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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Bedford Healthcare System in Massachusetts

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Figure 1. *Edith Nourse Rogers Memorial Veterans' Hospital of the VA Bedford Healthcare System in Massachusetts.*

Source: https://www.va.gov/bedford-health-care/locations/ (accessed April 4, 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 VA Bedford Healthcare System, which includes the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford and three outpatient clinics in Massachusetts.[1] The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the VA Bedford Healthcare System during the week of April 24, 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 five 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

[1] The healthcare system only provides inpatient services for mental health care.

improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 21.

VA Comments

The Veterans Integrated Service Network Director and Healthcare System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 23–24, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 1, 2, and 5 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 VA Bedford Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes.[1] The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[2]

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.[3] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[4]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[5]

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] The healthcare system only provides inpatient services for mental health care.

[2] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[3] 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.

[4] 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.

[5] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The VA Bedford Healthcare System includes the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford and three outpatient clinics in Massachusetts. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of April 24, 2023.[6] 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.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until 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.

[6] The OIG's last comprehensive healthcare inspection of the VA Bedford Healthcare System occurred in January 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in September 2021.

[7] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[10]

To assess this 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; Chief of Staff; Associate Director, Nursing and Patient Care Services; and Associate Director. The Chief of Staff and Associate Director, Nursing and Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team included an interim Chief of Staff and interim Associate Director, Nursing and Patient Care Services; the permanent positions had been vacant 10 months and 3 months, respectively. The Director, who had served since March 18, 2018, was the most tenured member of the team. The Associate Director assumed the role in February 2023.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the Director; interim Chief of Staff; interim Associate Director, Nursing and Patient Care Services; and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.[11]

Budget and Operations

The OIG noted that the system's fiscal year (FY) 2022 annual medical care budget of $271,392,067 had increased by approximately 10 percent compared to the previous year's budget of $247,647,105.[12] The interim Associate Director, Nursing and Patient Care Services and Associate Director discussed being unable to use the increased budget to improve staffing levels due to recruiting and hiring difficulties, particularly for nutrition and food service workers, licensed practical nurses, and nursing assistants. The Director and Associate Director stated the facility was not easily accessible to people who rely on public transportation because it lacked bus service at night and on weekends.

To address this problem, the Director reported coordinating with community leaders to provide staff with ride sharing services. The Director and interim Associate Director, Nursing and Patient Care Services said leaders closed a geriatric psychiatric unit and a small community living center due to staffing shortages, although the interim Associate Director, Nursing and Patient Care Services clarified that providers were able to offer the same care in other units. The Director further described increasing the number of staff providing home health services to the geriatric population, with the goal of increasing the amount of time patients spend at home rather than in the facility by 20 percent.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation

[11] The executive team had an interim Chief of Staff. During the inspection, the interim Chief of Staff was on leave, and another interim Chief of Staff was covering the position.

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

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

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

The system's scores for the selected question were lower than VHA averages over the three years. The Director stated the leadership team focused on developing a high-reliability organization and promoting a just culture and psychological safety.[15] The Director reported hiring a program manager for diversity, equity, and inclusion approximately eight months prior to the OIG site visit to work with employees and veterans. The Director also highlighted leaders' identification and training of psychological safety officers to support their efforts.

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

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA Bedford Healthcare System	3.7	3.8	3.7

Source: VA All Employee Survey (accessed November 22, 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.[16] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022.[17] Table 2 provides survey results for VHA and the healthcare system over time.

Patients' overall satisfaction with their primary and specialty care experiences generally decreased over time. The Director reported working with specialty care providers to ensure they

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

[15] "A high-reliability organization (HRO) 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. "Just culture is an environment that balances the need for an open and honest reporting environment with the end goal of organizational and behavioral improvement." VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

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

[17] The healthcare system does not provide inpatient medical/surgical care; therefore, no inpatient survey data were available.

understood the survey measure and identified actions to improve patient satisfaction. The Director also said patient advocates had face-to-face meetings with patients to obtain feedback on areas for improvement.

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
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	88.7	81.9	87.3	81.7	86.8
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	88.4	83.3	88.8	83.1	85.7

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

**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.[18] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[19] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[18] 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/.

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

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[20]

"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)."[21] 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."[22] 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."[23] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[24]

The Chief, Quality Management reported receiving daily emails about patient events entered in the Joint Patient Safety Reporting system and communicating the information to the Associate Director, Nursing and Patient Care Services and other staff as needed.[25] The Patient Safety Manager discussed running a report of patient safety events every morning, then reviewing it with executive leaders during daily meetings. The Risk Manager stated the Patient Safety Manager use Joint Commission and National Center for Patient Safety guidance to determine whether an adverse event meets criteria for a sentinel event. The Chief, Fiscal Service said leaders discuss sentinel events at daily safety huddles. According to the Chief, Quality Management, the Chief of Staff determines whether a sentinel event warrants an institutional disclosure.

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

[21] 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.

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

[23] VHA Directive 1004.08.

[24] 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.)

[25] "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.

Leadership and Organizational Risks Findings and Recommendations

VHA requires that when "an adverse event has resulted in or is reasonably expected to result in death or serious injury, an institutional disclosure must be performed regardless of when the event is discovered."[26] VHA also requires leaders to document the disclosure in the patient's electronic health record.[27] The OIG requested a list of sentinel events and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. The OIG found that leaders performed a clinical disclosure but not an institutional disclosure for one sentinel event that resulted in the patient's death.[28] Leaders not conducting an institutional disclosure may result in the patient or patient's representative being unaware of their rights and options for recourse. The Risk Manager said the Chief of Staff at the time of the event believed the clinical disclosure was adequate.

Recommendation 1

1. The Director ensures leaders conduct institutional disclosures for applicable sentinel events.[29]

[26] VHA Directive 1004.08.

[27] VHA Directive 1004.08.

[28] 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.

[29] 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: VA Bedford recognizes the importance of properly determining and conducting institutional disclosures for sentinel events to uphold the rights of patients and patient representatives. As a result of the OIG recommendation, we have put the following safeguards in place to ensure this happens in the future:

- Risk Management and Patient Safety huddle daily
- Sentinel events are tracked on a risk/patient safety huddle tracker under joint risk and patient safety issues until root cause analysis and institutional disclosure are completed.
- Risk utilizes a separate tracker for institutional disclosures, including those that were proposed [to] the Chief of Staff but declined.

In addition, compliance with this practice is reported by the Patient Safety Manager to the facility Quality, Safety, and Value committee quarterly via the safety report.

Finally, the Chief of Staff for Bedford VAMC is aware of the criteria for institutional disclosures per Directive 1004.08 for sentinel events.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[30] 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.[31] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[32]

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.[33] 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.[34]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[35] 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."[36] 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.[37]

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

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

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

[32] VHA Directive 1100.16.

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

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

[35] 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.

[36] VHA Directive 1190.

[37] VHA Directive 1190.

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to complete a root cause analysis for all events assigned an actual or potential safety assessment code score of 3.[38] The OIG found that staff did not complete a root cause analysis for 10 of 25 events with a safety assessment code score of 3 that occurred during FY 2022. The lack of a root cause analysis diminishes staff's ability to identify and mitigate system vulnerabilities, which is instrumental in reducing the risk of patient harm. The Patient Safety Manager reported staff were confused about due dates and missed completing some root cause analyses that year.

Recommendation 2

2. The Director ensures staff complete a root cause analysis for all events assigned an actual or potential safety assessment code score of 3.[39]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: VA Bedford recognizes the importance of a root cause analysis for every event assigned an actual or potential code score of 3. As a result of the OIG recommendation, VA Bedford's Patient Safety Managers have implemented a practice whereby a report is generated each month as a cross check that all SAC [safety assessment code] 3 events have an associated individual RCA [root cause analysis] or will be included in an Aggregate RCA.

The facility compliance with this OIG recommendation has been 100% since April of 2023. Going forward, Patient Safety will adhere to all National Center for Patient Safety timelines and inclusion criteria for individual and aggregated RCAs.

This data is reported quarterly at the organizational Quality, Safety and Value committee.

[38] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and how often it occurs. The safety assessment code is a "ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk)." 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." VHA Handbook 1050.01; VHA Directive 1050.01(1).

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

Medical 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."[40] 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."[41]

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

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.[44]

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.[45] 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

[40] 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.)

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

[44] VHA Handbook 1100.19.

[45] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[46]

The OIG interviewed key managers and selected and reviewed the privileging folders of 20 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[46] 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."[47] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[48]

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.[49]

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

- Community living center (4B)
- Mental health inpatient unit (F)
- Primary care clinic
- Urgent care clinic
- Women's health clinic

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

[48] VHA Directive 1608. 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.

[49] VHA Directive 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 free from undue wear.[50] The OIG found the following deficiencies in several patient care areas:

- Damaged walls and wood handrails[51]
- Soiled, stained, and damaged floors[52]
- Soiled sink, refrigerator, and freezer in a food storage area[53]
- Soiled and damaged bathroom partition and walls in a patient room designated as ready for admission[54]

Staff cannot properly clean damaged walls, handrails, and floors, and inadequate cleaning can lead to the spread of pathogens such as bacteria and mold to employees, visitors, and patients. The Associate Director said staff were unaware of the damage on the walls and handrails. The Environment of Care Coordinator attributed the soiled walls and floors to staffing shortages in the Environmental Management Services department. The Chief of Engineering further stated that because the floors contained asbestos, leaders had to contract out the repairs, which were in progress. Regarding the food storage area, the Infection Preventionist said that nutrition and Environmental Management Services department staff may have been confused about who was responsible for cleaning that area. Finally, the Chief of Engineering reported staff had ordered parts to repair the bathroom partition, but the items were on backorder.

Recommendation 3

3. The Associate Director ensures staff keep patient areas clean and free from undue wear.

[50] VHA Directive 1850.01, *Health Care Environmental Sanitation Program*, March 29, 2023.

[51] The OIG found damaged walls and wood handrails in community living center 4B.

[52] The OIG identified soiled, stained, and damaged floors in community living center 4B and mental health inpatient unit F.

[53] The OIG observed the soiled sink, refrigerator, and freezer in community living center 4B.

[54] The OIG noted a dirty and damaged partition and walls in mental health inpatient unit F.

Healthcare system concurred.

Target date for completion: August 15, 2024

Healthcare system response: VA Bedford understands the importance of environmental cleanliness and maintenance in the delivery of safe patient care as well as visitor and staff well-being. The identified areas of concern with building maintenance and cleanliness have been mitigated through the deployment of specially tasked teams. Bedford engineering department is working with a contractor to replace the wood handrails and are purchasing a washable laminate material to apply to the wood at nursing stations. Bathroom partitions and walls in the patient rooms have been repaired.

Going forward, a standard operating procedure has been created with a timeline to identify cleaning needs schedules on a daily, monthly, and quarterly basis (see attached).

Each day, the Environmental Services supervisor will make weekly purposeful rounds on the patient care areas in buildings 2, 4, 78 and 62. A checklist has been created to acknowledge that the rounding was done, the areas were found to be well maintained and clean (or immediate remediation), and that any staff generated cleaning or maintenance requests have been addressed. The goal is 90% of the 11 inpatient care floors will be clean and well maintained each week on rounding. The compliance with this supervisory checklist and % met will be reported by the Chief of Environmental services at the Environment of Care Committee meeting each month and quarterly through the Healthcare Operations Committee.

Nutrition and Food Services and Environmental Services are in the process of creating a service line agreement to clean and restock nutrition kitchens including refrigerators, freezers, floors, surfaces and under sinks on a quarterly basis beginning in March 2024. This will be documented on a comprehensive checklist found in each nutrition kitchen and reported to the Healthcare Operations Committee quarterly by the Chief of Nutrition services and has a facility goal of 100% compliance each quarter.

This recommendation remains open pending completion of the tracking of cleaning schedules until 90 percent compliance is maintained for six consecutive months.

VHA requires staff to check over-the-door alarms according to the manufacturer's guidelines in mental health inpatient units with corridor doors to patient sleeping rooms to ensure proper functioning.[55] The OIG found staff did not check over-the-door alarms each week, according to the manufacturer's guidelines. When staff do not follow guidelines to check alarms, they may

[55] 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 (MHEOCC)," October 18, 2022.

fail to alert them when patients are in immediate danger. The Patient Safety Manager stated staff were unaware of the weekly requirement.

Recommendation 4

4. The Director ensures staff check over-the-door alarms on the mental health inpatient unit according to the manufacturer's guidelines.

Healthcare system concurred.

Target date for completion: June 1, 2024

Healthcare system response: VA Bedford recognizes the importance of checking over-the-door alarms for Veterans on the inpatient units. This recommendation was immediately put into action following the OIG survey in April of 2023. Over the door alarms had been checked monthly from April 2022 to April 2023. Once the OIG recommendation was made, testing increased to weekly, and the practice has been ongoing since April 2023.

Going forward, the nurse manager for ward 78F will track over the door alarm testing weekly and it will be reported to the Quality, Safety and Value department monthly by the quality manager overseeing OIG recommendations.

The target date for completion of the requirements for this recommendation is June 1st, 2024, which will demonstrate 6 consecutive months of compliance.

Mental Health: Suicide Prevention Initiatives

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

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[60] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[61]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[62]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 18 patients who had a positive suicide screen in FY 2022 and received primary care services.

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

[57] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed March 10, 2022.

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

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

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

[61] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

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

Mental Health Findings and Recommendations

VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen in ambulatory care settings.[63] The OIG found that providers did not complete the evaluation the same day for 18 percent of patients with a positive screen. Failure to evaluate patients promptly could result in missed opportunities for providers to identify patients at imminent risk for suicide and intervene. The Chief, Mental Health and Suicide Prevention Coordinator stated that primary care providers assumed patients were already under the care of mental health providers and did not prioritize completing the evaluation during the primary care visit.

Recommendation 5

5. The Director ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in ambulatory care settings.[64]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: VA Bedford recognizes the importance of completing the Comprehensive Suicide Risk Evaluation [CSRE] on the same day as a positive suicide risk screen in ambulatory care settings to Veteran safety. This recommendation was completed prior to the OIG survey with evidence of greater than 6 months of sustainment at that time.

VA Bedford has sustained 100% compliance with the Suicide Prevention Risk Evaluation being completed on the same day as any positive CSSR-S [Columbia-Suicide Severity Rating Scale] since April of 2023 in addition to sustainment from October 2022 to April 2023.

Our ongoing plan: twice daily, our Suicide Prevention Coordinators receive an email report from VISN 1 with any positive C-SSRS and corresponding CSRE's in ambulatory care settings. If there is a positive C-SSRS with no CSRE, the Suicide Prevention team follows up with the appropriate staff member or team to ensure a same-day CSRE is completed. CSSRS and CSRE are both documented in CPRS [Computerized Patient Record System].

[63] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy.)"

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

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided five recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this 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 five 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 events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• None
Environment of Care	• Staff keep patient areas clean and free from undue wear. • Staff check over-the-door alarms on the mental health inpatient unit according to the manufacturer's guidelines.
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 1.[1]

Table B.1. Profile for VA Bedford Healthcare System (518)
(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	$257,674,931	$247,647,105	$271,392,067
Number of:			
• Unique patients	19,016	27,170	23,212
• Outpatient visits	201,601	251,938	213,604
• Unique employees§	1,191	1,147	1,039
Type and number of operating beds:			
• Community living center	240	238	238
• Domiciliary	56	51	51
• Medicine	48	25	21
• Residential rehabilitation	42	42	42
Average daily census:			
• Community living center	206	182	181
• Domiciliary	40	32	32
• Medicine	27	16	19
• Residential rehabilitation	26	16	23

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 20, 2024

From: Director, VA New England Healthcare System (10N01)

Subj: Comprehensive Healthcare Inspection of the VA Bedford Healthcare System in Massachusetts

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

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

Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts.

I have reviewed and concur with the recommendations, findings, and action plans set forth in this report.

(Original signed by:)

Ryan Lilly, MPA
Network Director
VA New England Healthcare System

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 16, 2024

From: Director, VA Bedford Healthcare System (518)

Subj: Comprehensive Healthcare Inspection of the VA Bedford Healthcare System in Massachusetts

To: Director, VA New England Healthcare System (10N01)

The Bedford VA Medical Center would like to thank the Office of Inspector General team for their review. Please find the attached response to each recommendation included in the report. Bedford VA Medical Center has completed, or is in process of completing, the OIG's recommended actions to strengthen the care we provide.

(Original signed by:)

Joan Clifford DNP, Healthcare System Director

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