Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-04192-97

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

January 29, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	San Francisco VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

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. We conducted the review the week of November 26, 2012.

Review Results: The review covered seven activities. We made no recommendations in the following two activities:

- Medication Management – Controlled Substances Inspections
- Preventable Pulmonary Embolism

The facility's reported accomplishments were the telehealth program and a redesigned systems improvement process.

Recommendations: We made recommendations in the following five activities:

Quality Management: Include the patient safety manager in the Leadership Board Committee. Gather observation bed use data. Ensure Emergency Medical Committee code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.

Environment of Care: Ensure that only sharps are disposed of in sharps containers and that Engineering conducts and documents initial safety inspections on non-patient equipment.

Coordination of Care – Hospice and Palliative Care: Include a dedicated administrative support person on the Palliative Care Consult Team. Ensure that all non-hospice and palliative care staff receive end-of-life training. Act upon hospice and palliative care consults within the timeframe required by local policy.

Long-Term Home Oxygen Therapy: Ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly and that home oxygen program patients have active prescriptions and are re-evaluated annually after the first year. Complete competency assessments are for all staff authorized to perform oxygen testing.

Nurse Staffing: Monitor the staffing methodology that was implemented in October 2012.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objective and Scope

Objective

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 objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

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

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism

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

The review covered facility operations for FY 2012 and FY 2013 through November 29, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the San Francisco VA Medical Center, San Francisco, California,* Report No. 11-02089-05, October 14, 2011). We made a repeat recommendation in EOC.

We surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 236 responded. We shared survey results with facility managers.

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

Reported Accomplishments

Telehealth Program

In FY 2012, the facility's telehealth program improved care for patients with congestive heart failure by reducing the number of hospitalizations by 46 percent and the number of ED visits by 63 percent. For the facility's community based outpatient clinics, the program reduced wait times for specialty fee care, such as dermatology; increased clinic access; and improved patient satisfaction. The program has been recognized at the national and VISN levels as a model for improving the care and well-being of veterans.

Redesigned Systems Improvement

In June 2012, the facility deployed a more strategic and cohesive approach to systems improvements. The Patient-Centered Systems Redesign Committee was restructured to serve as the focal point for planning and monitoring all improvement activities. The facility has actively and systematically participated in the management of critical local systems redesign and continuous improvement projects, such as the re-engineered discharge process, the enhancement of ED patient flow, and the improvement of inpatient bed utilization and orthopedic clinic and MH access.

Results and Recommendations

QM

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

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

NC	Areas Reviewed	Findings
X	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	• There was no evidence that the patient safety manager was a member of the Leadership Board Committee.
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	• The facility did not gather observation bed use data.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Seven months of Emergency Medical Committee meeting minutes reviewed: • There was no evidence that code reviews included screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center monthly.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the patient safety manager be included in the Leadership Board Committee.

2. We recommended that data about observation bed use be gathered.

3. We recommended that Emergency Medical Committee code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.

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.[2]

We inspected the locked MH, one medical/surgical, and the specialty care (intensive care, telemetry, transitional, and medical oncology) inpatient units. We also inspected the CLC, the ED, an outpatient behavioral health clinic, the women's health clinic, and the occupational and physical therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• On multiple units, non-sharps waste (such as paper and alcohol wipes) was disposed of in sharps containers. • There was no documented evidence that Engineering conducted initial safety inspections on non-patient equipment, such as personal heaters and coffee makers.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations and tracked identified deficiencies to closure.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that processes be strengthened to ensure that only sharps are disposed of in sharps containers.

5. We recommended that processes be strengthened to ensure that Engineering conducts and documents initial safety inspections on non-patient equipment.

Medication Management – CS Inspections

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

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of the CS Coordinator, the Chief Inspector, and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

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

Coordination of Care – HPC

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

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 15 non-HPC staff, there was no evidence that 6 had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
X	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	• Six of the 10 outpatient consults were not acted upon within the timeframe required by local policy.
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

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

Recommendations

6. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

7. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

8. We recommended that a process be established to ensure that HPC consults are acted upon within the timeframe required by local policy.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 10 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The Chief of Staff reviewed home respiratory care program activities at least quarterly.	• We found no evidence that program activities were reviewed quarterly in FY 2012.
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Five EHRs (14 percent) did not have active prescriptions for home oxygen. • Four EHRs (11 percent) contained no documentation of a re-evaluation after the first year.
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
X	The facility complied with any additional elements required by VHA or local policy.	• There was no documented evidence that competency assessments had been completed for two community based outpatient clinic staff who were authorized to perform oxygen testing.

Recommendations

9. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

10. We recommended that processes be strengthened to ensure that home oxygen program patients have active prescriptions and that patients are re-evaluated for home oxygen therapy annually after the first year.

11. We recommended that processes be strengthened to ensure that competency assessments are completed for all staff authorized to perform oxygen testing.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).[6]

We reviewed relevant documents, and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
X	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	• Expert panels were not convened until October 2012.
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that nursing managers monitor the staffing methodology that was implemented in October 2012.

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and 22 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." Three patients were identified for further discussion from the initial EHR review. However, we found that the facility had previously conducted appropriate reviews of these patients' care. We made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable pulmonary embolism received appropriate anticoagulation medication prior to the event.	
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Facility Profile (San Francisco/662) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$537.7
Number of:	
• **Unique Patients**	62,398
• **Outpatient Visits**	595,173
• **Unique Employees[c] (as of last pay period in FY 2012)**	2,130
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	124
• **CLC**	112
• **MH**	9
Average Daily Census: (through August 2012)	
• **Hospital**	86
• **CLC**	97
• **MH**	Not Reported
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Clearlake/662GG Downtown San Francisco/662GF Eureka/662GC San Bruno/662GE Santa Rosa/662GA Ukiah/662GD
VISN Number	21

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 of FY 2012 and outpatient satisfaction scores for quarter 4 of FY 2011 and quarters 1–3 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011	FY 2012		
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	66.5	68.9	55.6	58.1	57.5	63.3
VISN	70.0	70.1	57.4	58.1	55.8	57.4
VHA	64.1	63.9	54.5	55.0	54.7	54.3

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	14.0	9.7	9.9	20.0	24.6	18.5
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[d] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[e] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 16, 2013

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the San Francisco VA Medical Center, San Francisco, CA**

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

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

1. Attached is the action plan developed by the San Francisco VAMC in response to the recommendations received during their recent OIG CAP review as well as the Facility Director's memo.

2. The Facility concurs with the findings and will ensure the corrective action plan is implemented.

3. If you have any questions please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8370.

(original signed by:)
Sheila M. Cullen

Attachment

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 14, 2013

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

Subject: **CAP Review of the San Francisco VA Medical Center, San Francisco, CA**

To: Director, Sierra Pacific Network (10N21)

1. I appreciate the opportunity to provide comments to the draft report of Combined Assessment Program (CAP) review of the San Francisco VA Medical Center (SFVAMC).

2. In brief, I concur with all of the findings and suggested improvement actions. As you will note, the vast majority of the actions are well on their way to being complete.

3. In closing, I would like to express my thanks to the CAP review team. The team members were professional, helpful, and courteous.

(original signed by:)
C. Diana Nicoll, MD, PhD, MPA
Acting Medical Center Director

Attachment

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the patient safety manager be included in the Leadership Board Committee.

Concur

Target date for completion: November 30, 2012

Facility response: The Leadership Board charter was revised to include a Patient Safety Manager (PSM) as a standing member. A PSM began attending Leadership Board meetings as of 12/4/12.

Recommendation 2. We recommended that data about observation bed use be gathered.

Concur

Target date for completion: January 31, 2013

Facility response: Business office is collecting the required data elements and will provide UM/UR a monthly report, including a list of all patients who were admitted to the hospital from observation status, beginning in January 2013. Every month, the UM/UR staff will review the list of patients converted from observation to admission to see if they meet the observation criteria. If the number of admissions from observation is >30% in any quarter, facility observation criteria will be reviewed and an appropriate action taken. The data will be reported to the Leadership Board.

Recommendation 3. We recommended that Emergency Medical Committee code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code.

Concur

Target date for completion: December 12, 2012

Facility response: Code Blue Debriefing worksheets were revised to specifically include clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code and the minutes of the Emergency Medical Committee now reflect discussion of any identified clinical issues that may have contributed to the occurrence of a code.

Recommendation 4. We recommended that processes be strengthened to ensure that only sharps are disposed of in sharps containers.

Concur

Target date for completion: February 15, 2013

Facility response: The facility is taking the following actions.

- Post signage on the Sharps Container lock boxes: "NEEDLES & SHARPS ONLY --- ABSOLUTELY NO GLOVES OR TRASH"
- Since many staff do not understand the rationale for this requirement, we are launching a staff and visitor educational campaign using the Outlook Daily Bulletin and Electronic Bulletins (TV monitors) located throughout the Medical Center.
- During weekly EOC Rounds, the team will continue to monitor for compliance, remind staff that only needles and sharps belong in Sharps Containers and that band aids and gauze with small amounts of blood can go into the regular trash.
- If a pattern of non-compliance in any specific area is noted, staff in that area will be targeted for additional education.
- Employees have been asked to report the location of any sharps container with significant quantities of non-sharps to promote buy-in and accountability and those areas will be targeted for further interventions.

Recommendation 5. We recommended that processes be strengthened to ensure Engineering conducts and documents initial safety inspections on non-patient equipment.

Concur

Target date for completion: December 31, 2012

Facility response: Existing Engineering policy requires inspection of all equipment including VA-owned, leased, loaned, borrowed, donated, patient-owned, employee-owned, Research-owned, and any other equipment approved by Logistics and Service Chiefs for use in the medical center and clinics. A technician inspects the equipment's physical condition and records and labels the equipment with an Engineering approved sticker. The policy requires staff to request inspection of non-patient equipment, such as personal heaters and coffee makers, by submitting an electronic work order to Engineering Service.

Staff have been reeducated about this requirement by distributing a VAMC-wide notice informing all staff of the requirement and where to find the policy on the SFVAMC intranet. A new process has been established to record inspected non-patient equipment in a log managed by the Electrical section of the Maintenance Shop. Compliance is monitored by Engineering staff through spot checks during weekly EOC rounds. Findings are recorded and work orders are created for items needing

inspection. In addition to EOC Rounds, Engineering performs periodic sweeps to look for and tag new equipment. Compliance is reported quarterly to the EOC Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: June 1, 2013

Facility response: The San Francisco VA is committed to ensuring that the PCCT includes a dedicated 0.25 FTE administrative support person. Recruitment is underway and it is anticipated that this position will be filled no later than June 1, 2013. Until the new employee is on board, some of the duties for this position have been assigned to the current Geriatrics Palliative and Extended Care (GPEC) support staff and the Director of the Service.

Recommendation 7. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Concur

Target date for completion: March 30, 2013

Facility response: A Talent Management System learning module is being developed designed to teach end-of-life mandatory training to all staff providing direct patient care at SFVAMC, including all physicians who provide direct care, nurses, social work, mental health, pharmacists, nutrition, occupation and physical therapy staff. At the end of the module, staff will be able to 1) describe the needs of veterans and their families who are dealing with advanced illness, 2) describe resources provided by the VA to help veterans and their families who are dealing with advanced illness, and 3) describe the difference between hospice and palliative care. Compliance with TMS training will be reported in July to SFVA leadership. Future monitoring will occur similar to other mandatory training requirements.

Recommendation 8. We recommended that a process be established to ensure that HPC consults are acted upon within the timeframe required by local policy.

Concur

Target date for completion: February 15, 2013

Facility response: Medical Center Memorandum 11-84 "Palliative Care Consult Team (PCCT)" is being updated to include specific information on outpatient consults. This will include a policy on acting upon consults within 7 days, which would be consistent with the Consult Directive. The process for the outpatient palliative care clinic will be modified to ensure that all consults are acted upon within 7 days. Monitoring of timeliness of consult actions will be accomplished and reported to the ACOS of

Geriatrics Palliative and Extended Care (GPEC) on a quarterly basis. These results will also be included in the semiannual report to the Leadership Board.

Recommendation 9. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Concur

Target date for completion: September 17, 2012

Facility response: In September 2012 the Home Oxygen Program provided their first report to the Leadership Board which includes the Chief of Staff as a member. Reports will continue to be provided quarterly per Leadership Board report tracking log.

Recommendation 10. We recommended that processes be strengthened to ensure that home oxygen program patients have active prescriptions and that patients are re-evaluated for home oxygen therapy annually after the first year.

Concur

Target date for completion: April 1, 2013

Facility response: A working group including all stakeholders (Pulmonary Medicine, Outpatient Medicine, Nursing, IT, RT, Prosthetics, Leadership) was appointed and is meeting regularly. Opportunities for improvement have been identified including the way RT prescriptions are generated in CPRS, need for an automated reminder system for expiring prescriptions, and need for a program for oxygen testing in the CBOCs. The plan going forward includes implementing changes in CPRS (creating short-cuts and clinical reminders, as well as a policy order for RT personnel), and implementing a testing program in the CBOC, possibly in the form of a VTEL clinic. Status of prescriptions (active vs. expired) will be monitored monthly and reported to the Leadership Board.

Recommendation 11. We recommended that processes be strengthened to ensure that competency assessments are completed for all staff authorized to perform oxygen testing.

Concur

Target date for completion: November 30, 2012

Facility response: Oxygen testing is no longer being done in the CBOCs. If in the future the facility plans to have CBOC staff do oxygen testing, competencies will be developed for those staff.

Recommendation 12. We recommended that nursing managers monitor the staffing methodology that was implemented in October 2012.

Concur

Target date for completion: April 1, 2013

Facility response:

1. The expert panels were convened October 2012 and made recommendations that were forwarded on November 15 to the facility based panel which has met multiple times through November and December. Their final recommendations were forwarded to the Associate Director for Patient Care Services for review on January 9, 2013. The review with the Acting Medical Center Director is scheduled for January 18, 2013.

2. The NHPPD are currently monitored by Nursing Supervisors. Each tour of duty is reviewed by the Chief Nurses and the Associate Director for Patient Care Services. Currently, we utilize a form to document the NHPPD and staffing as well as the computer software, OneStaff. The data is reviewed daily by the Chief Nurses and the Associate Director for Patient Care. Beginning in January, the Nurse Managers are reporting the NHPPD from their units each month at the Nursing QM meeting and that report is included in the meeting minutes. The collective NHPPD for Nursing Service is reported to the Leadership Board quarterly to include:
    a. The overall NHPPD with any discrepancies
    b. The number of shifts where the NHPPD were not met
    c. Reasons for a shift not meeting NHPPD
    d. Steps that were taken to address the staffing when HPPD were not met
    e. Any adverse event occurring during this period of time when HPPD were not met

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Kathleen Shimoda, RN, Team Leader Daisy Arugay, MT Paula Chapman, CTRS Simonette Reyes, RN Jackelinne Melendez, MPA, Program Support Assistant

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Endnotes

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