US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida

CHIP Report | 23-00010-84 | February 22, 2024

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Figure 1. *James A. Haley Veterans' Hospital in Tampa, Florida.*
Source: https://www.va.gov/tampa-health-care/locations/ (accessed December 13, 2023).

Abbreviations

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 James A. Haley Veterans' Hospital and multiple 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 James A. Haley Veterans' Hospital during the week of February 6, 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 hospital's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued four recommendations to the Director and Associate Director in the Environment of Care and Mental Health areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this hospital. 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 19.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 21–22, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 3 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 James A. Haley Veterans' Hospital 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 hospital 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 James A. Haley Veterans' Hospital includes multiple outpatient clinics in Florida. General information about the hospital can be found in appendix B.

The inspection team conducted an on-site review the week of February 6, 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 hospital leaders complete corrective actions. The Executive Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the James A. Haley Veterans' Hospital occurred in March 2021. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in August 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 hospital'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 hospital 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 hospital 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, the Assistant Director had been in the position for just under a year, and the other five executive leaders had served over a year. To help assess executive leaders' engagement, the OIG interviewed the Director, 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.

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[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.

Budget and Operations

The OIG noted that the hospital's fiscal year (FY) 2022 annual medical care budget of $1,515,890,838 had increased by approximately 4 percent compared to the previous year's budget of $1,456,654,948.[10] The Director explained staff had not yet seen the impact of this increase due to long lead times for hiring staff and contracting construction projects. The Director also stated that the hiring process is complex, making it hard to bring additional staff on board.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] 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.[12] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the hospital over time.

The hospital's scores for the selected question indicated employees generally felt more comfortable disclosing suspected violations compared to VHA employees nationally. Executive leaders highlighted the importance of communication. The Chief of Staff stated that leaders' visits to staff workspaces had increased but could increase further. The Associate Director for Patient Care Services described how the use of visual communication boards provided staff opportunities to share information.

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
James A. Haley Veterans' Hospital	3.9	4.0	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).

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

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

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[13] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the hospital from FYs 2020 through 2022. Table 2 provides survey results for VHA and the hospital over time.

Inpatient scores indicated patients were more satisfied with the care they received at this hospital compared to VHA patients overall; however, the scores decreased slightly over time. The Deputy Director explained the slight downward trend was likely due to increased staff workload, which led to patients experiencing longer wait times for care. The Assistant Director reported the Veterans' Experience Council reviewed key metrics, such as how quiet the facility was at night, in its monthly meetings to find opportunities to improve the inpatient experience. Regarding the relatively high scores for outpatient care, the Chief of Staff highlighted employees' focus on quality of care and customer service.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Hospital	VHA	Hospital	VHA	Hospital
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	71.8	69.7	70.4	68.9	70.3
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	86.5	81.9	83.7	81.7	85.6
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	86.8	83.3	83.5	83.1	84.5

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8, 2022, and December 14, 2022).

**The response average is the percent of "Definitely yes" responses.*

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

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

Identified Factors Related to Possible Lapses in Care and Hospital 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.[14] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[15] 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.[16]

"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)."[17] 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."[18] 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."[19] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[20]

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

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

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

[17] 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.

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

[19] VHA Directive 1004.08.

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

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed information the Patient Safety Manager and Risk Manager provided. The Patient Safety Manager reported reviewing all Joint Patient Safety Reporting system entries to identify sentinel events, discussing them with executive leaders during daily morning meetings, then relaying the cases to the Risk Manager to determine whether to conduct an institutional disclosure.[21]

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[21] "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, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[22] 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.[23] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[24]

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.[25] 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.[26]

The OIG assessed the hospital's processes for conducting peer reviews of clinical care.[27] 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."[28] 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.[29]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed 10 deaths that occurred within 24 hours of inpatient admission during FY 2022. The team found that no suicides had occurred within seven days of discharge from an inpatient mental health unit during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[24] VHA Directive 1100.16.

[25] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[27] 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.

[28] VHA Directive 1190.

[29] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[30] 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."[31]

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

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.[34]

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.[35] 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

[30] 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.)

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[36]

The OIG interviewed key managers and selected and reviewed the privileging folders of 27 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires criteria for the FPPE process to be defined in advance and accepted by the LIP.[37] The OIG found that all nine FPPEs reviewed lacked evidence LIPs were aware of and had accepted the evaluation criteria before service chiefs initiated the process. This could have caused LIPs to misunderstand FPPE expectations. The Deputy Chief of Staff, Performance Improvement and Medical Staff Affairs attributed the noncompliance to lack of a standardized tracking process and insufficient administrative staff to ensure documentation is complete. 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.

[36] 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.

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

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.[38] 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."[39] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[40]

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.[41]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 11 patient care areas:

- Community living centers (C2, D3, and Hospice and Palliative Care Unit)
- Emergency Department
- Medical intensive care unit (4W)
- Medical/surgical inpatient unit (6S)
- Mental health inpatient unit (Acute Recovery Center 1)
- Primary care clinic (Primary Care Annex Charlie Clinic and Delta Clinic)
- Specialty care trailer (80)
- Women's health clinic (Primary Care Annex)

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

[39] VHA Directive 1608.

[40] 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.

[41] 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.[42] The OIG found the following deficiencies in several areas:

- Chairs with exposed foam padding in the community living centers' dining areas
- Hard water deposits on ice machines in the Emergency Department, medical intensive care unit, medical/surgical inpatient unit, and community living center (D3) nutrition areas
- Soiled and stained floors in the Emergency Department, medical intensive care unit, and mental health inpatient unit

Items or floors in disrepair cannot be properly cleaned, and lack of cleanliness may lead to the spread of disease. The Associate Director stated high turnover of interior design staff resulted in delays in procuring replacement furniture. The Associate Director further attributed noncompliance to a lack of guidance on how often to clean ice machines, adding that only Environmental Management Services supervisors can use the required cleaning product. The Associate Director also said only a limited number of staff strip and wax the floors due to chemical exposure concerns. Furthermore, Environmental Management Services staff reported challenges cleaning areas with high traffic volume and restricted access.

Recommendation 1

1. The Associate Director ensures staff keep areas used by patients clean and orderly.

[42] 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.) VHA Directive 1850.1, *Health Care Environmental Sanitation Program*, March 29, 2023.

Hospital concurred.

Target date for completion: June 30, 2024

Hospital response: The Medical Center Director will ensure that the identified units used are kept clean and orderly. The process will consist of the following initiatives:

(1) Furniture: Purchased new furniture for the Community Living Center dining area. The furniture will be inspected monthly and monitored for compliance to standards. The numerator is the number of chairs compliant with standards. The denominator is the total number of chairs inspected. The Chief Nurse of the Community Living Center will conduct the audit and report data to the Chief of Quality Management Service, who will report compliance rate monthly to the Environment of Care Committee, which is chaired by the Associate Director, until 90 percent compliance is achieved and sustained for six consecutive months.

(2) Ice machines: Inspected monthly for cleanliness. The numerator is the number of compliant inspections. The denominator is the number of inspections conducted on the identified ice machines. The Infection Control Specialist will conduct the inspections and will report compliance rate monthly to the Environment of Care Committee, which is chaired by the Associate Director, until 90 percent compliance is achieved and sustained for six consecutive months.

(3) Soiled and Stained Floors: The floors in the Emergency Department and Medical Intensive Care Unit are inspected for cleanliness monthly. Compliance will be determined by the percentage of inspections that meet the standard. The Infection Control Specialist will monitor compliance and will report the compliance rate monthly to the Environment of Care Committee, which is chaired by the Associate Director, until 90 percent compliance is achieved and sustained for six consecutive months.

The Joint Commission requires hospitals to reduce the risk of infection by ensuring staff keep clean equipment and supplies separate from dirty equipment and supplies.[43] The OIG noted 4 of the 11 areas inspected had clean and dirty items stored together, which may lead to the spread of disease.[44] The Associate Director reported that unit managers and staff were unaware of the requirement, and the facility did not have adequate space for separate clean and dirty storage.

[43] The Joint Commission, *Standards Manual*, E-dition, IC.01.04.01, July 1, 2023; The Joint Commission Resources, *Environmental Infection Prevention: Guidance for Continuously Maintaining a Safe Patient Care and Survey-Ready Environment*, 2018.

[44] The OIG identified the deficiencies in the medical intensive care unit, medical/surgical inpatient unit, and community living centers C2 and D3.

Recommendation 2

2. The Associate Director ensures staff store clean and dirty equipment and supplies separately.

Hospital concurred.

Target date for completion: June 30, 2024

Hospital response: The Medical Center Director will ensure that clean and dirty equipment and supplies are stored separately. The process will consist of the following initiatives:

(1) Separation of Dirty and Clean Equipment and Supplies: The healthcare system completed a performance improvement project at the identified areas to create a more organized and productive workspace. The areas will be inspected monthly. The numerator is the number of compliant inspections and the denominator is the number of inspections of the Clean Supply and Equipment Rooms. The Infection Control Specialist will conduct weekly inspections and will report compliance rate monthly to the Environment of Care Committee, which is chaired by the Associate Director, until 90 percent compliance is achieved and sustained for six consecutive months.

(2) Corrugated Cardboard Boxes: Education was provided to staff that items for delivery to clinical areas must be removed from any corrugated boxes prior to delivery. Additionally, Supply Chain Management staff were instructed that no items were to be delivered to clinical areas in corrugated boxes. Inspection will be conducted weekly in the identified areas. Compliance will be determined by the number of inspections without findings of corrugated boxes in clinical areas over the number of inspections. The Infection Control Specialist will conduct monthly inspections and will report the compliance rate monthly to the Environment of Care Committee, which is chaired by the Associate Director, until 90 percent compliance is achieved and sustained for six consecutive months.

VHA requires examination tables to be positioned so the foot faces away from the door.[45] The OIG found exam tables placed with the foot facing the door in the Emergency Department and women's health clinic. If the foot of the exam table faces a door, patient privacy may be compromised when the door is opened. The Associate Director explained staff positioned exam tables to accommodate medical personnel in small rooms, and some staff lacked understanding that cubicle curtains are insufficient to protect patient privacy.

[45] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

Recommendation 3

3. The Associate Director ensures staff place all examination tables with the foot facing away from the door.[46]

Hospital concurred.

Target date for completion: Completed

Hospital response: The Medical Center Director ensured all exam tables in the identified areas were repositioned ensuring the foot of the tables were not oriented towards the door openings and exam table orientation was done in accordance with VHA Directive 1330-01(6) and VHA Design Alert 149 Privacy of Veterans. This was completed on February 27, 2023, and confirmed by the Environment of Care Committee.

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

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[47] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[48] The suicide rate for veterans was higher than for nonveteran adults during 2020.[49] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[50]

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.[51] 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.[52]

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.[53]

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

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

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

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

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

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

[52] 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.)

[53] 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 suicide prevention coordinators to report suicide-related events monthly to "local mental health leadership and quality management."[54] The OIG found that from April 1, 2022, through September 30, 2022, the Suicide Prevention Coordinator did not report suicide-related events monthly to mental health leaders and quality management staff. The lack of monthly reporting could hinder leaders' oversight and result in missed opportunities for them to identify needed improvements in suicide prevention processes. The Chief, Quality Management stated executive leaders requested to schedule meetings to discuss suicide-related events every other month rather than monthly, and staff did not record attendance at these meetings, so it is unclear whether mental health leaders and quality management staff were present.

Recommendation 4

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

Hospital concurred.

Target date for completion: February 29, 2024

Hospital response: The Medical Center Director will ensure that the Mental Health Chief for At Risk Monitoring and Outreach (ARMOR) facilitates monthly reporting of the Suicide Prevention Report monthly to the Executive Leadership and the Quality Management Team. The Numerator is the total number of monthly Suicide Prevention Reports presented to the Executive Leadership with following individuals present Chief of ARMOR, and members from the Quality Management Team. The Denominator is the total number of Suicide Prevention Reports (One meeting per month with required attendees- Chief of ARMOR and Quality Management Team). The Chief of ARMOR will conduct monthly reporting to the Executive Leadership Team and members from Quality Management. The Suicide Prevention Coordinator will report compliance monthly to the Quality Patient Safety Board, which is chaired by the Hospital Director and Chief of Quality Management and Patient Safety until 90 percent compliance is achieved and sustained for six consecutive months.

[54] VHA Directive 1160.07.

Report Conclusion

To assist leaders in evaluating the quality of care at their hospital, the OIG conducted a detailed inspection of five clinical and administrative areas and provided four 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 hospital. 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 four 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	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• Staff keep areas used by patients clean and orderly. • Staff store clean and dirty equipment and supplies separately. • Staff place all examination tables with the foot facing away from the door.
Mental Health: Suicide Prevention Initiatives	• The Suicide Prevention Coordinator reports suicide-related events monthly to mental health leaders and quality management staff.

Appendix B: Hospital Profile

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

Table B.1. Profile for James A. Haley Veterans' Hospital (673)
(October 1, 2019, through September 30, 2022)

Profile Element	Hospital Data FY 2020*	Hospital Data FY 2021†	Hospital Data FY 2022‡
Total medical care budget	$1,339,500,435	$1,456,654,948	$1,515,890,838
Number of:			
• Unique patients	111,068	118,145	121,665
• Outpatient visits	1,437,387	1,698,701	1,619,163
• Unique employees§	5,246	5,318	5,174
Type and number of operating beds:			
• Community living center	64	64	64
• Domiciliary	33	33	33
• Medicine	402	402	402
Average daily census:			
• Community living center	37	31	34
• Domiciliary	19	10	13
• Medicine	252	233	254

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

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

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

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated hospital 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: January 22, 2024

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

Subj: Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, 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: Hospital Director Comments

Department of Veterans Affairs Memorandum

Date: January 10, 2024

From: Director, James A. Haley Veterans' Hospital (673)

Subj: Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida

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

1. I have reviewed the Comprehensive Healthcare Inspection report of the James A. Haley Veteran's Hospital in Tampa, Florida.
2. I have reviewed the document and concur with the recommendations.
3. I concur with the submitted action plans from our facility.
4. My team is committed to ensuring our Veterans continue to receive safe quality healthcare.

(Original signed by:)

David K. Dunning, MPA
Executive Director

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