TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
A-043 482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.				
1. The Governing Body failed to improve contracted security within the hospital. The hospital had identified contracted security problems with the Sheriff's Department since 2009 and the Governing Body did not improve security which resulted in a patient who went missing for 17 days and was found dead in a hospital emergency stairwell (See A-0084, A-0283, A-0273).	**A-043 482.12 Governing Body** **Finding 1 (failure to improve contracted security services- A0084, A0283, A0273):** **Action(s):** Following the discovery of Patient 1' body, San Francisco General Hospital (SFGH) leadership and the San Francisco Sheriff' Department (SFSD) leadership presented an update that same day regarding the finding of Patient 1' body and actions initiated that day in response to the incident to the ***Governing Body Joint Conference Committee (JCC)***, which includes the Director of the City and County of San Francisco Department of Public Health (CCSF-JCC) Following the discovery of Patient 1' body, the SFSD initiated daily stairwell checks for audible alarm activations in Building 5, Main Hospital; alarm activations are reported to the Administrator-on-Duty (AOD) to include in the daily AOD report. Upon review, it was discovered that emergency exit stairwell alarms were not standardized throughout Building 5 (Main Hospital Building) to maintain an audible constant alarm until manually deactivated. Hospital facilities staff replaced and standardized the emergency exit stairwell door alarms for Building 5 (main hospital) so that the alarms now maintain an audible constant alarm until manually deactivated by a key and the completion of a full stairwell	The chairs and/or designees of the key hospital committees addressing campus safety and security issues will audit the committee meeting minutes and attendance rosters quarterly for one year and annually thereafter to verify that SFSD representatives attend the key hospital committees addressing campus safety and security issues.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Chief Executive Officer • Secretary, Governing Body JCC • Hospital Associate Administrator for Support Services • SFSD Captain at SFGH
		Audit results will be reported quarterly to ***EOC Committee*** and to ***Quality Council*** for one year and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	
		The SFSD Training Officer, in collaboration with the SFGH Department of Education and Training (DET), will audit SFSD staff attendance at new employee hospital orientation and any other required hospital trainings quarterly for one year and annually thereafter.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	
		Audit results will be reported to the ***Quality Council*** quarterly for one year and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	
		The daily stairwell checks data, stairwell alarm activation data, stairwell alarm PM data, surveillance camera data, AeroScout data, SFSD missing/at-risk search data, Code Green drills data will be reported quarterly to ***EOC Committee*** for one year and annually	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	check. Emergency exit stairwell alarm deactivations and stairwell checks are now tracked and reported through the EOC Committee as a component of the SFGH and SFSD security performance measures**.** Following the discovery of Patient 1' body, SFSD leadership implemented use of ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** as the interim protocol for conducting a missing person search until development of a final SFSD search protocol. The hospital governing body developed an initial scope of work for and commissioned an independent external review of SFGH safety and security systems. Hospital leadership initiated daily checks of all internal and external stairwells in Building 5, Main Hospital; sweep results are now reported to the AOD to include in the daily AOD report. Hospital leadership clarified to the SFSD the video recording capabilities of existing equipment and operations and the technical procedure for copying the surveillance camera footage for Building 5, main hospital. Hospital leadership issued a memo regarding the use of emergency exits which was sent to the Management Forum group to be reviewed with all staff.	thereafter. SFGH SFSD representatives are on EOC Committee. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***. The ***Governing Body Joint Conference Committee (JCC)*** will review and approve the security services work order, including performance measures, quarterly for one year and annually thereafter.	• Annual, 2014 • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Hospital leadership developed and implemented protocols to operationalize the emergency exit door alarm response which is now formalized in ***EOC Policy Stairwell Security.*** Hospital leadership conducted a root cause analysis. Hospital facilities staff added the emergency exit stairwell door alarms to the preventative maintenance (PM) system for tracking; PM checks will be conducted every six months. Hospital facilities staff conducted a check of all newly installed alarms to verify that the continuous alarm setting is activated. Hospital leadership met with representatives from the current vendor of the security camera surveillance system to assess and implement full functionality of all Building 5 surveillance cameras; full functionality of all security surveillance cameras completed. Hospital leadership purchased an electronic tracking system (Aero Scout) for monitoring at risk patients. Hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient.			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Hospital leadership implemented re-orientation of the SFSD staff on hospital policies and procedures covered in the usual new employee hospital orientation program. The SFGH Chief Executive Officer (CEO) initiated a weekly meeting with hospital leadership and the San Francisco Sheriff' Department (SFSD) leadership to address identified challenges/concerns in real time. Hospital leadership added performance measures to the SFSD contract. The CCSF Sheriff assigned a Captain and an additional Lieutenant to the SFSD staff at SFGH for a total of three supervising officers to provide seven day a week supervisory coverage of the SFSD staff at SFGH. The CCSF Sheriff created a new position of Training Coordinator to add to the SFSD staff at SFGH in order to assist in the on-going training of SFSD staff, to ensure SFSD staff complete hospital orientation, annual training, and in-servicing on new/revised hospital policies and procedures, and to participate in review/revision of key hospital policies/procedures. Hospital leadership reviewed and revised the Environment of Care (EOC) Committee membership to ensure representation by appropriate staff, including SFSD staff, and to ensure committee reporting structure. SFSD, as a contracted service with the CCSF-DPH, is a participant on the key hospital committees addressing campus safety &			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	security issues: 1. Administrative Operations Meeting 2. Bed Meetings 3. Critical Incident Response Team 4. Code Green Task Force (At-Risk Missing Patients) 5. Disaster Council Committee 6. Employee Health & Safety 7. Environment of Care (EOC) Committee 8. Hospital Leadership Security Meeting 9. Infant/Child Security Program Committee (Code Pink) 10. Management Forum 11. Violence Prevention Team Hospital and SFSD leadership reinforced the expectation that SFSD representatives attend and are actively involved on key hospital committees addressing campus safety and security issues and will verify SFSD representatives' attendance at committee meetings. SFSD leadership assigned an SFSD deputy to assess operations in the SFGH SFSD radio/telephone communications center to identify opportunities for improvement and to ensure accurate record keeping. SFSD leadership created and implemented standard work/scripts for the radio/telephone operators in the SFGH SFSD communications center to ensure that accurate information is obtained and transmitted when SFGH staff call SFGH SFSD for assistance. SFSD leadership implemented "musters" (communication huddles/reports) with SFSD staff; these occur at change of shift to			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	communicate important information including updates on trainings and policies/procedures. SFSD leadership implemented assignment of SFSD staff to attend the twice daily admin/nursing "bed huddle" meetings and engage in communication regarding important patient care issues, including patients reported as AWOL/ missing, and relevant updates on training and policies/procedures. The hospital provided dedicated space for SFSD daily musters and staff training. SFSD leadership, in collaboration with SFGH leadership, developed and implemented a new SFSD protocol for conducting a search for missing/at risk person(s) on the SFGH hospital campus. Hospital leadership conducted an additional root cause analysis to include active participation by the SFSD. The Director of the City and County of San Francisco Department of Public Health (CCSF-DPH) initiated monthly meetings with the SFSD leadership to address identified challenges and concerns in real time. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** will be included in monthly new employee hospital orientation and in annual updates. SFSD is conducting training of SFSD staff on the new SFSD protocol for conducting a search for missing/at risk missing persons. Hospital leadership developed new ***Admin Policy 1.09/Patient Tracking System*** on the use of the new patient tracking system (Aero Scout) and will ensure staff training.			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
2. The Governing Body failed to ensure that Patient Rights were protected and enforced when a safe patient environment was not provided and patient privacy was not ensured. (See A115, A144 and A146)	**Finding 2 (failure to provide safe patient environment & failure to ensure patient privacy):** **Action(s) Safe Patient Environment:** Following the discovery of Patient 1' body, the SFSD initiated daily stairwell checks for audible alarm activations in Building 5, Main Hospital; alarm activations are reported to the Administrator-on-Duty (AOD) to include in the daily AOD report. Upon review, it was discovered that emergency exit stairwell alarms were not standardized throughout Building 5 (Main Hospital Building) to maintain an audible constant alarm until manually deactivated. Hospital facilities staff replaced and standardized the emergency exit stairwell door alarms for Building 5 (main hospital) so that the alarms now maintain an audible constant alarm until manually deactivated by a key and the completion of a full stairwell check. Emergency exit stairwell alarm deactivations and stairwell checks are now tracked and reported through the EOC Committee as a component of the SFGH and SFSD security performance measures. Following the discovery of Patient 1' body, SFSD leadership implemented use of ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** as the interim protocol for conducting a missing person search until development of a final SFSD search protocol.	The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct monthly audits of the ***Lifetime Clinical Record (LCR)*** of all employees of the City & County of San Francisco Department of Public Health (CCSF DPH) and of all employees of the University of California San Francisco (UCSF) who received care as patients at the hospital (emergency department, clinics, acute care, skilled nursing) to verify if the LCR access was appropriate.	• January, 2014 • Monthly	• Chief Executive Officer • Secretary, Governing Body JCC • Hospital Associate Administrator for Support Services • SFSD Captain at SFGH • Chief Nursing Officer • SFGH Privacy Officer
		The SFGH Privacy Officer and the SFGH Privacy Analyst conduct audits of the ***Lifetime Clinical Record (LCR)*** of any patient as requested by managers to verify if the LCR access was appropriate .e.g., media high profile cases, VIPs. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation.	• Upon request • Ongoing	
		The total number of audits conducted per month average between 25-30/month. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation. Audit results are reported quarterly to the ***SFGH Privacy Committee.***	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Quarterly	
		The SFGH Privacy Officer present an annual report regarding privacy issues to the ***SFGH Quality Council*** including results of the quarterly audits. In addition, they report any incidents of non-compliance with DPH and SFGH privacy policies which occur during the year at the next scheduled SFGH ***Quality Council.*** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference***	• Annual, 2014 • Annually	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	The hospital governing body developed an initial scope of work for and commissioned an independent external review of SFGH safety and security systems. Hospital leadership initiated daily checks of all internal and external stairwells in Building 5, Main Hospital; sweep results are now reported to the AOD to include in the daily AOD report. Hospital leadership clarified to the SFSD the video recording capabilities of existing equipment and operations and the technical procedure for copying the surveillance camera footage for Building 5, main hospital. Hospital leadership issued a memo regarding the use of emergency exits which was sent to the Management Forum group to be reviewed with all staff. Hospital leadership developed and implemented protocols to operationalize the emergency exit door alarm response which is now formalized in ***EOC Policy 13.08 Stairwell Security.*** Hospital leadership conducted a root cause analysis. Hospital facilities staff added the emergency exit stairwell door alarms to the preventative maintenance (PM) system for tracking; PM checks will be conducted every six months. Hospital facilities staff conducted a check of all newly installed alarms to verify that the	***Committee***. The SFSD Captain or designee conduct random audits of ten taped calls per month from the SFGH SFSD communications center to ensure compliance with confidentiality of protected health information. Audit results will be reported quarterly to ***EOC Committee***. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• Monthly • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Quarterly	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	continuous alarm setting is activated. Hospital leadership met with representatives from the current vendor of the security camera surveillance system to assess and implement full functionality of all Building 5 surveillance cameras; full functionality of all security surveillance cameras completed. Hospital leadership implemented re-orientation of the SFSD staff on hospital policies and procedures covered in the usual new employee hospital orientation program. Hospital leadership purchased an electronic tracking system (Aero Scout) for monitoring at risk patients. The SFGH CEO initiated a weekly meeting with hospital leadership and the San Francisco Sheriff' Department (SFSD) leadership to address identified challenges/concerns in real time. The CCSF Sheriff assigned a Captain and an additional Lieutenant to the SFSD staff at SFGH for a total of three supervising officers to provide seven day a week supervisory coverage of the SFSD staff at SFGH. The CCSF Sheriff created a new position of Training Coordinator to add to the SFSD staff at SFGH in order to maintain oversight of training and education activities to assist in the on-going training of SFSD staff, to ensure SFSD staff complete hospital orientation, annual training, and in-servicing on new/revised hospital policies and procedures, and to participate in review/revision of key			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	hospital policies/procedures. SFSD, as a contracted service with the CCSF-DPH, is a participant on the key hospital committees addressing campus safety & security issues: 1. Administrative Operations Meeting 2. Bed Meetings 3. Critical Incident Response Team 4. Code Green Task Force (At-Risk Missing Patients) 5. Disaster Council Committee 6. Employee Health & Safety 7. Environment of Care (EOC) Committee 8. Hospital Leadership Security Meeting 9. Infant/Child Security Program Committee (Code Pink) 10. Management Forum 11. Violence Prevention Team Hospital and SFSD leadership reinforced the expectation that SFSD representatives attend and are actively involved on key hospital committees addressing campus safety and security issues and will verify SFSD representatives' attendance at committee meetings. SFSD leadership assigned an SFSD deputy to assess operations in the SFGH SFSD radio/telephone communications center to identify opportunities for improvement and to ensure accurate record keeping. SFSD leadership created standard work/scripts for the radio/telephone operators in the SFGH SFSD communications center to ensure that accurate information is obtained and transmitted when SFGH staff call SFGH SFSD			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	for assistance. SFSD leadership, in collaboration with SFGH leadership, developed and is implementing a new SFSD protocol for conducting a search for missing/at risk person(s) on the SFGH hospital campus**.** SFSD leadership implemented "musters" (communication huddles/reports) with SFSD staff; these occur several times a day to communicate important information including updates on trainings and policies/procedures. SFSD leadership implemented formal assignment of SFSD staff to attend the twice daily (8 am, 8pm) admin/nursing "bed huddle" meetings and engage in communication regarding important patient care issues, including patients reported as AWOL/ missing, and relevant updates on training and policies/procedures. The hospital provided dedicated space for SFSD daily musters and staff training. Hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called **"Code Green**". A **"Code Green"** alert is initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. The SFGH SFSD will announce a "**Code Green"** alert on the overhead paging system, and a floor-by-floor search of the main hospital and other campus areas will be initiated.			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Hospital leadership conducted an additional root cause analysis to include active participation by the SFSD. The Director of the City and County of San Francisco Department of Public Health (CCSF-DPH) initiated monthly meetings with the SFSD leadership to address identified challenges and concerns in real time. Hospital leadership standardized the signage on the emergency evacuation exit doors in an effort to minimize use of these exits by patients, staff, and visitors. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** will be included in monthly new employee hospital orientation and in annual updates. Hospital leadership conducted a ***Sentinel Event Review*** regarding this incident with the			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Joint Commission. Hospital leadership developed new ***Admin Policy 1.09/Patient Tracking System*** on the use of the new patient tracking system (Aero Scout) and will ensure staff training. SFSD is conducting training of SFSD staff on the new SFSD protocol for conducting a search for missing/at risk missing persons. Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; ; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. Hospital leadership is in-servicing hospital and SFSD staff on the new "Code Green" procedure.			
3. The facility failed to ensure nursing services were provided in accordance with professional standards of practice and in a well-organized manner to ensure patients' safety in the hospital. (See A0385, A0395 and A0396)	**Finding 3 (failure to ensure nursing services were provided in accordance with professional standards of practice and in a well-organized manner to ensure patients' safety in the hospital A0385, A0395, A0396)** **Action(s):**	The Chief Nursing Officer and/or designees will conduct an audit of all current in-patients to ensure physician orders are completed and transcribed to the kardex, care plans are individualized, and close observation interventions are individualized to the patient; they will resolve any issues identified in real	• January 7, 2014 – January 10, 2014	• Chief Executive Officer • Secretary, Governing Body JCC • Chief Nursing

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	CN1 who provided the inaccurate description of the patient and who failed to follow the AOD instruction to report Patient 1 as a missing person to the SFSD was removed from CN duties, counseled regarding the findings, and placed on a developmental plan. Following a review of Patient 1's chart, nursing leadership discovered the physician order for coach/sitter had not been implemented. ***Nursing Policy 6.04/Close Observation of the Hospitalized Patient*** was reviewed by Med-Surg nurse managers with staff during staff meetings and during change of shift reports to clarify and remind staff of the requirement to implement physician orders. There was organizational inconsistency in the care of patients requiring close observation. As a result, Hospital, Nursing and Medical staff leadership re-designated ***Nursing Policy 6.04/Close Observation of the Hospitalized Patient*** as a hospital administrative policy. It is now ***Admin Policy 18.02/Close Observation of the Hospitalized Patient.*** Following the complaint validation survey, the Chief Nursing Officer assessed the nursing practice of staff caring for patients requiring close observation. The medical surgical units submitted daily logs of patients identified as at-risk and the Chief Nursing Officer conducted random chart reviews. The Chief Nursing Officer provided individual coaching to staff and used the assessment information to develop a nursing sensitive quality audit tool to monitor nursing practice.	time with coaching and feedback to staff. The Nurse Manager and/or designee will observe five staff per week during inter-shift handoff to ensure proper use of the end-of-shift communication tool. Audit results will be reported quarterly for one year to the ***Nursing Quality Forum*** and to the ***Quality Council*** and annually thereafter***.*** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***. Following the complaint validation survey, the Chief Nursing Officer assessed the nursing practice of staff caring for patients requiring close observation. The medical surgical units submitted daily logs of patients identified as at-risk and the Chief Nursing Officer conducted random chart reviews. The Chief Nursing Officer provided individual coaching to staff and used the assessment information to develop a nursing sensitive quality audit tool to monitor nursing practice.	• January, 2014 • Weekly • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually • Immediate • Complete	Officer • Chief Medical Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Hospital, Nursing and Medical staff leadership revised the policy to clarify close observation, actions nurses need to take when a physician orders close observation, requirements that implementation and discontinuation of close observation requires provider/nurse communication about the patient status, and documentation requirements for when close observation is implemented and/or discontinued. Hospital, Nursing and Medical leadership in-serviced staff on revised ***Admin Policy 18.02/Close Observation of the Hospitalized Patient.*** The Chief Nursing Officer is developing a standardized end of shift communication tool to facilitate inter-shift handoff focusing on the nursing specific quality indicators.			
A-084 482.12(e) (1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.				
1. *The Governing Body failed to improve contracted security within the hospital. The hospital had identified contracted security problems with the Sheriff's Department since 2009 and the Governing Body did not improve security which resulted in a patient who went missing for 17 days and was found dead in a hospital emergency stairwell (stairwell 8).*	**A-084 482.12 (e) (1) Contracted Services** **Action(s):** Following the discovery of Patient 1' body, San Francisco General Hospital (SFGH) leadership and the San Francisco Sheriff' Department (SFSD) leadership presented an update that same day regarding the finding and actions initiated that day in response to the finding to the ***Governing Body Joint Conference Committee (JCC)***, which includes the Director of the City and County of San Francisco Department of Public Health (CCSF-JCC).	The chairs and/or designees of the key hospital committees addressing campus safety and security issues will audit the committee meeting minutes and attendance rosters quarterly for one year and annually thereafter to verify that SFSD representatives attend the key hospital committees addressing campus safety and security issues. Audit results will be reported quarterly to ***EOC Committee*** and to ***Quality Council*** for one year and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	• Chief Executive Officer • Secretary, Governing Body JCC • Hospital Associate Administrator for Support Services • SFSD Captain at SFGH • Chief Nursing Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Following the discovery of Patient 1' body, SFSD leadership implemented use of ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** as the interim protocol for conducting a missing person search until development of a final SFSD search protocol. The hospital governing body developed an initial scope of work for and commissioned an independent external review of SFGH safety and security systems. Hospital leadership implemented re-orientation of the SFSD staff on hospital policies and procedures covered in the usual new employee hospital orientation program. The SFGH CEO initiated a weekly meeting with hospital leadership and the San Francisco Sheriff' Department (SFSD) leadership to address identified challenges/concerns in real time. Hospital leadership added performance measures to the SFSD contract. The CCSF Sheriff assigned a Captain and an additional Lieutenant to the SFSD staff at SFGH for a total of three supervising officers to provide seven day a week supervisory coverage of the SFSD staff at SFGH. The CCSF Sheriff created a new position of Training Coordinator to add to the SFSD staff at SFGH in order to assist in the on-going training of SFSD staff, to ensure SFSD staff complete hospital orientation, annual	The SFSD Training Officer, in collaboration with the SFGH Department of Education and Training (DET), will audit SFSD staff attendance at new employee hospital orientation and any other required hospital trainings quarterly for one year and annually thereafter.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	
		Audit results will be reported to the ***Quality Council*** quarterly for one year and annually thereafter. The ***Quality Council*** reports annually to the Governing Body Joint Conference Committee	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	
		Hospital leadership reviewed and revised the Environment of Care (EOC) Committee membership to ensure representation by appropriate staff, including SFSD staff, and to ensure committee reporting structure.	• Immediate • Complete	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	training, and in-servicing on new/revised hospital policies and procedures, and to participate in review/revision of key hospital policies/procedures. Hospital leadership reviewed and revised the Environment of Care (EOC) Committee membership to ensure representation by appropriate staff, including SFSD staff, and to ensure committee reporting structure. SFSD, as a contracted service with the CCSF-DPH, is a participant on the key hospital committees addressing campus safety & security issues: 1. Administrative Operations Meeting 2. Bed Meetings 3. Critical Incident Response Team 4. Code Green Task Force (At-Risk Missing Patients) 5. Disaster Council Committee 6. Employee Health & Safety 7. Environment of Care (EOC) Committee 8. Hospital Leadership Security Meeting 9. Infant/Child Security Program Committee (Code Pink) 10. Management Forum 11. Violence Prevention Team Hospital and SFSD leadership reinforced the expectation that SFSD representatives attend and are actively involved on key hospital committees addressing campus safety and security issues and will verify SFSD representatives' attendance at committee meetings. SFSD leadership assigned an SFSD deputy to			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	assess operations in the SFGH SFSD radio/telephone communications center to identify opportunities for improvement and to ensure accurate record keeping. SFSD leadership created standard work/scripts for the radio/telephone operators in the SFGH SFSD communications center template to ensure that accurate information is obtained and transmitted when SFGH staff call SFGH SFSD for assistance. SFSD leadership implemented "musters" (communication huddles/reports) with SFSD staff; these occur at change of shift to communicate important information including updates on trainings and policies/procedures. SFSD leadership implemented formal assignment of SFSD staff to attend the twice daily admin/nursing “bed huddle” meetings and engage in communication regarding important patient care issues, including patients reported as AWOL/ missing, and relevant updates on training and policies/procedures. The hospital provided dedicated space for SFSD daily musters and staff training. SFSD leadership, in collaboration with SFGH leadership, developed and is implementing a new SFSD protocol for conducting a search for missing/at risk person(s) on the SFGH hospital			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	campus. The Director of the City and County of San Francisco Department of Public Health (CCSF-DPH) initiated monthly meetings with the SFSD leadership to address identified challenges and concerns in real time. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment including use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. SFSD is conducting training of SFSD staff on the new SFSD protocol for conducting a search for missing/at risk missing persons. ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** will be included in monthly new employee hospital orientation and in annual updates. The ***Governing Body Joint Conference Committee (JCC)*** will review and approve the security services work order, including performance measures, quarterly for one year and annually thereafter.			
A-115 482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.				
1. *The hospital failed to provide a safe environment for a vulnerable patient when patient 1 wandered off her nursing unit and was not located in the building until after her death (A144)*	**A-115 482.13 Patient Rights** **Finding 1 (failure to provide safe environment):** **Action(s) Safe Patient Environment:** Following the discovery of Patient 1' body, the SFSD initiated daily stairwell checks for audible alarm activations in Building 5, Main Hospital; alarm activations are reported to the Administrator-on-Duty (AOD) to include in the	The chairs and/or designees of the key hospital committees addressing campus safety and security issues will audit the committee meeting minutes and attendance rosters quarterly for one year and annually thereafter to verify that SFSD representatives attend the key hospital committees addressing campus safety and security issues. Audit results will be reported quarterly to ***EOC Committee*** and to the Quality Council	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually • April, 2014 • July, 2014	• Chief Executive Officer • Secretary, Governing Body JCC • Hospital Associate Administrator for Support Services • Director, SFGH Rebuild • SFSD Captain at

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	daily AOD report. Upon review, it was discovered that emergency exit stairwell alarms were not standardized throughout Building 5 (Main Hospital Building) to maintain an audible constant alarm until manually deactivated. Hospital facilities staff replaced and standardized the emergency exit stairwell door alarms for Building 5 (main hospital) so that the alarms now maintain an audible constant alarm until manually deactivated by a key. Emergency exit stairwell alarm deactivations and stairwell checks are now tracked and reported through the EOC Committee as a component of the SFGH and SFSD security performance measures. Following the discovery of Patient 1' body, SFSD leadership implemented use of ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** as the interim protocol for conducting a missing person search until development of a final SFSD search protocol. The hospital governing body developed an initial scope of work for and commissioned an independent external review of SFGH safety and security systems. Hospital leadership initiated daily checks of all internal and external stairwells in Building 5, Main Hospital; sweep results are now reported to the AOD to include in the daily AOD report.	quarterly for one year and annually thereafter. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• October, 2014 • January, 2015 • Annual, 2014 • Annually	SFGH • Chief Nursing Officer
		The SFSD Training Officer, in collaboration with the SFGH Department of Education and Training (DET), will audit SFSD staff attendance at new employee hospital orientation and any other required hospital trainings quarterly for one year and annually thereafter.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	
		Audit results will be reported to the ***Quality Council*** quarterly for one year and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	
		The daily stairwell checks data, stairwell alarm activation data, stairwell alarm PM data, surveillance camera data, AeroScout data, SFSD missing/at-risk search data, Code Green drills data will be reported quarterly to ***EOC Committee*** for one year and annually thereafter. SFGH SFSD representatives are on EOC Committee. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	
		Hospital facilities staff added the emergency exit stairwell door alarms to the preventative maintenance (PM) system for tracking; PM checks will be conducted every six months.	• Semiannually	
		Hospital leadership purchased an electronic	• Ongoing	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Hospital leadership clarified to the SFSD the video recording capabilities of existing equipment and operations and the technical procedure for copying the surveillance camera footage for Building 5, main hospital. Hospital leadership issued a memo regarding the use of emergency exits which was sent to the Management Forum group to be reviewed with all staff. Hospital leadership developed and implemented protocols to operationalize the emergency exit door alarm response which is now formalized in ***EOC Policy 13.08 Stairwell Security.*** Hospital leadership conducted a root cause analysis. Hospital facilities staff added the emergency exit stairwell door alarms to the preventative maintenance (PM) system for tracking; PM checks will be conducted every six months. Hospital facilities staff conducted a check of all newly installed alarms to verify that the continuous alarm setting is activated. Hospital leadership met with representatives from the current vendor of the security camera surveillance system to assess and implement full functionality of all Building 5 surveillance cameras; full functionality of all security surveillance cameras completed. Hospital leadership implemented re-orientation of the SFSD staff on hospital	tracking system (Aero Scout) for monitoring at risk patients.		
		SFSD, as a contracted service with the CCSF-DPH, is a participant on the key hospital committees addressing campus safety & security issues: 1. Administrative Operations Meeting 2. Bed Meetings 3. Critical Incident Response Team 4. Code Green Task Force (At-Risk Missing Patients) 5. Disaster Council Committee 6. Employee Health & Safety 7. Environment of Care (EOC) Committee 8. Hospital Leadership Security Meeting 9. Infant/Child Security Program Committee (Code Pink) 10. Management Forum 11. Violence Prevention Team	• Immediately • Ongoing	
		Hospital leadership standardized the signage on the emergency evacuation exit doors in an effort to minimize use of these exits by patients, staff, and visitors.	• Immediately • Complete	
		SFSD is conducting training of SFSD staff on the new SFSD protocol for conducting a search for missing/at risk missing persons.	• Immediately • Ongoing	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	policies and procedures covered in the usual new employee hospital orientation program. Hospital leadership purchased an electronic tracking system (Aero Scout) for monitoring at risk patients. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** will be included in monthly new employee hospital orientation and in annual updates. The SFGH CEO initiated a weekly meeting with hospital leadership and the San Francisco Sheriff' Department (SFSD) leadership to address identified challenges/concerns in real time. The CCSF Sheriff assigned a Captain and an additional Lieutenant to the SFSD staff at SFGH for a total of three supervising officers to provide seven day a week supervisory			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	coverage of the SFSD staff at SFGH. The CCSF Sheriff created a new position of Training Coordinator to add to the SFSD staff at SFGH in order to assist in the on-going training of SFSD staff, to ensure SFSD staff complete hospital orientation, annual training, and in-servicing on new/revised hospital policies and procedures, and to participate in review/revision of key hospital policies/procedures. SFSD, as a contracted service with the CCSF-DPH, is a participant on the key hospital committees addressing campus safety & security issues: 1. Administrative Operations Meeting 2. Bed Meetings 3. Critical Incident Response Team 4. Code Green Task Force (At-Risk Missing Patients) 5. Disaster Council Committee 6. Employee Health & Safety 7. Environment of Care (EOC) Committee 8. Hospital Leadership Security Meeting 9. Infant/Child Security Program Committee (Code Pink) 10. Management Forum 11. Violence Prevention Team Hospital and SFSD leadership reinforced the expectation that SFSD representatives attend and are actively involved on key hospital committees addressing campus safety and security issues and will verify SFSD representative's attendance at committee meetings. SFSD leadership assigned an SFSD deputy to			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	assess operations in the SFGH SFSD radio/telephone communications center to identify opportunities for improvement and to ensure accurate record keeping. SFSD leadership created standard work/scripts for the radio/telephone operators in the SFGH SFSD communications center which is consistent with SBAR template to ensure that accurate information is obtained and transmitted when SFGH staff call SFGH SFSD for assistance. SFSD leadership, in collaboration with SFGH leadership, developed and is implementing a new SFSD protocol for conducting a search for missing/at risk person(s) on the SFGH hospital campus. SFSD leadership implemented "musters" (communication huddles/reports) with SFSD staff; these occur at change of shift to communicate important information including updates on trainings and policies/procedures. SFSD leadership implemented formal assignment of SFSD staff to attend the twice daily admin/nursing “bed huddle” meetings and engage in communication regarding important patient care issues, including patients reported as AWOL/ missing, and relevant updates on training and policies/procedures. The hospital provided dedicated space for SFSD daily musters and staff training. Hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. The Director of the City and County of San Francisco Department of Public Health (CCSF-DPH) initiated monthly meetings with the SFSD leadership to address identified challenges and concerns in real time. SFSD is conducting training of SFSD staff on the new SFSD protocol for conducting a search for missing/at risk missing persons. Hospital leadership conducted a ***Sentinel Event Review*** regarding this incident with the ***Joint Commission.*** Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record.			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation will be included in monthly new employee hospital orientation and in annual updates. Hospital leadership developed new ***Admin Policy 1.09/Patient Tracking System*** on the use of the new patient tracking system (Aero Scout) and will ensure staff training. SFSD is conducting training of SFSD staff on the new SFSD protocol for conducting a search for missing/at risk missing persons. Hospital leadership is in-servicing hospital and SFSD staff on the new "Code Green" procedure.			
2. *The hospital and its contracted security services did not have a coordinated search plan for missing persons (A144)*	**Finding 2 (lack of coordinated search plan):** **Actions(s):** SFSD leadership, in collaboration with SFGH leadership, developed and is implementing a new SFSD protocol for conducting a search for missing/at risk person(s) on the SFGH hospital campus. Hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. SFSD is conducting training of SFSD staff on the new SFSD protocol for conducting a	The daily stairwell checks data, stairwell alarm activation data, stairwell alarm PM data, surveillance camera data, AeroScout data, SFSD missing/at-risk search data, Code Green drills data will be reported quarterly to ***EOC Committee*** for one year and annually thereafter. SFGH SFSD representatives are on EOC Committee. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually • Annually	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	search for missing/at risk missing persons. Hospital leadership is in-servicing hospital and SFSD staff on the new "Code Green" procedure.			
3. *The hospital failed to ensure the confidentiality of Patient 1's medical information when four staff members accessed patient 1's Lifetime Care Record (LCR) without need and without authorization (A146)*	**<u>Finding 3 (failure to ensure confidentiality of Patient 1' medical information when 4 staff accessed Patient 1' LCR without need and without authorization):</u>** **Action(s):** Before and after these privacy breach incidents, hospital leadership has engaged in ongoing efforts via memos, emails, staff trainings, and employee annual update training to ensure that hospital staff are educated and knowledgeable about hospital and SFDPH privacy and security policies. The SFGH multidisciplinary ***Privacy Committee***, composed of the SFGH Privacy Officer and staff from the SFGH Privacy Office, the SFGH Chief Medical Officer, the SFGH Chief Communications Officer, representatives from the SFGH Legal Affairs, Regulatory Affairs, Health Information Systems departments , as well as representatives from both the SFGH and UCSF Risk Management and Information Systems Departments, meets monthly to review, discuss, and recommend policy involving privacy compliance issues. The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct ***"Privacy Rounds"*** within the hospital departments to educate hospital staff about privacy security and awareness, to validate staff knowledge	The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct monthly audits of the ***Lifetime Clinical Record (LCR)*** of all employees of the City & County of San Francisco Department of Public Health (CCSF DPH) and of all employees of the University of California, San Francisco (UCSF) who received care as patients at the hospital (emergency department, clinics, acute care, skilled nursing) to verify if the LCR access was appropriate.	• January, 2014 • Monthly	• SFGH Privacy Officer
		The SFGH Privacy Officer and the SFGH Privacy Analyst conduct audits of the ***Lifetime Clinical Record (LCR)*** of any patient as requested by managers to verify if the LCR access was appropriate .e.g., media high profile cases, VIPs. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation.	• Upon request • Ongoing	
		The total number of audits conducted per month average between 25-30/month. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation. Audit results are reported quarterly to the ***SFGH Privacy Committee.***	• Quarterly	
		The SFGH Privacy Officer presents an annual report regarding privacy issues to the ***SFGH Quality Council*** including results of the quarterly audits. In addition, they report any	• Annual, 2014 • Annually	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	regarding privacy security and awareness, as well as to identify issues requiring corrective action by managers. Findings are reported to the Privacy Committee. As noted, four of the privacy breaches were discovered during a routine audit of medical records of high profile patients by the SFGH Privacy Office on October 21, 2013. As noted, the four employees (RN 6 and the three contracted billing clerks) involved in these privacy breaches had been oriented to their responsibilities to protect the confidentiality of patient protected health information (PHI) and to medical information privacy requirements as evidenced by training documentation. RN 6 and the three contract billing clerks were placed on administrative leave by their respective HR departments pending completion of the Privacy Officer' investigation. RN6 voluntarily resigned; two of the three contracted billing clerks have subsequently been terminated from employment and one contracted billing clerk was returned to duty. Her LCR access is being randomly audited by the SFGH Privacy Office to ensure compliance with patient confidentiality. The Chief Nursing Officer (CNO) issued a memo to nursing staff reminding staff about their employee responsibility to protect patient privacy and confidentiality. The privacy breaches were disclosed to	incidents of non-compliance with DPH and SFGH privacy policies which occur during the year at the next scheduled SFGH ***Quality Council.*** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.		

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Patient 1' family representative by hospital leadership. The SFGH Privacy Officer issued a memo to all hospital staff reminding them about their employee responsibility to protect patient privacy and confidentiality. The ***SFGH Privacy Committee*** reports privacy related issues e.g., privacy breaches and staff education around privacy, to the Leadership Medical Executive Committee (MEC), to the Nursing Administrative Forum (NAF), and to the hospital Quality Council (QC).			
4. *The hospital failed to ensure the confidentiality of Patient 1's protected health information (PHI) when a contracted employee discussed Patient 1's PHI over the telephone with persons with no need and no authorization to receive such information (A146)*	**<u>Finding 4 (failure to ensure confidentiality of Patient 1;s PHI when a contracted employee discussed patient 1' PHI over the telephone with persons with no need and no authorization to receive such information:</u>** **Actions(s):** Before and after these privacy breach incidents, hospital leadership has engaged in ongoing efforts via memos, emails, staff trainings, and employee annual update training to ensure that hospital staff are educated and knowledgeable about hospital and SFDPH privacy and security policies. The SFGH multidisciplinary ***Privacy Committee***, composed of the SFGH Privacy Officer and staff from the SFGH Privacy Office, the SFGH Chief Medical Officer, the SFGH Chief Communications Officer, representatives from the SFGH Legal Affairs, Regulatory Affairs, Health Information Systems departments , as well as representatives from both the SFGH and UCSF	The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct monthly audits of the ***Lifetime Clinical Record (LCR)*** of all employees of the City & County of San Francisco Department of Public Health (CCSF DPH) and of all employees of the University of California, San Francisco (UCSF) who received care as patients at the hospital (emergency department, clinics, acute care, skilled nursing) to verify if the LCR access was appropriate.	• January, 2014 • Monthly	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH • SFGH Privacy Officer
		The SFGH Privacy Officer and the SFGH Privacy Analyst conduct audits of the ***Lifetime Clinical Record (LCR)*** of any patient as requested by managers to verify if the LCR access was appropriate .e.g., media high profile cases, VIPs. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation.	• Upon request • Ongoing	
		The total number of audits conducted per month average between 25-30/month.	• Quarterly	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Risk Management and Information Systems Departments, meets monthly to review, discuss, and recommend policy involving privacy compliance issues. The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct ***"Privacy Rounds"*** within the hospital departments to educate hospital staff about privacy security and awareness, to validate staff knowledge regarding privacy security and awareness, as well as to identify issues requiring corrective action by managers. Findings are reported to the Privacy Committee. The fifth privacy breach was discovered during the dispatch audio tape review by CMS surveyors On October 30, 2013. As noted, there was no documentation that SDS 16 had participated in hospital training for confidentiality, privacy and HIPPA. SDS 16 attended the reorientation of SFSD staff hospital policies and procedures covered in the usual new employee hospital orientation program hospital. SDS 16 has been reassigned to a non-DPH post. The Chief Nursing Officer (CNO) issued a memo to nursing staff reminding staff about their employee responsibility to protect patient privacy and confidentiality. The privacy breaches were disclosed to Patient 1' family representative by hospital leadership. The SFGH Privacy Officer issued a memo to all hospital staff reminding them about their	Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation. Audit results are reported quarterly to the ***SFGH Privacy Committee.***		
		The SFGH Privacy Officer will present an annual report regarding privacy issues to the ***SFGH Quality Council*** including results of the quarterly audits. In addition, they report any incidents of non-compliance with DPH and SFGH privacy policies which occur during the year at the next scheduled SFGH ***Quality Council.*** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• Annual, 2014 • Annually	
		The SFSD Captain or designee conducts random audits of ten taped calls per month from the SFGH SFSD communications center to ensure compliance with confidentiality of protected health information.	• January, 2014 • Monthly	
		Audit results will be reported quarterly to ***EOC Committee***. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Quarterly	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	employee responsibility to protect patient privacy and confidentiality. The ***SFGH Privacy Committee*** reports privacy related issues e.g., privacy breaches and staff education around privacy, to the Leadership Medical Executive Committee (MEC), to the Nursing Administrative Forum (NAF), and to the hospital Quality Council (QC).			
5. *The hospital failed to ensure that all contracted employees received annual training on their roles and responsibilities with regard to confidentiality, privacy and HIPPA (Health Information Privacy and Portability Act) (A146; and,*	**Finding 5 (failure to ensure that all contracted employees received annual training on their roles and responsibilities with regard to confidentiality, privacy, and HIPPA:** **Actions(s):** Hospital leadership implemented re-orientation of the SFSD staff on hospital policies and procedures covered the in the usual new employee hospital orientation program. The CCSF Sheriff created a new position of Training Coordinator to add to the SFSD staff at SFGH in order to assist in the on-going training of SFSD staff, to ensure SFSD staff complete hospital orientation, annual training, and in-servicing on new/revised hospital policies and procedures, and to participate in review/revision of key hospital policies/procedures.	The SFSD Training Officer, in collaboration with the SFGH Department of Education and Training (DET), will audit SFSD staff attendance at new employee hospital orientation and any other required hospital trainings quarterly for one year and annually thereafter.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH
		Audit results will be reported to the ***Quality Council*** quarterly for one year and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	
6. *The hospital failed to ensure the safety of their patients when there was no coordinated plan for fire and disaster response which included the contracted security personnel (A144)*	**Finding 6 (failed to ensure safety of patients when there was no coordinated plan for fire and disaster response which included the contracted security personnel:** **Actions(s):**	The chairs and/or designees of the key hospital committees addressing campus safety and security issues will audit the committee meeting minutes and attendance rosters quarterly for one year and annually thereafter to verify that SFSD representatives	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	SFSD, as a contracted service with the CCSF-DPH, is a participant on the key hospital committees addressing campus safety & security issues: 1. Administrative Operations Meeting 2. Bed Meetings 3. Critical Incident Response Team 4. Code Green Task Force (At-Risk Missing Patients) 5. Disaster Council Committee 6. Employee Health & Safety 7. Environment of Care (EOC) Committee 8. Hospital Leadership Security Meeting 9. Infant/Child Security Program Committee (Code Pink) 10. Management Forum 11. Violence Prevention Team Hospital and SFSD leadership reinforced the expectation that SFSD representatives attend and are actively involved on key hospital committees addressing campus safety and security issues and will verify SFSD representatives' attendance at committee meetings.	attend the key hospital committees addressing campus safety and security issues. Audit results will be reported quarterly to ***EOC Committee*** and to ***Quality Council*** for one year and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	
A-144 82.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting.				
1. *Patient 1, a confused woman, was not assigned a one-to-one personal assistant (1:1 Coach) as ordered by the physician which enabled Patient 1 to wander off her nursing unit without staff awareness for forty minutes. Patient 1 was able to walk through an alarmed fire escape door without anyone hearing the alarm, and Patient 1 was able to remain in a rarely used stairwell from 9/21/13 through 10/8/13 without anyone finding*	**A144 482.13 (c) (2) Patient Rights: Care in a Safe Setting** **Finding 1 (failure to assign 1:1 as ordered by MD , pt able to walk off unit unobserved, pt able to walk thru an alarmed door without anyone hearing, pt able to remain in rarely used stairwell without anyone finding/assisting her before pt died in the stairwell):**	The Chief Nursing Officer and/or designees will conduct an audit of all current in-patients to ensure physician orders are completed and transcribed to the kardex, care plans are individualized, and close observation interventions are individualized to the patient; they will resolve any issues identified in real time with coaching and feedback to staff**.** Audit results will be reported quarterly to the ***Nursing Quality Forum*** and to the ***Quality***	• January 7, 2014 – January 10, 2014 • April, 2014 • July, 2014	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH • Chief Nursing Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
and assisting her before Patient 1 died in the stairwell	**Actions(s):** ***Nursing Policy 6.04/Close Observation of the Hospitalized Patient*** was reviewed by nursing managers with staff during emergency staff meetings and during change of shift reports to clarify and remind staff of the requirement to implement physician orders. Following the discovery of Patient 1' body, the SFSD initiated daily stairwell checks for audible alarm activations in Building 5, Main Hospital; alarm activations are reported to the Administrator-on-Duty (AOD) to include in the daily AOD report. Upon review, it was discovered that emergency exit stairwell alarms were not standardized throughout Building 5 (Main Hospital Building) to maintain an audible constant alarm until manually deactivated. Hospital facilities staff replaced and standardized the emergency exit stairwell door alarms for Building 5 (main hospital) so that the alarms now maintain an audible constant alarm until manually deactivated by a key. Emergency exit stairwell alarm deactivations and stairwell checks are now tracked and reported through the EOC Committee as a component of the SFGH and SFSD security performance measures**.** Hospital leadership initiated daily check of all internal and external stairwells in Building 5, Main Hospital; sweep results are now reported to the AOD to include in the daily AOD report.	***Council*** and annually thereafter**.** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• October, 2014 • January, 2015 • Annual, 2014 • Annually	
		The daily stairwell checks data, stairwell alarm activation data, stairwell alarm PM data, surveillance camera data, AeroScout data, SFSD missing/at-risk search data, Code Green drills data will be reported quarterly to ***EOC Committee*** for one year and annually thereafter.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	
		SFGH SFSD representatives are on EOC Committee. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• Annual, 2014 • Annually	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Hospital leadership purchased an electronic tracking system (Aero Scout) for monitoring at risk patients. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. There was organizational inconsistency in the care of patients requiring close observation. As a result, Hospital, Nursing and Medical staff leadership re-designated ***Nursing Policy 6.04/Close Observation of the Hospitalized Patient*** as a hospital administrative policy. It is now ***Admin Policy 18.02/Close Observation of the Hospitalized Patient.*** Hospital, Nursing and Medical staff leadership revised the policy to clarify close observation, actions nurses need to take when a physician orders close observation, requirements that implementation and discontinuation of close observation requires provider/nurse communication about the patient status, and documentation requirements for when close observation is implemented and/or discontinued.			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** will be included in monthly new employee hospital orientation and in annual updates. Hospital, Nursing and Medical leadership in-serviced staff on revised ***Admin Policy 18.02/Close Observation of the Hospitalized Patient***. Hospital leadership is in-servicing hospital and			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	SFSD staff on the new "Code Green" procedure.			
2. *Hospital security did not have a coordinated plan on how to search for any missing patients whether they were classified as AWOL (Absent Without Leave), missing persons, medically at risk persons, or 5150/5250 (Legally Detained) On Hold. The hospital security staff did not follow the hospital policy and procedure titled AMA (Against medical Advice), AWOL, and Elopement: Patients Leaving (Hospital Name) Prior to Completion of their Evaluation or Treatment.*	**Finding 2 (SFSD did not have a coordinated plan on how to search for a missing patient whether they were classified as AWOL, missing persons, or 5150-5250 Legally Detained On Hold:** **Actions(s):** SFSD leadership, in collaboration with SFGH leadership, developed and is implementing a new SFSD protocol for conducting a search for missing/at risk person(s) on the SFGH hospital campus. Hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to	The daily stairwell checks data, stairwell alarm activation data, stairwell alarm PM data, surveillance camera data, AeroScout data, SFSD missing/at-risk search data, Code Green drills data will be reported quarterly to ***EOC Committee*** for one year and annually thereafter. SFGH SFSD representatives are on EOC Committee. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	• Chief Nursing Officer • Chief medical Officer • Hospital Associate Administrator for Support Services • SFSD Captain at SFGH

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	families, contacting patients after they depart and documentation in the medical record. Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. Hospital leadership is in-servicing hospital and SFSD staff on the new "Code Green" procedure.			
3. *The hospital and its contracted security service did not have a coordinated plan for their combined response to fires and other disasters such as an earthquake. This had the potential for a chaotic and ineffective response during actual emergencies.*	**<u>Finding 3 (hospital & its contracted security service did not have a coordinated plan for their combined response to fires and other disasters such as an earthquake:</u>** **Actions(s):** SFSD, as a contracted service with the CCSF-DPH, is a participant on the key hospital committees addressing campus safety & security issues: 1. Administrative Operations Meeting 2. Bed Meetings 3. Critical Incident Response Team 4. Code Green Task Force (At-Risk Missing Patients)	The chairs and/or designees of the key hospital committees addressing campus safety and security issues will audit the committee meeting minutes and attendance rosters quarterly for one year and annually thereafter to verify that SFSD representatives attend the key hospital committees addressing campus safety and security issues. Audit results will be reported quarterly to ***EOC Committee*** and to ***Quality Council*** quarterly for one year and annually thereafter.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH • Director of Emergency Management

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	5. Disaster Council Committee 6. Employee Health & Safety 7. Environment of Care (EOC) Committee 8. Hospital Leadership Security Meeting 9. Infant/Child Security Program Committee (Code Pink) 10. Management Forum 11. Violence Prevention Team Hospital and SFSD leadership reinforced the expectation that SFSD representatives attend and are actively involved on key hospital committees addressing campus safety and security issues and will verify SFSD representatives' attendance at committee meetings. SFGH utilizes the Hospital Incident Command System (HICS) to coordinate all emergency response activities. SFSD staff at SFGH are integrated into the SFGH HICS structure, with the Sheriff's Department Watch Commander (or a higher ranking staff member) serving as the Security Branch Director within the Incident Management Team (**see attached Job Action Sheet - Security Branch Director**) for most emergency activations. SFGH's overall Emergency Operations Plan and Hazard Specific Plans provide guidance for how SFSD and SFGH staff coordinate their efforts to manage the particular emergency. If the emergency situation is a law enforcement incident (e.g., bomb threat or hostage situation) where SFSD has jurisdictional authority for management of the incident, the SFSD Incident Commander would establish unified command with the SFGH Incident Commander.	SFSD performance during all HICS activations including exercises and actual incidents will be evaluated using the SFGH Emergency Management Performance Evaluation tools. The results of those evaluations will be reported to the ***Disaster Committee*** and the ***EOC Safety Committee***. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	SFGH has provided training on key actions for disaster and fire response to all SFSD staff. HICS Basics courses have been provided in the past for SFSD Watch Commanders and Unit Commanders, and most of these staff members have served as members of the HICS Incident Management Team during exercises or actual incidents. Following the CMS Complaint Validation Survey, hospital leadership identified the need to schedule additional HICS basic trainings to ensure that all current members of the SFSD leadership team at SFGH have a thorough working knowledge of the SFGH Emergency Operations Plan for response to fire, disaster and other emergencies. SFGH has established standards for monitoring of performance of critical tasks during emergency / disaster response incidents and exercises, including those related to security (**see attached Performance Evaluation form**). In addition to these basic performance standards for all hazards response, key actions for specific types of incidents are also included in the overall performance evaluations of exercises and actual incidents. SFSD has consistently performed well during emergency activations. SFGH and SFSD will ensure that all Sheriff's Department staff at SFGH have completed basic orientation to the SFGH Emergency Operations Plan and response procedures, as evidenced by New Employee Orientation documentation and annual update training records.			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	SFSD Watch Commanders, Unit Commanders, and other key SFSD staff will complete HICS Basics education.			
A-146 482.13(d) PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS Patient Rights: Confidentiality of Records				
1. *One staff member and three contracted Billing employees accessed Patient 1's Lifetime Care Record (LCR- medical record/electronic chart) without need or authorization and they reviewed confidential information in the LCR;*	**A-146 482.13 (d) Patient Rights: Confidentiality of Records** **Finding 1 (failure to maintain confidentiality of Patient 1' PHI when 4 staff accessed Patient 1' LCR without need or authorization & reviewed confidential information in the LCR):** **Actions(s):** Before and after these privacy breach incidents, hospital leadership has engaged in ongoing efforts via memos, emails, staff trainings, and employee annual update training to ensure that hospital staff are educated and knowledgeable about hospital and SFDPH privacy and security policies.	The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct monthly audits of the ***Lifetime Clinical Record (LCR)*** of all employees of the City & County of San Francisco Department of Public Health (CCSF DPH) and of all employees of the University of California, San Francisco (UCSF) who received care as patients at the hospital (emergency department, clinics, acute care, skilled nursing) to verify if the LCR access was appropriate.	• January, 2014 • Monthly	• SFGH Privacy Officer • Chief Nursing Officer
		The SFGH Privacy Officer and the SFGH Privacy Analyst conduct audits of the ***Lifetime Clinical Record (LCR)*** of any patient as requested by managers to verify if the LCR access was	• Upon request • Ongoing	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	The SFGH multidisciplinary ***Privacy Committee***, composed of the SFGH Privacy Officer and staff from the SFGH Privacy Office, the SFGH Chief Medical Officer, the SFGH Chief Communications Officer, representatives from the SFGH Legal Affairs, Regulatory Affairs, Health Information Systems departments , as well as representatives from both the SFGH and UCSF Risk Management and Information Systems Departments, meets monthly to review, discuss, and recommend policy involving privacy compliance issues. The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct ***"Privacy Rounds"*** within the hospital departments to educate hospital staff about privacy security and awareness, to validate staff knowledge regarding privacy security and awareness, as well as to identify issues requiring corrective action by managers. Findings are reported to the ***Privacy Committee.*** As noted, four of the privacy breaches were discovered during a routine audit of medical records of high profile patients by the SFGH Privacy Office on October 21, 2013. As noted, the four employees (RN 6 and the three contracted billing clerks) involved in these privacy breaches had been oriented to their responsibilities to protect the confidentiality of patient protected health information (PHI) and to medical information privacy requirements as evidenced by training documentation. RN 6 and the three contract billing clerks were	appropriate .e.g., media high profile cases, VIPs. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation.		
		The total number of audits conducted per month average between 25-30/month. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation. Audit results are reported quarterly to the ***SFGH Privacy Committee.***	• Quarterly	
		The SFGH Privacy Officer presents an annual report regarding privacy issues to the ***SFGH Quality Council*** including results of the quarterly audits. In addition, they report any incidents of non-compliance with DPH and SFGH privacy policies which occur during the year at the next scheduled SFGH ***Quality Council.*** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.***	• Annual, 2014 • Annually	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	placed on administrative leave by their respective HR departments pending completion of the Privacy Officer' investigation. RN 6 voluntarily resigned; two of the three contracted billing clerks have subsequently been terminated from employment and one contracted billing clerk was returned to duty. Her LCR access is being randomly audited by the SFGH Privacy Office to ensure compliance with patient confidentiality. The Chief Nursing Officer (CNO) issued a memo to nursing staff reminding staff about their employee responsibility to protect patient privacy and confidentiality. The privacy breaches were disclosed to Patient 1's family representative by hospital leadership. The SFGH Privacy Officer issued a memo to all hospital staff reminding them about their employee responsibility to protect patient privacy and confidentiality. The SFGH Privacy Committee reports privacy related issues e.g., privacy breaches and staff education around privacy, to the Leadership Medical Executive Committee (MEC), to the Nursing Administrative Forum (NAF), and to the hospital Quality Council (QC).			
2. *One contracted security person (SDS 16) discussed Patient 1's protected health information; and,*	**Finding 2 (failure to maintain confidentiality of patient 1' PHI when one contracted security person (SDS 16) discussed patient 1' PHI:**	The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct monthly audits of the ***Lifetime Clinical Record (LCR)*** of all employees of the City & County of San Francisco Department of Public Health (CCSF	• January, 2014 • Monthly	• SFGH Privacy Officer • Hospital Associate Administrator for

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Actions(s): Before and after these privacy breach incidents, hospital leadership has engaged in ongoing efforts via memos, emails, staff trainings, and employee annual update training to ensure that hospital staff are educated and knowledgeable about hospital and SFDPH privacy and security policies. The SFGH multidisciplinary ***Privacy Committee***, composed of the SFGH Privacy Officer and staff from the SFGH Privacy Office, the SFGH Chief Medical Officer, the SFGH Chief Communications Officer, representatives from the SFGH Legal Affairs, Regulatory Affairs, Health Information Systems departments , as well as representatives from both the SFGH and UCSF Risk Management and Information Systems Departments, meets monthly to review, discuss, and recommend policy involving privacy compliance issues. The SFGH Privacy Officer and the SFGH Privacy Analyst routinely conduct ***"Privacy Rounds"*** within the hospital departments to educate hospital staff about privacy security and awareness, to validate staff knowledge regarding privacy security and awareness, as well as to identify issues requiring corrective action by managers. Findings are reported to the ***Privacy Committee***. As noted, this privacy breach was discovered during the dispatch audio tape review by CMS surveyors On October 30, 2013. As noted, there was no documentation that SDS 16 had participated in hospital training for confidentiality, privacy and HIPPA.	DPH) and of all employees of the University of California, San Francisco (UCSF) who received care as patients at the hospital (emergency department, clinics, acute care, skilled nursing) to verify if the LCR access was appropriate.		Support Services • SFSD Captain at SFGH
		The SFGH Privacy Officer and the SFGH Privacy Analyst conduct audits of the ***Lifetime Clinical Record (LCR)*** of any patient as requested by managers to verify if the LCR access was appropriate .e.g., media high profile cases, VIPs. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation.	• Upon request • Ongoing	
		The total number of audits conducted per month average between 25-30/month. Questionable audit results are investigated with the manager and employee and action taken as indicated by the investigation. Audit results are reported quarterly to the ***SFGH Privacy Committee.***	• Quarterly	
		The SFGH Privacy Officer presents an annual report regarding privacy issues to the ***SFGH Quality Council*** including results of the quarterly audits. In addition, they report any incidents of non-compliance with DPH and SFGH privacy policies which occur during the year at the next scheduled SFGH ***Quality Council.*** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• Annual, 2014 • Annually	
		The SFSD Captain or designee conduct random audits of ten taped calls per month from the SFGH SFSD communications center	• February, 2014 • Monthly	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	SDS 16 attended the reorientation of SFSD staff hospital policies and procedures covered in the usual new employee hospital orientation program hospital. SDS 16 has been reassigned to a non-DPH post. The Chief Nursing Officer (CNO) issued a memo to nursing staff reminding staff about their employee responsibility to protect patient privacy and confidentiality. This privacy breach was disclosed to Patient 1's family representative by hospital leadership. The SFGH Privacy Officer issued a memo to all hospital staff reminding them about their employee responsibility to protect patient privacy and confidentiality. The SFGH Privacy Committee reports privacy related issues e.g., privacy breaches and staff education around privacy, to the Leadership Medical Executive Committee (MEC), to the Nursing Administrative Forum (NAF), and to the hospital Quality Council (QC).	to ensure compliance with confidentiality of protected health information. Audit results will be reported quarterly to ***EOC Committee***. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Quarterly	
3. The contracted security personnel had not participated in annual training on their roles and responsibilities with regard to confidentiality, privacy and HIPPA (Health Information Privacy and Portability Act).	**<u>Finding 3 (the contracted security personnel had not participated in annual training on their roles and responsibilities with regard to confidentiality, privacy, and HIPPA:</u>** **Actions(s):** Hospital leadership implemented re-orientation of the SFSD staff on hospital policies and procedures covered the in the usual new employee hospital orientation program.	The SFSD Training Officer, in collaboration with the SFGH Department of Education and Training (DET), will audit SFSD staff attendance at new employee hospital orientation and any other required hospital trainings quarterly for one year and annually thereafter. Audit results will be reported to the ***Quality Council*** quarterly for one year and annually thereafter.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually • April, 2014 • July, 2014 • October, 2014	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	The CCSF Sheriff created a new position of Training Coordinator to add to the SFSD staff at SFGH in order to assist in the on-going training of SFSD staff, to ensure SFSD staff complete hospital orientation, annual training, and in-servicing on new/revised hospital policies and procedures, and to participate in review/revision of key hospital policies/procedures.		• January, 2015 • Annually	
A-263 482.21 QAPI (Quality Assurance and Performance Improvement) The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.				
1. *The hospital Quality Assessment Performance Improvement (QAPI) program failed to set priorities for its performance improvement activities that focused on improving security for patients that go missing. The QAPI program had identified issues with missing persons since 2010 and the contracted security, Sheriff's Department, did not participate in improving hospital performance (see A-0383, A-0273, A-0084.*	**A-263 482.21 QAPI** **Finding 1 (hospital QAPI program failed to set priorities for its performance improvement activities that focused on improving security for patients that go missing.** **The QAPI program had identified issues with missing persons since 2010 and the contracted security, Sheriff' Department, did not participate in improving hospital performance which resulted in a patient who went missing for 17 days and was found dead in a hospital emergency stairwell:** **Actions(s):** The hospital QAPI AWOL patient project was not focused on tracking missing/at-risk patients. The 2010 PI AWOL Patient study included only those patients who were determined to have medical decision making capacity. In the study, patients with medical decision making capacity who chose to leave their assigned unit prior to completion of their treatment or evaluation were considered AWOL from the hospital.	Missing at-risk patient data will be reported quarterly for one year at ***EOC Committee*** and to ***Quality Council*** and annually thereafter. ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Hospital Associate Administrator for Support Services • SFSD Captain at SFGH • Chief Quality Officer • Patient Safety Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	To optimize patient care, effective April 1, 2011, all patients with medical decision making capacity who chose to leave his/her assigned unit prior to completion of their treatment or evaluation were discharged from the hospital. The goal was to accomplish a 60% decrease in AWOL by patients with medical decision making capacity events by August 1, 2011. Following the complaint validation survey, hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Tracking missing/at risk patients is now a QAPI Program indicator being tracked by the EOC Committee. SFGH SFSD representatives are EOC committee members.			
2. The hospital Quality Assessment Performance Improvement (QAPI) program failed to track missing persons as a quality indicator to improve contracted security services. The QAPI program had identified issues with missing persons since 2010 and did not include contracted security, Sheriff's Department, in improving hospital performance (A-0273, A-0283, A-0084.)	**Finding 2 the hospital QAPI) program failed to track missing persons as a quality indicator to improve contracted security services. The QAPI program had identified issues with missing persons since 2010 and did not include contracted security, Sheriff' Department, in improving hospital performance which resulted in a patient who went missing for 17 days and was found dead in a hospital emergency stairwell:** **Action(s):**	Missing at-risk patient data will be reported quarterly for one year at ***EOC Committee*** and to ***Quality Council*** and annually thereafter. ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Hospital Associate Administrator for Support Services • Captain, SFGH SFSD • Chief Quality Officer • Patient Safety Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	The hospital QAPI AWOL patient project was not focused on tracking missing/at-risk patients. The 2010 PI AWOL Patient study included only those patients who were determined to have medical decision making capacity. In the study, patients with medical decision making capacity who chose to leave their assigned unit prior to completion of their treatment or evaluation were considered AWOL from the hospital. To optimize patient care, effective April 1, 2011, all patients with medical decision making capacity who chose to leave his/her assigned unit prior to completion of their treatment or evaluation were discharged from the hospital. The goal was to accomplish a 60% decrease in AWOL by patients with medical decision making capacity events by August 1, 2011. Following the complaint validation survey, hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Tracking missing/at risk patients is now a QAPI Program indicator being tracked by the EOC Committee. SFGH SFSD representatives are EOC Committee members.			
3. The hospital failed to develop performance improvement projects to	**Finding 3 - the hospital failed to develop performance improvement projects to**	The data from the nursing and CPOE audits will be reported to ***Quality Council***. The	• Annual, 2014 • Annually	• Chief Quality Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
identify and reduce medical errors related to the implementation of physician orders, the use and monitoring of coach/sitters (patient Care Assistant assigned to monitor one patient on a continuous basis), and patient care planning. (See A-286)	**identify and reduce medical errors related to the implementation of physician orders, the use and monitoring of coach/sitters (Patient Care Assistant assigned to monitor one patient on a continuous basis), and patient care planning. This had the potential for harm especially to the most vulnerable patients who require coaches for safety:** **Actions(s):** Utilizing the data collected through the nursing audits (refer to Tag A-043, Finding 3), hospital leadership will review the data for trends and develop additional measures using the Plan-Do-Study-Act (PDSA) methodology to improve nursing practice related to transcription and implementation of physician orders, use and monitoring of coaches, and individualized patient care plans. The PI staff will collaborate with nursing leadership to develop a PI project focused on the Computerized Physician Order Entry (CPOE) process, and including Nursing work flow processes, to ensure appropriate transcription and implementation of physician orders, use and monitoring of coaches, and patient care planning.	***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.*** Utilizing the data collected through the nursing audits (refer to Tag A-043, Finding 3), hospital leadership will review the data for trends and develop additional measures using the Plan-Do-Study-Act (PDSA) methodology to improve nursing practice related to transcription and implementation of physician orders, use and monitoring of coaches, and individualized patient care plans. The PI staff will collaborate with nursing leadership to develop a PI project focused on the Computerized Physician Order Entry (CPOE) process, and including Nursing work flow processes, to ensure appropriate transcription and implementation of physician orders, use and monitoring of coaches, and patient care planning.	 • Immediately • Complete • Immediately • Ongoing	• Chief Nursing Officer • Director of Performance Improvement • Medical Director for Quality Management
A-273 482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS The hospital must ensure that the program data requirements are met.				
1. *The hospital Quality Assessment & Performance Improvement (QAPI) program failed to track missing persons as a quality indicator to improve contracted security services. The QAPI program had identified issues with*	**A-273 482.21 (a), (b)(1), (b)(2)(i), (b)(3) Data Collection & Analysis** **Finding 1 (The hospital (QAPI) program failed to track missing persons as a quality indicator to improve contracted security services. The**	Missing at-risk patient data will be reported quarterly for one year to ***EOC Committee*** and to ***Quality Council*** and annually thereafter. ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.***	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Hospital Associate Administrator for Support Services • Captain, SFGH SFSD • Chief Quality

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
missing persons since 2010 and did not include contracted security, sheriff's Department, in improving hospital performance.	**QAPI program had identified issues with missing persons since 2010 and did not include contracted security, sheriff' Department, in improving hospital performance which resulted in a patient who went missing for 17 days and was found dead in a hospital emergency stairwell:** **Actions(s):** Following the complaint validation survey, hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Tracking missing/at risk patients is now a QAPI Program indicator being tracked by the EOC Committee. SFGH SFSD representatives are EOC Committee members.	Tracking missing/at risk patients is now a QAPI Program indicator being tracked by the EOC Committee. SFGH SFSD representatives are EOC Committee members.	• Immediately • Ongoing	Officer • Patient Safety Officer
A-283 482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES The hospital must ensure that the program activities requirements are met.				
1. *The hospital Quality Assessment Performance Improvement (QAPI) program failed to set priorities for its performance improvement activities that focused on improving security for patients that go missing. The QAPI program had identified issues with missing persons since 2010 and did not include contracted security, sheriff's Department, in improving hospital performance (Cross ref. A273).*	**A-283 482.21 (b)(2)(ii), (c)(1), (c)(3) Quality Improvement Activities** **Finding 1 (The hospital Quality Assessment Performance Improvement (QAPI) program failed to set priorities for its performance improvement activities that focused on improving security for patients that go missing. The QAPI program had identified issues with missing persons since 2010 and did not include contracted security, sheriff'**	Missing at-risk patient data will be reported quarterly for one year to ***EOC Committee*** and to ***Quality Council*** and annually thereafter. ***Quality Council*** reports annually toe the ***Governing Body Joint Conference Committee.***	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annually	• Hospital Associate Administrator for Support Services • Captain, SFGH SFSD • Chief Quality Officer • Patient Safety Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Department, in improving hospital performance which resulted in a patient who went missing for 17 days and was found dead in a hospital emergency stairwell: **Actions(s):** The hospital QAPI AWOL patient project was not focused on tracking missing/at-risk patients. The 2010 PI AWOL Patient study included only those patients who were determined to have medical decision making capacity. In the study, patients with medical decision making capacity who chose to leave their assigned unit prior to completion of their treatment or evaluation were considered AWOL from the hospital. To optimize patient care, effective April 1, 2011, all patients with medical decision making capacity who chose to leave his/her assigned unit prior to completion of their treatment or evaluation were discharged from the hospital. The goal was to accomplish a 60% decrease in AWOL by patients with medical decision making capacity events by August 1, 2011. Following the complaint validation survey, hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Tracking missing/at risk patients is now a QAPI			

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Program indicator being tracked by the EOC Committee. SFGH SFSD representatives are EOC committee members.			
A-286 482.21(a),(c)(2), (e)(3) PATIENT SAFETY Performance improvement activities must track medical errors and adverse patient events				
1. *The hospital failed to develop performance improvement projects to identify and reduce medical errors related to the implementation of physician's order.*	**A286 482.21 (a), (c)(2), (e)(3) Patient Safety** **Finding 1 (hospital failed to develop performance improvement projects to identify and reduce medical errors related to the implementation of physician' orders):** **Actions(s):** The PI staff will collaborate with nursing leadership to develop a PI project focused on the Computerized Physician Order Entry (CPOE) process, and including nursing work flow processes to ensure appropriate transcription and implementation of physician orders, use and monitoring of coaches, and patient care planning.	The data from the CPOE audits will be reported to ***Quality Council***. ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.***	• Annual, 2014 • Annually	• Chief Quality Officer • Chief Nursing Officer • Director of Performance Improvement • Medical Director for Quality Management
2. *The hospital failed to develop performance improvement projects to identify and reduce medical errors related to the use and monitoring of coach/sitters (Patient Care Assistant assigned to monitor one patient on a continuous basis), and*	**Finding 2 (hospital failed to develop performance improvement projects re the use and monitoring of coach/sitters (Patient Care Assistant assigned to monitor one patient on a continuous basis):** **Actions(s):** Following the complaint validation survey, the Chief Nursing Officer assessed the nursing practice of staff caring for patients requiring close observation. The medical surgical units submitted daily logs of patients identified as at-risk and the Chief Nursing Officer conducted random chart reviews. The Chief Nursing Officer provided individual	The Chief Nursing Officer and/or designee will conduct an audit of all current in-patients to ensure close observation interventions, including the use of coach/sitters, are individualized to the patient; they will resolve any issues identified in real time with coaching and feedback to staff.	• January 7, 2014 – January 10, 2014	• Chief Nursing Officer • Chief Quality Officer • Patient Safety Officer
		The Nurse Manager and/or designee will observe five staff per week during inter-shift hand-off to ensure proper use of the end-of-shift communication tool.	• January, 2014 • Weekly	
		Audit results will be reported quarterly to the ***Nursing Quality Forum*** and to the ***Quality Council*** and annually thereafter**.** The ***Quality***	• April, 2014 • July, 2014 • October, 2014	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	coaching to staff and used the assessment information to develop a nursing sensitive quality audit tool to monitor nursing practice. The Chief Nursing Officer is developing a standardized end of shift communication tool to facilitate inter-shift handoff focusing on the nursing specific quality indicators, including the use of coach/sitters.	***Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• January, 2015 • Annual, 2014 • Annually	
3. *The hospital failed to develop performance improvement projects to identify and reduce medical errors related to the implementation of patient care planning.*	**Finding 3 (hospital failed to develop performance improvement project re nursing care plans:** **Actions(s):** Utilizing the data collected through the nursing audits, hospital leadership will review the data for trends and develop performance improvement (PI) projects focusing on patient care planning.	The Chief Nursing Officer and/or designee will conduct an audit of all current in-patients to ensure nursing care plans are individualized to the patient. They will resolve any issues identified in real time with coaching and feedback to staff.	• January 7, 2014 – January 10, 2014	• Chief Nursing Officer • Chief Quality Officer • Patient Safety Officer
		Utilizing the data collected through the nursing audits, hospital leadership will review the data for trends and develop performance improvement (PI) projects focusing on patient care planning.	• Immediately • Ongoing	
		Audit results will be reported quarterly to the ***Nursing Quality Forum*** and to the ***Quality Council*** and annually thereafter**.** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	
A-385 482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.				
1. *The facility failed to ensure all staff followed physician's order when Patient 1 had an order for coach/sitter on 9/20/13 but was discontinued by a licensed nurse without discussing it with the physician*	**A-385 482.23 Nursing Services** **Finding 1 (failed to ensure that all staff followed physician' order when Patient 1 had an order for coach/sitter on 9/20/13 but was**	The Chief Nursing Officer and/or designee will conduct an audit of all current in-patients to ensure physician orders are completed and transcribed to the kardex; they will resolve any issues identified in real time with	• January 7, 2014 – January 10, 2014	• Chief Nursing Officer • Chief Medical Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
(A-395).	**discontinued by a licensed nurse without discussing it with the physician :** **Actions(s):** There was organizational inconsistency in the care of patients requiring close observation. As a result, Hospital, Nursing and Medical staff leadership re-designated ***Nursing Policy 6.04/Close Observation of the Hospitalized Patient*** as a hospital administrative policy. It is now ***Admin Policy 18.02/Close Observation of the Hospitalized Patient.*** Hospital, Nursing and Medical staff leadership revised the policy to clarify close observation, actions nurses need to take when a physician orders close observation, requirements that implementation and discontinuation of close observation requires provider/nurse communication about the patient status, and documentation requirements for when close observation is implemented and/or discontinued. Hospital, Nursing and Medical leadership in-serviced staff on revised ***Admin Policy 18.02/Close Observation of the Hospitalized Patient.*** Following the complaint validation survey, the Chief Nursing Officer assessed the nursing practice of staff caring for patients requiring close observation. The medical surgical units submitted daily logs of patients identified as at-risk and the Chief Nursing Officer conducted random chart reviews. The Chief Nursing Officer provided individual coaching to staff and used the assessment information to develop a nursing sensitive quality audit	coaching and feedback to staff**.** Following the complaint validation survey, the Chief Nursing Officer assessed the nursing practice of staff caring for patients requiring close observation. The medical surgical units submitted daily logs of patients identified as at-risk and the Chief Nursing Officer conducted random chart reviews. The Chief Nursing Officer provided individual coaching to staff and used the assessment information to develop a nursing sensitive quality audit tool to monitor nursing practice. Audit results will be reported quarterly for one year to the ***Nursing Quality Forum*** and to the ***Quality Council*** and annually thereafter**.** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***.	 • Immediately • Complete • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	• Chief Quality Officer • Patient Safety Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	tool to monitor nursing practice.			
2. *The facility failed to ensure physician's order was carried out as ordered when Patient 8 had an order for 1:1 (one to one) coach/sitter but Patient 8 was put in a room with one facility staff coaching 3 (three) other patients who also had an order for 1:1 (coach/sitter). (A-395)*	**Finding 2 (failed to ensure physician' order was carried out as ordered when Patient 8 had an order for 1:1 (one to one) coach/sitter but Patient 8 was put in a room with one facility staff coaching 3 (three) other patients who also had an order for 1:1 coach/sitter:** **Actions(s):** There was organizational inconsistency in the care of patients requiring close observation. As a result, Hospital, Nursing and Medical staff leadership re-designated ***Nursing Policy 6.04/Close Observation of the Hospitalized Patient*** as a hospital administrative policy. It is now ***Admin Policy 18.02/Close Observation of the Hospitalized Patient.*** Hospital, Nursing and Medical staff leadership revised the policy to clarify close observation, actions nurses need to take when a physician orders close observation, requirements that implementation and discontinuation of close observation requires provider/nurse communication about the patient status, and documentation requirements for when close observation is implemented and/or discontinued. Hospital, Nursing and Medical leadership in-serviced staff on revised ***Admin Policy 18.02/Close Observation of the Hospitalized Patient***. Following the complaint validation survey, the Chief Nursing Officer assessed the nursing practice of staff caring for patients requiring close observation. The medical surgical units	The Chief Nursing Officer and/or designees will conduct an audit of all current in-patients to ensure close observation interventions are individualized to the patient; they will resolve any issues identified in real time with coaching and feedback to staff**.** Audit results will be reported quarterly for one year to the ***Nursing Quality Forum*** and to the ***Quality Council*** and annually thereafter**.** The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee***. Following the complaint validation survey, the Chief Nursing Officer assessed the nursing practice of staff caring for patients requiring close observation. The medical surgical units submitted daily logs of patients identified as at-risk and the Chief Nursing Officer conducted random chart reviews. The Chief Nursing Officer provided individual coaching to staff and used the assessment information to develop a nursing sensitive quality audit tool to monitor nursing practice.	• January 7, 2014 – January 10, 2014 • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually • Immediately • Complete	• Chief Nursing Officer • Chief Medical Officer • Chief Quality Officer • Patient Safety Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	submitted daily logs of patients identified as at-risk and the Chief Nursing Officer conducted random chart reviews. The Chief Nursing Officer provided individual coaching to staff and used the assessment information to develop a nursing sensitive quality audit tool to monitor nursing practice.			
3. *The facility failed to ensure nursing staff followed the instructions of the nursing administrator. On 9/21/13, the Nurse Administrator-on-Duty directed Charge Nurse 1 to report Patient 1 as a missing person on 9/21/13 but this information was not relayed to the Sheriff's Department Dispatcher (A-395)*	**Finding 3 (failed to ensure nursing staff followed the instructions of the nursing administrator. On 9/21/13, the Nurse Administrator-on-Duty directed Charge Nurse 1 to report Patient 1 as a missing person on 9/21/13 but this information was not relayed to the Sheriff' Department Dispatcher:** **Actions(s):** CN1 who provided the inaccurate description of the patient and who failed to follow the AOD instruction to report Patient 1 as a missing person to the SFSD was removed from CN duties, counseled regarding the findings, and placed on a developmental plan. Following the complaint validation survey, hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of***	The Code Green data and Code Green drills data will be reported quarterly to ***EOC Committee*** for one year and annually thereafter. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.***	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	• Chief Nursing Officer • Hospital Associate Administrator for Support Services

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	Their Treatment or Evaluation to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** will be included in monthly new employee hospital orientation and in annual updates.			
4. *The facility failed to ensure all staff follows policy and procedure on reporting a missing patient when Charge Nurse 1*	**Finding 4 (the facility failed to ensure all staff follows policy and procedure on reporting a missing patient when Charge Nurse 1 did not**	The Code Green data and Code Green drills data will be reported quarterly to ***EOC Committee*** for one year and annually	• April, 2014 • July, 2014 • October, 2014	• Chief Nursing Officer • Hospital Associate

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
did not give an accurate description of Patient 1 when patient was described as an African American woman and wearing a hospital gown. Patient 1 was Caucasian and was wearing her own clothes (A-395).	**<u>give an accurate description of Patient 1 when patient was described as an African American woman and wearing a hospital gown. Patient 1 was Caucasian and was wearing her own clothes when her body was found on the hospital' stairwell, 17 days after she was reported missing from her ward failure to individualize care plans for falls, AMS, elopement risk):</u>** **Actions(s):** CN1 who provided the inaccurate description of the patient and who failed to follow the AOD instruction to report Patient 1 as a missing person to the SFSD was removed from CN duties, counseled regarding the findings, and placed on a developmental plan. Hospital leadership created a ***Missing "At Risk" Patient Response Task Force*** which has developed and is implementing SFGH response procedures for missing "at risk" patients called ***"Code Green"***. A ***"Code Green"*** alert is an organizational response initiated by the AOD when a hospital-wide search is needed to locate a missing at-risk patient. Hospital leadership revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** to add an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it	thereafter. The ***EOC Committee*** reports to the ***Quality Council*** and the ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.***	• January, 2015 • Annual, 2014 • Annually	Administrator for Support Services

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. Hospital leadership is in-servicing hospital and SFSD staff regarding revised ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** including the use of an "AWOL/AMA Packet" to assist staff in managing situations where a patient leaves or attempts to leave the hospital prior to completion of their treatment, including the use of a checklist/script during AWOL patient reports to ensure the accuracy of the clinical and physical description information; it includes guidance on working with security services, communication of information to families, contacting patients after they depart and documentation in the medical record. ***Admin Policy 1.10/AMA, AWOL, & AWOL At-Risk: Patients Leaving SFGH Prior to the Completion of Their Treatment or Evaluation*** will be included in monthly new employee hospital orientation and in annual updates.			
5. The facility failed to develop an individualized plan of care for falls, altered mental status and elopement risks for Patient 1, 7, and 8 (A396)	**<u>Finding 5 (failed to develop an individualized plan of care for falls, altered mental status and elopement risks for Patient 1, 7, and 8):</u>** **Actions(s):** Utilizing the data collected through the nursing audits, hospital leadership will review the data for trends and develop performance improvement (PI) projects focusing on patient care planning, including but not limited to, care plans addressing falls risk, altered mental	The Chief Nursing Officer and/or designees will conduct an audit of all current in-patients to ensure care plans are individualized, including but not limited to care plans addressing falls risk, altered mental status, and elopement risk; they will resolve any issues identified in real time with coaching and feedback to staff. Utilizing the data collected through the nursing audits, hospital leadership will review	• January 7, 2014 – January 10, 2014 • Immediately • Ongoing	• Chief Nursing Officer • Chief Quality Officer • Patient Safety Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	status, and elopement risk.	the data for trends and develop performance improvement (PI) projects focusing on patient care planning, including but not limited to, care plans addressing falls risk, altered mental status, and elopement risk.		
		Audit results will be reported quarterly for one year to the ***Nursing Quality Forum*** and to the ***Quality Council*** and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.***	• April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	
A-395 482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.				
1. *Patient 1 had an order for coach/sitter on 9/20/13 but was discontinued by a licensed nurse without discussing it with the physician.* *Licensed staff did not follow policy & procedure on reporting a missing patient when Charge Nurse 1 did not give an accurate description of Patient 1 when patient was described as an African American woman and wearing a hospital gown. Patient 1 was Caucasian and was wearing her own clothes.* *Licensed staff did not follow the instruction from a nursing administrator. On 9/21/13, the Nurse Administrator on Duty directed Charge Nurse 1 to report Patient 1 as a missing person on 9/21/13 because the patient had an altered mental status (confused and disoriented) but this information was not relayed to the Sheriff's Department Dispatcher.*	**A-395 482.23(b)(3) RN Supervision of Nursing Care** **Finding 1 (failed to ensure nursing care was supervised and evaluated for 2 of eight sampled patients (Patient 1 and 8) when:** **Patient 1 had an order for coach/sitter on 9/20/13 but was discontinued by a licensed nurse without discussing it with the physician.** **Licensed staff did not follow policy & procedure on reporting a missing patient when Charge Nurse 1 did not give an accurate description of Patient 1 when patient was described as an African American woman and wearing a hospital gown. Patient 1 was Caucasian and was wearing her own clothes when her body was found on the hospital' stairwell, 17 days after she was reported missing from her ward.** **Licensed staff did not follow the instruction**	Nursing leadership will create a ***Nursing Leadership Satisfaction Survey t***o be distributed hospital-wide to evaluate the performance of CNs, Nurse Managers, and Administrators on Duty.	• TBD	• Chief Nursing Officer • Chief Quality Officer • Patient Safety Officer
		In collaboration with our nursing partners, the SFGH CNO is developing a leadership curriculum and skills tool focusing on communication, health care team collaboration, and supervision of nursing staff.	• Immediately • Ongoing	
		Using the leadership curriculum, the SFGH CNO and/or designees will in-service CNs, Nurse Managers, and Administrators on Duty to enhance supervision skills.	• TBD	

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
	from a nursing administrator. On 9/21/13, the Nurse Administrator on Duty directed Charge Nurse 1 to report Patient 1 as a missing person on 9/21/13 because the patient had an altered mental status (confused and disoriented) but this information was not relayed to the Sheriff' Department Dispatcher **Actions(s):** In collaboration with our nursing partners, the SFGH CNO is developing a leadership curriculum and skills tool focusing on communication, health care team collaboration, and supervision of nursing staff. Using the leadership curriculum, the SFGH CNO and/or designees will in-service CNs, Nurse Managers, and Administrators on Duty to enhance supervision skills.			
2. *Patient 8 had a physician's order for 1:1 (one to one) coach-sitter and was not carried out as ordered when Patient 8 was put in a room with one facility staff coaching 3 (three) other patients who also had an order for 1:1 coach/sitter.*	**Finding 2 (Patient 8 had a physician' order for 1:1 (one to one) coach-sitter and was not carried out as ordered when Patient 8 was put in a room with one facility staff coaching 3 (three) other patients who also had an order for 1:1 coach/sitter:** **Actions(s):** In collaboration with our nursing partners, the SFGH CNO is developing a leadership curriculum and skills tool focusing on communication, health care team collaboration, and supervision of nursing staff. Using the leadership curriculum, the SFGH CNO and/or designees will in-service CNs, Nurse Managers, and Administrators on Duty to enhance supervision skills.	Nursing leadership will create a ***Nursing Leadership Satisfaction Survey t***o be distributed hospital-wide to evaluate the performance of CNs, Nurse Managers, and Administrators on Duty.	• TBD	• Chief Nursing Officer • Chief Quality Officer • Patient Safety Officer

TAG: FINDING	ACTION PLAN	MONITORING	FREQUENCY	RESPONSIBLE
A-396 482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.				
1. *The hospital failed to develop an individualized nursing care plan for 3 of eight sampled patients (Patient 1, 7, &*) for fall risks, elopement risks or AWOL (Absent Without Official Leave) and altered mental status.*	**A 396 482.23 (b)(4) Nursing Care Plan Finding 1 (failed to develop an individualized nursing care plan for 3 of eight sampled patients (Patient 1, 7, &*) for fall risks, elopement risks or AWOL (Absent Without Official Leave) and altered mental status:** **Patient 1 - failure to care plan dementia/delirium, I elopement/AWOL, altered mental status):** **Patient 7 failure to care plan for cognition (mental status):** **Patient 8 - failure to care plan dementia, blindness as a falls risk** **Actions(s):** Utilizing the data collected through the nursing audits (refer to Tag A-043, Finding 3), hospital leadership will review the data for trends and develop additional measures using the Plan-Do-Study-Act (PDSA) methodology to improve nursing practice related to transcription and implementation of physician orders, use and monitoring of coaches, and individualized patient care planning.	The Chief Nursing Officer and/or designee will conduct an audit of all current in-patients to ensure care plans are individualized, including but not limited to, care plans addressing falls risk, dementia/delirium, elopement risk, altered mental status, cognition (mental status); they will resolve any issues identified in real time with coaching and feedback to staff. Audit results will be reported quarterly for one year to the ***Nursing Quality Forum*** and to the ***Quality Council*** and annually thereafter. The ***Quality Council*** reports annually to the ***Governing Body Joint Conference Committee.***	• January 7, 2014 – January 10, 2014 • April, 2014 • July, 2014 • October, 2014 • January, 2015 • Annual, 2014 • Annually	• Chief Nursing Officer • Chief Quality Officer • Patient Safety Officer