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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina

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Figure 1. *Ralph H. Johnson VA Medical Center in Charleston, South Carolina. Source: https://www.va.gov/charleston-health-care/locations/* (*accessed November 16, 2023*).

Abbreviations

AD/NPCS	Associate Director, Nursing and Patient Care Services
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 Ralph H. Johnson VA Medical Center and associated outpatient clinics in Georgia and South Carolina. 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 Ralph H. Johnson VA Medical Center the week of January 30, 2023. 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 four recommendations to the Medical Center Director, and one recommendation to the Veterans Integrated Service Network Director in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; Environment of Care; and Mental Health. 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 22.

VA Comments

The 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 Medical Center Director requested closure of recommendations 1, 3, 4, and 5 and provided supporting evidence for review. The OIG determined the evidence supported closure of recommendation 3 only. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

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 Ralph H. Johnson 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 Ralph H. Johnson VA Medical Center also provides care through multiple outpatient clinics in Georgia and South Carolina. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review the week of January 30, 2023.[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 medical center leaders complete corrective actions. The directors' 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 OIG's last comprehensive healthcare inspection of the Ralph H. Johnson VA Medical Center was initiated in February 2020. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in May 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 organization's 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 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 Medical Center Director (Director); Chief of Staff; Associate Director, Nursing and Patient Care Services (AD/NPCS); Associate Director; and Assistant Director. The Chief of Staff and AD/NPCS 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 about two years. The Director was permanently assigned in December 2014 and was the most tenured. The Associate Director and Assistant Director were both assigned in August 2019. The AD/NPCS and Chief of Staff joined the team in April and October 2020, respectively.

[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 et al., *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.

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, AD/NPCS, and Associate Director 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 $842,081,396 had increased by almost 5 percent compared to the previous year's budget of $805,836,586.[10] The Director said the additional funding was needed. The Associate Director said leaders used the increased funds to purchase equipment and supplies needed during the COVID-19 pandemic. The Associate Director also reported the medical center received additional money from the Coronavirus Aid, Relief, and Economic Security Act of 2020 and the American Rescue Plan Act of 2021, which included special purpose dollars to cover employees' salaries.[11] However, according to the Associate Director, leaders returned some funding received in FY 2022 to the VISN because it arrived late and therefore not used before the FY ended.

Furthermore, the Associate Director reported believing other contributing factors affected hospital operations, including extended wait-times on purchases (about 30 weeks for electrical panels); the $2,500 cap for hospital expenses charged to purchase cards; and the minor construction limit of $21 million, which was insufficient due to an increase in material costs since the pandemic.

Human Resources Modernization

Prior to FY 2019, Veterans Health Administration (VHA) human resources was mostly a "decentralized, facility-based service" that led to "time-to-hire delays, non-standardized process, and resource constraints."[12] In response, VHA began the process of "consolidating human resource functions from more than 140 local facilities to a shared services model" under each VISN.[13] The Director said that due to this reorganization, human resources staff are no longer located at the medical facilities, and facility executive leaders lack the ability to oversee their duties. The Associate Director reported that following human resources modernization, staff vacancies increased from 9.23 percent (304 positions) to over 25.27 percent (1,047 positions), which is a 10-year high in the vacancy rate. The acting Senior Strategic Business Partner added that the average number of days to hire an employee had increased from 91 to about 118 in the same period. The acting Senior Strategic Business Partner further reported using recruitment and

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

[11] Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136 (2020); American Rescue Plan Act of 2021, Pub. L. No. 117-2 (2021).

[12] "VHA Modernization: Develop Responsive Shared Services," VA Insider, accessed February 10, 2023. (This website is not publicly accessible.)

[13] "VHA Modernization: Develop Responsive Shared Services."

relocation incentives for qualified candidates seeking hard-to-fill positions such as registered nurses and medical support staff.

The Associate Director described a rise in the inpatient registered nurse vacancy rate of about 40 percent, which resulted in the closure of 19 inpatient acute care beds. The AD/NPCS added that human resources staff had made tentative or final job offers to about 15 nurse applicants, and if these applicants were hired, leaders would reopen the beds. The AD/NPCS also explained that supervisors assigned nurses from other areas within the facility to inpatient medical/surgical areas to support staff and prevent closure of additional beds.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[14] 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.[15] Table 1 provides relevant survey results for VHA and the medical center over time.

All Employee Survey scores appeared to indicate that employees felt as comfortable disclosing suspected violations compared to VHA employees overall. The AD/NPCS attributed the scores to leaders being transparent and having an open line of communication.

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
Ralph H. Johnson VA Medical Center	3.9	3.9	4.0

Source: VA All Employee Survey (accessed October 24, 2022).

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

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

[15] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

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.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time. Although the inpatient survey scores appeared to indicate patients were more willing to recommend this medical center compared to VHA patients nationally, the AD/NPCS reported challenges related to inpatient staffing, specifically nursing, environmental management service workers, and engineering employees. The AD/NPCS added that nursing leaders walked around the facility daily to meet all newly admitted patients and identify opportunities to improve patient experiences. Survey results also revealed that patient satisfaction with primary care declined over all three years; however, satisfaction with specialty care improved. The Chief of Staff stated that effects of the COVID-19 pandemic and staffing shortages negatively influenced patient satisfaction. The Chief of Staff also said the medical center employed a combination of part-time and contract specialty providers to sustain patients' access to care.

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

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 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	74.5	69.7	74.1	68.9	77.4
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	84.1	81.9	82.8	81.7	79.2
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	84.4	83.3	84.5	83.1	85.5

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed inpatient data December 8, 2022, and primary and specialty care data December 14, 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.[17] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[18] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[17] Frankel et al., *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/.

[18] The Joint Commission, *Standards Manual*, E-dition, July 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.[19]

"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)."[20] 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."[21] Furthermore, 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."[22] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[23]

The OIG requested a list of sentinel events, institutional disclosures, and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The AD/NPCS stated executive leaders and quality management staff reviewed events entered into the Joint Patient Safety Reporting system to determine whether they met sentinel event criteria.[24] The AD/NPCS further discussed being involved with the root cause analysis process for identified sentinel events.[25] The Chief of Staff said staff also considered appropriate follow-up actions, such as clinical or institutional disclosures, and reported making the final decision on whether to conduct an institutional disclosure.[26]

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

[20] 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.

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

[22] VHA Directive 1004.08.

[23] 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.)

[24] VHA uses the Joint Patient Safety Reporting system for data management of patient safety events such as medical errors and close calls. "VHA National Center for Patient Safety," Department of Veterans Affairs, accessed December 21, 2022, https://www.patientsafety.va.gov/about/faqs.asp.

[25] A root cause analysis is a comprehensive review of actual or potential patient safety events to identify system and process issues to prevent future occurrences. VHA Handbook 1050.01; VHA Directive 1050.01.

[26] "Clinical disclosure of adverse events is a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care." VHA Directive 1004.08.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[27] 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.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[29]

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.[30] 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.[31]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[32] 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."[33] 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.[34]

The OIG team interviewed key managers and staff and reviewed relevant documents. The OIG also reviewed four unexpected deaths that occurred within 24 hours of inpatient admission during FY 2022.[35]

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

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

[29] VHA Directive 1100.16.

[30] VHA Handbook 1050.01; VHA Directive 1050.01.

[31] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2023.

[32] 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.

[33] VHA Directive 1190.

[34] VHA Directive 1190.

[35] The OIG requested information regarding suicides that occurred within seven days of discharge from the inpatient mental health unit. Medical center staff provided information confirming that no suicides occurred that met those criteria during FY 2022.

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to complete a root cause analysis for all patient safety events receiving an actual or potential safety assessment code score of 3.[36] The OIG reviewed patient safety events that occurred in FY 2022 and found staff did not complete a root cause analysis for 2 of 12 adverse events with a safety assessment code score of 3. When staff do not thoroughly review adverse events, leaders may fail to identify system vulnerabilities that could lead to patient harm. The Patient Safety Manager said for these two events, leaders either initiated a process improvement plan or applied results from a previous root cause analysis for a similar incident.

Recommendation 1

1. The Medical Center Director ensures staff complete root cause analyses for all patient safety events assigned an actual or potential safety assessment code score of 3.

[36] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and how often it occurs using a one to three scale (3 = highest risk, 2 = intermediate risk, 1 = lowest risk). VHA Handbook 1050.01; VHA Directive 1050.01.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Medical Center Leadership is made aware of all patient safety reports during the Daily Patient Safety Huddle. The Medical Center Director lead[s] the Daily Patient Safety Huddle. The Medical Center Director is the approving official for all root cause analysis. The Chief of Quality Management attests a thorough clinical focused review was completed on the two events, which encompassed all the elements included in a root case analysis and follows the required Joint Commission elements. As such, system vulnerabilities were identified, plans were implemented and tracked to completion to mitigate further harm. Additionally, an external root cause analysis was conducted as required by a national contract for one event. To ensure compliance, the Patient Safety Manager will conduct monthly reviews of all Joint Patient Safety Reporting events with an actual or potential safety assessment code score of 3 and confirm a root cause analysis was conducted. The denominator is all Joint Patient Safety Reporting events with an actual or potential safety assessment code score of 3. The numerator is the number of Joint Patient Safety Reporting events with an actual or potential safety assessment code score of 3 with a completed root cause analysis. Data collection and monitoring began in February 2023. After receiving clarification from the Office Of Inspector General, the facility began official monitoring in October 2023 and will continue until 90 percent or higher compliance is achieved and maintained for six consecutive months. The Chief of Quality Manager will report quarterly compliance in the Clinical Executive Council.

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."[37] 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."[38]

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.[39] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[40]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE 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.[41]

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.[42] 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

[37] 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).

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[43]

The OIG interviewed key managers and selected and reviewed the privileging folders of 26 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria to be "defined in advance, using objective criteria accepted by the LIP."[44] The OIG found five of six FPPEs reviewed lacked evidence service chiefs defined the evaluation criteria before initiating the process. When service chiefs do not define evaluation criteria in advance, LIPs could misunderstand FPPE expectations. The Chief of Staff cited administrative errors at the service level, including unclear signature lines on the FPPE form and difficulty obtaining signatures from contract providers, as reasons for the lack of documentation. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

VHA requires practitioners from other facilities and who have equivalent specialized training and similar privileges to complete the Ongoing Professional Practice Evaluations for LIPs who are part of a "two-deep" service or specialty.[45] The OIG found that an in-house neurologist evaluated an LIP who was part of the "two-deep" Physical Medicine and Rehabilitation and Physiatry specialty. This resulted in the LIP providing care without a thorough and impartial evaluation. The Chief of Staff stated a practitioner in the same service line completed the evaluation because both LIPs performed similar services. The OIG identified a similar deficiency during the February 2020 inspection where similarly trained and privileged practitioners did not complete LIPs' Ongoing Professional Practice Evaluations.[46]

[43] 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.

[44] VHA Handbook 1100.19; VHA Directive 1100.21(1).

[45] The LIP is part of a "two-deep" service or specialty when only two LIPs at the facility perform the privileges granted. Assistant Under Secretary for Health for Clinical Services/CMO [Chief Medical Officer], "Revision Memo, Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," May 18, 2021.

[46] VA OIG, *Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina*, Report No. 20-00132-04, November 5, 2020.

Recommendation 2

2. The Veterans Integrated Service Network Director ensures external practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations for practitioners in "two-deep" services or specialties.

Veterans Integrated Service Network concurred.

Target date for completion: August 31, 2024

Veterans Integrated Service Network response: The Veterans Integrated Service Network Director will ensure external practitioners with equivalent specialized training and similar privileges complete clinical record reviews as part of the Ongoing Professional Practice Evaluations for practitioners in "two-deep" services or specialties. The Veterans Integrated Service Network Chief Medical Officer organized a Teams-based group to track compliance with the external chart review process and Ongoing Professional Practice Evaluations completion. The denominator is the number of Ongoing Professional Practice Evaluations for two-deep providers due each month. The numerator is the number of Ongoing Professional Practice Evaluations for two-deep providers with clinical reviews completed by an external practitioner with similar training and privileges each month. The Veterans Integrated Service Network Chief Medical Officer will monitor for compliance and sustainment and report monthly in the Veterans Integrated Service Network Healthcare Quality Safety Value Committee until 90 percent or higher compliance is achieved and maintained for six consecutive months. The Veterans Integrated Service Network Director and Quality Management Officer co-chair the Veterans Integrated Service Network Healthcare Quality Safety Value Committee.

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.[47] 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."[48] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[49]

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.[50]

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

- Emergency Department
- Intensive Care Unit
- Medical/surgical inpatient units (4B South and 4B North)
- Mental health inpatient unit (Acute Mental Health Unit 3A)
- Women's health clinic (Gynecological Clinic)

Environment of Care Findings and Recommendations

VHA requires staff to track any deficiencies identified during comprehensive environment of care inspections until they are resolved.[51] The OIG reviewed the medical center's FY 2022 inspection deficiency list and noted staff had not tracked several items to resolution. Incomplete resolution of deficiencies could pose threats to the physical safety and well-being of patients, staff, and visitors. The Chief, Safety Service reported using Performance Logic to track action

[47] 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.)

[48] VHA Directive 1608.

[49] 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.

[50] 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.)

[51] VHA Directive 1608.

plans and notify staff of resolution due dates.[52] The Chief, Safety Service further explained that if staff extended the due date on an action plan, the Safety and Occupational Health Specialist or the Chief, Safety Service did not receive an automated alert, resulting in the loss of tracking for those actions.

Recommendation 3

3. The Medical Center Director ensures the Safety and Occupational Health Specialist or designee tracks environment of care inspection deficiencies until they are resolved.[53]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director reviewed the recommendation and did identify additional reasons for noncompliance including issues within the supply chain and the requirement to use contracts due to purchase card limitations. At least 90 percent of the open actions reviewed at time of the survey were related to Interior Design and posed no safety threat to patients, staff, or visitors. The Comprehensive Environment of Care Rounds Coordinator reviewed open action reports weekly for items greater than 45 days. The Chief, Safety Service then reviewed progress and sent weekly email reminders to the respective service leader(s) with deficiencies. The Chief, Safety Service monitored and tracked environment of care deficiencies monthly and reported compliance on actions greater than 90 days to the Comprehensive Environment of Care Committee, formally known as the Environment of Care Committee, which is chaired by the Associate Director. Data collection and monitoring began in April 2023 and continued until 90 percent or higher compliance was achieved for six consecutive months.

There is full engagement and accountability of the Safety Service, respective Service Chiefs, and members of the Comprehensive Environment of Care Committee. Monitoring was completed monthly to ensure there was a standard process for tracking actions in the Performance Logic Report. From time of survey, February 2023, there were 72 actions greater than 90 days, and all actions were tracked and closed in September 2023 for a compliance rate of 100 percent.

VHA requires staff at facilities with mental health inpatient units to perform systematic environmental assessments using the Mental Health Environment of Care Checklist to identify

[52] "Performance Logic (PL) Rounding Center is a software platform for Environment of Care (EOC) rounds management across medical centers and hospital systems. This technology is designed to standardize the rounds process and provide automated deficiency tracking and reporting." "VA Technical Reference Model v 23.7," Department of Veterans Affairs, accessed July 12, 2023, https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=6726.

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

and address risks for patients under treatment.[54] Mental Health Environment of Care Checklist criteria state that staff should test panic alarms at least quarterly and document testing and VA police response times in a log.[55] The OIG reviewed the mental health inpatient unit alarm testing log from October through December 2022 and did not find documentation of police response times. Failure to monitor police response times may put patients, visitors, and staff at risk in the event of an actual emergency. The Chief, Police and Security reported that monitoring police response times was not a requirement, but police officers responded to panic alarm drills within two to three minutes.

Recommendation 4

4. The Medical Center Director ensures staff document police response times to panic alarm testing in the mental health inpatient unit at least quarterly.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Medical Center Director reviewed the recommendation and identified the following as reason: at the time of survey there were no VHA mandates, requirements or directives stipulating panic alarm testing response times. The Mental Health Environment of Care Checklist does provide guidance indicating periodic tested panic alarms should include response time. However, the response time was buried behind two selection boxes under the title "rationale". With the revised VHA Mental Health Environment of Care Checklist, the Chief, Police and Security added response times to the documentation for routine drills for the acute mental health unit (3A). The denominator is the total number of panic alarms tested each month in the acute mental health unit (3A). The numerator is the number of panic alarms tested in the acute mental health unit (3A) with documented police response times each month. The Chief, Police and Security began data collection and monitoring in February 2023. After receiving clarification from the Office Of Inspector General, the facility began official monitoring in October 2023 and will continue until 90 percent or higher compliance is achieved and maintained for six consecutive months. The Chief of Quality Management will report quarterly compliance to the Clinical Executive Council.

[54] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," October 18, 2022.

[55] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[56] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[57] The suicide rate for veterans was higher than for nonveteran adults during 2020.[58] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[59]

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.[60] 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.[61]

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.[62]

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

[57] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed February 15, 2023.

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

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

[60] 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.)

[61] 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.)

[62] 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 the suicide prevention coordinator to report suicide-related events monthly, which includes attempts and deaths, "to local mental health leadership and quality management."[63] The OIG found that the Supervisory Suicide Prevention Coordinator reported only suicide-related deaths, not attempts. When the coordinator does not report all suicide-related events, leaders may miss opportunities to implement actions to improve mental health services and the suicide prevention program. The Supervisory Suicide Prevention Coordinator reported believing they met the intent of the directive. The Supervisory Suicide Prevention Coordinator also reported providing all suicide events (attempts and deaths) to mental health leaders and quality management staff every month, beginning October 2022.

Recommendation 5

5. The Medical Center Director ensures the Supervisory Suicide Prevention Coordinator reports suicide-related events monthly to mental health leaders and quality management staff.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Chief of Mental Health attests that in October 2022 the facility identified not all suicide related events were being reported monthly to Mental Health leadership and Quality Management. The Veterans Integrated Service Network Chief Mental Health Officer developed a standardized tracking tool which was adopted by all facilities within the network. The facility Suicide Prevention Coordinator implemented the tracking tool and monitoring began in October 2022. After receiving clarification from the Office Of Inspector General, the facility began official monitoring in October 2023 and will continue until 90 percent or higher compliance is achieved and maintained for six consecutive months. The denominator equals the total number of suicide related events that occurred each month. The numerator equals the total number of suicide related events reported to Mental Health leadership and Quality Management each month. The Chief, Mental Health Services will report quarterly compliance in the Clinical Executive Committee.

[63] VHA Directive 1160.07.

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 five 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 five OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. Four recommendations are attributable to the Medical Center Director and one to the VISN Director. 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	• Staff complete root cause analyses for all patient safety events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• External practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations for practitioners in “two-deep” services or specialties.
Environment of Care	• The Safety and Occupational Health Specialist or designee tracks environment of care inspection deficiencies until they are resolved. • Staff document police response times to panic alarm testing in the mental health inpatient unit at least quarterly.
Mental Health: Suicide Prevention Initiatives	• The Supervisory Suicide Prevention Coordinator reports suicide-related events monthly to mental health leaders and quality management staff.

Appendix B: Medical Center Profile

The table below provides general background information for this highest complexity (1a) affiliated medical center reporting to VISN 7.[1]

Table B.1. Profile for Ralph H. Johnson VA Medical Center (534) (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	$667,912,490	$805,836,586	$842,081,396
Number of:			
• Unique patients	77,780	81,879	85,714
• Outpatient visits	965,707	1,062,761	1,011,593
• Unique employees§	2,762	2,766	2,695
Type and number of operating beds:			
• Community living center	28	28	28
• Medicine	67	67	67
• Mental health	25	25	25
• Surgery	32	32	32
Average daily census:			
• Community living center	13	12	7
• Medicine	34	45	40
• Mental health	18	18	18
• Surgery	12	12	12

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 Southeast Network (10N7)

Subj: Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina

To: Director, Office of Healthcare Inspections (54CH06)

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

1. I have completed a full review of the Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, SC draft report and concur with the findings.
2. I concur with the recommendations and action plan submitted by the Ralph H. Johnson VA Medical Center in Charleston, SC for recommendations 1, 3, 4, and 5. In addition, I concur with VISN 7's action plan for recommendation 2.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

David M. Walker, MD, MBA, FACHE
Network Director

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: December 8, 2023

From: Director, Ralph H. Johnson VA Medical Center (534)

Subj: Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina

To: Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, SC.
2. I have reviewed and concur with the recommendations in the OIG draft report. I have provided actions completed after our Comprehensive Healthcare Inspection to correct these findings with supporting documentation. Therefore, we are requesting closure for all facility recommendations (1, 3, 4 and 5).
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

(Original signed by:)

Scott R. Isaacks, FACHE

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rachel Agbi, DBA, MSN, Team Leader Ayesha Callaway, MSN, RN Patricia Calvin, MBA, RN Rowena Jumamoy, MSN, RN Carolyn McKay, LCSW Judy Montano, MS
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Sonia Whig, MS, RD Jarvis Yu, MS

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