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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Bay Pines VA Healthcare System in Florida

CHIP Report | **22-04014-130** | **April 10, 2024**

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Figure 1. *C.W. Bill Young VA Medical Center of the Bay Pines VA Healthcare System in Florida.*

Source: https://www.va.gov/bay-pines-health-care/locations/ (*accessed December 27, 2023*).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Bay Pines VA Healthcare System, which includes the C.W. Bill Young VA Medical Center and eight outpatient clinics in Florida. 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 Bay Pines VA Healthcare System during the week of February 27, 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 eight recommendations to the Director and Associate Director in the following areas of review: Leadership and Organizational Risks; Quality, Safety, and Value; 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 healthcare 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 25.

VA Comments

The Veterans Integrated Service Network Director and Healthcare System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 28–29, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 1 and 2 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Bay Pines VA 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 Bay Pines VA Healthcare System includes the C.W. Bill Young VA Medical Center and eight outpatient clinics in Florida. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of February 27, 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 healthcare system leaders complete corrective actions. The Healthcare System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the Bay Pines VA Healthcare System occurred in March 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews beginning 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 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 Director, Deputy Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, all six executive leaders were permanent in their roles. The Deputy Director was the most tenured leader and had been in the position over five years. The Associate Director and Assistant Director, the newest team members, were permanently appointed in September and November 2022, 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 Deputy Director, Chief of Staff, Associate Director for Patient Care Services, 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 $1,268,526,678 had increased by over 4 percent compared to the previous year's budget of $1,215,461,006.[11] The Deputy Director said the facility's budget was sufficient to support the current mission, and leaders returned approximately $30 million in unspent funds to VA. The Deputy Director also highlighted difficulties with the timely hiring and onboarding of staff, stating the facility was losing more staff than it was gaining, in part, due to the human resources modernization effort that has delayed the process. The Chief of Staff added that it was difficult to hire providers in the local area, and leaders used some of the budget increase for retention bonuses.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] 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.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The survey scores indicate that employees at this healthcare system were as comfortable disclosing suspected violations as VHA employees nationally. The Deputy Director said the scores reflected the healthcare system's efforts to become a high-reliability organization, with leaders encouraging front-line supervisors to frequently visit patient care areas to improve communication and relationships with staff.[14]

[10] At the time of the OIG site visit, the Director was not on-site and unavailable for interview.

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

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

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

[14] A high-reliability organization "is an organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

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
Bay Pines VA Healthcare System	3.8	3.8	3.9

Source: VA All Employee Survey (accessed November 8, 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.

Survey scores indicate that patient satisfaction in inpatient and outpatient settings generally declined over the three years. The Deputy Director discussed working to improve experiences by implementing an inpatient program called Commit to Sit, focused on providers sitting and conversing with patients to better coordinate care, and an outpatient program called Take a Moment in which providers spend more time with patients during visits to build relationships. The Deputy Chief of Staff reported hiring a veteran experience officer in May 2022, and the Deputy Director stated the officer had helped the executive leadership team understand patient experience data.

[15] "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	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	73.8	69.7	72.6	68.9	68.7
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	82.5	81.9	83.0	81.7	82.8
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	86.2	83.3	84.0	83.1	82.2

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

[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed December 22, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[17] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

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

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[19] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[20] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[22]

The Assistant Chief, Quality Systems described assuming the patient safety specialist's responsibilities in fall 2021 and implementing a new tracking process to review sentinel events and institutional disclosures every month. The Assistant Chief, Quality Systems and the Risk Manager spoke knowledgeably about sentinel events and institutional disclosures.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institutional disclosure of an adverse event "that resulted in or is reasonably expected to result in death or serious injury…including, for example sentinel

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

[19] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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

[21] VHA Directive 1004.08.

[22] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(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.)

events as defined by The Joint Commission."[23] VHA policy also states, "this disclosure is required even if clinical disclosure has already occurred."[24]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. One sentinel event resulted in the patient's death, and the OIG found that while leaders completed a clinical disclosure, they did not conduct an institutional disclosure. Failure to perform an institutional disclosure can reduce patients' and families' trust in the organization. Quality Systems staff reported leaders believed that immediate clinical disclosure and discussions with the family met the intent of an institutional disclosure.

Recommendation 1

1. The Director ensures leaders conduct institutional disclosures for applicable sentinel events.[25]

[23] VHA Directive 1004.08.

[24] A clinical disclosure 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.

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

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Director evaluated and determined that there were no additional reasons for noncompliance. The facility attests that reasons for noncompliance were considered when developing the action plan. Recognizing that a sentinel event requires an institutional disclosure (ID), both the Risk Manager and Patient Safety Manager are notified of each sentinel event and log relevant information in their respective sentinel event logs. The Risk Manager refers the sentinel event to the Chief of Staff, to initiate the ID process, and see it through to completion. The Risk Manager and the Patient Safety Manager reconcile their respective sentinel event logs monthly to ensure that all appropriate actions have been taken, and that Institutional Disclosures approved by the Chief of Staff have been completed.

The numerator equals the number of sentinel events for which an institutional disclosure was completed and the number of sentinel events that did not have an institutional disclosure for reasons outside of our control, such as lack of response by patient/family, patient/family declination, patient lack of capacity, or Chief of Staff determination.

The denominator equals the number of sentinel events requiring institutional disclosure in the six-month period.

A compliance threshold of 90 percent or greater was achieved for every sentinel event requiring an institutional disclosure.

We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[26] 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.[27] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[28]

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.[29] 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.[30]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[31] 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."[32] 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.[33]

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

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

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

[28] VHA Directive 1100.16.

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

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

[31] 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.

[32] VHA Directive 1190.

[33] VHA Directive 1190.

Quality, Safety, and Value Findings and Recommendations

VHA requires patient safety managers to ensure patient safety events assigned an actual or potential safety assessment code score of 3 receive a root cause analysis.[34] The OIG found that staff did not complete a root cause analysis for two applicable patient safety events that occurred in FY 2022. When staff do not thoroughly review the cause of an adverse event, it may limit leaders' awareness of system vulnerabilities that could lead to patient harm. The Chief, Quality Systems and the Patient Safety Manager reported being aware of the requirement but believing that conducting immediate and thorough investigations, including interviewing staff and assigning subsequent action items, met the intent of a root cause analysis.

Recommendation 2

2. The Director ensures staff complete a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.[35]

[34] A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls." 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(1).

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

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Director evaluated and determined that there were no additional reasons for noncompliance.

The facility attests that reasons for noncompliance were considered when developing this action plan. Effective immediately, a root cause analysis will be completed for every Joint Patient Safety Reporting (JPSR) event that receives an actual or potential Severity Assessment Code (SAC) score of three.

While actions, such as immediate and thorough collateral investigations may be taken by leadership following an adverse event (with the intent to immediately mitigate or eliminate risk), they will not be construed as meeting the intent of a root cause analysis.

The compliance numerator is the number of JPSR events with an actual or potential score of three that had either an individual Root Cause Analysis (RCA) or was incorporated into a qualifying aggregated review.

The compliance denominator is the number of JPSR events with an actual or potential SAC score of three.

A compliance threshold of 90 percent or greater was achieved for every JPSR event with an actual or potential SAC score of three that has a corresponding individual RCA or has been incorporated into an aggregated review.

We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

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."[36] 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."[37]

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

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[40]

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.[41] 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

[36] 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.)

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[42]

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

The OIG made no recommendations.

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

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[43] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[44]

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.[45]

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

- Community living centers (Central and East)
- Emergency Department
- Medical intensive care unit
- Medical/surgical inpatient unit (3D)
- Mental health inpatient unit
- Primary care clinic (Module B)

[43] 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.)

[44] 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.

[45] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Environment of Care Findings and Recommendations

VHA requires staff to keep areas used by patients clean and orderly.[46] The OIG found dirty ice machines in two patient food storage areas and dirty refrigerators in four.[47] In addition, the OIG found dirty floors in some patient care areas and dead insects in ceiling lights of multiple patient rooms.[48] Lack of cleanliness increases the potential spread of infections. The Chief Nurse of Mental Health and the Acting Chief Nurse of Community Living Center reported staff did not clean the ice machine and refrigerator in their unit due to a lack of clarity regarding cleaning responsibilities. Additionally, the nurse managers for the medical intensive care unit, Emergency Department, and medical/surgical inpatient unit cited a lack of staff oversight. Further, the Assistant Chief, Environmental Management Service and the Associate Director reported that Environmental Management Service staff knew about the requirements, but position vacancies and recruitment challenges had adversely affected their efficiency.

Recommendation 3

3. The Associate Director ensures Environmental Management Service staff keep areas used by patients clean and orderly.

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

[47] The OIG observed dirty ice machines in the medical intensive care unit and mental health inpatient unit and dirty refrigerators in the Emergency Department, medical/surgical inpatient unit, mental health inpatient unit, and community living center (Central).

[48] The OIG observed dirty floors in the Emergency Department, primary care clinic, medical/surgical inpatient unit, mental health inpatient unit, and community living centers and dead insects in the community living centers.

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system response: The Associate Director evaluated reasons for noncompliance and determined that there were no additional reasons for noncompliance. Deficiencies were corrected in March 2023 and the following compliance plans have been activated:

Dirty ice machines: as of June 5, 2023, charge nurses or designees conduct weekly cleanliness inspection of ice machines in nourishment areas. The numerator equals the number of cleanliness inspection conducted. The denominator equals the total number of weekly inspections. A 90 percent compliance rate, sustained for six consecutive months, was achieved on November 30, 2023.

Dirty refrigerators: as of April 02, 2023, charge nurses or designees complete weekly refrigerator cleanliness inspections in nourishment areas. The numerator equals the number of cleanliness inspection conducted. The denominator equals the total number of weekly inspections. A 90 percent compliance rate, sustained for six consecutive months, was achieved on September 30, 2023.

Dirty floors: As of December 11, 2023, Environmental Management Services (EMS) supervisors or designee conduct weekly inspections addressing floor cleanliness in patient care areas. The numerator equals the number of cleanliness inspection conducted. The denominator equals the total number of weekly inspections. A 90 percent compliance rate, sustained for six consecutive months, will be achieved on June 30, 2024.

Dead insects in lights: As of January 16, 2024, EMS supervisors or designee completes weekly inspections for insects in patient care areas. The numerator equals the number of insect inspection conducted. The denominator equals the total number of weekly inspections. A 90 percent compliance rate, sustained for six consecutive months, will be achieved on July 31, 2024.

Supporting evidence of corrected items and six consecutive months of monitoring logs demonstrating a minimum of 90 percent compliance, will be submitted for closure.

The Joint Commission requires medical center staff to maintain a safe environment and ensure "interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided."[49] The Joint Commission also requires hospital staff to keep "furnishings and equipment safe and in good repair."[50] The OIG found broken wall surfaces and

[49] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, EP 1.

[50] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, EP 26.

incomplete wall repairs in some patient care areas inspected and damaged furniture in others.[51] This could prevent effective cleaning and disinfection. The Emergency Department and medical intensive care unit nurse managers and the Chief, Facilities Management Service reported unit staff failed to submit work orders, so facility management staff were unaware of the wall damage. The Associate Director reported that facility management staffing shortages and delays in onboarding new hires hindered timely repair or replacement of damaged furniture.

Recommendation 4

4. The Associate Director ensures staff keep furnishings and walls in good repair.

Healthcare system concurred.

Target date for completion: June 30, 2024

Healthcare system response: The Associate Director evaluated reasons for noncompliance and determined that there were no additional reasons for noncompliance. Deficiencies were corrected by September 6, 2023. As of January 16, 2024, charge nurses or designees are conducting weekly Environment of Care (EOC) continuous readiness inspections in patient care areas.

The numerator equals the number of EOC continuous readiness inspections conducted. The denominator equals the total number of weekly inspections.

Supporting evidence of corrected items and six consecutive months of monitoring logs demonstrating a minimum of 90 percent compliance, will be submitted for closure.

VHA requires staff to use solid bottom shelves in storage areas to avoid contamination of supplies.[52] The OIG found missing solid bottom shelves in three of seven storage areas.[53] The absence of solid bottom shelves may cause floor cleaning products to contaminate medical supplies, which could lead to patient harm if used. The Logistics Chief reported staff were unaware of the requirement and removed the solid bottom shelves while rearranging supplies.

Recommendation 5

5. The Associate Director ensures staff use solid bottom shelves in storage areas.

[51] The OIG observed wall damage in the Emergency Department, medical intensive care unit, and medical/surgical inpatient unit and damaged furniture in the primary care clinic, medical intensive care unit, and medical/surgical inpatient unit.

[52] VHA Directive 1761.

[53] The OIG found deficiencies in the Emergency Department, mental health inpatient unit, and community living center (Central).

Healthcare system concurred.

Target date for completion: April 30, 2024

Healthcare system response: The Associate Director evaluated reasons for noncompliance and determined that there were no additional reasons for noncompliance. The missing solid bottom shelves were corrected on site and replaced with solid bottom shelves. The Inventory Management Specialist will conduct weekly supply room inspections that include a review of solid bottom shelves in storage areas. A supply room inspection log will be maintained with proof of inspection signatures.

The numerator equals the total number of inspections with solid bottom shelves inspected each month. The denominator equals the total number of required inspections each month.

Supporting evidence of corrected items and six consecutive months of monitoring logs demonstrating a minimum of 90 percent compliance, will be submitted for closure.

The Joint Commission requires that a medical center employee "inspects, tests, and maintains medical equipment."[54] The OIG found that staff did not inspect medical equipment in two of seven areas inspected.[55] Overlooking safety inspections on medical equipment may contribute to delays in care and patient harm if equipment malfunctions. The Biomedical Engineer attributed missing safety inspections to an oversight by biomedical engineering staff and lack of communication by clinical staff.

Recommendation 6

6. The Associate Director ensures staff inspect, test, and maintain medical equipment.

[54] The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03.

[55] Staff did not inspect medical equipment in the mental health inpatient unit and community living center (Central).

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system response: The Associate Director evaluated reasons for noncompliance and determined that there were no additional reasons for noncompliance. Survey identified medical equipment preventative maintenance (PM) deficiencies were corrected by April 13, 2023. As of January 16, 2024, the Supervisory Biomedical Equipment Support Specialist or designee will inspect medical equipment PM compliance monthly in the two survey-specific areas. This will be documented on the *Equipment Walk through Log.*

The compliance numerator will equal the actual number of inspections completed each month. The denominator will equal the two survey-specific area inspections per month.

Supporting evidence of corrected items and six consecutive months of monitoring logs demonstrating a minimum of 90 percent compliance, will be submitted for closure.

VHA requires staff to periodically test panic alarms in the mental health inpatient unit and document VA police response times.[56] The OIG found no evidence staff documented VA police response times for panic alarm testing in the mental health inpatient unit. If staff do not document response times, police may not be able change their process, if needed, to ensure timely response to emergencies. The Chief of Police reported being unaware of the requirement.

Recommendation 7

7. The Associate Director ensures staff document VA police response times for panic alarm testing in the mental health inpatient unit.

[56] 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.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Associate Director evaluated reasons for noncompliance and determined that there were no additional reasons for noncompliance. Inpatient Mental Health and Behavioral Sciences Service (MH&BSS) unit charge nurses or designees have been assigned panic alarm response time testing and are activating panic alarms for monthly testing. As of March 2024, VA police have been responding to the panic alarm tests, and the Assistant Chief Nurse, MH&BSS, utilizes *The Panic Alarm Testing Log for Inpatient MH&BSS* to document VA police response times.

The numerator equals the number of panic alarm tests with documented police response times. The denominator equals the number quarterly panic alarm tests. A compliance threshold of 90 percent or greater was achieved for monthly panic alarms monitored in the Inpatient Mental Health and Behavioral Sciences Service (MH&BSS) unit.

Supporting evidence of corrected items and six consecutive months of monitoring logs demonstrating a minimum of 90 percent compliance, will be submitted for closure.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[57] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[58] The suicide rate for veterans was higher than for nonveteran adults during 2020.[59] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[60]

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.[61] 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.[62]

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.[63]

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

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

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

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

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

[61] 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.)

[62] 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.)

[63] 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 to "local mental health leadership and quality management."[64] The OIG found the Suicide Prevention Coordinator reported suicide-related events to mental health leaders but not to quality management staff in April, June, July, and September 2022. When the coordinator does not report suicide-related events to quality management staff, they may miss opportunities to implement actions to improve mental health services and the suicide prevention program. The Suicide Prevention Supervisor reported being unaware of the requirement.

Recommendation 8

8. The Director ensures the Suicide Prevention Coordinator reports suicide-related events monthly to quality management staff.

Healthcare system concurred.

Target date for completion: June 30, 2024

Healthcare system response: The Director evaluated reasons for noncompliance and determined that there were no additional reasons for noncompliance. The Supervisor, Suicide Prevention is responsible for tracking and monitoring suicide-related events. A suicide-related event is described as suicide deaths or attempted suicides. The Supervisor, Suicide Prevention notifies Chief, Quality Systems Services, via the MS Teams Suicide Attempts and Deaths Reporting, of a confirmed suicide-related event.

The numerator equals the total number of suicide-related events reported to Chief, Mental Health & Behavioral Science Service, and Chief, Quality Systems Service each month. The denominator equals the total number of suicide-related events that occurred each month.

Supporting evidence of corrected items and six consecutive months of monitoring logs demonstrating a minimum of 90 percent compliance, will be submitted for closure.

[64] VHA Directive 1160.07.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided eight 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 eight OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Director and Associate 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	• Leaders conduct institutional disclosures for applicable sentinel events.
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	• None
Environment of Care	• Environmental Management Service staff keep areas used by patients clean and orderly. • Staff keep furnishings and walls in good repair. • Staff use solid bottom shelves in storage areas. • Staff inspect, test, and maintain medical equipment. • Staff document VA police response times for panic alarm testing in the mental health inpatient unit.
Mental Health: Suicide Prevention Initiatives	• The Suicide Prevention Coordinator reports suicide-related events monthly to quality management staff.

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 8.[1]

Table B.1. Profile for Bay Pines VA Healthcare System (516)
(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	$1,108,367,452	$1,215,461,006	$1,268,526,678
Number of:			
• Unique patients	109,418	118,892	117,271
• Outpatient visits	1,379,807	1,591,991	1,432,345
• Unique employees§	3,949	4,219	4,090
Type and number of operating beds:			
• Community living center	112	112	112
• Domiciliary	99	99	99
• Medicine	106	106	106
• Mental health	33	33	33
• Rehabilitation medicine	8	8	8
• Surgery	35	35	35
Average daily census:			
• Community living center	56	54	49
• Domiciliary	61	40	53
• Medicine	88	92	90
• Mental health	21	19	16
• Rehabilitation medicine	4	6	1

[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 healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census (cont.):			
• Surgery	13	13	11

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).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 29, 2024

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Comprehensive Healthcare Inspection of the Bay Pines VA Healthcare System in Florida

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

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

1. I appreciate the partnership with the VA OIG's office. I have reviewed the report and concur with the findings.
2. I have reviewed the Medical Facility Director's response including proposed actions and timelines and concur. VISN 8 will provide all necessary resources to complete all actions timely.

(Original signed by:)

David Isaacks, FACHE

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: January 28, 2024

From: Director, Bay Pines VA Healthcare System (516)

Subj: Comprehensive Healthcare Inspection of the Bay Pines VA Healthcare System in Florida

To: Director, VA Sunshine Healthcare Network (10N8)

1. Thank you for the opportunity to provide a response to the findings from the Comprehensive Healthcare Inspection of the Bay Pines VA Healthcare System.
2. I concur with the recommendations and will ensure the actions to correct the findings are completed and sustained as described in the responses. I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans.

(Original signed by:)

Paul M. Russo, MHSA, FACHE

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