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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta

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Figure 1. *Togus VA Medical Center of the VA Maine Healthcare System in Augusta.*

Source: https://www.va.gov/maine-health-care/locations/ (accessed April 26, 2023).

Abbreviations

ADPNS	Associate Director for Patient and Nursing 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 VA Maine Healthcare System, which includes the Togus VA Medical Center and multiple outpatient clinics in Maine. 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 VA Maine Healthcare System during the week of May 15, 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 healthcare system'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 11 recommendations to the Medical Center Director and Chief of Staff in all five areas of review. The OIG also issued a recommendation to the Veterans Integrated Service Network Chief Medical Officer in the Medical Staff Privileging review area. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for 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 32.

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 35–36, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

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

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on 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 VA Maine Healthcare System includes the Togus VA Medical Center and multiple outpatient clinics in Maine. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review the week of May 15, 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 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 VA Maine Healthcare System occurred in January 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in August 2021.

[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 healthcare system'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 healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

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

At the time of the OIG inspection, the executive team had worked together since the end of January 2023, when the ADPNS was assigned to the role. The Director had served the longest, since 2019.

[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 Chief of Staff, ADPNS, Deputy ADPNS, Associate Director, and Assistant Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.[10]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $571,659,163 had increased by approximately 5 percent compared to the previous year's budget of $543,493,353.[11] The Assistant Director reported using FY 2022 funds for staffing, medications, and operating costs. The Associate Director added that wages in the community had increased during the COVID-19 pandemic, which made it challenging to recruit and retain staff. The Chief of Staff said the rural location and salary caps made it difficult to recruit specialty care and mental health providers.

The Assistant Director said leaders allocated $1.2 million for local projects, which included dental suite, simulation laboratory, and community living center renovations; tile flooring replacement; parking area pavement; and plumbing and steam upgrades.[12] The Assistant Director identified additional FY 2022 construction projects, including combining the Saco and Portland community-based outpatient clinics, building a new community-based outpatient clinic in Rumford, and adding bronchoscopy and infusion suites in the medical center.

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

[10] The Director was unavailable during the week of the inspection, and the Associate Director was serving as the Acting Director. Because the ADPNS was new to the role at the healthcare system, the OIG also interviewed the Deputy ADPNS.

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

[12] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

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

without fear of reprisal.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The system's scores for the selected question were higher than VHA's for all three years. The Associate Director attributed this to the Director creating safety forums for staff to share ideas and discuss concerns. The Deputy ADPNS added that staff often led the safety forums and spoke about lessons learned. The ADPNS conveyed the system's plan for sustaining the All Employee Survey scores, which included executive leaders' frequent visits throughout the medical center and outpatient clinics to identify problems and address staff concerns.

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
VA Maine Healthcare System	3.9	4.0	4.0

Source: VA All Employee Survey (accessed November 28, 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 healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

Inpatient, primary care, and specialty care satisfaction scores were consistently higher than VHA averages, which implies patients were more satisfied with their care than VHA patients nationally. The Chief of Staff explained that when patient issues arose, leaders conducted service recovery measures such as contacting patients directly to resolve concerns.[16] Additionally, the

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

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

[16] VHA defines service recovery as one of the fundamental elements of customer service and a process involving staff's ability to quickly identify concerns, communicate resolution actions, and provide an "opportunity to turn a potentially negative experience into a positive one" for veterans, families, beneficiaries, caregivers, and survivors. VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

Chief of Staff reported involving clinical pharmacists to manage medications for inpatients with hypertension and diabetes to enhance patient satisfaction. The Associate Director conveyed how staff sustained patient satisfaction scores by creating an environment where patients were treated like family. The Chief of Staff and Associate Director also described community living center residents participating in social events, such as the winter carnival, which included a parade and tree lighting. The ADPNS added that staff developed collaborative relationships between services, such as nursing and nutrition, to enhance continuity of care.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	77.4	69.7	81.1	68.9	79.6
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	87.9	81.9	88.4	81.7	87.9
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	89.4	83.3	88.4	83.1	88.2

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 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 Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] According to The

[17] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2022, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

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 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] 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."[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 and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. The Associate Director explained that leaders hired two new patient safety managers and one specialist within the last year. One of the patient safety managers described the adverse event reporting process and said staff enter adverse events in the Joint Patient Safety Reporting system, then patient safety staff review the

[18] 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.

[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(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

entries each morning and discuss them with executive leaders during morning meetings.[24] The Chief of Quality Management added that staff review Joint Commission guidelines to determine whether adverse events also meet sentinel event criteria. The chief also stated staff report all sentinel events to The Joint Commission, except those that occurred in the community living center.

Leadership and Organizational Risks Findings and Recommendations

VHA states the patient safety manager is responsible for "validating that immediate actions are taken following a patient safety event that protect other patients from harm and preserve relevant information that assists in fully understanding the event."[25] VHA requires that when "an adverse event has resulted in or is reasonably expected to result in death or serious injury, an institutional disclosure must be performed regardless of when the event is discovered."[26] VHA also requires leaders to document the disclosure in the patient's electronic health record.[27]

The OIG identified a sentinel event documented in the Joint Patient Safety Reporting system for FY 2022 that involved a patient's death and found staff conducted a root cause analysis only.[28] In reviewing facility documentation, the OIG also identified a fall involving a community living center resident who sustained multiple fractures. The OIG found staff did not conduct institutional disclosures for the patient death or the fall. Failure to conduct institutional disclosures may reduce patients' trust in the organization.

One of the patient safety managers agreed that staff entered the patient's fall as an adverse event in the Joint Patient Safety Reporting system and conducted a root cause analysis, but acknowledged it was an error for staff to not identify it as a sentinel event. For the sentinel event involving the patient death, the Risk Manager said the electronic health record did not list next of kin, but staff had identified a relative during the week of the OIG inspection; the Risk Manager reported planning to review the case again with the Chief of Staff to determine whether they should conduct an institutional disclosure.

[24] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022.

[25] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[26] VHA Directive 1004.08.

[27] VHA Directive 1004.08.

[28] A root cause analysis "is a comprehensive team-based, system-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

Recommendation 1

1. The Medical Center Director ensures leaders identify and evaluate sentinel events and conduct and document institutional disclosures when criteria are met.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director will ensure that staff identify and evaluate sentinel events and conduct and document institutional disclosures when criteria are met. Starting in May of 2023, the Patient Safety Team and Risk Manager initiated weekly meetings to discuss any significant potential or actual adverse patient safety events. For each event, the program staff review the facts of the event, the potential and actual safety assessment code (SAC), they discuss if the event meets the criteria of a sentinel event, determine if an institutional disclosure, a Root Cause Analysis (RCA), and/or protected peer review(s) for quality management may be required. This ongoing meeting allows for shared knowledge of patient safety events to ensure required reviews and disclosures are initiated when appropriate. The program staff utilize the Patient Safety/Risk Management Event Tracking tool to ensure all reviews are completed. The Patient Safety Team reports all sentinel events to Executive Leadership. The Risk Manager is responsible for discussing any potential events they may warrant an institutional disclosure with the Chief of Staff.

The Patient Safety Manager will monitor ongoing compliance to ensure 100% of documented patient safety events that meet criteria for a sentinel event are documented as a sentinel event in the Joint Patient Safety Reporting System and reported to the risk manager for potential disclosure. The compliance rate will be reported monthly to the Patient Safety Committee at each meeting.

The Risk Manager will monitor ongoing compliance to ensure 100% of institutional disclosures are completed when criteria are met. Documentation of the completed institutional disclosures will be monitored through the Patient Safety/Risk Management Event Tracking Tool.

The numerator will be the monthly number of sentinel events that meet criteria for an institutional disclosure and have a completed institutional disclosure documented. The denominator will be the total number of sentinel events meeting criteria for institutional disclosures.

The Accreditation Specialist will report the compliance for both the documentation of sentinel events and completion of institutional disclosures to the Quality and Patient Safety Committee monthly until six consecutive months 100% compliance is provided.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[29] 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.[30] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[31]

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.[32] 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.[33]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[34] 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."[35] 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.[36]

The OIG team interviewed key managers and staff and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

VHA states that "RCAs [root cause analyses] are performed based on the Safety Assessment Code (SAC) matrix and include any event receiving an actual or potential SAC score of 3 in the Joint Patient Safety Reporting (JPSR) system."[37] The OIG found staff did not initiate a root cause analysis for three adverse events with a potential safety assessment code score of 3. When

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

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

[31] VHA Directive 1100.16.

[32] VHA Handbook 1050.01; VHA Directive 1050.01(1).

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

[34] 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.

[35] VHA Directive 1190.

[36] VHA Directive 1190.

[37] 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 1 to 3 scale (3 = highest risk, 2 = intermediate risk, 1 = lowest risk). VHA Handbook 1050.01; VHA Directive 1050.01(1).

staff do not thoroughly review patient safety events, it may limit leaders' awareness of system vulnerabilities that could lead to patient harm. A patient safety manager attributed the deficiency to staff turnover and lack of training. The Chief of Quality Management explained the prior patient safety manager departed the position unexpectantly in February 2022; another staff member was detailed to the role, then permanently assigned in September 2022. The Chief of Quality Management further described the department's expansion with the addition of a patient safety specialist in April 2022 and a second patient safety manager in November 2022.

Recommendation 2

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

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director will ensure that staff complete a root cause analysis (RCA) for all patient safety events assigned an actual or potential safety assessment code (SAC) score of 3. Starting in May of 2023, the Patient Safety Team and Risk Manager initiated weekly meetings to discuss any significant potential or actual adverse events. For each event, the program staff review the facts of the event, the potential and actual SAC scores, they discuss if the event meets the criteria of a sentinel event, determine if an institutional disclosure, an RCA and/or protected peer review(s) for quality management may be required. This ongoing meeting allows for shared knowledge of patient safety events to ensure required reviews and disclosures can be initiated when appropriate. The program staff utilize the Patient Safety/Risk Management Event Tracking tool to ensure all reviews are completed as required.

In May of 2023, the Patient Safety Team initiated reviews of all potential and actual SAC 3 Joint Patient Safety Reporting (JPSR) reports from the previous month to ensure each event is assigned to an RCA or an aggregate category.

The Patient Safety Team will monitor ongoing compliance to ensure that 100% of documented patient safety events that are assigned a potential or actual SAC 3 have been assigned to an RCA or aggregate category and will provide a summary of these events and associated RCA or aggregate category to the Patient Safety Committee monthly.

The Accreditation Specialist will report the compliance of potential or actual SAC 3 patient safety events assigned to an RCA or aggregate category to the Quality and Patient Safety Committee monthly until six consecutive months of 100% compliance is achieved. The numerator will be the number of potential or actual SAC 3 patient safety events assigned an RCA. The denominator will be the total number of patient safety events assigned a potential or actual SAC 3.

The Joint Commission leadership standards state the facility's governing body is ultimately responsible for patient safety and quality of care.[38] VHA defines governance as "the process by which VA Senior Leadership makes decisions, provides strategic direction and maintains accountability in a transparent and collaborative manner."[39] Further, The Joint Commission expects leaders to use "data and information to guide decisions and to understand variation" for patient safety and quality processes.[40] The OIG found quality management staff had a process to track patient mortality but did not use the data to identify any trends in FY 2022. Failure to identify data trends may hinder opportunities for leaders to improve patient safety.

The Chief of Quality Management stated three different committees reviewed mortality-related events, but the OIG determined staff did not report mortality data to the executive committee of the governing board as required in the system charter. However, the Chief of Quality Management said staff began reporting mortality data to the Quality, Safety, and Value Committee in FY 2023. The OIG verified that reporting to the Quality, Safety, and Value Committee began in April 2023 and noted the Director and Chief of Quality Management co-chaired the committee. The OIG did not make a recommendation but remains concerned VHA does not have specific enterprise-wide expectations for tracking and trending mortality data.

[38] The Joint Commission, *Standards Manual*, E-dition, LD.01.03.01, January 1, 2022.

[39] VA Directive 0214, *Enterprise Governance Structure and Process*, May 14, 2019.

[40] The Joint Commission, *Standards Manual,* E-dition, LD.03.02.01, January 1, 2022.

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."[41] 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."[42]

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.[43] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[44]

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.[45]

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.[46] 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

[41] 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.)

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

[44] VHA Handbook 1100.19.

[45] VHA Handbook 1100.19.

[46] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[47]

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

At the time of reprivileging, VHA requires service chiefs to consider relevant Ongoing Professional Practice Evaluation data when recommending the continuation of LIPs' privileges to an executive committee of the medical staff. Such data must be easily retrievable and may include results of electronic health record reviews, outcome data, or direct observation.[48] The OIG did not find evidence service chiefs consistently recommended LIPs' continued privileges to the Clinical Executive Board based, in part, on Ongoing Professional Practice Evaluation data.[49] This resulted in the Clinical Executive Board recommending renewal of privileges to the Director without a thorough review of the LIPs' practices. The Chief of Surgery reported being unable to locate the Ongoing Professional Practice Evaluation data. The OIG issued a similar recommendation to the one below in a prior CHIP report.[50]

Recommendation 3

3. The Chief of Staff ensures service chiefs recommend reprivileging for licensed independent practitioners based, in part, on Ongoing Professional Practice Evaluation data.

[47] 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.

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

[49] This healthcare system's executive committee of the medical staff was called the Clinical Executive Board.

[50] VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine*, Report No. 18-01152-14, November 28, 2018.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Chief of Staff will ensure service chiefs recommend reprivileging for licensed independent practitioners based, in part, on Ongoing Professional Practice Evaluation data. In June of 2023, the clinical service chiefs were given the expectation that ongoing professional practice evaluation (OPPE) data is required for re-privileging actions to be presented at the Medical Executive Committee (formally the Clinical Executive Board) by way of the Professional Standards Board. Starting in June of 2023, the Credentialing and Privileging Analyst initiated tracking of the completed OPPE documentation required for re-privileging each month. The tracking is provided to the Credentialing and Privileging manager for ongoing monitoring.

The Credentialing and Privileging Manager will ensure the clinical service chiefs provide the complete OPPE data when re-privileging action is required at least 90% of the time.

The compliance will be reported to the Quality and Patient Safety Committee by the Accreditation Specialist until six consecutive months of 90% or greater compliance is provided. The numerator is the number of providers with a completed OPPE data packet presented to the Medical Executive Committee via the Professional Standards Board minutes. The denominator will be the number of providers requiring re-privileging.

VHA requires the FPPE process to "be defined in advance, using objective criteria accepted by the LIP."[51] The OIG did not find evidence LIPs consistently accepted the FPPE criteria in advance. When LIPs are not aware of the criteria used to evaluate their performance, they may not understand FPPE expectations during this initial period. The Chief of Dental Service reported having a verbal conversation with an LIP but did not document the discussion until the FPPE was completed. The Chief of Medicine Service attributed the documentation delay to an administrative oversight due to decreased staff in the service. 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 also requires staff to report FPPE results to an executive committee of the medical staff.[52] The OIG did not find evidence service chiefs consistently reported FPPE results to the Clinical Executive Board, which could result in insufficient evidence to support privileging recommendations. The Chief of Staff reported the Clinical Executive Board meeting minutes lacked the information reported to the board due to the vacant secretary position, which was

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

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

covered by two temporary staff members who were responsible for drafting the minutes. The Chief of Staff also acknowledged the committee approved meeting minutes with either incorrect or missing documentation. The OIG issued a similar recommendation to the one below in a prior CHIP report.[53]

Recommendation 4

4. The Chief of Staff ensures staff report licensed independent practitioners' Focused Professional Practice Evaluation results to the Clinical Executive Board.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Chief of Staff will ensure staff report licensed independent practitioners' Focused Professional Practice Evaluation (FPPE) results to the Medical Executive Committee (formally the Clinical Executive Board). The minutes from the Professional Standards Board include evidence service chiefs consistently report FPPE results when determining privileging actions.

In June of 2023, VA Maine Healthcare system created an orientation guide for newly hired Chief of Staff's secretaries. The orientation guide includes guidance on drafting the Medical Executive Committee meeting minutes, including specific guidance on how to embed the Professional Standards Board minutes for each meeting.

The Credentialing and Privileging Manager provides ongoing monitoring to ensure the Professional Standards Board recommendations are presented to the Medical Executive Committee and documented in the Medical Executive Committee minutes 90% of the time.

The Accreditation Specialist will report the compliance rate to the Quality and Patient Safety Committee until 90% compliance is provided for six consecutive months. The numerator will be the number of completed FPPE results presented to the Medical Executive Committee. The denominator will be the number of expected FPPEs.

VHA requires the VISN chief medical officer to oversee the privileging process at the VISN's medical facilities.[54] The OIG observed the healthcare system's Credentialing and Privileging Program had two similar recommendations from a prior comprehensive healthcare inspection.[55] Additionally, the OIG noted the VISN Chief Medical Officer had multiple pathways for

[53] VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine*.

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

[55] VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine*.

oversight of the privileging processes but missed opportunities to identify and mitigate gaps, which could have corrected inconsistent processes. The VISN 1 Deputy Chief Medical Officer explained that because of the pandemic, VISN leaders had changed the comprehensive in-person auditing process to a monthly virtual review of only two random provider profiles per facility.

Recommendation 5

5. The Veterans Integrated Service Network Chief Medical Officer provides effective oversight of credentialing and privileging processes at the healthcare system.

Veterans Integrated Service Network concurred.

Target date for completion: September 30, 2024

Veterans Integrated Service Network response: The VISN Chief Medical Officer (CMO) provides regular oversight in the privileging process, including weekly one on one meetings with the Chief of Staff (COS), weekly Chief of Staff calls including all COS across the VISN, reviewing the results of each facility's Credentialing & Privileging (C&P) Facility Self-Assessment (FSA) and a yearly site visit focused solely on the C&P process for the site. VISN C&P Officer meets with C&P Managers weekly and the full group monthly. The VISN CMO, Deputy Chief Medical Officer (DCMO) and C&P Officer ensured that all sites completed their Facility Self-Assessments (FSA) this year and created an action plan. The VISN C&P Officer attended the debriefs for each site where their leadership was made aware of any deficiencies and action plans. The VISN CMO office will show continued oversight by providing a summary of the FSA findings to the VISN Healthcare Delivery Council (HDC) and a follow up of Action Plan completion 90 days after the presentation. In addition, the VISN will complete a site visit focused on Credentialing and Privileging for each site where FSA results and current review of the C&P program are validated and discussed. Oversight will be documented in the minutes of the HDC meetings and in the presentations by the C&P Officer at site visits.

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."[56] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[57]

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.[58]

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

- Community living center (Togus Springs)
- Emergency Department
- Inpatient Mental Health Unit
- Medical/surgical inpatient unit (3 North)
- Special Care Unit
- Women's Health Clinic

Environment of Care Findings and Recommendations

VHA requires facility leaders to have a comprehensive environment of care program, which includes staff conducting environmental inspections at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered," and

[56] 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.)

[57] 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.

[58] 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; VHA Directive 1142(1).

documenting completion of each inspection.[59] Additionally, VHA requires the comprehensive environment of care coordinator to arrange physical inspections and maintain the records.[60] The OIG reviewed the FY 2022 environment of care inspection summary report and found staff did not inspect some clinical areas at least twice and other clinical areas at all.[61] This could have prevented staff from proactively identifying unsafe conditions. The Safety Officer reported staff completed the inspections at the time they were due but was unable to provide evidence to the OIG.

Recommendation 6

6. The Medical Center Director ensures the comprehensive environment of care coordinator schedules environment of care inspections at the required frequency and verifies staff complete and document them.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director will ensure the staff member responsible for the comprehensive environment of care inspections schedules and documents environment of care inspections at the required frequency. The Safety Specialist corrected the schedule for the environment of care inspections in May of 2023. The updated schedule ensures the requirements for inspections and submission of inspection findings occurs at a minimum frequency of once per fiscal year in non-patient areas and twice per fiscal year in all areas where patient care is delivered.

The Safety Specialist will ensure that each inspection is completed at least 90% of the time according to the schedule. Compliance will be audited through the Performance Logic system and will report the compliance rate of completed scheduled environment of care inspections to the Environment of Care Committee quarterly.

The Accreditation Specialist will report the compliance rate to the Quality and Patient Safety Committee monthly until six consecutive months of 90% or greater compliance is achieved. The numerator will be the number of environment of care inspections that were completed for the month and the denominator will be the number of environment of care inspections scheduled for the month.

[59] VHA Directive 1608.

[60] VHA Directive 1608.

[61] Staff did not inspect the following locations twice in FY 2022: multiple outpatient clinics and the community living center at the Togus VA Medical Center; and community-based outpatient clinics in Bangor, Caribou, Houlton, Lewiston, Lincoln, Portland, and Rumford.

VHA requires staff to periodically test panic alarms in the inpatient mental health unit and document VA police response times.[62] The OIG found evidence of monthly alarm testing, but no documentation of VA police response times. This may result in an unsafe environment for patients, visitors, and staff since timely responses affect the overall success of police intervention. The Chief of Police stated that police test alarms and record response times; however, during the inspection week, police did not provide the supporting documentation.

Recommendation 7

7. The Medical Center Director ensures staff document police response times to panic alarm testing in the Inpatient Mental Health Unit.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director will ensure that police response times to panic alarm testing in the Inpatient Mental Health Unit is tested monthly and documented. The VA Maine Healthcare System Police Lieutenant tests the police response times to the panic alarm tests on the Inpatient Mental Health Unit (Unit 63) monthly. The Lieutenant ensures that the test and response time are documented on the updated monthly panic alarm testing log. The updated testing log captures the date and time the panic alarm was initiated, the time the officer responds to the Inpatient Mental Health Unit, and the responding officer's starting location. Use of this document started in May of 2023, and is tracked and monitored monthly by the Chief of Police to ensure the testing is completed and documented 100% of the time. The Chief of Police will provide monthly compliance reports to the Patient Safety Committee.

The documentation compliance will be reported to the Quality and Patient Safety Committee monthly by the Accreditation Specialist until six consecutive months of 100% compliance is provided. The numerator will be the completion and documentation of panic alarm testing and police response times monthly. The denominator will be the total number of times panic alarm testing initiated monthly.

VHA requires staff to test over-the-door alarms per the manufacturer's recommendations for all doors to inpatient mental health unit sleeping rooms.[63] The manufacturer's guidelines for the alarms recommend staff test them weekly and an outside maintenance provider tests them annually. The OIG did not find evidence staff tested over-the-door alarms on sleeping rooms

[62] VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in VHA*, September 12, 2022, amended October 13, 2022; 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," April 10, 2023.

[63] VHA Directive 1167; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

weekly. If staff do not test alarms per the manufacturer's recommendations, the alarms may fail to alert them when patients are in immediate danger. A patient safety manager and the Inpatient Mental Health Nurse Manager reported being unaware of the manufacturer's recommendations for testing. The patient safety manager also reported staff had been testing quarterly until March 2023, then changed to testing monthly.

Recommendation 8

8. The Medical Center Director ensures staff follow the manufacturer's recommendations for testing over-the-door alarms on Inpatient Mental Health Unit sleeping room doors.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director will ensure that staff follow the manufacturer's recommendations for testing over-the-door alarms on Inpatient Mental Health Unit sleeping room doors. In May of 2023, the over-the-door alarm documentation tool was revised to clearly identify the location of all over the door alarms that are required to be tested. Staff were provided just in time training on the requirement to test and document the over-the-door alarms weekly. A formal staff competency was drafted, and all applicable inpatient mental health unit staff were trained utilizing the new competency by September 30, 2023.

The Inpatient Mental Health Nurse Manager will ensure the over-the-door alarm testing is completed weekly on applicable doors 100% of the time. The Inpatient Mental Health Nurse Manager will provide ongoing compliance reports to the Patient Safety Committee monthly.

The Accreditation Specialist will report the testing and documentation compliance to the Quality and Patient Safety Committee monthly until six consecutive months of 100% compliance is provided. The numerator will be the weekly completion and documentation of over-the-door alarm testing for each alarm. The denominator will represent the total number of weekly over-the-door alarms tested.

VHA requires inpatient mental health unit staff to ensure a safe environment of care, supported by using the Mental Health Environment of Care Checklist during inspections.[64] The OIG reviewed the system's FY 2022 Mental Health Environment of Care Checklist reports and observed pillows, shower curtains, and ceiling material that did not align with the mental health environment of care requirements, despite staff documenting that all checklist standards were

[64] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Directive 1167.

met.[65] Failure to address environmental safety concerns could result in patient, visitor, or staff injury.

The Acting Chief of Environmental Management Services reported supplying breathable cloth pillows for the inpatient mental health rooms and being unaware that vinyl pillows were in use. The acting chief also explained that due to the design of the shower floors, which allowed water to leak into the bathroom, staff had tried several types of shower curtains. A patient safety manager provided the OIG with a VISN waiver for the non-solid ceilings located in the hallway outside the nurse's direct line of sight; the waiver included a mitigation plan to continuously monitor the area via cameras, but the OIG found it did not address the ceiling material, and the video monitor was unattended. The patient safety manager attributed the waiver not including the ceiling type to a lack of attention to detail. Another patient safety manager reported using the patient safety assessment tool instead of the Mental Health Environment of Care Checklist, which is more detailed, when making inspection rounds.

VHA requires inpatient mental health unit entrances to be designed "to avoid patient elopement and provide staff visibility and oversight for safety."[66] A sally port entrance provides a secure entry pathway through two synchronized controlled-access doors to ensure only one door can be opened at a time. The OIG observed the first point of entry to the Inpatient Mental Health Unit via a secured elevator required staff to use their badges for access directly into the sally port area. However, when exiting the unit, the OIG observed that the elevator door could be opened simultaneously with the unit door and badge access was not required. Failure to address environmental safety concerns in the Inpatient Mental Health Unit could result in patient elopement. The Inpatient Mental Health Unit Assistant Nurse Manager reported being unaware the doors could open simultaneously.

Recommendation 9

9. The Medical Center Director ensures staff maintain a safe environment in the Inpatient Mental Health Unit.

[65] The OIG observed vinyl pillows (suffocation risk); shower curtains not made of a breathable material, not easy to break away, and not hung in flush-mounted tracks (suffocation and self-harm risks); and sections of the hallway ceilings not in employees' direct line of sight and not made of solid material (self-harm and elopement risks).

[66] Department of Veterans Affairs, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities,* January 2021.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director ensures staff maintain a safe environment in the Inpatient Mental Health Unit. On May 18, 2023, all non-breathable pillows were removed from the Inpatient Mental Health Unit. On May 18, 2023, the Acting Chief of Environmental Management Services purchased safety pillows for the Inpatient Mental Health Unit. The Nurse Manager for the Inpatient Mental Health Unit implemented a new environment of care checklist tool that is completed at least once a day to ensure the environment remains safe. The new checklist requires verification that the pillows available on the unit are breathable. The Patient Safety Manager created a Mental Health Environment of Care Checklist (MHEOCC) Safety Education module that was provided to all Inpatient Mental Health staff in July of 2023. Since implementation of the new Environmental Checklist in August of 2023, 100% of environmental checks have been completed at least once daily. The Inpatient Mental Health Nurse Manager will continue to monitor overall completion of the Environmental Checklist and ensure appropriate actions are taken when deficiencies were noted. The compliance rate will be reported to the Quality and Patient Safety Committee by the Accreditation Specialist monthly until six consecutive months of compliance at 90% or greater is provided. The numerator will be the number of daily environmental checks completed each month. The denominator will be the number of daily environmental checks required each month. The Inpatient Mental Health Nurse Manager will provide ongoing compliance reports to the Patient Safety Committee monthly.

The Chief of Facilities Management coordinated the removal of all shower curtains by the end of May 2023. New MHEOCC compliant shower doors were installed on June 21, 2023.

The non-solid ceilings are still in place. The Patient Safety Manager has requested a waiver through the MHEOCC process to maintain the non-solid ceilings with appropriate mitigation plans in place. The National Center for Patient Safety has deferred the waiver pending completion of a Direct Line of Sight Standard Operating Procedure. The Standard Operating Procedure outlines the observation requirements for the ceiling. This Standard Operating Procedure is pending publication and is expected to be published by March 31, 2024. Once the document is published, the waiver will be resubmitted for approval by June 30, 2024. The status of this action will be reported to the Quality and Patient Safety Board by the Accreditation Specialist monthly until the waiver is approved by the National Center for Patient Safety MHEOCC Board.

The Inpatient Mental Health Nurse Manager requires staff complete 15-minute safety checks of the staff member in the video-monitor room. A sign in and sign out sheet was established to document any transition in the monitor room responsibilities. This process ensures that a staff member is providing observation of the unit via the video-monitoring room at all times. The Mental Health Inpatient Nurse Manager will monitor documentation of the 15-minute safety check of the staff member in the video-monitor room for completion of the check for each day at

least 90% of the time. The Inpatient Mental Health Nurse Manager will provide ongoing compliance reports to the Patient Safety Committee monthly.

The compliance rate will be reported to the Quality and Patient Safety Committee by the Accreditation Specialist monthly until six consecutive months of compliance at 90% or greater is provided. The numerator will be the completed documentation of the 15-minute safety checks of the staff member in the video-monitor room for each day of the month. The denominator will be the total number of required monthly safety checks.

The sally port entrance has been reviewed by the Chief of Facilities Management and the company responsible for building automation and security systems and they were unable to identify an engineered delay for the door scanners. To mitigate the risk for elopement, the Nurse Manager has posted signage alerting staff to use the alternate entrance to the administrative space of the Inpatient Mental Health Unit instead of entering directly onto the unit after exiting the elevator. The staff in the video-monitor room are responsible for allowing staff without badge access to enter the unit. The video-monitor room staff will only grant access to the administrative space for staff visiting the unit instead of allowing staff to enter the unit directly.

As part of the Patient Safety Program, the Patient Safety Manager will provide ongoing monitoring of elopements from the inpatient mental health unit with a target of zero elopements via the sally port.

The Accreditation Specialist will report the compliance rate to the Quality and Patient Safety Committee monthly until six consecutive months of no elopements via the sally port is provided. The numerator is the number of monthly elopements via the sally port from inpatient mental health unit. The denominator will be the number of days in the month.

The Occupational Safety and Health Administration requires staff to post hazard warning signs where potentially infectious materials are located.[67] The OIG identified areas that lacked the appropriate signage.[68] A lack of hazard signage could place patients, staff, and visitors at risk for exposure to infectious materials. The Safety Officer said the door leading to the biohazard room was a fire door and no signage was allowed to be posted on this type of door. The Safety Officer did not provide a reason why the other locations lacked required signage.

[67] "Biological hazard signs. The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents." 29 C.F.R. § 1910.145(e)(4).

[68] The OIG observed required hazard warning signs were missing on the Inpatient Mental Health Unit, medical/surgical inpatient unit (3 North), Special Care Unit, and Women's Health Clinic.

Recommendation 10

10. The Medical Center Director ensures staff post hazard warning signs on all access doors where potentially infectious materials are located.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director will ensure staff post hazard warning signs on all access doors where potentially infectious materials are located. The Safety Officer confirmed on February 21, 2024, that the required hazard warning signs were posted in all required areas.

The Safety Specialist will ensure appropriate hazard signage is in place on all access doors where potentially infectious materials are located during scheduled environment of care inspections. If required signage is not in place a deficiency will be documented on the environment of care inspection report. The Safety Specialist will provide the ongoing compliance to the Environment of Care Committee quarterly.

Compliance with hazard warning signage will be reported to the Quality and Patient Safety Committee monthly by the Accreditation Specialist until six consecutive months of 90% or greater compliance is achieved. The numerator will be the number of access doors observed during the environment of care inspections for the month requiring hazard warning signage have appropriate signage posted. The denominator will be the total number of access doors requiring hazard warning signage.

VHA requires all medical facilities to "provide a safe, clean, and high quality environment of care for Veterans, their families, visitors, and employees."[69] The OIG observed an open space in the concrete wall with loose concrete pieces next to the entrance of a patient care building and a large crack in the main hallway flooring. In the six patient care areas inspected, the OIG observed

- damaged walls with taped signage,
- dirty heating and air conditioning vents,
- damaged or stained ceiling tiles,
- dusty medication cabinets,
- corrugated boxes stored in clean areas,
- opened juice containers with missing expiration dates, and

[69] VHA Directive 1608.

- inconsistent documentation for eyewash station testing.[70]

Dirty, damaged, or disorganized patient care areas increase the risk of contamination, pathogen exposure, and other safety risks. The Safety Officer reported the entrance wall was part of a project to remove a radiator, and Facilities Management Service staff had not yet completed the repair. The Associate Director stated the large flooring crack had previously been identified and plans for repairs were ongoing. The Acting Chief of Environmental Management Services cited inability to access secured areas to remove the dust on top of the medication cabinets, and lack of attention to detail for the dusty ventilation grills. The Chief of Facilities Management Service explained staff could not replace ceiling tiles in occupied patient care areas. Additionally, the Chief of Facilities Management Service reported believing staff did not repair the holes in the walls due to a lack of communication among multiple service lines. The Chief of Nutrition and Food Service acknowledged being unaware that staff failed to label juice containers after opening them.

Recommendation 11

11. The Medical Center Director ensures staff keep patient care areas safe and clean.

[70] Corrugated boxes are an infection control concern because they can house pests and droppings, which can later become an infestation. "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed February 27, 2023, https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/infection-prevention-and-control. The OIG observed the deficiencies in the Emergency Department, community living center (Togus Springs), medical/surgical inpatient unit (3 North), Special Care Unit, Women's Health Clinic, and Inpatient Mental Health Unit.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director will ensure staff keep patient care areas safe and clean. Managers are responsible for notifying Facility Management Services through the submission of work orders when something requires repair such as damaged walls, dirty vents, or damaged or stained ceiling tiles. Any repairs that require a more urgent response can be telephoned to the Facility Management Service for repair. Staff may also alert Safety Staff via the "Hazard Reporting" link on the facility reporting Intranet home page. Staff members who complete the comprehensive environment of care inspections provide just in time training with unit managers and staff when concerns are identified such as removing corrugated boxes from clean areas, monitoring expiration dates of food and drinks, and documentation of eyewash station testing.

The Safety Manager will monitor compliance to ensure 90% of reported deficiencies have action plans or are closed within 14 days. The Safety Specialist will provide ongoing reports quarterly to the Environment of Care Committee with the percentage of deficiencies with current action plans or closed within 14 days.

The compliance rate will be reported to the Quality and Patient Safety Committee by the Accreditation Specialist monthly until six consecutive months of 90% compliance is provided. The numerator will be the number of monthly deficiencies with current action plans or closed within 14 days. The denominator will be the total number of monthly deficiencies reported.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[71] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[72] The suicide rate for veterans was higher than for nonveteran adults during 2020.[73] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[74]

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.[75] 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.[76]

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.[77]

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 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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

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

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

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

[75] 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.)

[76] 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.)

[77] 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

In ambulatory care settings, VHA requires designated staff to complete a suicide risk evaluation following a positive screen. Staff should complete the evaluation on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as in situations where urgent or emergent care is needed.[78] In these situations, once staff confirm patient safety, they should complete the evaluation within 24 hours of the positive screen.[79] The OIG estimated staff did not complete the evaluation for 40 (95% CI: 26 to 54) percent of patients who had a positive screen, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[80] Failure to complete the evaluation poses a patient safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The former Suicide Prevention Coordinator identified barriers to completing the evaluation, including lack of staff training.[81]

Recommendation 12

12. The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

[78] 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)."

[79] 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)."

[80] 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.

[81] The Suicide Prevention Coordinator reported assuming the role in August 2022, after the former Suicide Prevention Coordinator transitioned into a new role in FY 2022.

Healthcare system concurred.

Target date for completion: June 30, 2024

Healthcare system response: The Chief of Staff will ensure designated staff complete the Comprehensive Suicide Risk Evaluation (CSRE) on the same calendar day as a positive suicide risk screen unless a situation requires urgent or emergent care for the ambulatory care patient with a positive suicide screen. In these instances, the designated provider will complete the CSRE note by selecting "Unable / Unwilling to Complete" and document the risk mitigation plan.

In January of 2023, the Suicide Prevention Team started receiving reports twice daily containing the names of any patients with a positive Columbia Suicide Severity Rating Scales (C-SSRS) that did not have an associated CSRE. In the event of an incomplete CSRE, the Suicide Prevention Team will contact the provider who assumed responsibility for completing the CSRE to ensure completion of the CSRE will occur on the same business day. A third list containing names of patient with a positive C-SSRS is reviewed by the Suicide Prevention Team in the electronic health record at 1500 each day. In the event the responsible provider does not respond or complete the CSRE within a reasonable amount of time from Suicide Prevention outreach, a member of the Suicide Prevention Team will make every possible effort to reach the Veteran and complete a CSRE the same day to ensure safety.

In March of 2023 the Suicide Prevention Coordinator initiated the Suicide Prevention Data Analysis Committee, which meets monthly. This workgroup reviews any trends identified in timely completion of the CSRE, overall completion rates for both the C-SSRS and CSRE, in addition to Suicide Prevention metrics data captured in national reports. The meeting minutes are presented at the Patient Safety Council on a quarterly basis. Overall compliance with CSRE completion is provided monthly by the Suicide Prevention Coordinator to the Executive Committee of the Governing Body.

The Suicide Prevention Coordinator will ensure that 100% of required CSREs are completed on the same calendar day for six consecutive months. The numerator will be the number of CSREs that are completed the same calendar day and the denominator will be the number of CSREs that were required to be completed on the same calendar day.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided 12 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 healthcare system. 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 12 OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Medical Center Director, Chief of Staff, and Veterans Integrated Service Network Chief Medical Officer. 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	• Leaders identify and evaluate sentinel events and conduct and document institutional disclosures when criteria are met.
Quality, Safety, and Value	• Staff complete a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• Service chiefs recommend reprivileging for licensed independent practitioners based, in part, on Ongoing Professional Practice Evaluation data. • Staff report licensed independent practitioners' Focused Professional Practice Evaluation results to the Clinical Executive Board. • The Veterans Integrated Service Network Chief Medical Officer provides effective oversight of credentialing and privileging processes at the healthcare system.
Environment of Care	• The comprehensive environment of care coordinator schedules environment of care inspections at the required frequency and verifies staff complete and document them. • Staff document police response times to panic alarm testing in the Inpatient Mental Health Unit. • Staff follow the manufacturer's recommendations for testing over-the-door alarms on Inpatient Mental Health Unit sleeping room doors. • Staff maintain a safe environment in the Inpatient Mental Health Unit. • Staff post hazard warning signs on all access doors where potentially infectious materials are located. • Staff keep patient care areas safe and clean.

Review Areas	Recommendations for Improvement
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 1.[1]

Table B.1. Profile for VA Maine Healthcare System (402)
(October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$469,667,457	$543,493,353	$571,659,163
Number of:			
• Unique patients	40,834	43,300	45,704
• Outpatient visits	397,454	467,459	500,590
• Unique employees§	1,260	1,395	1,365
Type and number of operating beds:			
• Community living center	100	100	36
• Medicine	26	26	26
• Mental health	20	20	20
• Surgery	4	4	4
Average daily census:			
• Community living center	49	39	34
• Medicine	19	21	22
• Mental health	8	8	9
• Surgery	1	1	1

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 "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 23, 2024

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta

To: Director, Office of Healthcare Inspections (54CH03)

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta, Maine.
2. I have reviewed and concur with the recommendations, findings, and action plans set forth in this report.

(Original signed by:)

Ryan Lilly, MPA
Network Director
VA New England Healthcare System

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 22, 2024

From: Director, VA Maine Healthcare System (402)

Subj: Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta

To: Director, VA New England Healthcare System (10N1)

1. I have reviewed the draft report, Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta, Maine. I concur with the findings and recommendations.
2. I have reviewed and concur with the submitted action plans for the healthcare system.
3. I would like to thank the OIG Inspection Team for a comprehensive review of the VA Maine Healthcare System.

(Original signed by:)

Tracye B. Davis, FACHE
Medical Center Director, VA Maine HCS

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