation regarding PRN effectiveness documentation:

All inpatient licensed nursing staff will receive additional education regarding the timeframe for documentation of PRN effectiveness post-medication administration by February 2, 2009.

A daily audit of PRN effectiveness documentation will be performed for all inpatient units beginning February 9, 2009, until a benchmark of 90% is achieved for each unit. Once a unit achieves the benchmark, a weekly audit will be completed for one month. If benchmarks continue to be maintained, the audit frequency will be reduced to monthly, for three months. Once a unit achieves ongoing compliance, quarterly audits will be performed. If at any time, a unit falls below the standard, the audits will be reinstituted at the prior frequency.

Consistent with the VASDHS Nursing Service shared governance model, a sub-team consisting of members of both Nursing Practice and Nursing Performance Improvement Councils will be formed to address the deficiency in documentation of appropriate actions when pain medications prove ineffective. The sub-team will review the current Nursing Pain Management policy and make recommendations for process improvement and monitoring. The sub-team will provide a report, including action plan, to the Nursing Coordinating Council by April 2009.

Recommendation 9. We recommended that the VISN Director ensure that the VASDHS Director requires pharmacists to improve compliance with SMP documentation requirements.

Concur

Target date of completion: February 29, 2009

Planned Action: Pharmacy Service will develop a standardized template note for those patients who are placed on the Self Medication Program

and will assure appropriate staff training is conducted for use of this note and all documentation of Self Medication patient education/training. Pharmacy Service will develop a formalized process for recording (listing) those patients on the Self Medication Program. Compliance will be monitored for a 6 month timeframe.

Recommendation 10. We recommended that the VISN Director ensure that the VASDHS Director takes action to improve compliance with VHA's BC screening performance measure and timeliness of mammogram reports.

Concur

Date of implementation: December 2008

Action: VASDHS concurs with the OIG CAP recommendation to improve compliance with VHA's BC screening performance measure and timeliness of mammogram reports.

In 2008, BC screening (mammography) was performed through a sharing agreement with the Naval Medical Center San Diego (NMCSD). Dictation of reports was done by a NMCSD contracted dictation service. The contracted dictation service was identified as responsible for the significant delays in the timeliness of reports. The delay in the timeliness of reports impacted meeting the performance target for the last two quarters of 2008.

The dictation contractor issue was resolved when the NMCSD discontinued their contract and hired a new contracting service. All backlogged reports were delivered and new reports were sent in a timely manner during the month of November.

VASDHS is no longer contracting with NMCSD for mammography screening services. As of December, mammography is now available on site. Results are reported within 48 to 72 hours.

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