Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02089-05

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

October 14, 2011

Washington, DC 20420

Why We Did This Review

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

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

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

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
ED	emergency department
EN	enteral nutrition
EOC	environment of care
facility	San Francisco VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IC	infection control
MEC	Medical Executive Committee
MM	medication management
OSHA	Occupational Health and Safety Administration
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the San Francisco VA Medical Center, San Francisco, CA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of August 8, 2011.

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

- Coordination of Care
- Management of Workplace Violence

The facility's reported accomplishments were being recognized as a Center of Excellence for Primary Care Education and implementing the hospitalist program.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure that providers assess and document all required elements prior to performing moderate sedation and that medical record reviews include monitoring of unauthenticated progress note addenda.

Physician Credentialing and Privileging: Initiate Focused Professional Practice Evaluations for all physicians prior to the physicians delivering care, and ensure results of the evaluations are reported to the Medical Executive Committee.

Registered Nurse Competencies: Identify unit-specific competencies for the 2B medical-surgical unit that are consistent with nursing assignments. Ensure that ongoing competency validation documentation is complete, current, and legible.

Environment of Care: Complete annual bloodborne pathogens training and N95 respirator fit testing, and monitor compliance. Ensure appropriate disposal of non-sharps waste.

Enteral Nutrition Safety: Revise facility infection control policy to include enteral nutrition infection control expectations.

Medication Management: Require pharmacy staff to observe safe work practices when handling hazardous drugs in the pharmacy compounding area. Ensure all infusion clinic nursing staff are trained in the safe handling of chemotherapy medications.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- 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

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

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

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- MM
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through August 11, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the San Francisco VA*

Medical Center, San Francisco, California, Report No. 08-02445-44, December 15, 2008). The facility had corrected all findings from our previous review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 255 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Reported Accomplishments

Center of Excellence for Primary Care Education

In January 2011, the facility was recognized as one of five Centers of Excellence in Primary Care Education. The mission of this center is to develop and implement a model of patient-centered education. It brings together health care providers and trainees in various disciplines to build core knowledge and skills to be applied to individual and shared team panels of patients.

Hospitalist Program

The facility implemented a hospitalist program to provide adequate, timely, and efficient care and to improve physician trainee education and supervision for all medicine unit patients. This program has grown from 1 physician in July 2010 to 12 physicians as of August 2011. Benefits include increased care coordination for patients with substantial discharge barriers, more timely response to medicine consult requests, proactive medical management support for three surgical services, and increased physician involvement with facility improvement efforts.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant

documents. We identified the following areas that needed improvement.

Moderate Sedation. VHA requires providers to assess patients and document findings prior to performing moderate sedation.[1] In 2 of the 10 procedure records reviewed, we did not find documented evidence that providers assessed patients for all required elements. Missing elements included assessment of airway, review of abnormalities of major organ systems, and review of current medications.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include monitoring of unauthenticated documentation.[2] The facility appropriately monitored discharge summaries, operative notes, and progress notes; however, we did not find a similar review process for unauthenticated progress note addenda.

Recommendations

1. We recommended that processes be strengthened to ensure providers assess and document all required elements prior to performing moderate sedation.

2. We recommended that processes be strengthened to ensure that medical record reviews include monitoring of unauthenticated progress note addenda.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

FPPE. VHA requires that FPPEs be initiated for all physicians prior to the physicians delivering care and that FPPE results be reported to the MEC for consideration in making the recommendation on privileges for newly hired physicians.[3] We reviewed the profiles of five newly hired physicians. We found deficiencies in four profiles. For two physicians, FPPEs were not initiated prior to the physicians'

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

delivering care, and for three physicians, FPPE results had not been reported to the MEC.

Recommendation

3. We recommended that processes be strengthened to ensure that FPPEs are initiated for all physicians prior to the physicians delivering care and that FPPE results are reported to the MEC.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy and processes, interviewed nurse managers, and examined initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Process and Documentation. The Joint Commission requires that clinical staff are deemed competent to perform their job responsibilities. A competency validation policy or process is required for staff who provide patient care, treatment, or services. Core competencies, such as falls prevention, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as an intensive care unit. Local procedures require assessment and validation of competencies to be done when the RN is hired and then annually thereafter.

We found that unit-specific RN competencies had not been identified for the 2B medical-surgical unit. Additionally, 8 of the 12 RN competency folders did not contain sufficient evidence that core and/or unit-specific competencies were validated annually. Furthermore, 7 of the 12 folders had validation documentation that was incomplete and/or contained illegible signatures.

Recommendations

4. We recommended that managers identify unit-specific RN competencies for the 2B medical-surgical unit that are consistent with nursing assignments.

5. We recommended that processes be strengthened to ensure that ongoing RN competency validation documentation is complete, current, and legible.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected selected inpatient (the acute medical-surgical, mental health, intensive care, and CLC) units, the same day surgery and post-anesthesia care units, the dental and plastic surgery clinics, and the ED. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

IC. OSHA requires that employees with occupational exposure risk receive annual training on the OSHA Bloodborne Pathogens Rule. We reviewed 24 employee training records and found that 3 employees did not have the required training.

If facilities use N95 respirators, OSHA requires that designated employees are fit tested annually. We reviewed 25 employee training records and determined that 9 designated employees did not have the required annual fit testing.

Waste Disposal. Local policies and state regulations define infectious (biohazardous) waste and sharps waste. Only certain medical sharps items (for example, contaminated needles, syringes, and scalpel blades) are to be disposed of in sharps containers. We found that sharps containers in several locations contained non-medical sharps waste (such as paper wrappers, plastic items, and alcohol wipes). These items should have been disposed of as regular waste.

Recommendations

6. We recommended that annual OSHA Bloodborne Pathogens Rule training and N95 respirator fit testing be completed and that compliance be monitored.

7. We recommended that only sharps items be disposed of in sharps containers.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review,

and we interviewed key employees. We identified the following area that needed improvement.

EN IC Policy. VHA requires that facility IC policy address EN.[4] We reviewed facility IC policy and determined that it did not address IC expectations for EN, such as hand washing prior to EN administration and donning gloves.

Recommendation

8. We recommended that facility IC policy be revised to include EN IC expectations.

MM

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications, and the administration of those medications in the infusion clinic, and we interviewed employees. We identified the following area that needed improvement.

Safe Work Practices. The American Society of Health-System Pharmacists requires safe handling of hazardous drugs to minimize contamination and ensure staff and patient safety. Staff must change gloves whenever they exit and re-enter the biological safety cabinet and must wear clean gloves when handling the final preparation. In the pharmacy compounding area, we observed a pharmacy technician with contaminated gloves exiting the biological safety cabinet and re-entering without changing gloves.

Local policy requires that employees handling hazardous drugs receive training on safe handling of these drugs. Nursing managers told us that nursing staff routinely transport chemotherapy medications from the pharmacy to the infusion clinic for administration. While most infusion clinic nursing staff had completed the required training for safe handling of chemotherapy medications, we did not find documented evidence that all had received this training.

Recommendation

9. We recommended that safe work practices be observed when handling hazardous drugs in the pharmacy compounding area and that all infusion clinic nursing staff be trained in the safe handling of chemotherapy medications.

[4] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and advance directives in accordance with applicable requirements.

We reviewed patients' medical records and the facility's advance care planning policy and determined that the facility generally met VHA requirements. We made no recommendations.

Management of Workplace Violence

The purpose of this review was to evaluate whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 13–18 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[5]		
Type of Organization	Tertiary care medical center	
Complexity Level	Level 1-A	
VISN	21	
Community Based Outpatient Clinics	San Francisco, CA San Bruno, CA Santa Rosa, CA Ukiah, CA Clearlake, CA Eureka, CA	
Veteran Population in Catchment Area	271,819 enrollees	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	Hospital – 124 Psychosocial Residential Rehabilitation Treatment Program – 9	
• **CLC/Nursing Home Care Unit**	112	
• **Other**	0	
Medical School Affiliation(s)	University of California, San Francisco	
• **Number of Residents**	182	
	Current FY (through May 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$501.0	$460.7
• **Medical Care Expenditures**	$375.8	$460.7
Total Medical Care Full-Time Employee Equivalents	2,209.7	2,155.6
Workload:		
• **Number of Station Level Unique Patients**	52,738	56,668
• **Inpatient Days of Care:**		
• **Acute Care**	21,506	33,443
• **CLC/Nursing Home Care Unit**	20,471	35,247
Hospital Discharges	3,465	5,548
Total Average Daily Census (including all bed types)	170.74	188.19
Cumulative Occupancy Rate (in percent)		
• **Acute Care**	69.2	67.9
• **CLC/Nursing Home Care Unit**	73.5	81.3
• **Psychosocial Residential Rehabilitation Treatment Program**	71.5	68.9
Outpatient Visits	357,698	481,415

[5] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance**	**Repeat Recommendation? Y/N**
QM			
1. Require consistent documentation of QM data analyses discussions, and implement and evaluate actions to address problems or trends.	All committees use the MEC minutes template showing discussion, actions, and follow-up. QM monitors data aggregation and discussion elements.	Y	N
2. Require that a process for comprehensive monitoring of medication reconciliation is maintained and that actions are taken to improve compliance.	Medication reconciliation is completed by providers at admission and discharge. Documentation compliance is reported to service chiefs monthly and to the MEC quarterly. Pharmacy reviews of medication reconciliation accuracy are reported to the MEC quarterly.	Y	N
3. Require that individual restraint and seclusion use are monitored and that aggregate restraint data is analyzed for trends.	Nursing reviews restraints and seclusion monthly. QM aggregates and analyzes the data, and results are presented to the MEC and nursing leadership quarterly.	Y	N
Pharmacy Operations and Controlled Substance Inspections			
4. Ensure completion of required annual training for inspectors assigned to research laboratories and completion of competency assessments for all controlled substance inspectors.	Inspectors assigned to research laboratories have received the required training and competency assessments.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance	Repeat Recommendation? Y/N
EOC			
5. Ensure that actions are taken to address identified fire safety, security, and IC deficiencies.	Identified EOC deficiencies have been addressed.	Y	N
6. Comply with required annual training, and clarify expectations and responsibilities of the team and EOC inspections.	Multidisciplinary Safety Inspection Team members have received the required training, and inspection expectations have been clarified.	Y	N
ED and Urgent Care Center Operations			
7. Ensure that actions are taken to correct identified EOC deficiencies in the ED.	The facility has a new ED, and EOC deficiencies have been addressed.	Y	N
8. Require that all inter-facility transfer documentation complies with VHA policy and that patient transfers are monitored and evaluated for compliance.	Inter-facility transfer documentation monitoring data shows compliance with policy.	Y	N
MM			
9. Require that nurses consistently document pain medication effectiveness within the required timeframe.	Timely documentation of pain medication effectiveness exceeded the goal of 85 percent in FY 2010 and FY 2011 (through July 2011).	Y	N
Coordination of Care			
10. Require timely dictation and posting of discharge summaries and consistent recording of discharge orders in medical records.	The facility monitors timely posting of discharge summaries and recording of discharge orders in all medical records.	Y	N

VHA Satisfaction Surveys

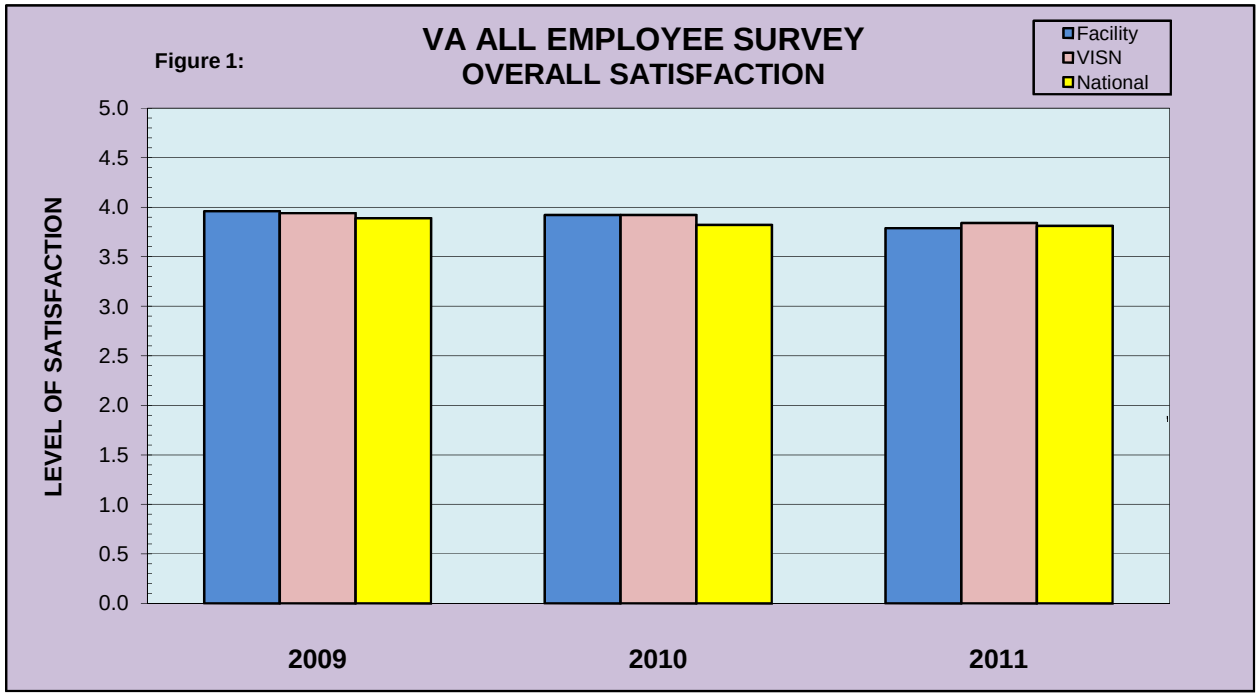
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	69.3	61.7	56.2	63.9	63.2	60.6
VISN	71.5	59.3	56.9	70.5	60.5	59.4
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[6] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2007–2010.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	12.15	8.85	9.95	11.68	18.01	14.66
VHA	12.54	9.24	12.02	12.99	19.66	15.15

[6] Congestive heart failure is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens 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 in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 3, 2011

From: Network Director, VISN 21 (10N21)

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

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

Director, Management Review Service (VHA 10A4A4 Management Review)

1. Thank you for the opportunity to review the draft of the OIG CAP report for the San Francisco VAMC site visit that was conducted during the week of August 8, 2011. Recommendations that were made by the team were valid and we concur with those recommendations. My staff will ensure completion of their action plans as described in the attachment by the established target dates.

2. If you have any questions regarding the submission please contact Ms Terry Sanders, VISN 21 Associate Quality Management Officer at (707) 562-8370.

(original signed by:)
Sheila M. Cullen

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 30, 2011

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

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

To: Network Director, VISN 21 (10N21)

1. I appreciate the opportunity to provide comments to the draft report of the Combined Assessment Program (CAP) review of the San Francisco VA Medical Center (SFVAMC). I carefully reviewed the report, as well as my notes from the exit briefing on August 11, 2011.

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 be completed. The remaining proposed remedies will be completed in the next few months.

3. I am pleased with the overall inspection results. This only fortifies the level of commitment our staff have towards caring for the veteran.

4. In closing, I would like to express my thanks to the CAP review team. The team members were professional, comprehensive, and focused. I appreciated that the survey team discussed issues. The education sessions regarding fraud and abuse awareness were also helpful and well received by those who attended. The collective interest and efforts of the CAP review team have helped improve our clinical and business practices at VAMC San Francisco.

(original signed by:)
Lawrence H. Carroll, Director

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure providers assess and document all required elements prior to performing moderate sedation.

Concur

Target date of implementation/completion: Three month monitoring period began in September and will end November 30, 2011.

Planned Action: During the timeout performed before every invasive procedure, the IR attending is confirming with the IR nurse that the pre-procedure note and pre-sedation notes (for those patients receiving moderate sedation) have been signed and completed fully. The IR attending and the IR nurse are signing the pre-sedation nursing form accordingly. A random sample of 10 records will be reviewed monthly for compliance for three months. Compliance will be monitored through the Radiology QI Committee.

Once the VISN wide template note, titled "Pre-procedure verification checklist," currently under development, has been finalized, successfully piloted and made available to IR, it will be used to ensure that the pre-procedure and pre-sedation notes have been completed.

Recommendation 2. We recommended that processes be strengthened to ensure that medical record reviews include monitoring of unauthenticated progress note addenda.

Concur

Target date of implementation/completion: Completed September 9, 2011. Monitoring will be ongoing.

Planned Action: Unauthenticated progress note addenda are being monitored monthly by HIMS. Data is being reviewed, analyzed for trends by provider, note type, etc. and will be reported to the Medical Records Committee (MRC). As trends are identified, corrective actions will be developed and effectiveness of the actions monitored.

Recommendation 3. We recommended that processes be strengthened to ensure that FPPEs are initiated for all physicians prior to the physicians delivering care and that FPPE results are reported to the MEC.

Concur

Target date of implementation/completion: August 12, 2011.

Planned Action: A new process was implemented in May 2011, prior to the OIG survey, to electronically monitor requests for and completion of FPPEs and to assure all FPPEs are provided to the MEC for review prior to approval of renewal of privileges. However, records from prior to implementation of the new process were not in compliance resulting in the above recommendation. This new process was reviewed by OIG and found to meet requirements.

Recommendation 4. We recommended that managers identify unit-specific RN competencies for the 2B medical-surgical unit that are consistent with nursing assignments.

Concur

Target dates of implementation/completion:
Action #1: Completed September 30, 2011.
Action #2: December 15, 2011.

Planned Action:
(1) Survey compliance with 2011 core competencies and report to AMCD/PCS. (2) Nursing is reviewing current core competencies and is updating for 2012. Nurse Managers will identify unit specific competencies for their respective units. Develop a centralized list of all unit specific competencies.

Recommendation 5. We recommended that processes be strengthened to ensure that ongoing RN competency validation documentation is complete, current, and legible.

Concur

Target date of implementation/completion: December 15, 2011.

Planned Action: A new facility policy addressing competency assessment was developed, including a template for documentation of competency assessment. The template will be implemented and Nurse manager's will audit unit competency files of new nursing staff employees quarterly and results will be reported to Nursing Leadership. 95% of all reviewed competency files will contain required unit specific core competencies.

Recommendation 6. We recommended that annual OSHA Bloodborne Pathogens Rule training and N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date of implementation/completion: September 30, 2011. Monitoring will be ongoing.

Planned Action: Reports of compliance for completion of the mandatory Bloodborne Pathogens training module will be run from the Talent Management System (TMS) every 6 months and provided to supervisors for follow-up with their staff. Environmental Health and Safety (EH&S) and Infection Control (IC) will risk stratify staff/staff assignments and determine which staff need to be in the TB-N95 Respirator Program to assure an accurate and complete staff listing. Continue using contractor support to assist with individual staff fit testing. Compliance will be monitored by EH&S and reported to both the ICC and the EOC Committees.

Recommendation 7. We recommended that only sharps items be disposed of in sharps containers.

Concur

Target date of implementation/completion: September 15, 2011. Monitoring will be ongoing.

Planned Action: Infection Control and EH&S have increased emphasis on the proper use of sharps containers in new employee orientation. Nurse Managers have specifically reminded their staff to use sharps containers for disposal of sharps only. Checking contents of sharps containers has been added as an item to Environment of Care (EOC) rounds. EMS will also monitor containers as they are replaced. Violations of proper disposal will be reported to the EOC Committee and evaluated for trends and action. Monitoring will ensure that 95% of all sharps containers have only proper content.

Recommendation 8. We recommended that facility IC policy be revised to include EN IC expectations.

Concur

Target date of implementation/completion: August 26, 2011.

Planned Action: A reference was added to the IC Manual under a new heading, Enteral Nutrition. A short IC/EN reference has also been added to the facility policy on Enteral & TPN Feeding. References are also in Nursing Service Procedure (NSP) 75 and NSP-75A.

Recommendation 9. We recommended that safe work practices be observed when handling hazardous drugs in the pharmacy compounding area and that all infusion clinic nursing staff be trained in the safe handling of chemotherapy medications.

Concur

Target date of implementation/completion: December 15, 2011.

Planned Action: Pharmacy staff have been re-educated about the importance of obtaining and placing all needed drugs/supplies in the Biological Safety Cabinet (BSC) prior to preparing chemotherapy, and to change gloves whenever re-entering the BSC. All nursing staff who transport chemotherapy will complete an in-service education on safe handling of chemotherapy medications. A module on safe handling of chemotherapy drugs is being implemented in TMS and added as an element of annual mandatory training to the learning plans of staff that transport chemotherapy.

OIG Contact and Staff Acknowledgments

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