DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Southern Nevada Healthcare System in North Las Vegas

CHIP REPORT | REPORT #22-00062-139 | JUNE 28, 2023

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Figure 1. *North Las Vegas VA Medical Center of the VA Southern Nevada Healthcare System.*

Source: https://www.va.gov/southern-nevada-health-care/locations/.

Abbreviations

ADPCS/NE	Associate Director for Patient Care Services/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Southern Nevada Healthcare System, which includes the North Las Vegas VA Medical Center and multiple outpatient clinics in Nevada. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)

The OIG conducted an unannounced inspection of the VA Southern Nevada Healthcare System during the week of May 2, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued three recommendations to the Director, Chief of Staff, and Associate Director in the following areas of review: Leadership and Organizational Risks, Medical Staff Privileging, and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 22.

Conclusion

The OIG issued three recommendations for improvement to the Director, Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for these leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care.

VA Comments

The interim Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 24–25, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Southern Nevada Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The VA Southern Nevada Healthcare System includes the North Las Vegas VA Medical Center and associated outpatient clinics in Nevada. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from July 9, 2018, through May 5, 2022, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that healthcare system leaders developed based on the reasons for noncompliance.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[5] The OIG's last comprehensive healthcare inspection of the VA Southern Nevada Healthcare System occurred in July 2018. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in December 2019 and a laboratory accreditation survey in April 2022.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this healthcare system's leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Medical Center Director (Director), Deputy Medical Center Director (Deputy Director), Chief of Staff, Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE), Associate Director, and Assistant Director. The Chief of Staff and ADPCS/NE oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for over 3 months since the appointment of the Associate Director on January 30, 2022. The Chief of Staff had served in the role for over 19 years, the Assistant Director for more than 9 years, the Director for over 2 years, the Deputy Director for more than 1 year, and the ADPCS/NE for approximately

[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen, *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

8 months.[10] To help assess the executive leaders' engagement, the OIG interviewed the Director, Deputy Director, Chief of Staff, and ADPCS/NE regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $791,065,928 had increased by nearly 6.5 percent compared to the previous year's budget of $742,979,578.[11] The Director stated that the current budget was adequate, and that funds were allocated for new clinical positions. The Director also reported funds supported COVID-19 pandemic efforts, which included adding new inpatient beds, hiring additional nurses, and covering overtime costs. The Director discussed the greater need for mental health services for staff and patients due to pandemic stressors and reported expanding chaplain services and increasing the number of mental health providers to address the demand. Additionally, the Director stated that leaders used some of the budget to purchase care in the community.[12]

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).[14]

[10] The Assistant Director, who started in the role in September 2012, had two instances of serving in other temporary positions during the more than nine-year period.

[11] Veterans Health Administration (VHA) Support Service Center.

[12] VA provides care to patients through community providers in certain circumstances. "Community Care," Department of Veterans Affairs, accessed April 20, 2023, https://www.va.gov/communitycare/programs/veterans/general_care.asp.

[13] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

[14] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

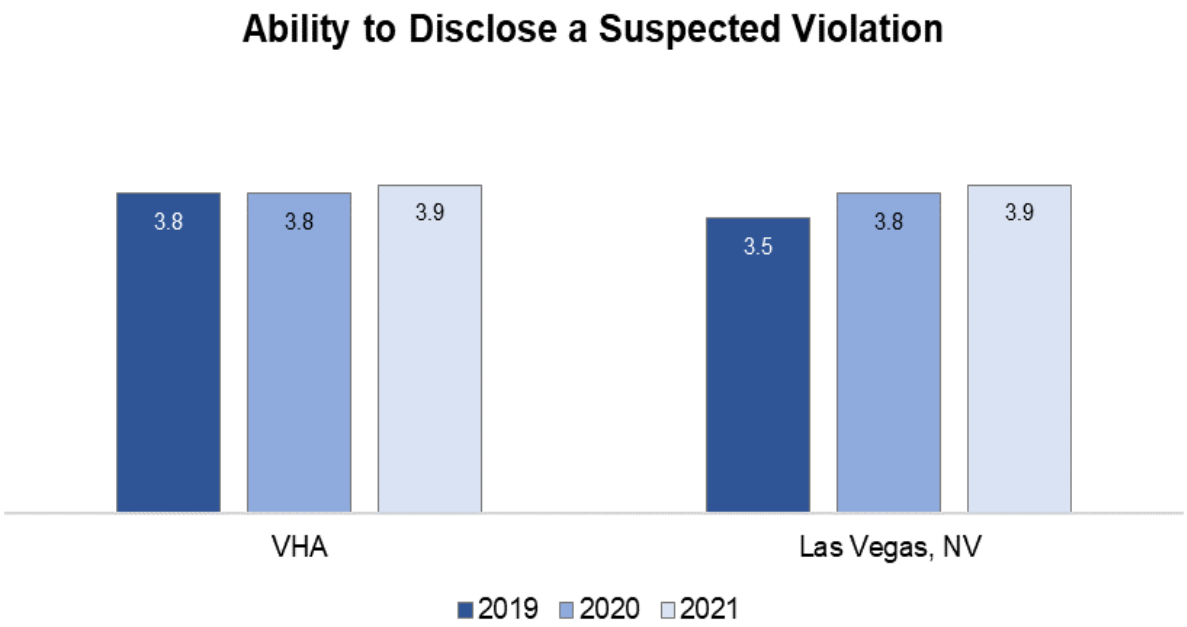

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed April 4, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

Veterans Health Administration (VHA) uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[15]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.[17]

[15] "Patient Experiences Survey Results," VHA Support Service Center.

[16] "Patient Experiences Survey Results," VHA Support Service Center.

[17] Scores are based on responses by patients who received care at this healthcare system.

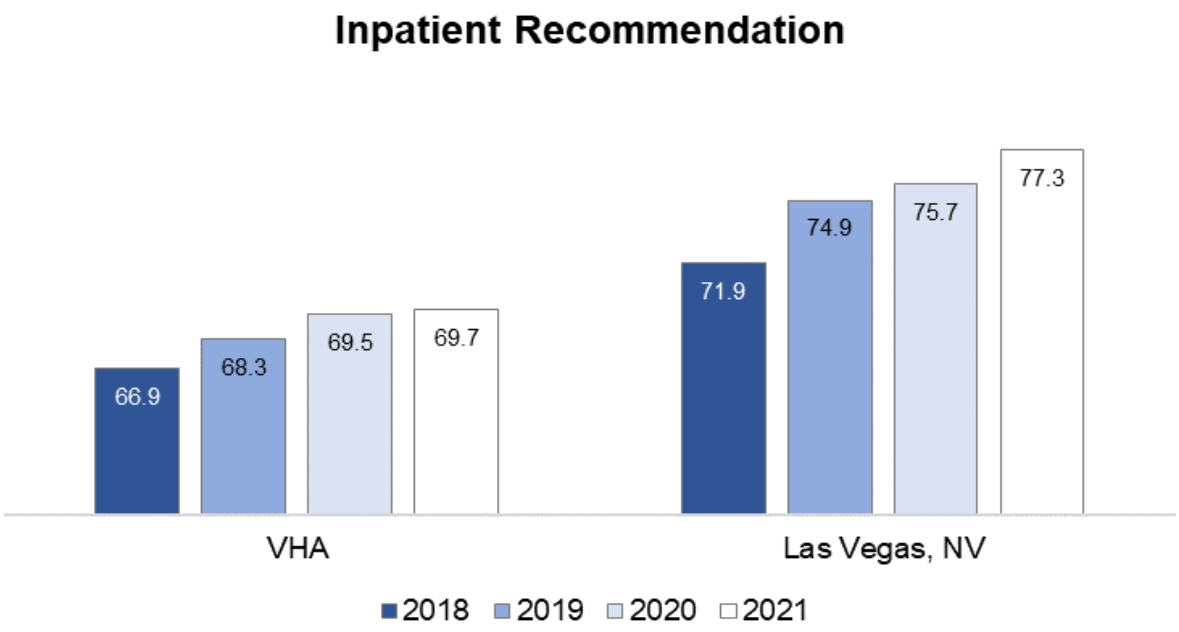

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Definitely yes" responses.

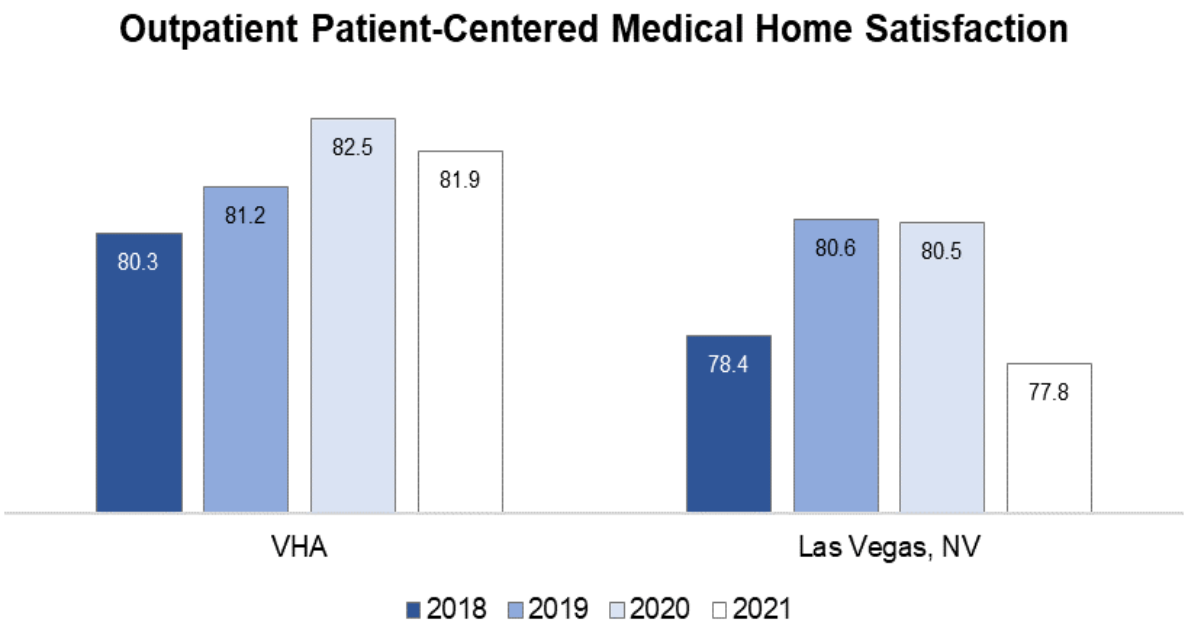

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

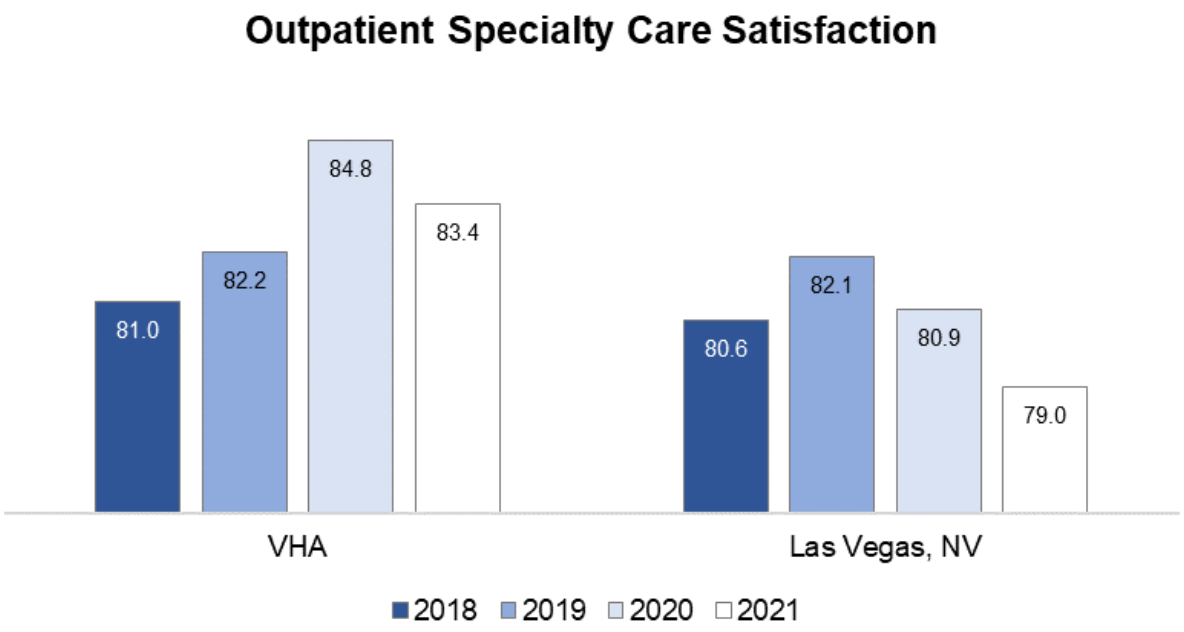

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[18] A sentinel event is an incident or condition that "results in death, permanent harm, or severe temporary harm and [when] intervention [is] required to sustain life."[19] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[20] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been

[18] Frankel, *A Framework for Safe, Reliable, and Effective Care;* "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[19] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[20] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

affected by an adverse event resulting from a systems issue."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[22] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[23]

The Director stated that leaders reported events from the patient safety reporting system during morning huddles. The Director discussed making sure staff were aware of the patient safety reporting process and the importance of entering data into the system. The Director also reported that the Chief of Staff, in collaboration with the ADPCS/NE, determined whether an event warranted disclosure and stated that executive leaders always erred on the side of disclosing adverse events to patients.

The OIG reviewed sentinel events and institutional and large-scale disclosures reported by healthcare system staff that occurred since July 9, 2018 (the prior OIG CHIP site visit). Although the Director was able to discuss the adverse event reporting process, the OIG noted a concern with the institutional disclosure process.

Leadership and Organizational Risks Findings and Recommendations

VHA requires that when "an adverse event has resulted in or is reasonably expected to result in death or serious injury, an institutional disclosure must be performed regardless of when the event is discovered."[24] The OIG identified that leaders did not complete institutional disclosures for all sentinel events that may have contributed to patient deaths. Failure to conduct institutional disclosures following a sentinel event may reduce patients' trust in the organization. The Chief Quality, Safety, Value indicated the noncompliance with conducting institutional disclosures for all sentinel events was due to internal procedural gaps.

[21] VHA Directive 1004.08.

[22] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

[23] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[24] VHA Directive 1004.08.

Recommendation 1

1. The Director evaluates and determines additional reasons for noncompliance and ensures leaders evaluate sentinel events and conduct institutional disclosures when criteria are met.

Healthcare system concurred.

Target date for completion: January 31, 2024

Healthcare system response: The Director reviewed the reason(s) for non-compliance when developing the following action plan. As a result of the inspection, Patient Safety and Risk Management staff meet to communicate and discuss adverse events/sentinel events and to ensure an Institutional Disclosure (ID) occurs when appropriate.

Adverse events that are identified as a sentinel event (SE) will be reviewed. When criteria are met, leaders will ensure that ID is performed as appropriate. Compliance will be tracked through Survey Readiness Committee until 90% compliance is achieved and sustained for 6 months.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[25] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[27]

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system's committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[28] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[29] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[30]

Finally, the OIG assessed the healthcare system's culture of safety.[31] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

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[25] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[26] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[27] VHA Directive 1100.16.

[28] A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

[31] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[32] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[33]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[34] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[35]

VHA defines the Focused Professional Practice Evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[36] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[37] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[38]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[39] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

[32] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[40]

The OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members who had an FPPE or Ongoing Professional Practice Evaluation completed.

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria "to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director."[41] The OIG found that, based on the privileging folders reviewed, service chiefs did not consistently make LIPs aware of the evaluation criteria before initiating the FPPE process. When practitioners are not informed of the evaluation criteria in advance, they may misunderstand FPPE expectations during this critical initial performance period. The Chief of Staff reported that service chiefs discussed FPPE expectations during service-level orientation. The OIG did not make a recommendation, but without VHA requiring documentation that practitioners were informed of the criteria used to evaluate their performance, facility leaders cannot monitor compliance.

VHA requires another practitioner with similar training and privileges to evaluate the clinical practice of LIPs.[42] Of the solo or few LIPs' Ongoing Professional Practice Evaluations reviewed, not all were completed by another practitioner with similar training and privileges.[43] This may have resulted in the practitioner continuing to deliver care without a thorough evaluation of their clinical competency, which could have jeopardized quality of care. The Chief of Staff reported believing the requirement was met because VISN 21 credentialing and privileging staff arranged the solo practitioners' Ongoing Professional Practice Evaluations.

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[40] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[41] VHA Handbook 1100.19.

[42] VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021.)

[43] VHA refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners." The OIG considers few practitioners as being two providers in the facility who are privileged in a particular specialty.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures practitioners with similar training and privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.

Healthcare system concurred.

Target date for completion: January 31, 2024

Healthcare system response: The Chief of Staff reviewed the reason for non-compliance when developing the following action plan. The facility has implemented a process that includes VISN assistance with OPPE chart reviewers for solo/few practitioners with similar training and privileges complete the OPPE evaluation. The facility process has been modified to ensure that reviewer's and reviewee's privileges are evaluated, compared, and approved by the facility's Service Chief prior to sending to VISN for external review.

100% of all OPPEs for solo/few providers will be reviewed to ensure that proper evaluation of training and privileges were determined to be similar. Compliance will be tracked through Professional Standards Board until 90% compliance is achieved and sustained for 6 months.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[44] The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[45]

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.[46] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.[47]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 10 patient care areas:

- Dental clinic

[44] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded this directive and replaced it with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.)

[45] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008.

[46] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[47] Opioids are medications that are "effective at reducing pain" but "when taken in excess, can lead to respiratory arrest." Naloxone is a highly effective treatment for reversing an opioid overdose. "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, "Automated External Defibrillators (AEDs)," accessed December 16, 2021, https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds. "Pharmacy Benefits Management Services," Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

- Emergency Department
- Intensive care unit
- Medical/surgical inpatient units (5 East, 6 East, and 6 West)
- Mental health inpatient unit
- Primary care clinic
- Rehabilitation medicine clinic
- Surgical outpatient clinic (podiatry/vascular/orthopedic)

Environment of Care Findings and Recommendations

VHA requires electrical receptacles and switches in mental health units to be covered by metal plates and secured by tamper-resistant screws. VHA also requires receptacles to be flush with the wall.[48] The OIG found that electrical receptacles for call buttons in all patient rooms in the mental health inpatient unit were plastic, lacked metal plates and tamper-resistant screws, and were not flush to the wall. The receptacles posed a significant risk to suicidal patients who could easily break the plastic material and weaponize it into a sharp object, have access to electrical currents, or create a hanging point for self-harm. The Deputy Associate Nurse Executive/Behavioral Health reported consulting a subject matter expert at the VHA National Center for Patient Safety, who indicated the call button receptacles complied with the Mental Health Environment of Care Checklist. However, the Deputy Associate Nurse Executive/Behavioral Health provided a response to the OIG that did not fully address the concern. The Deputy Associate Nurse Executive/Behavioral Health acknowledged having a follow-up consultation with the subject matter expert while the OIG was onsite, and the expert determined the receptacles did not comply with the checklist because they were plastic instead of metal, not secured with tamper-resistant screws, and presented a hanging point.

Recommendation 3

3. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures electrical receptacles and switches in the mental health unit are covered by metal plates, secured by tamper-resistant screws, and receptacles are flush to the wall.

[48] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, September 30, 2020.

Healthcare system concurred.

Target date for completion: December 29, 2023

Healthcare system response: The Associate Director reviewed the reason for non-compliance when developing the following action plan. On August 11, 2022, tamper resistant screws were installed by Biomedical technician for each call button in each patient room on the 20-bed inpatient mental health unit so that the plastic plate could no longer be easily removed. Upon clarification with OIG, this recommendation is specific to call button receptacles. The facility is in the process of changing each of the 20 plastic plates on the call button receptacles and will secure with tamper resistant screws. Mitigation actions were initiated at the time of identification of risk and include 1) 15-minute rounding for all patients and 2) Environmental rounds twice per day to enhance safety unit until the receptacles can be replaced.

Biomedical technician will report progress of the change-out process through the Environment of Care Committee until 100% of the call button receptacles have been replaced.

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[49] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[50]

VHA implemented various evidence-based approaches to reduce veteran suicides, including a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[51] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[52] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Emergency Department or urgent care center and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 42 randomly selected patients who were seen in the Emergency Department or urgent care center from December 31, 2020, through August 1, 2021.

[49] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

[50] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

[51] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[52] Deputy Under Secretary for Health for Operations and Management memo, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions," October 1, 2021.)

Mental Health Findings and Recommendations

The OIG made no recommendations.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided three recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and Associate Director. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• Leaders evaluate sentinel events and conduct institutional disclosures when criteria are met.
Quality, Safety, and Value	• None
Medical Staff Privileging	• Practitioners with similar training and privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.
Environment of Care	• Electrical receptacles and switches in the mental health unit are covered by metal plates, secured by tamper-resistant screws, and receptacles are flush to the wall.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• None

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 21.[1]

Table B.1. Profile for VA Southern Nevada Healthcare System (593) (October 1, 2018, through September 30, 2021)

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Total medical care budget	$559,788,525	$742,979,578	$791,065,928
Number of:			
• Unique patients	65,901	64,737	70,342
• Outpatient visits	909,116	823,038	930,667
• Unique employees§	2,280	2,577	2,567
Type and number of operating beds:			
• Domiciliary	20	20	40
• Medicine	80	80	80
• Mental health	20	20	20
• Surgery	10	10	10
Average daily census:			
• Domiciliary	–	9	16
• Medicine	58	52	58
• Mental health	16	15	15
• Surgery	2	2	2

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

**October 1, 2018, through September 30, 2019.*
†October 1, 2019, through September 30, 2020.
‡October 1, 2020, through September 30, 2021.
§Unique employees involved in direct medical care (cost center 8200).

[1] VHA medical facilities are classified according to a complexity model; a designation of "1b" indicates a facility with "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." "Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 5, 2023

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

Subj: Comprehensive Healthcare Inspection of the VA Southern Nevada Healthcare System in North Las Vegas

To: Director, Office of Healthcare Inspections (54CH02)

Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. Thank you for the opportunity to respond to the draft report, Comprehensive Healthcare Inspection of the VA Southern Nevada Healthcare System in North Las Vegas.
2. I have reviewed the findings and recommendations in the OIG draft report. I concur with the submitted action plans.

(Original signed by:)

Ada Clark, FACHE, MPH
Interim Network Director
VA Sierra Pacific Network (VISN 21)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 5, 2023

From: Director, VA Southern Nevada Healthcare System (593/00)

Subj: Comprehensive Healthcare Inspection of the VA Southern Nevada Healthcare System in North Las Vegas

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

1. We appreciate the opportunity to review the draft report of recommendations from the OIG Comprehensive Healthcare Inspection of the VA Southern Nevada Healthcare System in North Las Vegas conducted at the VA Southern Nevada Healthcare System the week of May 2, 2022.
2. Please find the attached response to each recommendation included in the report. We have completed, or in the process of completing, actions to resolve these issues.

(Original signed by:)

William J. Caron, PT, MHA, FACHE
Medical Center Director/CEO
VA Southern Nevada Healthcare System

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