Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03658-64

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

January 6, 2012

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

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EOC	environment of care
facility	VA San Diego Healthcare System
FY	fiscal year
HF	heart failure
MM	medication management
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA San Diego Healthcare System, San Diego, 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 October 17, 2011.

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

- Coordination of Care
- Medication Management
- Psychosocial Rehabilitation and Recovery Centers

The facility's reported accomplishments were Joint Commission recognition, a nursing award for excellence, and an improved wait time for compensation and pension examinations.

Recommendations: We made recommendations in the following five activities:

Moderate Sedation: Ensure that pre-sedation assessment documentation includes all required elements and that patients are re-evaluated immediately prior to sedation. Require that informed consents are completed appropriately and that timeouts are performed accurately.

Quality Management: Ensure Medical Record Committee meeting minutes document strong, specific action items.

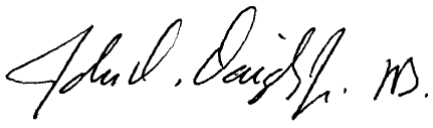
Environment of Care: Ensure that fire extinguishers receive monthly safety checks and that safety inspections are conducted on all ceiling lifts in the community living center and documented. Require all laser users to complete laser safety training, and monitor compliance.

Colorectal Cancer Screening: Ensure patients with positive screening test results receive diagnostic testing within the required timeframe. Notify patients of colonoscopy and biopsy results within the required timeframe, and document notification.

Polytrauma: Monitor compliance with polytrauma training requirements.

Comments

The Veterans Integrated Service Network and Acting 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:

- COC
- CRC Screening
- EOC
- MM
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might 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 2010, FY 2011, and FY 2012 through October 21, 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 VA San Diego Healthcare System, San Diego, California,* Report No. 08-03085-57, January 23, 2009). 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 236 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. An electronic survey was made available to all facility employees, and 355 responded. Survey results were shared 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

Joint Commission Recognition

The facility is one of 20 VA medical centers from across the Nation to be recognized as a Top Performer on Key Quality Measures for 2010. This recognition distinguishes facilities that are top performers in using evidence-based care processes closely linked to positive patient outcomes. The facility was recognized for attaining and sustaining excellence in 22 accountability measures for heart attack, HF, pneumonia, and surgical care.

Silver Beacon Award for Excellence

The facility's direct observation unit received the Silver Beacon Award for Excellence for 2011–2014 from the American Association of Critical-Care Nurses. This award recognizes individual units that have successfully aligned their practices with the association's standards for optimal care. For patients and their families, this award signifies exceptional care through improved outcomes. For critical care nurses, this award represents a positive work environment with greater collaboration, higher staff morale, and lower staff turnover.

Improved Compensation and Pension Wait Time

In 2011, the facility reduced its compensation and pension examination wait time from 44 days in January to 27 days in September. This was achieved by hiring additional examiners, implementing report templates, and establishing additional clinic locations to expedite request processing while improving access to care.

Results
Review Activities With Recommendations

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 12 medical records, and training/competency records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
X	Informed consent was completed appropriately and performed prior to administration of sedation.
X	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment and Re-Evaluation Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[1] None of the medical records reviewed had documentation of the time and nature of last oral intake, and eight did not include a review of tobacco use.

VHA also requires that patients be re-evaluated immediately before moderate sedation for any changes since the prior assessment.[2] Three patients' medical records had no evidence of re-evaluation immediately prior to the procedure.

Informed Consent and Timeout. VHA requires that the patient's signature consent be obtained prior to sedation[3] and that the pre-procedure timeout include verification of a valid consent form.[4] Although the timeout we observed included verification of

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers,* May 1, 2006.
[2] VHA Directive 2006-023.
[3] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009.
[4] VHA Directive 2010-023, *Ensuring Correct Surgery and Invasive Procedures,* May 17, 2010.

documented informed consent one medical record contained no evidence that the patient's signature consent was obtained prior to sedation even though timeout documentation stated that informed consent was verified.

Recommendations

1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

2. We recommended that processes be strengthened to ensure that patient re-evaluation is performed immediately prior to sedation.

3. We recommended that processes be strengthened to ensure that all informed consents are completed appropriately and that timeouts are performed accurately.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
X	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	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 local policy.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific elements and to monitor the documentation, implementation, and evaluation of action items.[5] Although we found evidence of monthly medical record quality reviews, we did not find evidence of strong, specific action items documented in Medical Record Committee meeting minutes. For example, the facility reported variation in compliance rates for unapproved abbreviation. The corresponding actions and conclusions in the meeting minutes did not specifically address this issue.

Recommendation

4. We recommended that processes be strengthened to ensure that Medical Record Committee meeting minutes document strong, specific action items.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

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 inpatient units (medicine, surgery, intensive care, spinal cord injury, CLC, and mental health), the primary care and dental clinics, and the operating room. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
X	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
X	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	Mental Health Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Fire Safety. The Joint Commission requires that fire extinguishers receive monthly safety checks. We found fire extinguishers without current safety checks in the CLC, medicine, surgery, and mental health units and in the operating room.

Environmental Safety. VA policy requires that an inspection of each ceiling lift in the CLC be completed after installation and documented on the After Installation Checklist.[6] We requested inspection documentation for 10 CLC ceiling lifts. There was no documentation of the inspections for any of the lifts.

[6] VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.

Laser Safety Training. Local policy requires that all laser users be trained on the proper use of this equipment. Two of the 11 employee training records reviewed did not have this training documented for FY 2011.

Recommendations

5. We recommended that processes be strengthened to ensure that fire extinguishers receive monthly safety checks.

6. We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the CLC and documented.

7. We recommended that all laser users complete laser safety training and that compliance be monitored.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[7] Of the 20 patients, 4 had appropriate consults submitted, but diagnostic testing was not scheduled or completed. Twelve of the 16 patients who received diagnostic testing did not receive that testing within the required timeframe.

Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[8] Thirteen of the 16 patients who had diagnostic testing did not have documented evidence of timely notification in their medical records.

VHA also requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[9] Of the 12 patients who had a biopsy, 10 records did not contain documented evidence of timely notification.

[7] VHA Directive 2007-004, *Colorectal Cancer Screening,* January 12, 2007 (corrected copy).
[8] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
[9] VHA Directive 2007-004.

Recommendations

8. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

9. We recommended that processes be strengthened to ensure that patients are notified of colonoscopy and biopsy results within the required timeframe and that clinicians document notification.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 20 medical records of patients with positive traumatic brain injury results, and 10 employee training records, and we interviewed key staff. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings.
	Case Managers were assigned to outpatients and provided frequent, timely communication.
	Outpatients had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
X	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Training. VHA requires staff working with polytrauma patients to have training in age-appropriate interventions, assistive technology, pain management, and other areas.[10] Eight training records did not contain evidence of all required training**.**

Recommendation

10. We recommended that the facility monitor compliance with VHA polytrauma training requirements.

[10] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Review Activities Without Recommendations

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 24 HF patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

MM

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below shows the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of Mental Health Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of Mental Health Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Acting Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 20–28 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[11]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	22	
Community Based Outpatient Clinics	Chula Vista, CA Escondido, CA El Centro, CA San Diego, CA Oceanside, CA	
Veteran Population in Catchment Area	222,299	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	193 – 29 of which are Psychosocial Residential Rehabilitation Treatment Program	
• **CLC/Nursing Home Care Unit**	39	
• **Other**	0	
Medical School Affiliation(s)	University of California San Diego School of Medicine	
• **Number of Residents**	617	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$553.9	$503.8
• **Medical Care Expenditures**	$547.2	$503.8
Total Medical Care Full-Time Employee Equivalents	2,518.5	2,423.3
Workload:		
• **Number of Station Level Unique Patients**	72,200	66,895
• **Inpatient Days of Care:**		
o **Acute Care**	54,431	54,010
o **CLC/Nursing Home Care Unit**	9,486	11,143
Hospital Discharges	7,587	7,106
Total Average Daily Census (including all bed types)	175	179
Cumulative Occupancy Rate (in percent)	75.8	77.2
Outpatient Visits	722,371	666,127

[11] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Require that clinicians complete all assigned peer reviews within the designated timeframes.	In FY 2011, the overall peer review completion rates were timely. The 45-day peer review timeliness was 97 percent, and the120-day peer review timeliness was 100 percent.	N
2. Require that all procedure areas consistently report procedures volume and complications data, including moderate sedation events, to the Procedure and Anesthesia Care Council to identify and address trends.	Overall complication, volume, and event rates are reviewed by the services and reported to the Procedure and Anesthesia Care Council. A reporting matrix was formally established and adopted in March 2009. The electronic sedation monitor database was also established for reporting sedation-related events from procedural areas. This is reviewed by the council monthly.	N
3. Require that the patient advocate provide detailed patient complaint analyses and that the Veteran Employee Service Council thoroughly discuss trend analyses and take appropriate actions.	Survey of Healthcare Experiences of Patients performance measure results and patient advocate reports are presented quarterly to the Veteran Employee Service Council. Patient survey results are made available monthly by the Office of Quality and Performance and presented for trending purposes at Veteran Employee Service Council meetings.	N
4. Require that the local policy for life support training be revised to include processes to be followed when training certificates expire and that the tracking mechanism include all employees who require the training and actions taken when the certificates expire.	A policy was written in 2009 to address the needs of a tracking mechanism for life support training. The current policy expired in March of 2011, and a new policy is currently under review by the Medical Executive Committee.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Pharmacy Operations		
5. Ensure that actions are taken to address the identified pharmacy physical security deficiency.	All pharmacy related physical security deficiencies have been corrected.	N
EOC		
6. Ensure that actions are taken to address identified equipment maintenance and infection control deficiencies.	Identified equipment maintenance and infection control deficiencies have been addressed.	N
Emergency/Urgent Care Operations		
7. Ensure that mental health patients discharged from the emergency department receive written discharge instructions and that clinicians document in the medical record that patients verbalized understanding.	Mental health patients receive discharge instructions, and facility audits show compliance with the documentation requirement.	N
MM		
8. Require that nurses consistently document pain medication effectiveness within the required timeframe.	Monitoring of pain medication effectiveness documentation shows good compliance with policy.	N
9. Require pharmacists to improve compliance with the self-medication program documentation requirements.	Pharmacy has taken appropriate actions to address this requirement.	N
COC		
10. Ensure that actions are taken to improve compliance with VHA's breast cancer screening performance measure and timeliness of mammogram reports.	The facility's performance measure scores for breast cancer screening are consistent with VISN and national scores, and timeliness of mammography reports is monitored.	N

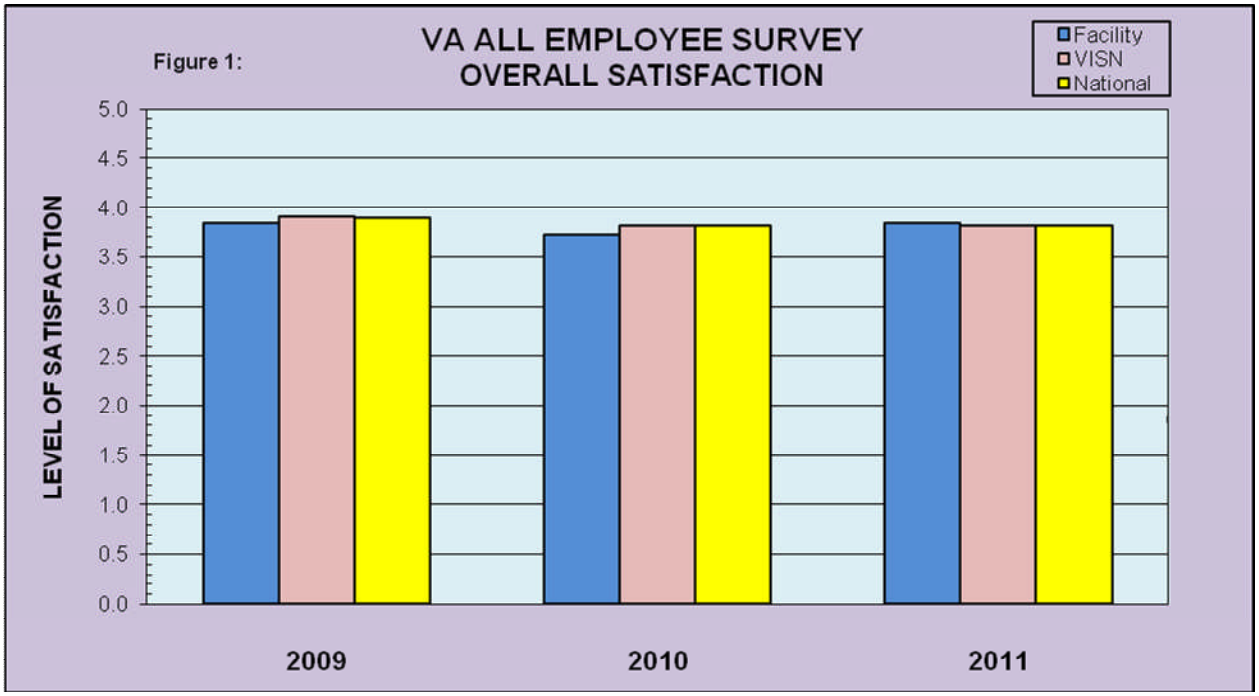
VHA Satisfaction Surveys

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 satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	72.0	53.0	67.9	60.5	55.7	49.5
VISN	65.3	53.5	63.3	54.9	55.1	49.8
VHA	64.1	54.4	63.9	55.9	55.3	54.2

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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[12] 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, 2007, and June 30, 2010.[13]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	13.3	8.1	12.0	18.9	25.9	19.7
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[12] 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. Congestive HF 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.

[13] 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: December 15, 2011

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

Subject: **CAP Review of the VA San Diego Healthcare System, San Diego, CA**

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

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

1. I concur with the findings and recommendations in the report of the Combined Assessment Program Review of the VA San Diego Healthcare System, San Diego, CA.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

(original signed by:)
Stan Johnson, MHA, FACHE

Attachment

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 7, 2011

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

Subject: **CAP Review of the VA San Diego Healthcare System, San Diego, CA**

To: Director, VA Desert Pacific Healthcare System (10N22)

1. Enclosed are the responses to the recommendations in the draft Office of Inspector General's report of our Combined Assessment Program review.

2. If you have any questions or wish to discuss the report, please contact me at (858) 642-3201.

(original signed by:)
Robert M. Smith, MD

Enclosure

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 processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: January 31, 2012

Planned Action: The following plan has been developed to address the recommendation that the pre-sedation assessment documentation includes all required elements.

The MD Pre-Sedation Assessment template was revised to include the following:

- Time and nature of last oral intake: [text box]
- Tobacco, Alcohol or substance abuse:
    - There is no history of tobacco, alcohol or other substance use that will affect the sedation plan
    - The patient has a history of tobacco, alcohol or other substance use and the sedation plan will be altered: [text box]

The approved changes will be implemented in CPRS by December 16, 2011. All providers performing procedures requiring sedation will be educated on the changes made to the MD Pre-Sedation Assessment template by January 31, 2012.

Beginning February 2012, the Procedure and Anesthesia Care Council (PACC) will randomly audit 50 sedation cases on a monthly basis to measure compliance with completion of the pre-sedation assessment including the review of tobacco use and the time/nature of last oral intake until a minimum of 90% compliance is achieved. Once the benchmark is achieved and maintained for three consecutive months, the frequency of the audits will be decreased to quarterly and incorporated into the routine audits of all procedures. The results of these audits will be reported to PACC and the Medical Executive Council (MEC).

Recommendation 2. We recommended that processes be strengthened to ensure that patient re-evaluation is performed immediately prior to sedation.

Concur

Target date for completion: January 31, 2012

Planned Action: The following plan has been developed to address the recommendation that patient re-evaluation is performed immediately prior to sedation. (Note: This recommendation resulted from sedation procedures reviewed by the OIG that were performed in the Emergency Department (ED). Other areas within the Medical Center performing sedation were in compliance with this requirement. Thus, the action plan focuses on the ED.)

The MD Pre-Sedation Assessment template was revised to include a check box and language to document that the "pre-procedural examination (patient re-evaluation) was performed immediately prior to sedation and included review of vital signs, respiratory and cardiovascular examination, and mental status."

The ED Nurse Sedation Note was revised to reflect the continuous nature of patient care in a monitored ED bed. Pre-procedure vital signs immediately prior to sedation, as well as intra-procedural assessment and post-procedural assessment are now clearly documented. In addition, a clinician co-signature will be required on the ED Nurse Sedation Note to document and reflect the collaborative and continuous monitoring of moderate sedation in the Emergency Department.

The approved changes will be implemented in CPRS by December 16, 2011. All providers performing procedures requiring sedation will be educated on the changes made to the MD Pre-Sedation Assessment template, the requirement to re-evaluate the patient immediately prior to sedation, and the co-signature requirement on the ED Nurse Sedation Note by January 31, 2012.

Beginning February 2012, the PACC will audit ED sedation cases on a monthly basis for compliance with the completion of the patient re-evaluation immediately prior to sedation until a minimum of 90% compliance is achieved. Because the number of sedation cases in the ED is low, 100% will be audited. Audits will be identified from patients in whom sedating medications were used to assure complete case finding. Once the benchmark is achieved and maintained for three consecutive months, the frequency of the audits will be decreased to quarterly and incorporated into the routine audits of all procedures. The results of these audits will be reported monthly to the PACC and the Medical Executive Council (MEC).

Recommendation 3. We recommended that processes be strengthened to ensure that all informed consents are completed appropriately and that timeouts are performed accurately.

Concur

Target date for completion: January 31, 2012

Planned Action: The following plan has been developed to address the recommendation that all informed consents are completed appropriately and that timeouts are performed accurately. (Note: This recommendation resulted from sedation procedures reviewed during the OIG visit that were performed in the Emergency

Department (ED). Other areas within the Medical Center performing sedation were in compliance with these requirements. Thus, the action plan focuses on the ED.)

The ED Sedation template was revised to include documentation/verification that informed consent was completed per facility policy and that the timeout was conducted based upon the Universal Protocol Checklist.

All providers and clinical staff involved in performing and assisting with sedation procedures in the ED will be educated on the requirement to obtain and document informed consent prior to sedation, the changes to the ED Sedation template, the Universal Protocol (time-out) requirements, and documentation of the process by January 31, 2012.

Beginning February 2012, the PACC will audit ED sedation cases on a monthly basis for compliance with completion of the informed consent process and Universal Protocol (time-out) requirements prior to sedation as documented in the ED Sedation Note and Procedure Note titles. The audits will be done monthly until a minimum of 90% compliance is achieved. Because the number of sedation cases in the ED is low, 100% of ED sedation cases will be audited. Audits will be identified from patients in whom sedating medications were used to assure complete case finding. Once the benchmark is achieved and maintained for three consecutive months, the frequency of the audits will be decreased to quarterly and incorporated into the routine audits of all procedures. The results of these audits will be reported monthly to the PACC and the Medical Executive Council (MEC).

Recommendation 4. We recommended that processes be strengthened to ensure that Medical Record Committee meeting minutes document strong, specific action items.

Concur

Target date for completion: January 31, 2012

Planned Action: The following plan of action has been implemented to strengthen the Medical Record Committee (MRC) meeting minutes to assure that the minutes reflect documentation of strong, specific action items.

The template used for the MRC minutes was revised to include a section for documenting specific actions taken by the Committee as well as individuals/service responsible for the action and required follow up. Each month the MRC reviews specific, required data elements for compliance. Areas of noncompliance are discussed and analyzed for issues/trends requiring action. When issues are identified and using the revised template, the Committee will document strong, specific actions to be taken to resolve the issues. The Committee will track these action items to completion and all of the information will be documented in the monthly minutes utilizing the revised template. In addition, the MRC minutes will be reviewed each month by the Chief of Staff/Medical Executive Committee to assure full implementation of this requirement.

Recommendation 5. We recommended that processes be strengthened to ensure that fire extinguishers receive monthly safety checks.

Concur

Target date for completion: December 31, 2011

Planned Action: The following plan has been implemented to assure fire extinguishers receive monthly safety checks.

Bar code scanners have been implemented to verify the location and date of the fire extinguisher inspection. The use of the bar code scanner will allow the fire extinguisher inspector to electronically document the date of the inspection of the fire extinguisher into the AEMS/MERS Equipment database. The inspector will still initial and date the inspection tag on the fire extinguisher. After the inspections are completed, the inspector will down load the scanner information into the AEMS/MERS System, using the same method as equipment inventories are currently conducted. The use of the bar code scanner will allow Engineering to maintain an accurate record of the location and inspections of individual fire extinguishers. This system will allow Engineering to track the completion of the inspection and assure the fire extinguishers are inspected within a 30 day cycle as required by NFPA codes.

Engineering will verify the completion of the monthly inspection of fire extinguishers as part of the weekly Environment of Care Rounds. Results of the safety checks will be reported monthly to the Environment of Care Committee (EOCC).

Recommendation 6. We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the CLC and documented.

Concur

Target date for completion: December 31, 2011

Planned Action: The following plan of action has been developed to assure that required safety inspections are performed and documented on ceiling lifts in the CLC.

Engineering will re-inspect the existing ceiling lifts in the CLC to the Equipment Manufacturer's specifications. Documentation of completed safety inspections will be maintained electronically, with hardcopy stored within the Engineering Service. Completion of the required safety inspections will be reported to the Environment of Care Committee and followed to completion.

Recommendation 7. We recommended that all laser users complete laser safety training and that compliance be monitored.

Concur

Target date for completion: March 31, 2012

Planned Action: The following plan has been implemented to assure that all required laser safety training is completed and compliance monitored.

Deficiencies were identified among anesthesia staff supporting laser procedures within the Operating Room. A list of current personnel who work with or around lasers at VASDHS was generated on October 20, 2011 and correlated with completion of required laser safety training. As of December 1, 2011, 29 of the 36 identified with a training deficiency have completed the required training. The targeted training completion date for the remaining 7 workers is January 15, 2012.

The LSO will manage a comprehensive list of employees that require laser safety training (including expiration dates). Training compliance will be tracked monthly and reported to the EOCC quarterly.

The LSO will work in conjunction with the Education Department to develop an online training and tracking mechanism in TMS. Target date for completion is March 1, 2012.

Recommendation 8. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: December 31, 2011

Planned Action: The following plan of action has been implemented to assure that patients with positive CRC screening test results such as fecal occult blood tests (+FOBT) receive diagnostic testing (colonoscopy) within the required timeframe.

The GI Section has instituted a process of having the GI nurse case manager coordinate scheduling of colonoscopy procedures for patients with +FOBT tests to assure that patients are promptly scheduled and that colonoscopies are completed within 60 days of the FOBT results. This process involves the following steps: (1) the laboratory forwards to the GI Section all patient names with + FOBT test results twice a week; (2) the GI nurse case manager assures that the patients are notified of the results of the FOBT and documents patient notification in CPRS; and (3) if clinically indicated, the nurse case manager enters a consult for the colonoscopy. The consult will be flagged as "+FOBT" so that the schedulers know to schedule the patient into the special colonoscopy procedure clinic which is being created to assure that the procedure is completed within the 60 day requirement. A list of these patients is given to the GI clinic scheduler, who will call and schedule the procedure with the patient within 30 days. This will allow for patient cancellation and rescheduling so that the final procedure is completed within the accepted time frame of 60 days. The GI nurse case manager will continually monitor this process and work closely with the GI schedulers to assure that colonoscopies are completed within this time frame.

The GI Section began Saturday clinics on October 29, 2011, to work down the backlog of colonoscopy procedure consults. The Saturday procedure clinic will continue to the

end of December, 2011. The GI Section will implement by January 2012 a designated colonoscopy clinic one afternoon per week that will be reserved for patients with +FOBT.

The GI Section will conduct audits of the number of patients with +FOBT who complete colonoscopy testing within 60 days. The audits will be done monthly until a minimum of 90% compliance is achieved. Once the benchmark is achieved and maintained for three consecutive months, the frequency of the audits will be decreased to quarterly and incorporated into the routine audits of all procedures. The results of these audits will be reported monthly to the MEC and Chief of Staff.

Recommendation 9. We recommended that processes be strengthened to ensure that patients are notified of colonoscopy and biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: December 31, 2011

Planned Action: The following process is being implemented to assure that patients are notified of colonoscopy and biopsy results within the required timeframe and that the notification is documented.

The current GI Section procedure is to give every patient a copy of their colonoscopy procedure report immediately after the procedure. The nurse responsible for discharging the patient provides the patient with a printed procedure note. On October 12, 2011, the following statement was added to the nursing post procedure note template: "The patient was given a copy of the procedure report and questions were answered" to improve documentation.

For those patients who had biopsies, the procedure and biopsy results are reviewed within one week of the procedure by a GI physician and comments are added to the procedure report regarding these results and the subsequent recommendation. Direct communication occurs with patients when positive results are found. A copy of the revised procedure note and biopsy report will be mailed to the patient with a cover letter explaining that they should discuss the results with their Primary Care Provider and contact the GI Section if there are any additional questions. The GI Section is in the process of creating a letter template in CPRS that will allow the GI physician reviewing the pathology reports to upload the pathology results and recommendation into the template. A letter will automatically be generated, saved in CPRS and a copy mailed to the patient. The letter is electronically sent from CPRS to the mailroom where it is printed, folded, placed in an envelope, addressed and mailed to the patient. This automated process will be completed by December 31, 2011. Until this process is completely implemented, the GI Secretary will mail results to the patients and will maintain documentation in the GI office that this has been done.

The GI section will conduct monthly audits of the number of patients who are notified of their procedure and biopsy results within the required timeframe. The audits will be

done monthly until a minimum of 90% compliance is achieved. Once the benchmark is achieved and maintained for three consecutive months, the frequency of the audits will be decreased to quarterly and incorporated into the routine audits of all procedures. The results of these audits will be reported monthly to the MEC and Chief of Staff.

Recommendation 10. We recommended that the facility monitor compliance with VHA polytrauma training requirements.

Concur

Target date for completion: March 1, 2012

Planned Action: The following plan has been implemented to assure compliance with VHA Directive 2009-028.

The VA PM&R Program office has recommended that all TBI/Polytrauma providers complete a onetime web-based (or book based) training entitled "VHA: Traumatic Brain Injury" via the Talent Management System (TMS).

The San Diego VA has been designated as a Polytrauma Support Clinic Team (PSCT), and receives educational and training guidance at the national level as well as from our Polytrauma Network Site (PNS) at West Los Angeles and our Polytrauma Rehabilitation Center (PRC) at Palo Alto. VHA Handbook 1172.1 (*Polytrauma Rehabilitation Centers*) defines training requirements for PRCs such as Palo Alto, but not for PSCTs such as exists at the VA San Diego Health Care System. Neither Handbook 1172.1, nor VHA Directive 2009-028 (*Polytrauma-Traumatic Brain Injury (TBI) System of Care*) defines training requirements for PSCTs. Discussions with the VHA National TBI/Polytrauma Director confirmed that there are no absolute requirements in place for ongoing training of the core PSCT staff.

A current list of the core members of the San Diego PSCT corresponding to those listed in Appendix E of VHA Directive 2009-028 will be compiled by December 31, 2011. All identified core members of the PSCT will complete the "VHA-Traumatic Brain Injury" training module and document completion within TMS by February 29, 2012. Completion of training will be monitored by the Director of the PSCT and reported to the MEC no later than March 2012. All future members of the PSCT will have this training requirement documented as part of their initial competency.

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