Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00607-483

Combined Assessment Program Review of the San Francisco VA Health Care System San Francisco, California

August 24, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CLC	community living center
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	San Francisco VA Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RPIE	Rapid Process Improvement Events
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of June 22, 2015.

Review Results: The review covered eight activities and a follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following three activities:

- Coordination of Care
- Emergency Airway Management
- Surgical Complexity

The facility's reported accomplishments were several improvement efforts to increase inpatient efficiency, the Telehealth Program, and the Veterans Justice Outreach Program.

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

Quality Management: Review privilege forms annually, and document the review. Ensure licensed independent practitioners' folders do not contain non-allowed information.

Environment of Care: Ensure that Environment of Care Committee meeting minutes track open items to resolution and that Infection Control Committee meeting minutes reflect discussion of all identified high-risk areas and implementation of actions to address those areas. Keep patient care areas clean. Ensure personal protective equipment gowns and eyewear are readily available in all patient care areas. Promptly remove outdated commercial supplies from sterile supply rooms and expired medications from patient care areas. Secure medication carts when not in use.

Medication Management: Consistently implement corrective actions for issues identified during monthly community living center medication storage area inspections, and monitor the changes until issues are fully resolved. Revise the policy for safe use of automated dispensing machines to include minimum competency requirements for users. Require that designated employees receive automated dispensing machine training and competency assessment. Ensure that parenteral syringes are not used to measure oral liquid medications.

Computed Tomography Radiation Monitoring: Perform and document computed tomography quality assurance checks each weekday.

Advance Directives: Hold advance directive discussions requested by inpatients, and document the discussions using the required advance directive note titles.

Follow-Up on Environment of Care Issue: Dispose of only sharps items in sharps containers.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–33, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM
- Follow-Up on EOC Issue

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

The review covered facility operations for FY 2014 and FY 2015 through June 19, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the San Francisco VA Medical Center, San Francisco, California,* Report No. 12-04192-97, January 29, 2013). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 305 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 525 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

RPIEs – Inpatient Efficiency Efforts

The facility conducted an inpatient flow value stream May 5–9, 2014. A value stream maps how the veteran moves through the facility. From this effort, the project team identified 13 RPIEs to be undertaken over a 15-month period, focusing on improving inpatient efficiencies. Examples of RPIE areas identified include bed management, discharge communication, code green management, utilization review, and a discharge lounge.

The Bed Management System RPIE revised the facility's admission priorities and workflow and restructured nurse staffing by cross training staff, resulting in increased flexibility between units. The discharge communication RPIE increased the number of patients discharged prior to 2:00 p.m. each day. The code green management RPIE created a greater awareness among staff of the proper use of the code system. The utilization management RPIE launched a real-time admission review pilot to test the effect of real-time Emergency Department admission reviews on the assigned level of care. The discharge lounge RPIE established a waiting area for discharged patients ready to leave the hospital but awaiting transportation, which has resulted in freeing up beds earlier in the day.

Telehealth Program

In FY 2014, the facility's Telehealth Program improved care for veterans enrolled in the Home Telehealth Program by reducing bed days of care by 70 percent at 6 months and

64 percent at 12 months and reducing total hospitalizations by 33 percent at 12 months. The telehealth and teledermatology clinical videos helped reduce wait times for specialty care, increase access, and improve veteran satisfaction. The facility anticipates further expansion and growth of the Telehealth Program once it fills current vacancies, adds new staff, and secures dedicated space to operate the program.

Veterans Justice Outreach Program

The facility's Veterans Justice Outreach Program in downtown San Francisco was recognized for providing innovative work with incarcerated veterans. The program helped develop a veterans' justice court and legal clinics at several facility locations. The goal is to help veterans with untreated MH and substance abuse issues receive and stay connected to treatment over a longer period of time in lieu of incarceration. Treatment may range from residential and structured outpatient treatments to drop-in groups at the downtown outpatient clinic. Because most of the veterans involved in this court are currently homeless or at risk for homelessness, the program provides them the opportunity to be considered for permanent housing through the Department of Housing and Urban Development – VA Supportive Housing Program. For veterans who complete the program, charges may be dismissed or reduced, which is helpful in securing future employment and housing.

Results and Recommendations

QM

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

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 10 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Facility managers did not review privilege forms annually. • All 10 licensed independent practitioners' folders reviewed contained non-allowed information.	**1.** We recommended that facility managers review privilege forms annually and document the review. **2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.[b]

We inspected the intensive care and locked MH units, two medical/surgical (1A and 2B) units, the CLC (B and C areas), the Emergency Department, and a primary care clinic. Additionally, we reviewed relevant documents and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	Three months of EOC Committee meeting minutes reviewed: • Minutes did not include tracking of open items to resolution.	**3.** We recommended that Environment of Care Committee meeting minutes track open items to resolution**.**
	The facility conducted an infection prevention risk assessment.		
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.	Two months of Infection Control Committee meeting minutes reviewed: • Minutes did not include discussion of all the facility's high-risk areas identified in the infection prevention risk assessment. • Minutes did not reflect implementation of actions to address all high-risk areas.	**4.** We recommended that Infection Control Committee meeting minutes reflect discussion of all identified high-risk areas and implementation of actions to address those areas.
	The facility had established a process for cleaning equipment.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Of the seven patient care areas, three had dirty floors, and one had dusty surfaces.	**5.** We recommended that facility managers ensure patient care areas are clean and monitor compliance.
X	The facility met infection prevention requirements.	• Four of seven patient care areas did not have personal protective equipment gowns and eyewear readily available. • Two sterile supply rooms contained outdated commercial supplies.	**6.** We recommended that facility managers ensure personal protective equipment gowns and eyewear are readily available in all patient care areas and monitor compliance. **7.** We recommended that employees promptly remove outdated commercial supplies from sterile supply rooms and that facility managers monitor compliance.
X	The facility met medication safety and security requirements.	• Two of seven patient care areas had expired medications. • Medication carts in two of three patient care areas were unlocked and unattended.	**8.** We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance. **9.** We recommended that employees secure medication carts when not in use and that facility managers monitor compliance.
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
NA	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for Construction Safety	Findings	Recommendations
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected one CLC area, a medical/surgical unit (2B), the Emergency Department, and the post-anesthesia care unit and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
X	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.	• The facility did not consistently implement corrective actions for issues identified during monthly CLC medication storage area inspections.	**10.** We recommended that the facility consistently implement corrective actions for issues identified during monthly community living center medication storage area inspections and that facility managers monitor the changes until issues are fully resolved.
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include minimum competency requirements for users. • On the post-anesthesia care unit, nursing employees did not have documentation of training and competency assessment for automated dispensing machines.	**11.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include minimum competency requirements for users and that facility managers monitor compliance. **12.** We recommended that facility managers ensure designated employees receive automated dispensing machine training and competency assessment and monitor compliance.
X	The facility employed practices to prevent wrong-route drug errors.	• On the medical/surgical unit and in the CLC, employees reported that parenteral syringes were used to measure liquid medications when dose amounts differed from the unit dose packages supplied.	**13.** We recommended that facility managers ensure that parenteral syringes are not used to measure oral liquid medications and monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 38 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 10 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 47 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
X	The facility complied with any additional elements required by VHA or local policy.	Local CT policy reviewed, which required assigned CT technologists to perform quality assurance checks each weekday: • March–May 2015, technologists did not document 13 of 64 quality assurance checks (20 percent).	**14.** We recommended that computed tomography technologists perform and document quality assurance checks each weekday and that facility managers monitor compliance.

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Seven of the 15 applicable EHRs did not contain documentation that employees held the discussions requested. • For three of the eight AD discussion notes, employees did not use the required note titles.	**15.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions using the required advance directive note titles and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents, and we conversed with key managers. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including the EAM coverage schedule for 30 selected dates from January 1 through June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner		
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activity With Previous CAP Recommendations

Follow-Up on EOC Issue

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with sharps container waste.

Non-Sharps Waste. During our previous CAP review, we found that on multiple units, non-sharps waste was disposed of in sharps containers. During this review, we also identified sharps containers with non-sharps waste on multiple units.

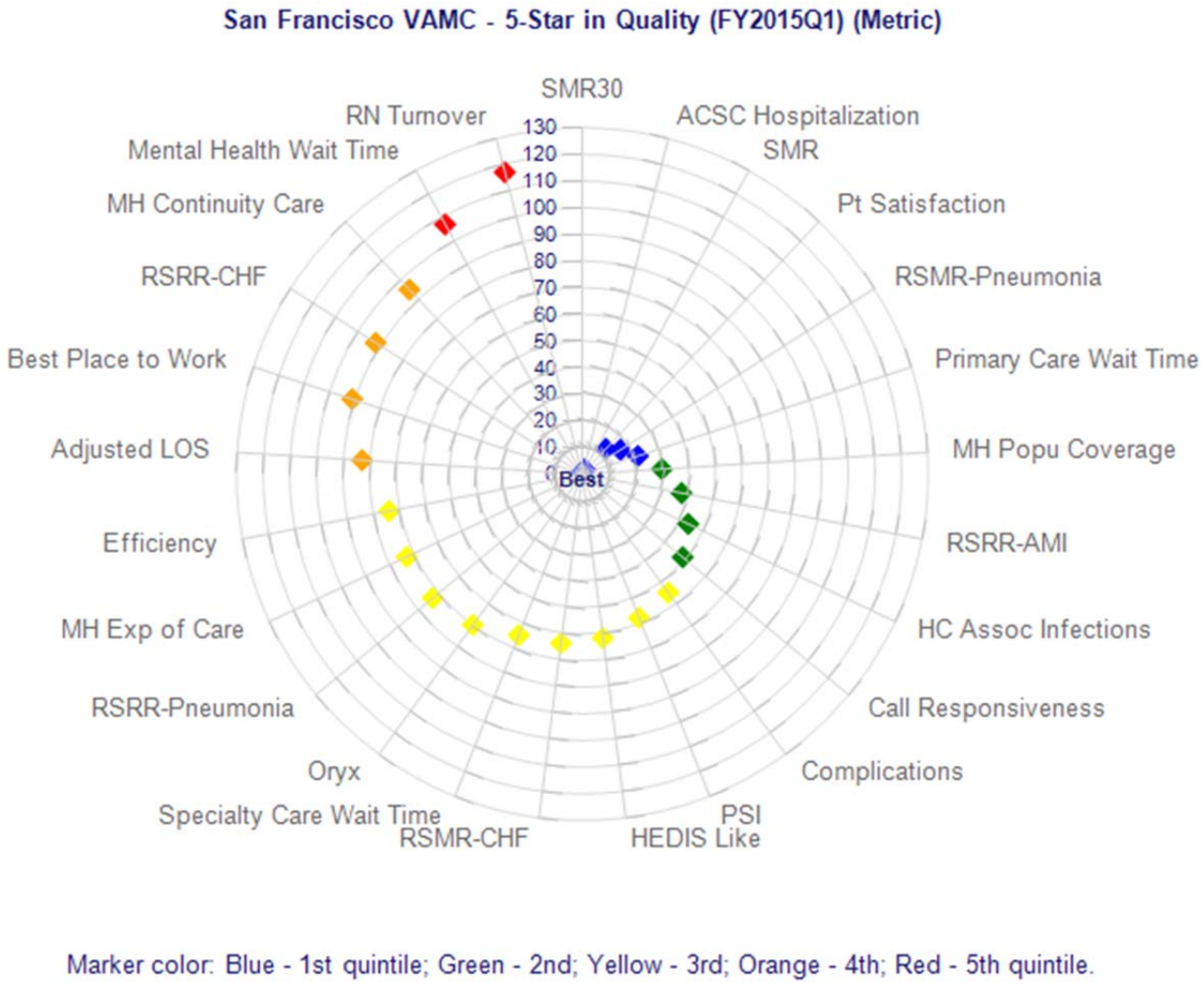
Recommendation

16. We recommended that facility managers ensure that only sharps are disposed of in sharps containers and monitor compliance.

Facility Profile (San Francisco/662) FY 2015 through June 2015[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$564.6
Number of:	
• **Unique Patients**	57,285
• **Outpatient Visits**	595,474
• **Unique Employees**[2]	2,479
Type and Number of Operating Beds (as of May 2015):	
• **Hospital**	124
• **CLC**	120
• **MH**	12
Average Daily Census (as of May 2015):	
• **Hospital**	103
• **CLC**	96
• **MH**	10
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Santa Rosa/662GA Eureka/662GC Ukiah/662GD San Bruno/662GE San Francisco/662GF Clearlake/662GG
VISN Number	21

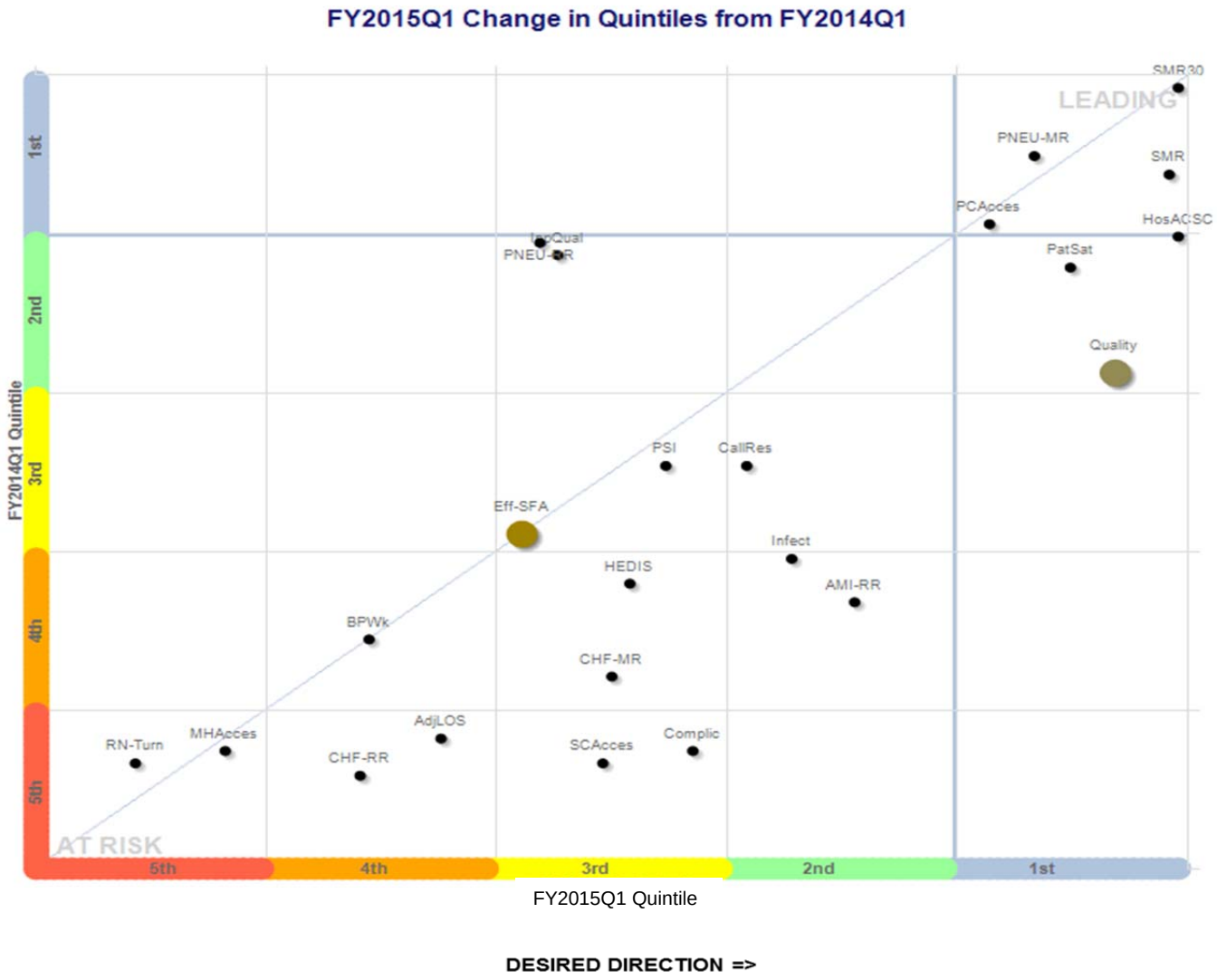
[1] All data is for FY 2015 through June 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: July 29, 2015

From: Director, VA Sierra Pacific Network (10N21)

Subject: **CAP Review of the San Francisco VA Health Care System, San Francisco, CA**

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

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

1. Thank you for the opportunity to review the site visit report. I concur with the report as well as the attached action plan submitted by San Francisco Health Care System in response to the findings.

2. Should you have any questions regarding the action plan, please contact Terry Sanders, Associate Quality Manager for V21 at (707) 562-8370.

Sheila M. Cullen

Attachments

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: July 29, 2015

From: Director, San Francisco VA Health Care System (662/00)

Subject: **CAP Review of the San Francisco VA Health Care System, San Francisco, CA**

To: Director, VA Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations for the OIG CAP Review conducted at the San Francisco VA Health Care System June 22–25, 2015.

2. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing, actions to resolve these issues.

Bonnie Graham

Bonnie S. Graham, MBA
Director, San Francisco VA Health Care System

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility managers review privilege forms annually and document the review.

Concur

Target date for completion: August 31, 2015

Facility response: Notice will be sent to all Clinical Managers 90 days prior to due date for review and/or revision of the master Clinical Privilege forms and Scopes of Practice. A calendar for reviews will be established and monitored monthly with a goal of reviewing 10% per month. Progress will be reviewed by the Professional Standards Board monthly using a tracking log maintained by the Medical Staff Office.

Recommendation 2. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: December 31, 2015

Facility response: The Medical Staff Office has begun systematically pulling all of the non-allowed information from the practitioners credentialing folders beginning July 21, 2015. Twenty five percent of the folders will be scrubbed each month and progress will be reported monthly to the Chief of Quality Management using a tracking log.

Recommendation 3. We recommended that Environment of Care Committee meeting minutes track open items to resolution**.**

Concur

Target date for completion: July 31, 2015

Facility response: Action items were submitted to OIG EOC Auditor on June 23, 2015. Discussed at the June EOC meeting were open items and resolution. Also shared, were Engineering (ENG) reports from other VA facilities to our local ENG Service to use as a guide and help them format reports and discuss at the EOCC meetings. The EOCC will continue to monitor and track open items to resolution on the facilities new committee SharePoint containing meeting minutes and action plan tracking. Open items at the EOCC meetings and reflect detailed information in the

EOCC minutes. Action item tracking and updates will be discussed at monthly committee meetings.

Recommendation 4. We recommended that Infection Control Committee meeting minutes reflect discussion of all identified high-risk areas and implementation of actions to address those areas.

Concur

Target date for completion: July 14, 2015

Facility response: High risk areas from our Infection Control Risk Assessment are listed and tracked on our Infection Control Dashboard. A permanent agenda item will be added to the ICC Meeting to specifically address the status of actions and goals for High Risk areas, beginning with the July 14, 2015 ICC meeting.

Recommendation 5. We recommended that facility managers ensure patient care areas are clean and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Training of all Environmental Management Service (EMS) employees on routine Housekeeping will be completed by July 31, 2015. EMS Supervisors will be conducting written monthly inspections in their areas of responsibility to ensure employees are held accountable for the cleanliness of their assigned areas. Random monthly inspections will be conducted by the EMS Asst. Chief to ensure that the EMS Supervisors are being held accountable for the cleanliness of their assigned areas. Monthly inspections will be reported to the EOC Committee and all information will be tracked and trended on an EMS Service tracking log.

Recommendation 6. We recommended that facility managers ensure personal protective equipment gowns and eyewear are readily available in all patient care areas and monitor compliance.

Concur

Target date for completion: October 31, 2015

Facility response: Staff can now access the necessary PPE in the Omni Cells in all areas. Face shields are now stocked in all Omni Cells. All areas with deficient PPE gowns and eye wear were stocked by July 24, 2015. The CLC has cabinets in hallways that will have shelves added and be repurposed for storing PPE. This is expected to be completed by August 31, 2015. Nursing Chiefs met the week of 7/06/15 to assess and make plans for storage needs of Acute Care and Ambulatory Care. Anticipated completion for additional storage is October 1, 2015. A working group has been formed to develop a system to provide continual monitoring and projection of future needs.

Recommendation 7. We recommended that employees promptly remove outdated commercial supplies from sterile supply rooms and that facility managers monitor compliance.

Concur

Target date for completion: July 24, 2015

Facility response: Facility managers have checked all supply areas and those found to be deficient will have the outdated items replaced. A log sheet has been developed to monitor compliance and results will reported at the weekly Logistics Staff meeting and will be included on the agenda and recorded in the minutes.

Recommendation 8. We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: All areas were reviewed with Nurse Managers and discussed at unit huddles. Retraining was provided on the need to check expiration dates every time meds are removed, to include expiration dates of vials. Charge Nurses and Nurse Managers are asked to include expiration dates on the weekly inventory. Daily EOC care rounds will be completed by the unit Charge Nurse and compliance will continue to be checked quarterly by Pharmacy. The daily Charge Nurse log will be reported at the monthly Nursing Division meeting and recorded in the meeting minutes.

Recommendation 9. We recommended that employees secure medication carts when not in use and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: All medication carts have automatic timed lockouts. The need to physically lock carts and not to depend on the automatic time out was discussed with Nurse Managers and staff during all shift changes. This action will be reported and recorded at the August 2015 Nursing Division meeting. Random checks by Charge Nurses and Nurse Managers will be done throughout the day. Daily EOC care rounds will be completed by the Unit Charge Nurse. The daily Charge Nurse log will be reported at the monthly Nursing Division meeting and included in the minutes.

Recommendation 10. We recommended that the facility consistently implement corrective actions for issues identified during monthly community living center medication storage area inspections and that facility managers monitor the changes until issues are fully resolved.

Concur

Target date for completion: October 31, 2015

Facility response: Nursing Education provided training to all shifts on 6/29, 6/30, 7/6 and 7/10. Training rosters will be maintained by Nurse Managers. Pharmacy Service will review monthly medication storage area inspections during their monthly QI Committee meetings.

Recommendation 11. We recommended that the facility revise the policy for safe use of automated dispensing machines to include minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2015

Facility response: Pharmacy Service will update MCM 119-22 to include Automated Dispensing Machine competency requirements.

Recommendation 12. We recommended that facility managers ensure designated employees receive automated dispensing machine training and competency assessment and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Nurse Manager will ensure that all nurses will have this competency documentation in their unit files by September 30, 2015. New hire RNs will have the competency documentation completed at the time of unit orientation. Nursing Service created an Omni Cell competency training to be provided at in service trainings for staff during the months of July and August. A copy of the training sign in sheets will be placed in staff personnel folders and training compliance will be reported at the October 2015 Nurse Executive Committee.

Recommendation 13. We recommended that facility managers ensure that parenteral syringes are not used to measure oral liquid medications and monitor compliance.

Concur

Target date for completion: October 1, 2015

Facility response: Nursing Education provided training to all shifts on 6/29, 6/30, 7/6 and 7/10 regarding the use of syringes. PO syringes were ordered to be stocked in the Omni Cell, separate from IV syringes and clearly labeled. Daily EOC care rounds will be completed by the Unit Charge Nurse. The daily Charge Nurse log will be reported at the monthly Nursing Division meeting and included in the minutes.

Recommendation 14. We recommended that computed tomography technologists perform and document quality assurance checks each weekday and that facility managers monitor compliance.

Concur

Target date for completion: September 1, 2015

Facility response: All CT technologists will be trained to perform QA testing and document QA testing daily. Testing will be recorded in a daily log and reported to the Medical Executive Committee on a quarterly basis.

Recommendation 15. We recommended that employees hold advance directive discussions requested by inpatients and document the discussions using the required advance directive note titles and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2015

Facility response: Upon admission, Social Workers will review all Inpatient Nursing Admission notes to ascertain if patient requested advance directive education. If the patient has been educated, does not want education, or is unable or unavailable to be educated, the Social Worker will document all occasions of service related to advance directive education in the Advance Directive Discussion note. Compliance will be monitored through the facilities Coordination of Care quarterly chart reviews, which are now reported each quarter to the VISN. The compliance target for Advanced Directive is 95%.

Recommendation 16. We recommended that facility managers ensure that only sharps are disposed of in sharps containers and monitor compliance.

Concur

Target date for completion: November 1, 2015

Facility response: EMS took over the enforcement of sharp containers waste compliance from Nursing Service on July 13, 2015. EMS will educate staff, monitor compliance, and report to the EOC Committee its findings monthly.

Office of Inspector General
Contact and Staff Acknowledgments

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

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.