US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin

CHIP Report	22-04134-63	February 8, 2024

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Figure 1. *Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin. Source: https://www.va.gov/milwaukee-health-care/locations/.*

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
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 Clement J. Zablocki VA Medical Center, which includes multiple outpatient clinics in Wisconsin. 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 suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Clement J. Zablocki VA Medical Center during the week of December 5, 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 medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued six recommendations to the Director and Chief of Pharmacy Services in the Environment of Care and Mental Health areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for 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. The results

are detailed throughout the report, and the recommendations are summarized in appendix A on page 21.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 23–24, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 2 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 Clement J. Zablocki VA Medical Center 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 medical center 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 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): 13, 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 (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Clement J. Zablocki VA Medical Center also provides care through four outpatient clinics in Wisconsin.[5] General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review during the week of December 5, 2022.[6] During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] 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 medical center leaders complete corrective actions. The Executive Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that 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 four locations are Appleton, Cleveland, Green Bay, and Union Grove.

[6] The OIG's last comprehensive healthcare inspection of the Clement J. Zablocki VA Medical Center occurred in January 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in January 2022.

[7] 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.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] 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.[10]

To assess this medical center's leadership and risks, the OIG considered the following 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 medical center 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 medical center had a leadership team consisting of the Director, Deputy Director, Assistant Director, Associate Director for Patient Care Services (ADPCS), and Chief of Staff. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team consisted of the interim Director, acting Deputy Director, acting Assistant Director, ADPCS, and Chief of Staff. The Chief of Staff, who had served since April 1998, was the most tenured member of the team.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the interim Director, Chief of Staff, and ADPCS regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $941,398,228 had increased by approximately 6 percent compared to the previous year's budget of $887,591,623.[11] According to the interim Director, most of the additional funds covered costs for care in the community.[12] The interim Director and ADPCS also stated they used some of the money to raise salaries and expand staffing. In addition, the Chief of Staff reported spending funds to renovate the dialysis and radiation oncology units and surgical suites. The interim Director and Chief of Staff also highlighted higher costs for some medications. Despite the larger budget, the number of hospital beds decreased, which the interim Director and ADPCS attributed to nursing shortages.

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 medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's scores for the selected question were similar to VHA's for all three years. The leaders stated that communication was key to achieving and maintaining the All Employee Survey scores. The interim Director said leaders sought to be transparent and available to all staff members, and the Chief of Staff added that transparency was important to building employee trust. The ADPCS further commented that leaders continued to communicate that staff could report suspected violations without reprisal.

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

[12] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed November 15, 2023, https://www.va.gov/communitycare/.

[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.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Clement J. Zablocki VA Medical Center	3.8	3.9	3.9

Source: VA All Employee Survey (accessed October 18, 2022).

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from October 2019 (FY 2020) to July 2022 (FY 2022). Table 2 provides survey results for VHA and the medical center over time.

The OIG noted patients' satisfaction with their primary care experiences significantly increased; however, satisfaction with inpatient and specialty care declined. The interim Director explained that many staff had left the facility, resulting in fewer available inpatient beds, and leaders restricted visitation due to the COVID-19 pandemic, which may have lowered inpatient satisfaction. The ADPCS indicated that leaders were rebuilding the inpatient staffing team and offering several recruitment and retention incentives such as tuition benefits and flexible scheduling.

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

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 to 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	77.2	69.7	76.3	68.5	67.2
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?*†	82.5	83.8	81.9	86.8	81.0	96.0
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	88.7	83.3	87.3	82.0	83.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 7, 2022).

**The response average is the percent of "Definitely yes" responses.*
†*The response average is the percent of "Very satisfied" and "Satisfied" responses.*

Identified Factors Related to Possible Lapses in Care and Medical Center 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.[16] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[17] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[17] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. 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, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[18]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[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 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.[22]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information quality management staff provided. The Patient Safety Manager reported discussing adverse events with executive leaders during daily morning huddles. The Patient Safety Manager also described reviewing Joint Commission standards and VHA guidelines to determine whether an adverse event should be classified as a sentinel event. The Patient Safety Manager and Risk Manager said they discussed sentinel events to decide whether leaders should perform an institutional disclosure. The Risk Manager further reported reviewing sentinel events with the Chief of Staff to make the final decision and coordinating the institutional disclosures.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[19] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in 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.

[21] VHA Directive 1004.08.

[22] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The new directive contains similar language regarding patient safety as the rescinded handbook.)

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[23] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[25]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[26] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[27]

The OIG assessed the medical center'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 assessments of care" that consistently contribute to quality management efforts at the individual provider level.[30]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed 12 unanticipated deaths that occurred within 24 hours of inpatient admission during FY 2022. The OIG determined that no suicides occurred within seven days of discharge from the inpatient mental health unit during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

[24] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[25] VHA Directive 1100.16.

[26] VHA Handbook 1050.01; VHA Directive 1050.01.

[27] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[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.

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."[31] 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."[32]

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.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. 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.[35]

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.[36] 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 under the chief of staff. VHA also requires facilities to have credentialing and

[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced the 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.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[37]

The OIG interviewed key managers and selected and reviewed the privileging folders of 29 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[37] 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.

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 VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[38] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[39]

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 inspected 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.[40]

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:

- Community living centers (Independence Hall, Palliative Care Heroes Corner, and Valor Point)
- Emergency Department
- Intensive care unit (2B)
- Medical/surgical inpatient units (5C North, 6C North, and 6C South)
- Mental health inpatient unit (3C)
- Primary care women's health clinic (Red Clinic)

[38] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[39] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[40] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023.)

Environment of Care Findings and Recommendations

VHA requires staff to keep areas used by patients clean and safe.[41] Further, VHA requires staff to keep storerooms clean and uncluttered with no visible dust or soil.[42] The OIG found

- one unit had a dirty air ventilation duct,
- two nutrition areas had stained sinks,
- two nutrition areas had expired food in freezers,
- four units had soiled and stained floors, and
- four supply rooms had soiled shelves.[43]

Dirty air ventilation ducts, food preparation areas, supply rooms, and floors, as well as possible consumption of expired food, pose health hazards to patients and staff. The unit's acting Nurse Manager and the Chief Engineer both said they were unaware of the dirty air ventilation duct. The Chief of Environmental Management Services and an assistant nurse manager cited inattention to detail and inadequate food storage space as the reasons for noncompliance. The Chief of Environmental Management Services also stated staff could not properly strip and wax the floors in two areas due to the high volume of foot traffic, were scheduled to clean one area, and missed cleaning the last area due to inattention to detail. The Chief of Environmental Management Services attributed the dusty and dirty shelves in supply rooms to staff's inattention to detail.

Recommendation 1

1. The Director ensures staff keep all areas clean and safe.

[41] VHA Directive 1850, *Environmental Programs Service*, March 31, 2017. (VHA rescinded and replaced this directive with VHA Directive 1850, *Environmental Programs Service*, January 30, 2023.)

[42] VHA Directive 1761.

[43] Staff store food and beverages for patients in nutrition areas. The OIG noted the dirty air ventilation duct in Independence Hall community living center; stained sinks in the nutrition areas in medical/surgical inpatient units 5C and 6C North; expired food in freezers in nutrition areas in medical/surgical inpatient unit 6C North and Palliative Care Heroes Corner community living center; soiled and stained floors in the Emergency Department, mental health inpatient unit 3C, and medical/surgical inpatient units 5C and 6C North; and supply rooms with dusty and dirty bottom shelves in the Emergency Department, the primary care women's health Red Clinic, intensive care unit 2B, and medical/surgical inpatient unit 6C North.

Medical center concurred.

Target date for completion: May 31, 2024

Medical center response: The Assistant Director reviewed the recommendation and did not identify any additional reasons for noncompliance. Environmental Management Services (EMS) addressed staffing deficits through aggressive hiring to fill vacancies. New and existing EMS staff were trained/retrained on cleaning protocols/expectations. Inspections of the indicated areas described by the Office of the Inspector General (OIG) will be carried out by a member of the Quality Management staff. Reporting will be provided by the Accreditation Specialist to the Environment of Care Council until six consecutive months of 90 percent compliance is maintained. The numerator is the number of compliant observations, and the denominator is the total number of observations.

VHA requires environmental management services staff to cultivate an orderly appearance and keep the environment protected from undue wear.[44] The OIG found heating unit vent covers with rust and chipping paint in multiple rooms in a medical/surgical inpatient unit and walls with holes and peeling wallpaper in multiple patient rooms in two community living centers.[45] Staff cannot properly clean heating units and walls with heavy damage, and inadequate cleansing can lead to the spread of pathogens such as bacteria and mold. The acting Nurse Manager for one of the units and the Chief Engineer both stated they were unaware of the issues with the vent covers and believed staff had not noticed the rust and chipping paint. The Rehabilitation, Extended Community Care Division Manager further reported staff planned to repair the walls and remove wallpaper but had not started due to the number of current patients.

Recommendation 2

2. The Director ensures staff keep the medical center well maintained.[46]

[44] VHA Directive 1850.

[45] The OIG found heating unit vent covers with rust and chipping paint in multiple patient rooms in medical/surgical inpatient unit 6C South and walls with holes and peeling wallpaper in multiple patient rooms in Independence Hall and Palliative Care Heroes Corner community living centers.

[46] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: The Assistant Director reviewed this recommendation and did not identify any additional reasons for noncompliance. Staff submit and Facilities Management (FM) assigns and completes repairs to correct Environment of Care (EOC) deficiencies, recording work order completion in the ProLogic tracking system. The Clement J. Zablocki VA Medical Center has been in full compliance with this recommendation, maintaining greater than 90 percent compliance since January 2023. The EOC Council, which oversights physical environment within the facility will continue to monitor the Environment of Care Program and outcomes at its monthly meetings.

VHA requires that "access to medications must be limited to those individuals approved by the VA medical facility."[47] The OIG discovered the pneumatic tube system used to transport medications from the pharmacy to other locations was unrestricted at four access points, leaving medications accessible to unapproved staff and other individuals.[48] Unauthorized access to medications can lead to inappropriate use and cause harm to patients or staff. The Accreditation Specialist stated that leaders had identified this practice as a potential vulnerability; however, despite the VHA requirement, staff did not change the process because The Joint Commission did not identify the issue during its 2022 survey.

Recommendation 3

3. The Chief of Pharmacy Services limits medication access to approved staff members.

[47] VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022. (VHA amended this directive October 4, 2023.)

[48] The OIG observed the four unrestricted pneumatic tube stations in mental health inpatient unit 3C, medical/surgical inpatient units 6C North and 6C South, and Independence Hall community living center.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Chief of Staff reviewed this recommendation and did not identify any additional reasons for noncompliance. Utilizing existing technology within the pneumatic tube system, Pharmacy will utilize Personal Identification Numbers (PIN) for each unsecured location identified by the Office of the Inspector General (OIG) to which medications are being sent. The use of a PIN will require the approved team member at the location to which the medication is being sent to enter a corresponding PIN to "unlock" the system and release the tube for delivery. The implementation of this process will secure all medications being transported, eliminating the potential of unauthorized access. The Environment of Care Council will oversee the progression of this practice change, and the Accreditation Specialist will provide monthly reports on its progress until completion.

VHA requires all clean and sterile storage rooms to "have a stable environment without extreme changes in temperature or humidity."[49] The OIG found that in two of the three community living centers inspected, staff did not store commercially packaged sterile wound care supplies in a temperature- and humidity-controlled storage room. When medical supplies are not stored in the appropriate conditions, they may become contaminated or lose their efficacy. A nurse manager and program manager both reported being unaware of the storage requirements.

Recommendation 4

4. The Director ensures staff store sterile supplies in temperature- and humidity-controlled storage rooms.

[49] VHA Directive 1761.

Medical center concurred.

Target date for completion: July 15, 2024

Medical center response: The Assistant Director reviewed this recommendation and did not identify any additional reasons for noncompliance. The practice of utilizing stocked wound care carts was eliminated from described areas on 12/1/2023. The RN removes only the needed supply of commercially packaged sterile wound care supplies from the temperature and humidity controlled clean utility room that will be needed for wound care for Veterans being treated on that specific shift. Wound Care nurses will provide education to staff nurses caring for Veterans who reside within the Community Living Center(s) (CLC) via email, unit-based posting, and follow-up review at 1/2024 unit meetings. Leaders of the CLC neighborhoods will conduct monthly checks for commercially packaged sterile wound care supplies for six (6) months (January through June 2024) to ensure continued compliance with this practice change. At the end of the six (6) month period the Leaders will determine if the checks can be discontinued.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[50] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[51] The suicide rate for veterans was higher than for nonveteran adults during 2020.[52] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[53]

Due to the prevalence of suicide among at-risk veterans, VHA implemented 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.[54] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[55]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[56]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 48 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[50] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[51] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

[52] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[53] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[54] 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.)

[55] 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);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[56] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.[57] The OIG estimated that providers did not evaluate 40 (95% CI: 26 to 54) percent of patients for suicide risk following a positive screen, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[58] When providers do not evaluate patients for suicide risk, they may miss signs of imminent danger. The Mental Health Division Co-Manager reported a combination of factors, including patients' resistance and providers' clinical judgment that the evaluation was not needed, as reasons for noncompliance.

Recommendation 5

5. The Director ensures providers complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen.

Medical center concurred.

Target date for completion: July 31, 2024

Medical center response: The Acting Chief of Staff reviewed this recommendation and did not identify any additional reasons for noncompliance. Two additional staff members were hired: a Suicide Prevention Coordinator (SPC) and a Suicide Prevention Program Manager. The SPC team provided enhanced education to Mental Health clinics on the use of a newly developed algorithm identifying steps needed to complete the Comprehensive Suicide Risk Evaluation (CSRE) for Veterans who screen positive on the Columbia Suicide Severity Rating Scale (CSSR-S). The SPC team expanded/will expand education to Specialty Clinics and Primary Care. The Mental Health Division Data Analyst ensures monthly analysis of CSRE completion for Veterans with a positive CSSR-S. Reporting will be provided by the Mental Health Division Manager/delegate to the Medical Executive Committee until six consecutive months of 90 percent compliance is maintained. The numerator is timely CSRE completions. The denominator is the total number of Veterans who screen positive.

[57] 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);" 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)."

[58] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

VHA requires providers to notify the suicide prevention team of patients who report suicidal behaviors (suicide attempt or preparatory behavior) during the evaluation.[59] The OIG estimated that providers did not notify the suicide prevention team of 73 (95% CI: 43 to 100) percent of patients who reported suicidal behaviors, which is statistically significantly above the OIG's 10 percent deficiency benchmark. Lack of notification of suicidal behaviors to the suicide prevention team delays further evaluation and mental health intervention. The Mental Health Division Co-Manager reported believing the electronic health record automatically alerted the Suicide Prevention Coordinator once providers documented the suicide evaluation.

Recommendation 6

6. The Director ensures providers notify the suicide prevention team of patients who report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

Medical center concurred.

Target date for completion: May 31, 2024

Medical center response: The Acting Chief of Staff reviewed this recommendation and did not identify any additional reasons for noncompliance. Two additional staff members were hired: a Suicide Prevention Coordinator (SPC) and a Suicide Prevention Program Manager. An addendum is documented to provide evidence that the SPCs received notification of a Veteran's endorsing suicidal behavior when a positive Comprehensive Suicide Risk Evaluation (CSRE) has been obtained by another member of the health care team. The Mental Health Division Data Analyst will audit all (100 percent of the population) records of Veterans who have had a positive CSRE during that month for the presence of the SPCs' addendum. Reporting will be provided by the Mental Health Division Manager/delegate to the Medical Executive Committee until six consecutive months of 90 percent compliance is maintained. The numerator is the number of SPC addendums present. The denominator is the total number of Veterans with a positive CSRE.

[59] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting;" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting."

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided six recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Director and Chief of Pharmacy Services. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• Staff keep all areas clean and safe. • Staff keep the medical center well maintained. • The Chief of Pharmacy Services limits medication access to approved staff members. • Staff store sterile supplies in temperature- and humidity-controlled storage rooms.
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen. • Providers notify the suicide prevention team of patients who report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

Appendix B: Medical Center Profile

The table below provides general background information for this highest complexity (1a) affiliated medical center reporting to VISN 12.[1]

Table B.1. Profile for Clement J. Zablocki VA Medical Center (695) (October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$798,441,617	$887,591,623	$941,398,228
Number of:			
• Unique patients	61,042	61,521	61,641
• Outpatient visits	707,468	809,881	796,340
• Unique employees§	3,565	3,727	3,665
Type and number of operating beds:			
• Community living center	111	111	111
• Domiciliary	125	125	125
• Medicine	196	158	143
Average daily census:			
• Community living center	107	95	96
• Domiciliary	53	43	46
• Medicine	114	122	106

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, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center 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: December 26, 2023

From: Director, VA Great Lakes Health Care System (10N12)

Subj: Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin

To: Director, Office of Healthcare Inspections (54CH01)

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin, draft report.
2. I have reviewed the document and concur with the Recommendations.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin.

(Original signed by:)

Daniel S. Zomchek, Ph.D., FACHE
Network Director, VISN 12

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: December 26, 2023

From: Executive Director, Clement J. Zablocki VA Medical Center (695)

Subj: Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin

To: Director, VA Great Lakes Health Care System (10N12)

1. I have reviewed the Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin, draft report.
2. I have reviewed the document and concur with the Recommendations.
3. I concur with the submitted action plans from our facility.
4. I would like to thank the OIG Inspection team for a thorough review of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin.

(Original signed by:)

James McLain, FACHE

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