



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Program Review
of the Washington DC VA
Medical Center



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Figure 1. Washington DC VA Medical Center (Source:
<https://vaww.va.gov/directory/guide/>, accessed on August 1, 2018)

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
RRT	Rapid Response Team
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Washington DC VA Medical Center (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the overall efforts of the Office of Inspector General (OIG) to ensure that our nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's areas of focus at the time of the review are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health;
7. Long-Term Care;
8. Women's Health; and
9. High-Risk Processes.

This review was conducted during an unannounced visit made during the week of May 21, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality. The OIG's Rapid Response Team simultaneously visited the Facility to conduct a spot-check on areas in which recommendations for improvement had been made in a report published three months prior to determine if remediation efforts appeared to be on track (see Appendix A).

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consisted of the Acting Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Acting Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Leadership Board having oversight for groups such as Medical Executive; Nurse Executive; and Quality, Safety, and Value Executive Councils. The leaders are members of the Executive Leadership Board through which they are to track, trend, and monitor quality of care and patient outcomes.

The Acting Director and Acting Associate Director assumed their assigned 120-day positions on April 23, 2018, and April 30, respectively. At the time of the OIG visit there had been three Acting Directors assigned to the Facility since April 2017. The Chief of Staff has been in the position since January 10, 2016. The ADPCS was permanently assigned on September 10, 2017. The Assistant Director served in an acting capacity since November 2017 and was permanently assigned on May 7, 2018.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted opportunities for improvement. The current leaders verbalized a strong desire to improve the culture of the organization; however, the frequent change in key leadership positions made it difficult to strive for or ensure a stable workplace environment where employees are comfortable with bringing forth issues and concerns. In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that the Facility's scores were below the Veterans Health Administration (VHA) average and that Facility leaders had implemented processes and plans to improve patient experiences.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is “a way to understand the similarities and differences between the top and bottom performers” within VHA.¹ Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current “1-Star” rating.

¹ VHA’s Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a “star” rating system to designate a facility’s performance in individual measures, domains, and overall quality.

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>. (Website accessed on April 16, 2017.)

Additionally, the OIG reviewed accreditation agency findings and Patient Safety Indicator data and identified the presence of organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

The OIG noted findings in six of the eight areas of clinical operations reviewed as well as an incidental finding that significantly impacts the delivery of quality care. In all, the OIG issued 18 recommendations that are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. These are briefly described below.

Quality, Safety, and Value

The OIG found a general lack of consistent processes for identification of opportunities for improvement, implementation of recommended actions, and evaluation of effectiveness of actions taken with Utilization Management (UM), Patient Safety, and Root Cause Analysis (RCA) processes.² Thus, the OIG identified deficiencies in protected peer reviews, utilization management, and patient safety that warranted recommendations for improvement. The protected peer review deficiency represents a repeat finding from the June 2014 Combined Assessment Program review.³

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in using evidence from Focused and Ongoing Professional Practice Evaluations to determine continuation of privileges. This was a repeat finding for Focused Professional Practice Evaluations identified during the June 2014 Combined Assessment Program review.⁴

Environment of Care

The OIG noted privacy measures were in place at the facility and its CBOC. The OIG did not detect any issues with emergency management processes. The OIG observed that the entrance to the nurse's station on inpatient Mental Health unit 3D East had an entry door capable of being secured; however, the height of the door was low enough for a patient to be able to reach over to open it. The OIG noted deficiencies in infection prevention, environmental cleanliness, sterile supplies, medical equipment safety, and mental health seclusion room safety.

² VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

³ VA Office of Inspector General, *Combined Assessment Program Review of the Washington DC VA Medical Center*, Report No. 14-02065-230, August 1, 2014.

⁴ VA Office of Inspector General, *Combined Assessment Program Review of the Washington DC VA Medical Center*, Report No. 14-02065-230, August 1, 2014.

Medication Management

The OIG found that prior to January 2018, the controlled substances (CS) program was not compliant with VHA requirements. A new CS Coordinator (CSC) and alternate CSC were assigned in January 2018, and the OIG found that improvements were evident starting in February 2018, with general compliance noted with requirements for CSC reports, CSC and CS Inspectors' completion of required training, and pharmacy inspections. However, the OIG found actions lacking identified annual physical security survey deficiencies, failing to restrict staff involved in monthly reviews of inventory balance adjustments, not including CSC duties in functional statements or position descriptions, and not reconciling stock returned to the pharmacy.

Long-Term Care

The OIG noted compliance with the provision or access to geriatric evaluation, provision of care, development of plans of care, and implementation of interventions in plans of care when indicated. However, the OIG identified a deficiency in program oversight.

High-Risk Processes

The OIG noted compliance with the presence of a policy for use and care of central lines, annual risk assessment, review and discussion of central line-associated bloodstream infection (CLABSI) data, patient education, and use of a checklist. However, the OIG identified a deficiency in staff education.

Incidental Finding

The OIG found that 1,550 inches of patient reports dating back to 2014 had not been scanned into the electronic health records (EHR). This caused patient results within these records to not be available to healthcare providers. As of the May 2018 OIG visit, the contractors were apparently still unable to access the EHR system to commence document scanning.

Summary

In the review of key care processes, the OIG issued 18 recommendations that are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this Facility. The intent is for Facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Acting Veterans Integrated Service Network Director and Acting Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 75–76, and the responses within the body of the report for the full text of the Directors' comments.) The OIG considers recommendation 14 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

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Washington DC VA Medical Center (facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.⁵ Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.⁶ Figure 2 shows the direct relationship that leadership and organizational risks have with the processes used to deliver health care to veterans.

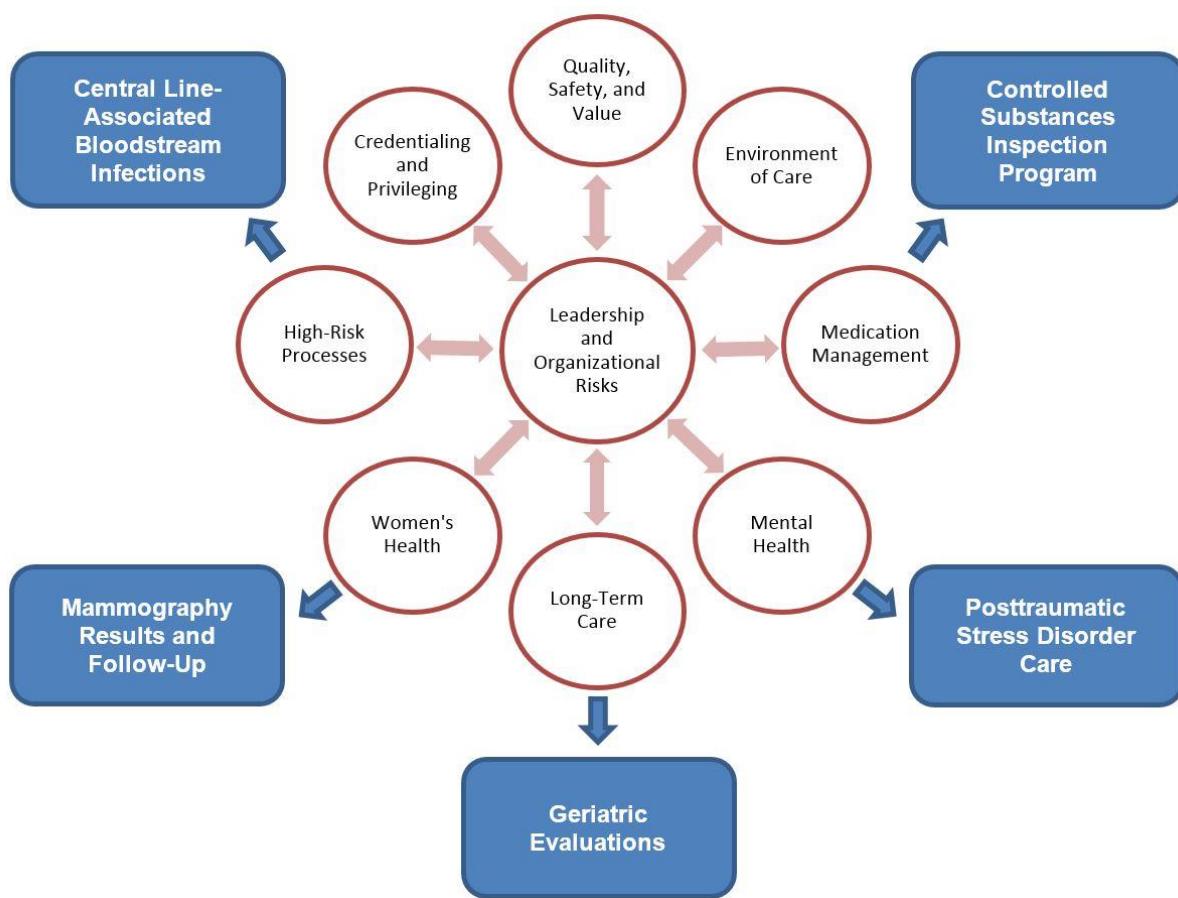
To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women’s Health: Mammography Results and Follow-Up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).⁷

⁵ Carol Stephenson, “The role of leadership in managing risk,” *Ivey Business Journal*, November/December 2010. <https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/>. (Website accessed on March 1, 2018.) See also, Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, “The role of hospital managers in quality and patient safety: a systematic review,” *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (Website accessed on March 1, 2018.)

⁶ Institute for Healthcare Improvement, “How risk management and patient safety intersect: Strategies to help make it happen,” March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (Website accessed on March 1, 2018.)

⁷ CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

**Figure 2. FY 2018 Comprehensive Healthcare Inspection Program
Review of Healthcare Operations and Services**



Source: VA OIG

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;⁸ and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for June 9, 2014,⁹ through May 21, 2018, the date when an unannounced week-long site visit commenced.

This report's recommendations for improvement target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the Facility completes corrective actions. The Acting Director's comments submitted in response to the recommendations in this report appear within each topic area.

While on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

⁸ The OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect Facility accreditation status.

⁹ This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all the selected clinical areas of focus.¹⁰ To assess the Facility's risks, the OIG considered the following organizational elements:

1. Executive leadership stability and engagement,
2. Employee satisfaction and patient experience,
3. Accreditation/for-cause surveys and oversight inspections,
4. Indicators for possible lapses in care, and
5. VHA performance data.

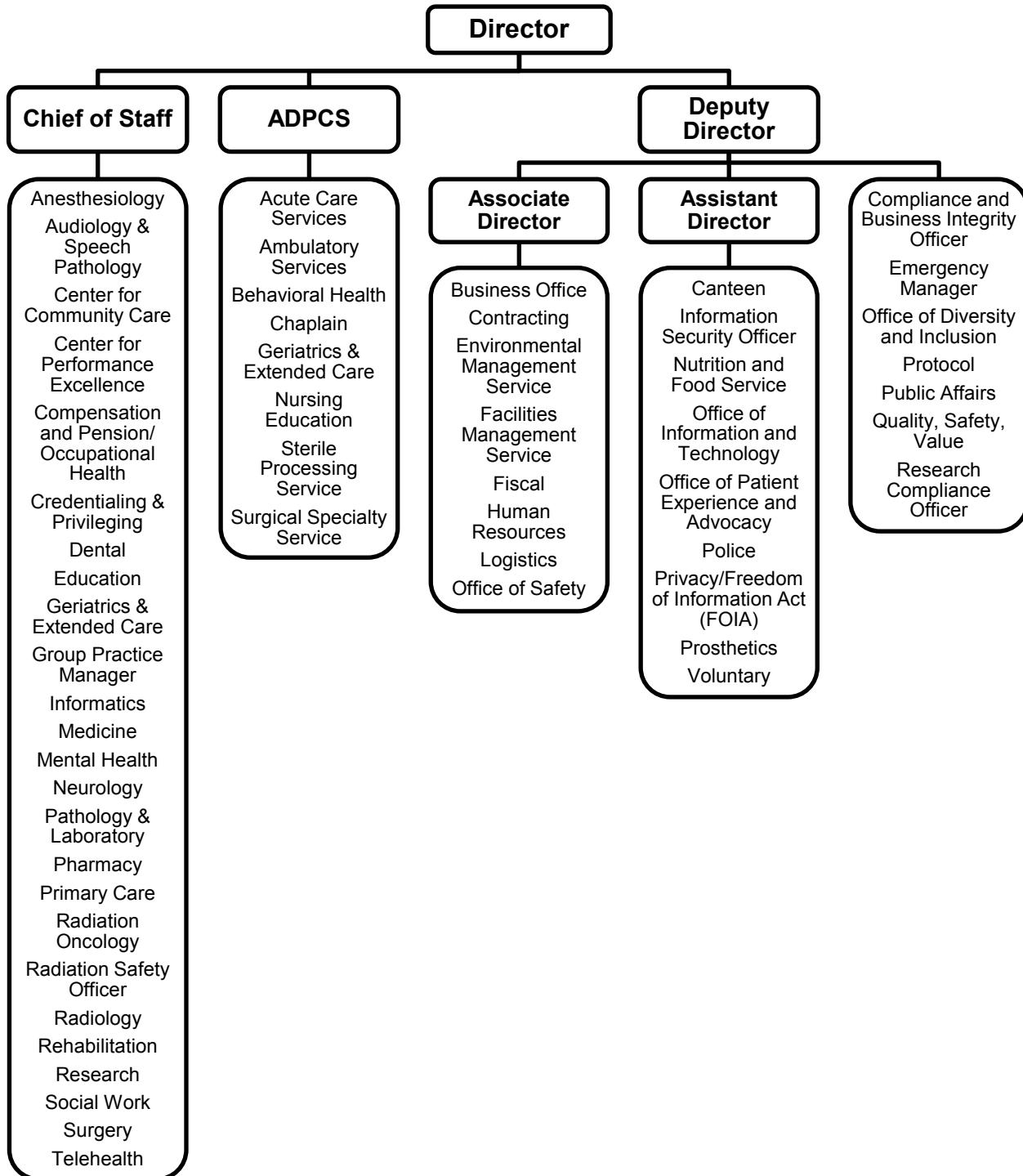
Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Acting Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Acting Associate Director, and Assistant Director. It was reported to OIG that while the organization chart shows a Deputy Director position, that position was eliminated in April 2018. The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

It is important to note that the Acting Director and Acting Associate Director assumed their assigned 120-day positions on April 23, 2018, and April 30, respectively. At the time of the OIG visit there had been three Acting Directors assigned to the Facility since April 2017. The Chief of Staff has been in the position since January 10, 2016. The ADPCS was permanently assigned on September 10, 2017. The Assistant Director served in an acting capacity since November 2017 and was permanently assigned on May 7, 2018.

¹⁰ L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement, Innovation Series White Paper*. 2006.

<http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx>. (Website accessed on February 2, 2017.)

Figure 3. Facility Organizational Chart

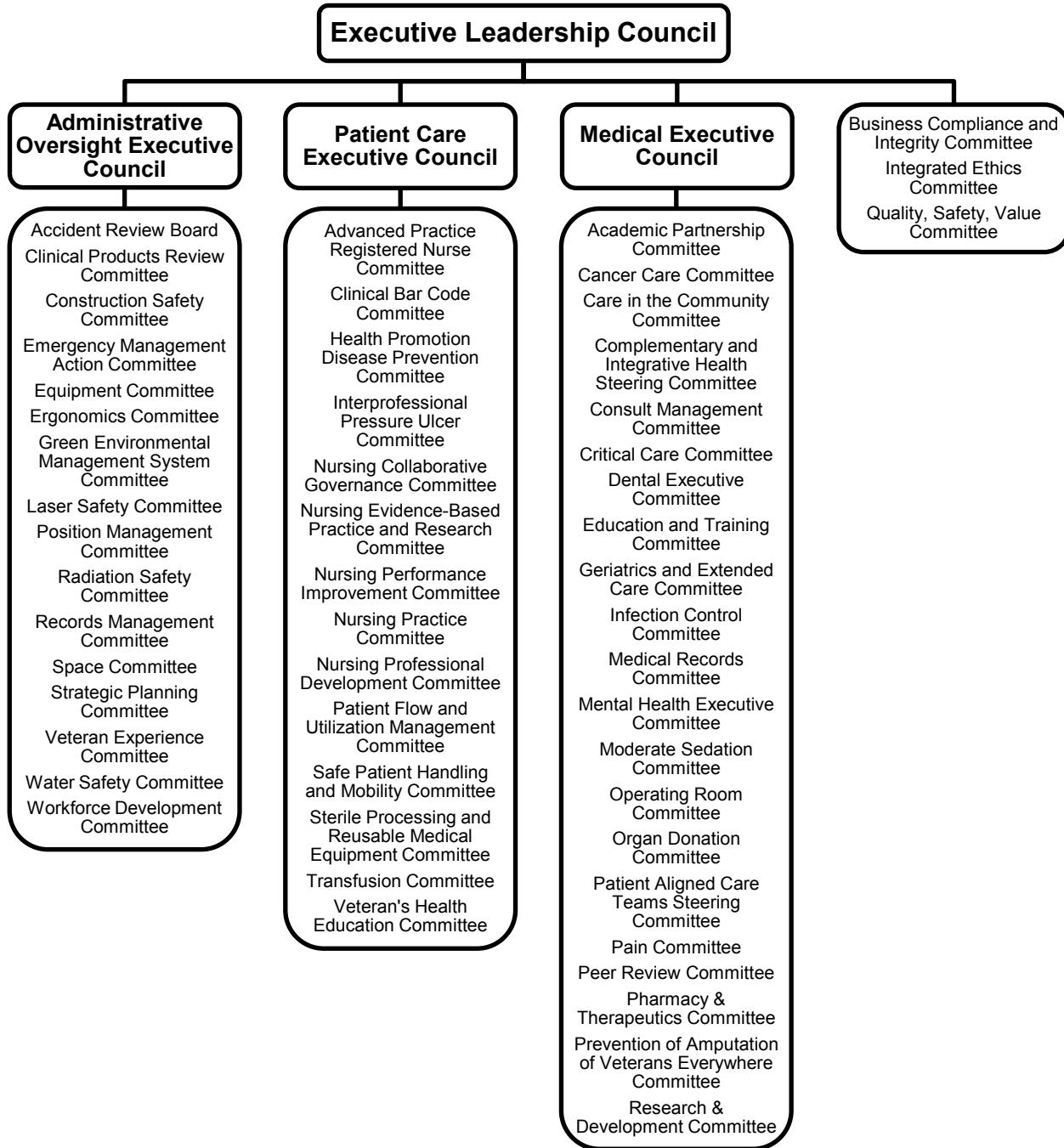
Source: Washington DC VA Medical Center (received May 23, 2018)

To help assess engagement of Facility executive leadership, the OIG interviewed the Acting Director, Chief of Staff, ADPCS, and Acting Associate Director regarding their knowledge of

various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about current employee and patient survey results. Selected Strategic Analytics for Improvement and Learning (SAIL) metrics were discussed and senior leaders acknowledged that attention to these metrics, to maintain or improve performance, was lacking. These are discussed more fully below.

The leaders were also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Executive Leadership Board, which is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes. The Acting Director serves as the chairperson with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Board also has oversight of various working groups, such as the Medical Executive Council; Patient Care Executive Council; and Quality, Safety, Value Committee (see Figure 4).

Figure 4. Facility Committee Reporting Structure

Source: Washington DC VA Medical Center (received December 14, 2018)

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several points in response to VA leadership inquiries on VA culture and organizational health. 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 facility leadership.

To assess employee attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.¹¹

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey. The Facility average for both selected leadership survey questions was below the VHA average.¹² The same general trend was noted for the members of the executive leadership team.

**Table 1. Survey Results on Employee Attitudes toward Facility Leadership
(October 1, 2016, through September 30, 2017)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i>	0–100 where HIGHER scores are more favorable	67.7	63.0	71.9	57.8	65.9	63.7	65.8
All Employee Survey Q59. <i>How satisfied are you with the job being done by the executive leadership where you work?</i>	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	2.9	3.1	2.8	3.9	3.1	3.3

Source: VA All Employee Survey (accessed April 20, 2018)

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The Facility averages for the selected survey questions were similar to or higher than the VHA average for the Director and ADPCS. Results for the Associate and Assistant Directors were similar to or lower than VHA average and results for the Chief of Staff were lower than VHA averages. Opportunities for improvement appear to exist particularly for

¹¹ Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director.

¹² The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

the Chief of Staff, who was the only leader in the position at the time this survey was conducted, to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns.

**Table 2. Survey Results on Employee Attitudes toward Workplace
(October 1, 2016, through September 30, 2017)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey Q43. <i>My supervisor encourages people to speak up when they disagree with a decision.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.6	4.0	3.4	3.8	3.6	3.7
All Employee Survey Q44. <i>I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	3.8	3.7	3.4	4.2	3.9	3.8
All Employee Survey Q75. <i>I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	3.7	3.9	3.7	4.2	3.7	3.7

Source: VA All Employee Survey (accessed April 20, 2018)

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four items from the survey period of October 1, 2016, through September 30, 2017, that reflect patient attitudes towards Facility leaders (see Table 3). For this Facility, all four patient survey results reflected lower care ratings than the VHA average.

**Table 3. Survey Results on Patient Attitudes toward Facility Leadership
(October 1, 2016, through September 30, 2017)**

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.7	49.5
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	83.4	77.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	74.9	66.1
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	75.2	70.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 12, 2017)

Accreditation Surveys and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for-cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.¹³ Table 4 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint

¹³ The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

Commission (TJC).¹⁴ The most recent OIG Hotline report had multiple recommendations for improvement that remained open at the time of this inspection.¹⁵

Of particular note is the OIG's previously issued report, *Critical Deficiencies at the Washington, DC VA Medical Center (Critical Deficiencies)*, released in March 2018.¹⁶ The severity and reach of the report's findings regarding persistent Facility failures prompted the OIG's Rapid Response Team members to initiate a follow-up site visit during the time of the CHIP review. The intent was to assess the facility's progress in implementing corrective actions called for in that report.¹⁷ Appendix A addresses the results of this follow-up review.

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities¹⁸ and College of American Pathologists.¹⁹ Additional considerations included the Long Term Care Institute's inspections of the Facility's Community Living Center,²⁰ and the Paralyzed Veterans of America's inspection of the Facility's spinal cord injury/disease unit and related services.²¹

¹⁴ TJC provides an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care. TJC has been accrediting VA medical facilities for over 35 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

¹⁵ A closed status indicates that the Facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

¹⁶ VA Office of Inspector General, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018. <https://www.va.gov/oig/pubs/VAOIG-17-02644-130.pdf>.

¹⁷ Recommendations 1–3, 5–15, 18, 21–24, and 26–31 were directed to the Washington DC VA Medical Center.

¹⁸ The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

¹⁹ For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

²⁰ Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

²¹ The Paralyzed Veterans of America inspection took place September 26, 2016. This Veteran Service Organization review does not result in accreditation status.

Table 4. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Combined Assessment Program Review of the Washington DC VA Medical Center, Washington, DC, August 1, 2014</i>)	June 2014	23	0
OIG (<i>Review of Community Based Outpatient Clinics and Primary Care Clinic Reviews at Washington DC VA Medical Center, Washington, DC, July 28, 2014</i>)	June 2014	8	0
OIG (<i>Healthcare Inspection – Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center, Washington, District of Columbia, November 16, 2015</i>)	July 2014	3	0
OIG (<i>Critical Deficiencies at the Washington DC VA Medical Center, March 7, 2018</i>)	March 2018	25	25
TJC • Regular <ul style="list-style-type: none">◦ Hospital Accreditation◦ Behavioral Health Care Accreditation◦ Home Care Accreditation • Behavioral Health Opioid Program	April 2017 June 2017	37 2 2 9	0 0 0 0

Sources: OIG and TJC (Inspection/survey results verified with the Acting Director on May 22, 2018.)

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 lists the reported patient safety events resulting in patient harm and disclosures, which are key indicators of risk, since the OIG's previous June 2014 Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinics Reviews inspections through the week of May 21, 2018.²²

**Table 5. Summary of Selected Organizational Risk Factors
(June 2014 to May 21, 2018)**

Factor	Number of Occurrences
Sentinel Events ²³	4
Institutional Disclosures ²⁴	11
Large-Scale Disclosures ²⁵	0

*Source: Washington DC VA Medical Center's Patient Safety Manager
(received May 23, 2018)*

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.²⁶ The rates presented are specifically applicable for this Facility, and lower rates

²² It is difficult to quantify an acceptable number of adverse occurrences because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the Washington, DC Medical Center is a highest complexity (1a) affiliated Facility as described in Appendix C.)

²³ A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

²⁴ Institutional disclosure of adverse events (sometimes referred to as "administrative disclosures") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during 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.

²⁵ Large-scale disclosure of adverse events (sometimes referred to as a "notification") 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 failure.

²⁶ Agency for Healthcare Research and Quality, <https://www.qualityindicators.ahrq.gov/>. (Website accessed on March 8, 2017.)

indicate lower risks. Table 6 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

**Table 6. Patient Safety Indicator Data
(October 1, 2015, through September 30, 2017)**

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 5	Facility
Pressure ulcers	0.60	1.12	1.56
Death among surgical inpatients with serious treatable conditions	100.97	121.02	176.47
Iatrogenic pneumothorax ²⁷	0.19	0.14	0.19
Central venous catheter-related bloodstream infection	0.15	0.13	0.57
In-hospital fall with hip fracture	0.08	0.03	0.12
Perioperative hemorrhage or hematoma	1.94	1.34	2.06
Postoperative acute kidney injury requiring dialysis	0.88	0.62	1.04
Postoperative respiratory failure	5.55	2.57	1.72
Perioperative pulmonary embolism or deep vein thrombosis	3.29	4.73	3.21
Postoperative sepsis	4.00	2.88	6.45
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.00	0.00

Source: VHA Support Service Center

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

Seven Patient Safety Indicator measures (pressure ulcers, death among surgical inpatients with serious treatable conditions, central venous catheter-related bloodstream infection, in-hospital fall with hip fracture, perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, and postoperative sepsis) showed a higher observed rate of occurrence within the DC VA Medical Center than VHA and VISN 5. The Patient Safety Indicator measure for iatrogenic pneumothorax showed a higher observed rate than VISN 5. The Facility leaders were unable to provide evidence of ongoing monitoring or evaluation for the Patient Safety Indicators discussed above because they lacked a defined process to do so.

²⁷ Northwestern Medicine. <http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care>. (The website was accessed on January 14, 2019.) A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is one which was caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one “way to understand the similarities and differences between the top and bottom performers” within VHA.²⁸

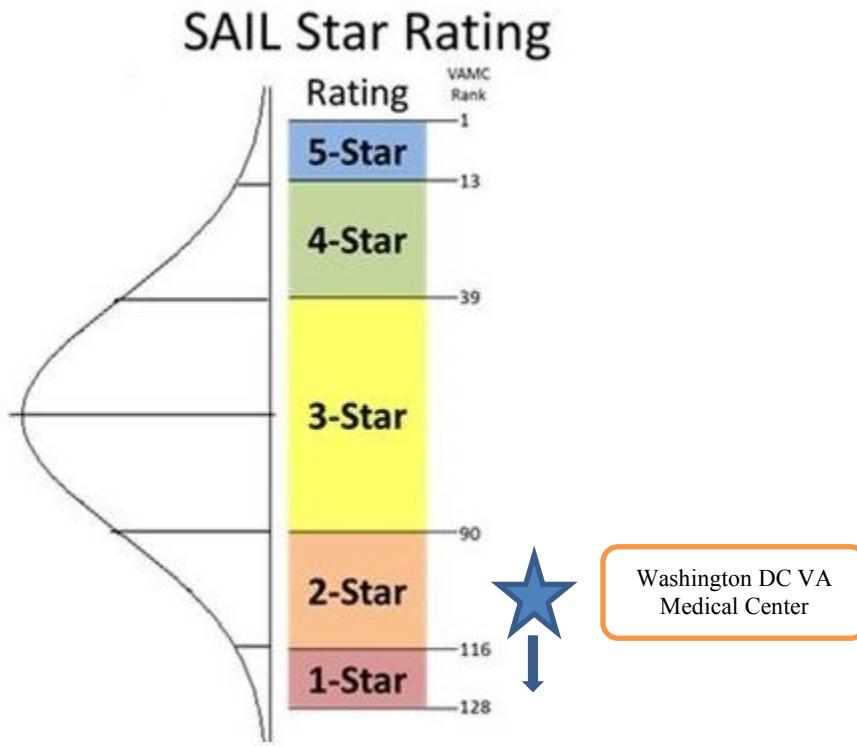
VA also uses a star-rating system where facilities with a “5-Star” rating are performing within the top 10 percent of facilities and “1-Star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.²⁹ As of June 30, 2017, the Facility was rated at “2-Star” for overall quality. Updated data as of June 30, 2018, indicates that the Facility rating declined to “1-Star” for overall quality.

²⁸ VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model,

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>.
(Website accessed on April 16, 2017.)

²⁹ According to the methods established by the Strategic Analytics for Improvement and Learning (SAIL) Model, this is based on normal distribution ranking quality domain of 128 VA Medical Centers.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)

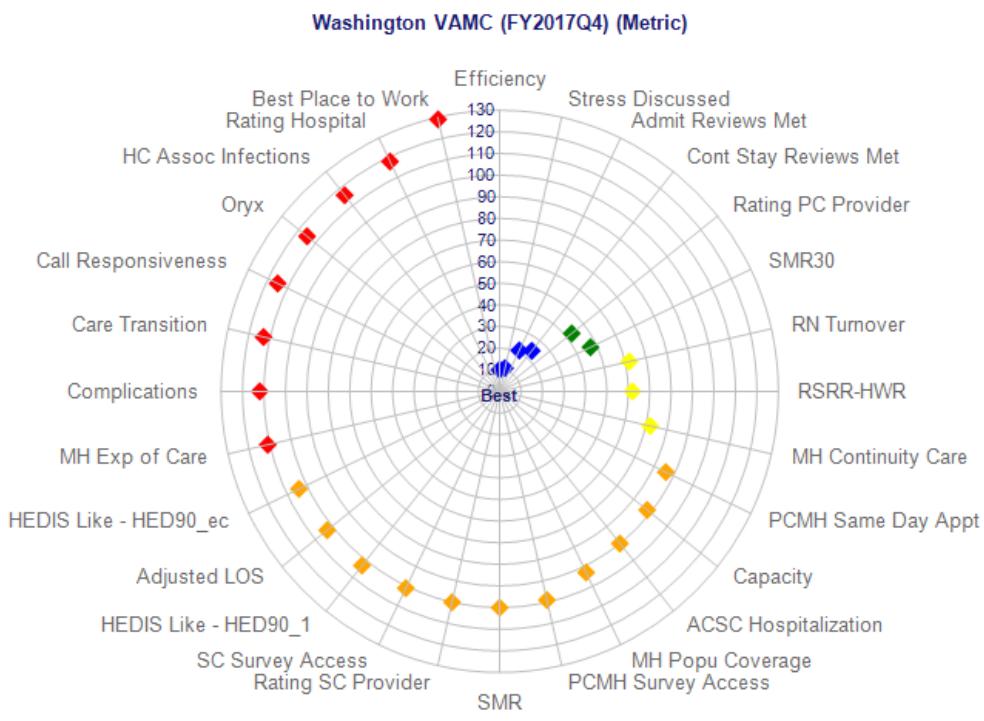


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed April 20, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, [Patient] Stress Discussed and Rating (of) Primary Care (PC) Provider).³⁰ Metrics that need improvement are denoted in orange and red (for example, Capacity, Complications, and Healthcare (HC) Associated Infections).

³⁰ For information on the acronyms in the SAIL metrics, please see Appendix E.

**Figure 6. Facility Quality of Care and Efficiency Metric Rankings
(as of September 30, 2017)**



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix D for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix E.

Conclusion

Strong and stable leadership is essential for sustained improvement. During the past year, the Facility leadership has undergone frequent changes, which presents organizational risks. This is evidenced by the lack of solid evidence of ongoing, coordinated efforts to improve identified deficiencies, employee relations, and patient care. Organizational leaders support efforts related to enhancing patient safety, quality care, and other positive outcomes. However, the organizational risk factors detailed in this report, if uncorrected, can perpetuate noncompliance with requirements and/or lapses in patient safety measures. Corrective processes must be fully implemented and continuously monitored. The Facility leadership team was aware of the selected SAIL metrics and expressed a desire to address problem areas. In doing so, they must continue to take actions that improve care and performance of the Quality of Care and Efficiency metrics that are likely contributing to the current "1-Star" rating. These actions should be

integrated into a comprehensive action plan responsive to prior reports and ongoing problem identification.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.³¹ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³²

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,³³ utilization management (UM) reviews,³⁴ and patient safety incident reporting with related root cause analyses (RCAs).³⁵

VHA has implemented approaches to improve patient safety, including the reporting of such incidents to the VHA National Center for Patient Safety. The reporting helps VHA to learn about system vulnerabilities and how to address them as well as implement required RCAs to allow for more accurate and rapid communication of potential and actual causes of harm to patients.³⁶

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:³⁷

- Protected peer reviews

³¹ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

³² Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³³ According to VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010, this is a peer evaluation of the care provided by individual providers within a selected episode of care. (This directive has since been rescinded by VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.)

³⁴ According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

³⁵ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.)

³⁶ VHA Handbook 1050.01.

³⁷ For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Implementation of improvement actions recommended by the Peer Review Committee
- UM
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of Physician UM Advisors' decisions in the National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Entry of all reported patient incidents into VHA's patient safety reporting system³⁸
 - Annual completion of a minimum of eight RCAs³⁹
 - Provision of feedback about RCA actions to reporting employees
 - Submission of annual patient safety report

Conclusion

The OIG found a general lack of consistent processes for identifying opportunities for improvement, implementing recommended actions, and evaluating the effectiveness of actions taken with UM, Patient Safety, and RCA processes. The OIG identified the following deficiencies in protected peer reviews, utilization management, and patient safety that warranted recommendations for improvement. The OIG found a repeat finding in protected peer review processes previously identified during the June 2014 Combined Assessment Program review.⁴⁰

³⁸ WebSPOT has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR), and it is expected that all previous patient safety event reporting systems will have been discontinued by July 1, 2018.

³⁹ According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs, with the balance being aggregated reviews or additional individual RCAs.

⁴⁰ VA Office of Inspector General, *Combined Assessment Program Review of the Washington DC VA Medical Center*, Report No. 14-02065-230, August 1, 2014.

Quality Management Improvement Activities

VHA requires that, when improvement actions are identified through Peer Review and/or RCA processes, there is implementation of those actions and monitoring for improvement.⁴¹ Protected peer review findings and those actions identified during RCAs can have both immediate and long-term impact in patient care by revealing areas for improvement. Six of eight applicable protected peer reviews had no evidence that the recommended improvement actions were implemented. The COS and Risk Manager reported that these protected peer review actions were discussed at Facility Peer Review Committee meetings; however, there was a lack of oversight in closing the actions. This protected peer review finding is a repeat finding from the June 2014 OIG Combined Assessment Program review.⁴² Further, four of five RCA actions were not fully implemented. Patient Safety staff and the Acting QSV Chief could not provide a reason why RCA action implementation was lacking. This resulted in the potential for continued patient harm and missed opportunities for improvement.

Recommendation 1

1. The Facility Director ensures that recommended actions from peer reviews and root cause analyses are implemented and monitored for improvement.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The root cause analyses actions for improvement will be reported by the Patient Safety Manager to the Quality, Safety, Value Council monthly and the peer review actions for improvement will be reported by the Risk Manager to the Medical Executive Council monthly. Evidence of compliance will be that 80% of all actions are closed prior to their target date and the remaining 20% are closed within 30 days of their target completion date. Target date is being set to ensure compliance monitoring for two quarters.

Utilization Management: Required Reviews

VHA requires that facility UM reviewers conduct a minimum of 75 percent of acute inpatient admissions and continued stay reviews and enter the data into the National Utilization Management Integration database.⁴³ This ensures that admissions and continued days of care are appropriate for the patient's diagnosis and treatment.

⁴¹ VHA Directive 2010-025; VHA Handbook 1050.01; VHA Directive 1026.

⁴² VA Office of Inspector General, *Combined Assessment Program Review of the Washington DC VA Medical Center*, Report No. 14-02065-230, August 1, 2014.

⁴³ VHA Directive 1117.

The OIG found from April 1, 2017, through May 31, 2018, Facility UM reviewers performed 69 percent of required reviews, falling short of the 75 percent requirement. This resulted in insufficient evaluations of admission and continued stay appropriateness. The Acting QSV Chief and a UM Nurse reported that inpatient stay admissions and continued stay reviews were not completed over the past 12 months due to staffing vacancies and reassignments of staff.⁴⁴

Recommendation 2

2. The Chief of Staff ensures that assigned staff complete at least 75 percent of all inpatient admissions and continued stay reviews and monitors the staff's compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: Review of utilization management reviews will be presented by the Utilization Manager to the Patient Care Executive Council at a minimum of monthly to ensure that all reviews are being completed within the expected timeframe. Evidence of compliance will be at least 75% of all admissions, observation stays, and subsequent days of care are reviewed and entered into the NUMI [National Utilization Management Integration] application. Target date is being set to ensure compliance monitoring for two quarters.

Utilization Management: Data Review

VHA requires that an interdisciplinary facility group review UM data.⁴⁵ An interdisciplinary review ensures that a comprehensive approach is taken when reviewing UM data to identify opportunities for improvement throughout the facility. From April 1, 2017, through March 31, 2018, UM data was not reviewed by an interdisciplinary group. According to Facility leaders, UM data was supposed to be reported to the Facility Quality Council; however, the OIG found no evidence that the Quality Council received or reviewed any UM data. This resulted in missed opportunities for improving the utilization of Facility resources. The Acting QSV Chief and current UM staff could not provide a reason why the Quality Council had not reviewed or analyzed data.

Recommendation 3

3. The Chief of Staff ensures an interdisciplinary Facility group reviews utilization management data and monitors the group's compliance.

⁴⁴ VA Office of Inspector General, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018. <https://www.va.gov/oig/pubs/VAOIG-17-02644-130.pdf>.

⁴⁵ VHA Directive 1117.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The Medical Center has updated the Governance Structure to incorporate a Utilization Management Sub-Committee. This sub-committee's focus is on the utilization management processes, workflows, and data. The sub-committee consists of an interdisciplinary group from across the facility who provide direction and support to the utilization management program. This subcommittee will review all NUMI data quarterly with the expectation that at least 75% of all reviews are completed within the prescribed timeframe and 75% of all Provider Reviews are completed within the prescribed timeframe. Target date is being set to ensure compliance monitoring for two quarters.

Patient Safety: Root Cause Analyses

VHA requires timely feedback be provided to staff who submit close call and adverse event reports that result in an RCA.⁴⁶ This establishes trust in the patient safety system and ensures staff are aware that their concern was addressed. All five RCAs reviewed by the OIG lacked evidence that the individual or department reporting the incident received feedback or education regarding actions taken. This resulted in missed opportunities to establish employee trust in the system and to positively reinforce a culture of safety. Patient Safety staff and the Acting QSV Chief could not provide a reason why reporting individuals or departments did not receive feedback.

Recommendation 4

4. The Facility Director ensures that the Patient Safety Manager provides feedback of root cause analysis results to the reporting individuals or departments and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The Patient Safety Manager will include a detailed report on all root cause analyses performed to the Quality, Safety, Value Council quarterly. The report will include a summary of the lessons learned, the actions being taken to prevent a reoccurrence, and the feedback provided to those individuals/departments who reported the incident. Evidence of compliance with this action includes 90% of all root cause analyses are reported and the report includes all the elements noted. Target date is being set to ensure compliance monitoring for two quarters.

⁴⁶ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIPs).⁴⁷

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.⁴⁸

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual’s license. Clinical privileges need to be specific, based on the individual’s clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.⁴⁹

The purpose of this part of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months before the on-site visit,⁵⁰ and 20 LIPs who were re-privileged within 12 months before the visit.⁵¹ The OIG evaluated the following performance indicators:

- Credentialing
 - Current licensure
 - Primary source verification
- Privileging
 - Verification of clinical privileges
 - Requested privileges

⁴⁷ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Provision was due for recertification October 31, 2017, but has not been updated.)

⁴⁸ VHA Handbook 1100.19.

⁴⁹ VHA Handbook 1100.19.

⁵⁰ The 18-month period was from November 21, 2016, through May 21, 2018.

⁵¹ The 12-month review period was from May 21, 2017, through May 21, 2018.

- Facility-specific
- Service-specific
- Provider-specific
- Service chief recommendation of approval for requested privileges
- Medical Staff Executive Committee decision to recommend requested privileges
- Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
 - Evaluation initiated
 - Timeframe clearly documented
 - Criteria developed
 - Evaluation by another provider with similar training and privileges
 - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
 - Determination to continue privileges
 - Criteria specific to the service or section
 - Evaluation by another provider with similar training and privileges
 - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in using evidence from FPPEs and OPPEs to determine continuation of privileges. The OIG found a repeat finding for FPPE identified during the June 2014 Combined Assessment Program review.⁵²

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's profile and reported to an appropriate Medical Staff committee. The process involves the evaluation of privilege-specific competence of the practitioner who has no

⁵² VA Office of Inspector General, *Combined Assessment Program Review of the Washington DC VA Medical Center*, Report No. 14-02065-230, August 1, 2014.

previously documented evidence of competently performing the requested privileges. Evaluation methods may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.⁵³

For 3 of 10 LIPs, the Facility's Professional Standards Board recommended continuation of initially granted privileges even though the FPPE results (primarily EHR reviews) were incomplete. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. For 7 of 10 LIPs, there was documentation of completed FPPE reviews; however, there was no evidence that the FPPEs were presented for review in the specified timeframe to the Facility's Professional Standards Board. This resulted in providers continuing to deliver care without consideration of the results of the evaluation when the decision was made to continue initially granted privileges. The COS reported that there is no tracking mechanism or oversight to ensure the reviews are completed and/or submitted for review. The lack of reporting FPPE results to the Facility's Professional Standards Board for review is the repeat finding from the June 2014 OIG Combined Assessment Program review.⁵⁴

Ongoing Professional Practice Evaluations

VHA requires that the determination to continue LIP privileges be based in part on the results of OPPE activities, such as results of EHR reviews, outcome data, and direct observation.⁵⁵ These elements allow the facility to identify professional practice trends that impact patient care, safety, and quality of care.

For 6 of 20 LIPs who were re-privileged, the Facility's Professional Standards Board recommended continuation of initially granted privileges even though the OPPE results (primarily EHR reviews) were incomplete. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. For 10 of 14 LIPs with completed OPPE reviews, there was no evidence that the OPPEs were presented to the Facility's Professional Standards Board for review in the specified timeframe. This resulted in providers continuing to deliver care without consideration of the results of the evaluation. The Chief of Staff reported that the service chiefs were expected to submit a copy of the OPPE activity files to the Credentialing and Privileging office; however, there was a lack of oversight to ensure compliance.

⁵³ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012 (due for recertification October 31, 2017, but has not been updated).

⁵⁴ VA Office of Inspector General, *Combined Assessment Program Review of the Washington DC VA Medical Center*, Report No. 14-02065-230, August 1, 2014.

⁵⁵ VHA Handbook 1100.19.

Recommendation 5

5. The Chief of Staff ensures that Focused and Ongoing Professional Practice Evaluations are completed, and that the Professional Standards Board reviews these evaluations in considering whether to continue provider privileges, and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The Credentialing and Privileging Service tracks all ongoing professional practice evaluations (OPPE) and Focused Professional Practice Evaluations (FPPE). Completed OPPEs will be presented to the Professional Standards Board by the due date at least 90% of the time. Completed FPPEs will be presented to the Professional Standards Boards by the due date at least 90% of the time. Target date is being set to ensure compliance monitoring for two quarters.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.⁵⁶

The purpose of this facet of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked Mental Health Unit and with Emergency Management processes.⁵⁷

VHA requires managers to ensure capacity for mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty.

Inpatient mental health settings must also provide a healing, recovery-oriented environment.⁵⁸

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis (HVA) and developing an Emergency Operations Plan (EOP).⁵⁹ These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,⁶⁰ Occupational Safety and Health Administration,⁶¹ and

⁵⁶ VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

⁵⁷ Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

⁵⁸ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

⁵⁹ VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

⁶⁰ TJC. EOC standard EC.02.05.07.

⁶¹ Occupational Safety and Health (OSHA) is part of the US Department of Labor. OSHA assures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

National Fire Protection Association standards.⁶² The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected six inpatient units—Community Living Center (CLC) Freedom Way West, Medicine 4C, Mental Health 3D East, Surgery 2D, intensive care, and post-anesthesia care—in addition to the Emergency Department and Outpatient Clinic Yellow. The team also inspected the Charlotte Hall CBOC. The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
 - EOC rounds
 - EOC deficiency tracking
 - Infection prevention
 - General safety
 - Environmental cleanliness
 - General privacy
 - Women veterans' exam room privacy
 - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
 - General safety
 - Medication safety and security
 - Infection prevention
 - Environmental cleanliness
 - General privacy
 - Exam room privacy
 - Availability of medical equipment and supplies
- Locked Mental Health Unit
 - Biannual Mental Health EOC Rounds
 - Nursing station security

⁶² National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and property and economic loss due to fire, electrical, and related hazards.

- Public area and general unit safety
- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies
- Emergency Management
 - Hazard Vulnerability Analysis (HVA)
 - Emergency Operations Plan (EOP)
 - Emergency power testing and availability

Conclusion

The OIG noted privacy measures were in place at the parent Facility and representative CBOC and did not note any issues with emergency management processes. However, the OIG noted that the entrance to the nurse's station on the inpatient Mental Health Unit 3D East had an entry door with a height that was low enough for a patient to reach over and open. The OIG also identified deficiencies in infection prevention, sterile supplies, environmental cleanliness, medical equipment safety, and mental health seclusion room safety that warranted recommendations for improvement.

Parent Facility: Infection Prevention

TJC requires hospitals to minimize risks for acquiring and transmitting infections, thus reducing potential exposure by patients, visitors, and employees to infectious diseases.⁶³ The OIG noted the presence of excessive and uncontrolled dust in the CLC-Freedom Way (West) construction area located immediately adjacent to the patient seating/dining area and patient rooms. The OIG contacted infection control, an engineering technician, and contracting representatives while on site to remediate the situation.

The OIG also found that the weekly Infection Control Construction Safety Rounds from March 22, 2018, to May 17, 2018,⁶⁴ identified that the sticky walk-off mats at the construction sites were dirty and required immediate correction. The Facility staff, however, did not address this persistent inspection finding, thereby undercutting infection controls used to protect patients, visitors, and staff.

⁶³ TJC. Infection Prevention and Control standard IC.01.03.01 EP1 and EOC standard EC.04.01.05 EP1.

⁶⁴ Infection Control Risk Assessment-Construction Safety Rounds—March 22, April 12 and 19, and May 10 and 17, 2018.

Recommendation 6

6. The Associate Director ensures that safety and infection prevention processes are in place at construction sites and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: Construction rounds are conducted at a minimum weekly for all active construction areas to ensure compliance with all standards of construction safety along with compliance with infection control standards. The Project Manager in Facilities Management Service will review the weekly rounds once they are completed to ensure action to remediate the issues identified are taken and to track/trend any concerns with specific projects or vendors. The Project Manager will provide a monthly report on construction safety rounds and appropriate remediation activities to the Administrative Oversight Executive Council. The goal is to close 90% of all items within seven days of identification [by] construction rounds. Target date is being set to ensure compliance monitoring for two quarters.

Parent Facility: Sterile Supplies

TJC requires hospitals to minimize risks for acquiring and transmitting infections, thus reducing patients, visitors, and employee's potential exposure to infectious diseases.⁶⁵ The OIG noted that three of seven patient care supply/medication rooms (storage areas not stocked by Logistics staff) contained expired or unsealed intravenous (IV) fluid bags. Facility managers stated that staff were aware that unsealed IV bags were to be discarded; however, staff failed to take action.

Recommendation 7

7. The Associate Director for Patient Care Services ensures that nursing staff dispose of expired or unsealed supplies and monitors the staff's compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The Medical Center's environment of care rounds are completed weekly and each patient care area is assessed bi-annually. The results of the rounds are reported to the Administrative Oversight Executive Council. The environment of care group will report on all expired/outdated items identified during the rounds with on the spot correction during inspection. Evidence of compliance will be a 100% compliance. Target date is being set to ensure compliance monitoring for two quarters.

⁶⁵ TJC. Infection Prevention and Control standard IC.01.03.01 EP1 and EOC standard EC.04.01.05 EP1.

Facility and CBOC Cleanliness and Maintenance

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices,⁶⁶ and keep furnishings and equipment safe and in good repair.⁶⁷ This ensures a clean and safe healthcare environment. The OIG noted problems with cleanliness and maintenance throughout the Facility and at the Charlotte Hall CBOC.

During the on-site inspection, the OIG identified a serious and widespread lack of cleanliness and maintenance throughout the patient care areas. At the parent Facility, the OIG inspected 78 patient rooms and 7 supply storage closets in 8 patient care areas. Specifically, the OIG found that seven patient care areas had dirty, stained, or damaged floor tiles and dirty, stained, or damaged walls; dirty, dusty, and/or rusty ventilation grills; and stained, dusty, cracked, and/or broken ceiling tiles. Six patient care areas had damaged furniture and light fixtures, three patient care areas had privacy curtains needing repair or replacement, and three patient care areas had dusty fire sprinkler heads.

At the Charlotte Hall CBOC, the OIG inspected 14 rooms. Specifically, the OIG found that 8 rooms had missing, damaged, dirty, or stained floor tiles; 10 rooms had dead insects in the light fixtures; 4 rooms had dusty or dust-clogged ventilation grills; 4 rooms had walls with holes or large cracks; and 3 rooms had dirty or damaged light fixtures.

Facility managers stated the reasons for the lack of general cleanliness and repairs in the patient care areas were that Environmental Management Service (EMS) housekeeping staff were not following room cleaning procedures, EMS supervisors were not spot-checking rooms after cleaning, and a designated EOC team was not performing rounds as required.

Recommendation 8

8. The Associate Director ensures that a safe and clean environment is maintained throughout the Facility and monitors compliance.

⁶⁶ TJC. EOC standards EC.02.06.01 EP01, EP20, and EP26.

⁶⁷ TJC. EOC standards EC.04.01.01 and EP14.

Facility concurred.

Target date for completion: March 31, 2019

Facility response: The Environmental Management Service (EMS) front-line supervisors conduct follow-up evaluations of patient care areas twice per shift and examine a random selection of cleaned patient care rooms after discharge to determine the cleanliness of these areas. The supervisors complete a rounding tool which is then turned-in to the Deputy Chief of Environmental Services. Evidence of compliance will be through EMS submitting the trends of the rounding tool to the Administrative Oversight Executive Council on a quarterly basis and ad hoc for any significant findings. The Medical Center's environment of care rounds are completed weekly and each patient care area is assessed bi-annually. The results of the rounds are reported to the Administrative Oversight Executive Council. The environment of care group will report on all cleanliness elements identified during the rounds with a specific focus to ensure appropriate closure of these findings within the prescribed 14-day timeframe. Evidence of compliance will be a 90% closure rate within the prescribed timeline. Target date is being set to ensure compliance monitoring for two quarters.

Medical Equipment Inventory and Safety Inspections

VHA's Center for Engineering and Occupational Safety and Health requires facilities to have a mechanism or method in place for equipment users to be confident that the equipment they are using is safe and functional.⁶⁸ The OIG found 10 pieces of equipment in the CLC and the Charlotte Hall CBOC with safety inspection stickers that were missing or not visible: two patient lifts in the CLC and eight pieces of physical therapy exercise equipment at the Charlotte Hall CBOC. As a result, clinical staff could not be confident that the pieces of equipment were safe to use for patient care.

The Chief of Biomedical Services stated that the process for new equipment is for Biomedical Service staff to perform an initial safety and performance test. If the staff determines that the equipment requires preventative maintenance, then the staff will place an inspection sticker on the equipment. If the Biomedical Service staff determines that the equipment does not require preventative maintenance, then the staff will not attach an inspection sticker. However, this process does not clearly communicate to clinical staff whether all equipment is safe for patient use. Upon further review, the OIG found that the Biomedical Services staff inspected the two patient lifts but never applied the safety inspection stickers. The OIG also found that Biomedical Services staff never inventoried, inspected, or added the eight pieces of physical therapy exercise equipment mentioned earlier to the preventative maintenance program. The Chief of Biomedical Services stated that Facility staff did not follow proper inspection processes.

⁶⁸ VHA Center for Engineering and Occupational Safety and Health (CEOSH), *Medical Equipment Management Guidebook*, October 2011.

Recommendation 9

9. The Associate Director ensures all applicable equipment is inspected and identified as safe for patient use and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2019

Facility response: The eight pieces of physical therapy equipment identified during the inspection were removed from service and have since been excessed by Logistics Service. The two patient lifts in the CLC were immediately inspected by Biomedical Engineering. The Medical Center's environment of care rounds are completed weekly and each patient care area is assessed bi-annually as noted in Recommendation 8. The results of the rounds are reported by the Hospital Safety Office to the Administrative Oversight Executive Council. The environment of care group will report on all equipment which is identified as out of compliance during the rounds with a specific focus to ensure appropriate closure of these findings. Evidence of compliance will be a 95% closure rate within 14-days. Additionally, the Biomedical Engineering Department will report quarterly to the Administrative Oversight Executive Council on the status of all equipment preventative maintenance for the Medical Center. Evidence of compliance is completion of all preventative maintenance on equipment identified in accordance with the Medical Center's Medical Equipment Management Plan. Target date is being set to ensure compliance monitoring for two quarters.

Inpatient Mental Health Patient and Staff Safety

VHA requires that inpatient rooms designated for seclusion be structured to prevent patient injury. This requirement includes that floors be made of material that provides cushioning and the only furniture in the room is a psychiatric-style box bed bolted to the floor.⁶⁹ The OIG found that the floor in the designated seclusion room on the mental health unit lacked any cushioning, and there was additional furniture (specifically, two chairs) in the room. This could result in harm to patients or staff while in the seclusion room. Facility staff thought they met the requirements and were compliant with the Mental Health EOC checklist.

Recommendation 10

10. The Associate Director ensures the mental health seclusion room flooring provides cushioning.

Facility concurred.

Target date for completion: January 31, 2019

⁶⁹ VHA Mental Health EOC Checklist, December 8, 2016.

Facility response: The in-patient psychiatry unit in collaboration with the Facility's Interior Designer and Facilities Management Department is actively engaged in selecting an appropriate cushioning floor for the seclusion room. The floor is intended to be selected and installed no later than January 31, 2019.

Recommendation 11

11. The Associate Director ensures the furniture in the mental health seclusion room is limited to an appropriate style bed and monitors for compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The In-Patient psychiatry unit will install the approved furniture for the seclusion room no later than December 31, 2018. Monitoring for compliance will occur through the Environment of Care Rounds which is conducted twice annually for every patient care area. Due to the nature of the seclusion room, this area will be inspected at a minimum quarterly by the Interdisciplinary Safety Inspection Team to ensure the seclusion room only contains the approved furniture and no other furniture and/or equipment has been placed into this room. The percentage of inspections where the seclusion room only contains the approved furniture and/or equipment will be monitored for a 90% compliance through the Administrative Oversight Executive Council. Target date is being set to ensure compliance monitoring for two quarters.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.⁷⁰ Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase patient safety issues and elevates the liability risk to healthcare organizations.⁷¹

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.⁷² Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSIs), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.⁷³ The OIG interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;⁷⁴ monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;⁷⁵ CS inspection quarterly trend reports for the prior four quarters;⁷⁶ and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
 - Monthly summary of findings to the Director
 - Quarterly trend report to the Director
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Annual physical security survey of the pharmacy/pharmacies by VA Police

⁷⁰ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (Website accessed on August 21, 2017.)

⁷¹ American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

⁷² VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁷³ VA Office of Inspector General, Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities, Report No. 14-01785-184, June 10, 2014.

⁷⁴ The review period was October 1, 2017, through March 31, 2018.

⁷⁵ The review period was April 1, 2017, through March 31, 2018.

⁷⁶ The four quarters were from April 1, 2017, through March 31, 2018.

- CS ordering processes
- Inventory completion during Chief of Pharmacy transition
- Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
 - Free from conflicts of interest
 - CSC duties included in position description or functional statement
 - Completion of required CSC orientation training course
- Requirements for CSIs
 - Free from conflicts of interest
 - Appointed in writing by the Director for a term not to exceed three years
 - Hiatus of one year between any reappointment
 - Completion of required CSI certification course
 - Completion of required annual updates and/or refresher training
- CS area inspections
 - Completion of monthly inspections
 - Rotations of CSIs
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of CS orders
 - Performance of CS inspections by CSIs
- Pharmacy inspections
 - Monthly physical counts of the CS in the pharmacy by CSIs
 - Completion of inspections on day initiated
 - Security and documentation of drugs held for destruction⁷⁷
 - Accountability for all prescription pads in pharmacy

⁷⁷ The “Destructions File Holding Report” lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG found that prior to January 2018, the CS program was not compliant with VHA requirements. A new CSC and alternate CSC were assigned in January 2018, and the OIG found that improvements were evident starting in February 2018, with general compliance noted with requirements for CSC reports, CSC and CSI training, and pharmacy inspections. However, the OIG found lack of corrective actions for identified annual physical security survey findings, inadequate restriction of staff involved in monthly reviews of inventory balance adjustments, failures to include CSC duties in functional statements or position descriptions, and no reconciliation of stock returned to the pharmacy. These deficiencies warranted OIG recommendations for improvement.

Annual Physical Security Survey

VHA requires that the Chief of VA Police follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.⁷⁸ This ensures security of medication stored in the pharmacy. The Facility's 2018 annual physical security survey, conducted in October 2017, identified 14 deficiencies. The Chief of Pharmacy was unable to provide evidence that 11 of 14 deficiencies were addressed or corrected, which could result in the loss or theft of controlled substances. It was reported to the OIG that due to pharmacy leadership transitions in the prior two years, the deficiencies were not fully evaluated or addressed.

Recommendation 12

12. The Facility Director ensures that all deficiencies identified on the Annual Physical Security Survey are addressed or corrected and monitors compliance.

⁷⁸ VHA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The Annual Physical Security Survey was completed by Police Service and a remediation plan has been established in collaboration with Pharmacy Service. The facility is working through a vendor to implement additional security controls in order to ensure that the pharmacy is secure in accordance with VA Police Standards. Evidence of compliance will be 100% completion of all identified deficiencies. Police Service will re-survey the Pharmacy Service and will submit a report to the Administrative Oversight Executive Council on the status on all identified deficiencies after the completion of the implementation plan. The Administrative Oversight Executive Council will monitor the status of the plan through development to completion.

Restriction of Staff Involved in Inventory Balance Adjustments

VHA requires that the pharmacy staff assigned to monitor controlled substance inventory balance adjustments differ from the staff who perform and document the balance adjustments.⁷⁹ This minimizes an opportunity for CS diversions. The OIG found four pharmacy staff that monitored balance adjustments also had electronic access to perform CS balance adjustments, which increases the potential for CS diversions. Pharmacy leaders were not aware that the electronic access was to be limited.

Recommendation 13

13. The Facility Director ensures that electronic access for performing or monitoring controlled substance balance adjustments is limited to appropriate staff and monitors compliance.

⁷⁹ VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: June 30, 2019

Facility response: As part of the controlled substance inspection report the controlled substance coordinator will report on the names of the staff who have the VISTA keys which allow for entering balance adjustments. The Pharmacy Service will establish a standard operating procedure surrounding which roles in the Pharmacy Service are issued these specific keys no later than November 15, 2018 and will submit an electronic report on who has access to these VISTA keys monthly to the Controlled Substance Coordinator. This report will be incorporated into the monthly Controlled Substance Coordinators report to the Quality, Safety, Value Council. Monthly compliance will be 100% validation that only those roles identified in the pharmacy's SOP have access to this security key. Target date is being set to ensure compliance monitoring for two quarters.

Controlled Substance Coordinator Duties

VHA requires that the CSC and Alternate CSC duties be included in the employee's position description or functional statement. These duties may be added as an addendum to the job description.⁸⁰ This ensures that CSC tasks are assigned and clearly communicated and that the coordinator(s) are given appropriate time to adequately complete the required duties. The OIG found that the CSC and Alternate CSC's position description or functional statement did not include CSC duties. This could result in unclear communication of assigned duties and expectations. The CSC reported this as an administrative oversight.

Recommendation 14

14. The Facility Director ensures that the duties of the Controlled Substance Coordinator and Alternate Controlled Substance Coordinator are included in the employees' position description or functional statement.⁸¹

⁸⁰ VHA Directive 1108.02(1).

⁸¹ The OIG reviewed sufficient evidence that the facility had completed improvement actions and considered this recommendation closed prior to publication of this report.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: The Chief of Quality, Safety, and Value revised the functional statement of the Quality, Safety, Value Consultant Registered Nurse to include a statement that from this cadre of nursing staff a Controlled Substance Coordinator and alternate will be appointed. The duties for this position will be outlined in a designation memorandum which will be placed in the nurse's competency folder.

Reconciliation of Return of Stock

VHA requires CS program staff to reconcile the distribution (restocking/refilling) of CS to every automated dispensing cabinet and one random day's return of expired or overstock of CS to pharmacy.⁸² This reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with returning CS. The OIG found that CS reconciliations of the returns to pharmacy stock had not occurred in any of the 10 CS areas for the six months of CS inspection reports reviewed.⁸³ The reason for noncompliance was that the requirement was overlooked by the newly assigned CSC when program changes were made in January 2018.

Recommendation 15

15. The Facility Director ensures that a reconciliation of controlled substance return to pharmacy stock is performed during controlled substance inspections and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: As part of the controlled substance inspection report the controlled substance coordinator will ensure that a reconciliation of controlled substance return to pharmacy stock is performed during all inspections. This is reported monthly to the Quality, Safety, Value Council. Monthly compliance will be 90% or greater completion rate of performing this reconciliation.

Target date is being set to ensure compliance monitoring for two quarters.

⁸² VHA Directive 1108.02(1).

⁸³ November 2017 through April 2018.

Mental Health: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur “following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one’s physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate.”⁸⁴ For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.⁸⁵

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.⁸⁶ VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient’s PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.⁸⁷

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 31 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

⁸⁴ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

⁸⁵ VHA Handbook 1160.03.

⁸⁶ A PTSD screen is not required if the patient received a PTSD diagnosis in an outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

⁸⁷ Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Long-Term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.⁸⁸ As a group, veterans experience more chronic disease and disability than their nonveteran peers. VA must plan for the growing health demands by aging veterans and have mechanisms in place for delivering those services in an appropriate and cost-effective manner.⁸⁹ Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.⁹⁰

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.⁹¹ This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.⁹² Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.⁹³

In determining whether the Facility provided an effective geriatric evaluation, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the EHRs of 25 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to GE
- Program oversight and evaluation
 - Evidence of GE program evaluation
 - Evidence of performance improvement activities through leadership board
- Provision of clinical care
 - Medical evaluation by GE provider
 - Assessment by GE nurse

⁸⁸ VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

⁸⁹ VHA Directive 1140.04.

⁹⁰ Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

⁹¹ Public Law 106-117.

⁹² VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

⁹³ VHA Directive 1140.04.

- Comprehensive psychosocial assessment by GE social worker
- Patient or family education
- Plan of care based on GE
- Geriatric management
 - Implementation of interventions noted in plan of care

Conclusion

Generally, the OIG noted compliance with provision or access to GE, provision of care, development of plans of care, and implementation of interventions in plans of care when indicated. However, the OIG identified a deficiency in program oversight.

Program Oversight and Evaluation

VHA requires that GE performance improvement activities be coordinated with Quality Management and reviewed by the leadership board responsible for oversight of all performance improvement activities at the Facility.⁹⁴ This ensures that the leadership team reviews GE data and provides the opportunity to identify practice improvements, ensures appropriate actions were taken, and measures the effectiveness of actions on a regular basis. The OIG reviewed Quality Council minutes from March 2017 through March 2018 and did not find evidence that performance activities were reported to the committee.⁹⁵ Absence of reporting performance improvement activities to the leadership board may cause delays in addressing GE issues and implementing appropriate action plans. The Chief of Geriatrics & Extended Care and QSV staff reported to the OIG that due to multiple senior and quality leadership changes, the GE performance improvement activities were not presented at the Quality Council meetings.

Recommendation 16

16. The Chief of Staff ensures that the geriatric evaluation performance improvement activities are reviewed by the appropriate leadership board and monitors compliance.

⁹⁴ VHA Directive 1140.04.

⁹⁵ VHA Directive 1140.11.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The Geriatric and Extended Care Service will develop a comprehensive data management plan along with development of performance improvement activities associated with the need to improve performance. This plan and all subsequent data associated with the Geriatrics and Extended Care Program will be discussed quarterly at the Medical Executive Council with a focus on those areas which require improvement. Evidence of compliance will be 100% completion of the data review at the Medical Executive Council meeting for a minimum of two quarters.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.⁹⁶ Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.⁹⁷ The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.⁹⁸

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.⁹⁹

The OIG examined whether the Facility complied with particular VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The OIG also reviewed the EHRs of 48 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient
- Performance of follow-up mammogram if indicated

⁹⁶ U.S. Breast Cancer Statistics. <http://www.BreastCancer.org>. (Website accessed on May 18, 2017.)

⁹⁷ VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011. (This handbook was rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.)

⁹⁸ Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

⁹⁹ VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended July 24, 2018, and further amended July 24, 2018).

- Performance of follow-up study

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.¹⁰⁰ Central lines “refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,”¹⁰¹ central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.¹⁰²

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a “primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site.”¹⁰³

Infections occurring on or after the third calendar day following admission to an inpatient location are considered “healthcare-associated.”¹⁰⁴ The patient’s age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.¹⁰⁵

The OIG’s review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The OIG also reviewed the training records of 19 clinical employees involved in inserting and/or managing central lines.

The OIG evaluated the following performance indicators:

¹⁰⁰ TJC. Infection Prevention and Control standard IC.01.03.01.

¹⁰¹ Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

¹⁰² These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

¹⁰³ The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

¹⁰⁴ The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

¹⁰⁵ Association for Professionals in Infection Control and Epidemiology, 2015.

- Presence of Facility policy on the use and care of central lines
- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

Generally, the OIG noted that Facility staff had a policy for the use and care of central lines, performed an annual risk assessment, reviewed and discussed CLABSI data, provided patient education, and used a checklist for insertion and maintenance of central lines. The Facility has also made recent improvements to their program to reduce CLABSI. In FY 2017, the Infection Prevention staff noted that the Facility's CLABSI rates had increased in FY 2016 and FY 2017 and were also greater than the national rate. Upon review, the Facility Infection Prevention staff identified that half of the infections were related to Peripherally Inserted Central Catheters,¹⁰⁶ which are inserted and maintained by the intravenous (IV) team. Additionally, the OIG identified the following deficiency in staff education that warranted a recommendation for improvement.

CLABSI Staff Training

TJC requires that staff involved in managing (inserting and maintaining) central lines receive CLABSI and infection prevention education upon hire and periodically thereafter as determined by the organization.¹⁰⁷ This ensures that involved staff are aware of what is necessary to prevent central line infections. The OIG found no evidence of the required training for 5 of 19 selected employees. The reasons provided for noncompliance by the Associate Chief Nurse for Nursing Education and Research were that three staff members assigned to the IV team received a “one-time review at the time of hire to ensure their skills meet the requirements of the position,” but the Nurse Manager responsible for the IV Team had no records of initial CLABSI prevention training or any subsequent training. Furthermore, the ED Nurse Manager reported that the two ED staff members did not receive training due to lack of oversight.

¹⁰⁶ Peripherally inserted central catheters are a form of intravenous access that can be used for a prolonged period of time.

¹⁰⁷ TJC. National Patient Safety Goals standard NPSG.07.04.01.

Recommendation 17

17. The Associate Director for Patient Care Services ensures that all registered nurses involved in the insertion and/or management of central lines receive the required central line-associated bloodstream infection and infection prevention education and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2019

Facility response: Nursing Service will develop and implement standardized education and training regarding central line-associated blood stream infection and prevention education for all registered nurses who insert and manage central lines no later than December 31, 2018. The training will be completed no later than January 31, 2019. The completed training will be documented in the nursing staff's Talent Manager System (TMS) profile. All new nursing staff attend nursing orientation which includes a session on prevention of central line-associated bloodstream infection and infection prevention education. Evidence of compliance will be reported to the Quality, Safety, Value Council with an expected completion rate of greater than 90% for the existing staff and compliance of 100% for new nurses.

Incidental Finding

In July 2016, VISN 5 conducted a Clinical Quality Review of the Washington DC VA Medical Center. A recommendation was made to “eliminate the backlog of documents waiting to be scanned into the medical record.” The action plan outlined steps to obtain contractors to assist with reducing the scanning backlog.

Patient Safety: Medical Record Scanning Backlog

VHA requires timely filing or scanning of reports into patients’ EHRs.¹⁰⁸ The OIG found that 1,550 inches of patient reports dating back to 2014 had not been scanned into the EHR system. This prevented healthcare providers from accessing patient results to perform a comprehensive evaluation of the patients’ healthcare needs and provide timely quality care. According to the Acting QSV Chief, the Facility submitted contracting packets to the Veteran Service Center Personnel Security Office on April 16, 2017, so that procedures could be followed to protect the privacy and security of patient information.¹⁰⁹ The facility awarded contracts to seven companies to scan backlogged documents into the EHR in January 2018; however, the administrative processing of contracted staff caused further delays. Only after the Facility contacted the National Contracting Office for their assistance did the VISN Contracting Officer approve and submit the contract for processing by the Veteran Service Center on April 11, 2018. As of the May 2018 OIG visit, the contractors were apparently still unable to access the EHR system to commence scanning the documents.

Recommendation 18

18. The Facility Director ensures the Chief of Health Information Management facilitate the timely scanning of clinical reports into the electronic health record and monitors compliance.

¹⁰⁸ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

¹⁰⁹ The Veteran Service Center Personnel Security Office ensure that contractor security requirements are met in accordance with Office of Personnel Management and other federal regulations through processes that include fingerprint submission and adjudication, verification and reciprocity of existing investigations, requesting new investigations, and management and sponsorship of personnel identity verification badges.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The Facility currently has 940 inches of a backlog of clinical reports that need to be scanned into the electronic medical record. The facility has assessed and catalogued the backlog and determined that 800 inches are identified as having no impact to patient care as these documents are adjunctive to the care that has been provided to the acute in-patient. For example, the 800 inches includes copies of discharge instructions where the patient signed the document. The discharge instructions are generated from the Electronic Medical Record, so the medical information is already a part of the Medical Record. The remaining 140 inches of backlog includes copies of community care reports which were assessed by a registered nurse when the report was received by the facility, but these reports were not actively scanned when they were received. The 140 inches have been identified as the priority portion of the backlog to be scanned into the Medical Record. The facility is utilizing additional resources within the Medical Center to reduce the backlog. The facility has employed two contracted staff who are responsible for scanning all generated documents once the document has been created and scanning these records. The Care in the Community records which are sent from community providers to the Medical Center are scanned immediately upon receipt by the Care in the Community staff to ensure no additional backlog is created with these types of records. To reduce the 140 inches of backlog, the Medical Center will reduce a total of 25 inches per month. This process will be monitored by the facility Records Manager through the completion of a monthly audit to assess the total number of inches remaining of the backlog. This report will be presented to the Quality, Safety, Value Council on a monthly basis beginning December 2018 and monitored until elimination of the backlog of the community care reports.

Appendix A: Summary Table of the OIG Rapid Response Team's Review Findings

In a separate, but coordinated effort with the CHIP team, the Office of Inspector General (OIG) deployed a Rapid Response Team (RRT) to the Facility from May 21–25, 2018, to follow up on specific concerns related to the OIG's previously issued recommendations in the report *Critical Deficiencies at the Washington, DC VA Medical Center (Critical Deficiencies)* that was released in March 2018.¹¹⁰ That report concluded that the Facility suffered a series of systemic and programmatic failures that made it challenging for healthcare providers to consistently deliver timely and quality patient care and made 40 recommendations to improve operations. Those recommendations addressed supply and equipment availability, sterile storeroom cleanliness, and unresolved prosthetics consults, among other identified problems.

The purpose of the May 2018 OIG RRT inspection was to assess the remediation status of selected deficient conditions that could directly impact patient care and safety. While all 40 of the report's recommendations will be tracked quarterly in accordance with OIG follow-up practices, the OIG RRT focused on spot-checking the areas of concern listed in the following table.

Table A.1. Follow-Up from the March 2018 *Critical Deficiencies* Report

OIG Areas of Concern	Associated Recommendation Number
Availability of Supplies	1
Patient Safety and Other Quality, Safety, and Value Activities	5, 6
Cleanliness of Clean/Sterile Storerooms ¹¹¹	8
Sterile Processing Service Activities	10, 11, 12, 13, 14, 15
Prosthetics Consults	17
Human Resource Leadership and Staffing Activities	19, 20
Medication Management and Other Pharmacy-Related Issues	None ¹¹²

Source: VA OIG RRT

¹¹⁰ VA Office of Inspector General, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018, <https://www.va.gov/oig/pubs/VAOIG-17-02644-130.pdf>.

¹¹¹ This refers to the status of clean and sterile storerooms across the facility and was reviewed in conjunction with the CHIP team.

¹¹² OHI conducted preliminary on-site work on several pharmacy and medication management-related allegations in 2017. The Facility had already begun corrective actions, so this *Critical Deficiencies* report follow-up did not include recommendations in these areas.

The OIG RRT inspected clean/sterile storerooms and other supply storage areas; interviewed clinicians, managers, and Facility leaders; reviewed Facility policies, meeting minutes, quality management documents, competency data, and consult information; and evaluated Facility staffing and other human resource (HR)-related activities. The OIG RRT reviewed several patients' electronic health records to assess quality of care.

Summary of RRT Findings

The OIG RRT conducted the site visit to ensure that positive actions were being taken and patient safety concerns were being addressed. The OIG RRT found substantial improvements in some previously deficient areas and minimal improvement in others. In most areas reviewed, however, the OIG RRT found that corrective actions had thus far resulted in moderate improvements. Because less than three months had elapsed from the release date of the March 2018 *Critical Deficiencies* report to the OIG's subsequent site visit to the Facility, not enough time had elapsed to evaluate the corrective actions beyond determining whether efforts seemed to be heading in the right direction or appeared stalled.

This report does not address all of the areas reviewed by the OIG RRT related to the issue areas listed in Table 7; rather, it describes several examples of the Facility leaders' compliance and corrective actions as of the May 2018 site visit.

Substantial Improvements

Availability of Supplies

The early March 2018 *Critical Deficiencies* report referenced a range of examples in which patients were put at risk because of the lack of immediate access to supplies. These included the unavailability of laparoscope testing supplies, dialysis bloodlines, oxygen nasal tubing, and other significant items. That report further noted that “[o]f 30 healthcare providers interviewed, at least 24 reported having had problems with supplies, instruments, or equipment.”

In late May 2018, 50 of 55 (91 percent) clinicians and managers interviewed by OIG RRT members said that the availability of supplies had improved. Further, the OIG RRT found adequate stock of previously reported shortages, including

- Testing supplies for insulation of laparoscopes,
- Bloodlines for dialysis,
- Oxygen nasal cannulas,
- Vascular patches,
- Sequential compression devices,
- Biopsy guns, and
- Disposable surgical staplers.

Prosthetic Consults

The *Critical Deficiencies* report noted that more than 10,000 prosthetic consults were open or pending as of March 31, 2017. As of May 23, 2018, the backlog of prosthetic consults had been reported as eliminated. No prosthetic consults were pending 30 days or more. There were 461 pending prosthetic consults, of which 372 were pending 0–5 days, 76 were pending 6–9 days, and 13 were pending 10–29 days. The Facility was able to achieve these results by hiring a permanent Service chief and nearly doubling the Prosthetics Service staff, and by rearranging the way in which incoming consults were reviewed, worked, and dispositioned. The OIG closed this recommendation related to prosthetic consults.¹¹³

Minimal Improvements

Patient Safety

The *Critical Deficiencies* report demonstrated that the Patient Safety Manager was not consistently scoring the Severity Assessment Code (SAC) for patient safety events in accordance with Veterans Health Administration (VHA) policy. Moreover, the *Critical Deficiencies* report stated that of the 376 patient safety events related to supplies, instruments, or equipment, 146 were not scored, and the remainder were not SAC scored higher than 1.¹¹⁴ Because VHA policy does not require further review of incidents with a SAC score of 1, opportunities to improve patient safety could have been missed.

The OIG RRT found that 416 of 419 (99 percent) patient safety events reviewed during its May 2018 site visit were scored as a 1.¹¹⁵ However, the OIG RRT identified four events that were scored as a 1 that the team felt warranted a SAC score of 2. While in three instances, the patients may not have experienced adverse outcomes, systems issues were present that warranted further review. In the fourth case, the patient's provider did not order anticoagulant medication after a coronary artery bypass graft surgery. One week later, the patient was re-admitted to the Facility with a diagnosis of pulmonary embolism—a life-threatening condition that could have been related to the lack of the appropriate anticoagulation medication. The OIG RRT notified the Facility's Quality Manager about this patient and the possible need for further evaluation.

¹¹³ The OIG closed recommendation 17 on July 13, 2018, after receipt of VA's first quarterly status report.

¹¹⁴ VHA Handbook 1050.01, "When a severity category is paired with a probability category for either an actual event or close call, a ranked matrix score (3=highest risk, 2=intermediate risk, 1=lowest risk) results. These ranks, or SACs, can then be used for doing comparative analysis and deciding who needs to be notified about the event."

¹¹⁵ The OIG included all events (not just supplies, instruments, and equipment) that were closed in FY 2018 through May 21, 2018.

Sterile Processing Service

The *Critical Deficiencies* report identified multiple problems with Sterile Processing Service (SPS) staff competencies that included expired or undated competencies, lack of documentation regarding required training, and competencies not consistently updated to keep pace with manufacturer's issuance of instructions. While conditions improved over the course of the initial review, the March 2018 recommendation focused on inappropriate and outdated SPS staff competencies.

The OIG RRT noted during its May 2018 site visit that SPS standard operating procedures and competencies were under review and were being incorporated into the competency grids following approval. While SPS competencies were a work in progress, the process appeared to be more organized and compliant with VHA policy.¹¹⁶

The *Critical Deficiencies* report noted that as of August 2017, the electronic loaner (borrowed) instrument tracking system had been purchased and implemented.¹¹⁷ It was not accessible, however, for several reasons, including that an information security issue was reported; staff had not completed a business justification needed for approval to access the non-VA system; and the vendor had not been paid. Instead of using the electronic tracking system, SPS staff were using a paper log to track loaner trays.

During a follow-up contact with SPS leaders in August 2018, the OIG was told that the loaner tracking system had been implemented and progress made; however, some SPS staff were still using a paper log to track loaner instruments.

HR

The *Critical Deficiencies* report documented that high turnover rates in HR leadership may have contributed to the failures of the Facility to resolve a variety of issues. From January 2012 through July 2017, the Facility had 10 HR Chiefs in a combination of acting and permanent capacities.

In late May 2018, the acting Facility Director described the HR department as his most "problematic" Service. The Veterans Integrated Service Network 5 HR Officer was detailed as the Facility's HR Chief, and reportedly, two of the three HR supervisor positions were vacant.

Also, in May 2017, the acting Associate Director at that time told OIG inspectors that a position management review, which included justification of departmental organization charts and

¹¹⁶ VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.

¹¹⁷ From the *Critical Deficiencies* report, page 35: "When [Facility] staff know in advance that they do not have the instruments they need for a certain procedure, they may borrow specialized instruments from vendors or other sources." "Loaner instruments are considered nonsterile and must be received, inspected, recorded, decontaminated, and sterilized in SPS."

validation of authorized and actual staff positions, would be completed in 2017. However, the *Critical Deficiencies* report stated, “[t]o...determine where key vacancies and gaps existed, the OIG requested a complete list of authorized positions. The [Facility’s] Fiscal Service was unable to provide the requested information because of inaccurate organizational charts.”

At the time of the May 2018 OIG RRT site visit, the organizational charts with proposed positions had not been completed, although due on the last day of the spot inspection.¹¹⁸

Status of Remaining Recommendations

As of May 24, 2018, the Facility was taking reasonable actions to address the remaining recommendations outlined in Table 7. In most areas, conditions were improving. For example, staffing had improved in Logistics and SPS, relevant committees had reengaged, and processes appeared to be focused on fixing the problems rather than responding to crises.

As of October 10, 2018, the Facility and VHA submitted updates reflecting additional corrective actions and progress in implementing recommendations. Based on this information, the OIG was able to close recommendation 13 from *Critical Deficiencies*, and six additional recommendations that address issues beyond those identified by the inspections discussed in this report.¹¹⁹

As many of the problems and corrective actions are complex, more work and time is needed to gauge progress and sustainability of improvements relative to the remaining recommendations.

Conclusion

Since publication of the March 2018 *Critical Deficiencies* report, the Facility has made substantial improvements in several areas, including the availability of supplies and eliminating the backlog of prosthetic consults. Improvements have been slow to take shape in some HR and SPS-related functions and areas. Largely, though, the OIG RRT found that corrective actions were being implemented and progress was being made in implementing OIG recommendations. Additional time and oversight is needed to fully evaluate whether those actions have been effective in addressing and remediating the deficient conditions.

¹¹⁸ The organizational charts were due to HR on Friday, May 25, 2018, the day the OIG RRT left the site.

¹¹⁹ Recommendation 13 states, “The Medical Center Director verifies that SPS managers maintain an accurate Master List for reusable medical equipment and file copies of manufacturer’s instructions as required by VHA policy.” The other six recommendations that have been closed were related to information privacy, follow-up of an NPOSP site visit, and nonclinical audit findings.

Appendix B: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data 	Eighteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs 	<ul style="list-style-type: none"> • Recommended actions from peer reviews and RCAs are implemented and monitored for improvement. 	<ul style="list-style-type: none"> • Staff complete at least 75 percent of all inpatient admissions and continued stay reviews. • An interdisciplinary Facility group reviews UM data. • The Patient Safety Manager provides feedback of RCA results to the reporting individuals or departments.
Credentialing and Privileging	<ul style="list-style-type: none"> • Medical licenses • Privileges • FPPEs • OPPEs 	<ul style="list-style-type: none"> • FPPEs and OPPEs are completed and the Professional Standards Board reviews these evaluations in the consideration to continue provider privileges. 	<ul style="list-style-type: none"> • None
Environment of Care	<ul style="list-style-type: none"> • Parent Facility <ul style="list-style-type: none"> ◦ EOC rounds and deficiency tracking ◦ Infection prevention 	<ul style="list-style-type: none"> • Safety and infection prevention processes are in 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies ● CBOC <ul style="list-style-type: none"> ○ General safety ○ Medication safety and security ○ Infection prevention ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies ● Locked Mental Health (MH) Unit <ul style="list-style-type: none"> ○ Biannual MH EOC rounds ○ Nursing station security ○ Public area and general unit safety ○ Patient room safety ○ Infection prevention ○ Availability of medical equipment and supplies ● Emergency Management <ul style="list-style-type: none"> ○ Hazard Vulnerability Analysis (HVA) ○ Emergency Operations Plan (EOP) ○ Emergency power testing and availability 	<p>place at construction sites.</p> <ul style="list-style-type: none"> ● Nursing staff dispose of expired or unsealed supplies. ● A safe and clean environment is maintained throughout the Facility. ● Applicable equipment is inspected and identified as safe for patient use. ● The MH seclusion room flooring provides cushioning. ● Furniture in the MH seclusion room is limited to an appropriate style bed. 	
Medication Management	<ul style="list-style-type: none"> ● CSC reports ● Pharmacy operations ● Annual physical security survey ● CS ordering processes 	<ul style="list-style-type: none"> ● Deficiencies identified on the Annual Physical Security Survey are addressed or corrected. ● Electronic access for performing or 	<ul style="list-style-type: none"> ● The duties of the CS Coordinator and Alternate CS Coordinator are included in the employees' position description or functional statement.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections 	<ul style="list-style-type: none"> monitoring CS balance adjustments is limited to appropriate staff. • Reconciliation of CS return to pharmacy stock is performed during CS inspections. 	
Mental Health: Posttraumatic Stress Disorder Care	<ul style="list-style-type: none"> • Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Long-Term Care: Geriatric Evaluations	<ul style="list-style-type: none"> • Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Geriatric evaluation performance improvement activities are reviewed by an appropriate leadership board.
Women's Health: Mammography Results and Follow-Up	<ul style="list-style-type: none"> • Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
High-Risk Processes: Central Line-associated Bloodstream Infections	<ul style="list-style-type: none"> • Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Registered nurses involved in the insertion and/or management of central lines receive the required central line-associated bloodstream infection and infection prevention education.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Incidental Finding	<ul style="list-style-type: none">• None	<ul style="list-style-type: none">• Clinical reports are scanned in a timely manner into the EHR.	<ul style="list-style-type: none">• None

Appendix C: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this highest complexity (1a) affiliated Facility reporting to VISN 5.¹²⁰

**Table C.1. Facility Profile for Washington (688)
(October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015 ¹²¹	Facility Data FY 2016 ¹²²	Facility Data FY 2017 ¹²³
Total Medical Care Budget Dollars	\$570,944,564	\$585,375,223	\$610,845,284
Number of:			
• Unique Patients	72,717	73,674	72,868
• Outpatient Visits	761,946	762,583	714,188
• Unique Employees ¹²⁴	2,219	2,102	2,140
Type and Number of Operating Beds:			
• Community Living Center	120	120	120
• Intermediate	26	26	26
• Medicine	73	73	73
• Mental Health	28	28	28
• Neurology	8	8	8
• Surgery	40	40	40
Average Daily Census:			
• Community Living Center	87	92	93
• Intermediate	12	17	16
• Medicine	61	66	72
• Mental Health	22	19	17

¹²⁰ The VHA medical centers are classified according to a facility complexity model. The “1a” designation indicates a Facility with high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs. “Affiliated” means the Facility is associated with a medical residency program.

¹²¹ October 1, 2014, through September 30, 2015.

¹²² October 1, 2015, through September 30, 2016.

¹²³ October 1, 2016, through September 30, 2017.

¹²⁴ Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2015 ¹²¹	Facility Data FY 2016 ¹²²	Facility Data FY 2017 ¹²³
• Neurology	4	4	3
• Surgery	18	18	14

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

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

VA Outpatient Clinic Profiles¹²⁵

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 9 provides information relative to each of the clinics.

Table C.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)¹²⁶

Location	Station No.	PC Workload/Encounters	Mental Health Workload/Encounters	Specialty Care Services ¹²⁷ Provided	Diagnostic Services ¹²⁸ Provided	Ancillary Services ¹²⁹ Provided
Fort Belvoir, VA	688GA	12,272	6,562	Dermatology Gastroenterology Poly-Trauma Anesthesia General Surgery	n/a	Pharmacy Weight Management Nutrition
Washington, DC	688GB	2,011	560	Dermatology Poly-Trauma	n/a	Nutrition

¹²⁵ Includes all outpatient clinics in the community that were in operation as of February 15, 2018.

¹²⁶ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

¹²⁷ Specialty care services refer to non-PC and non-mental health services provided by a physician.

¹²⁸ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

¹²⁹ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

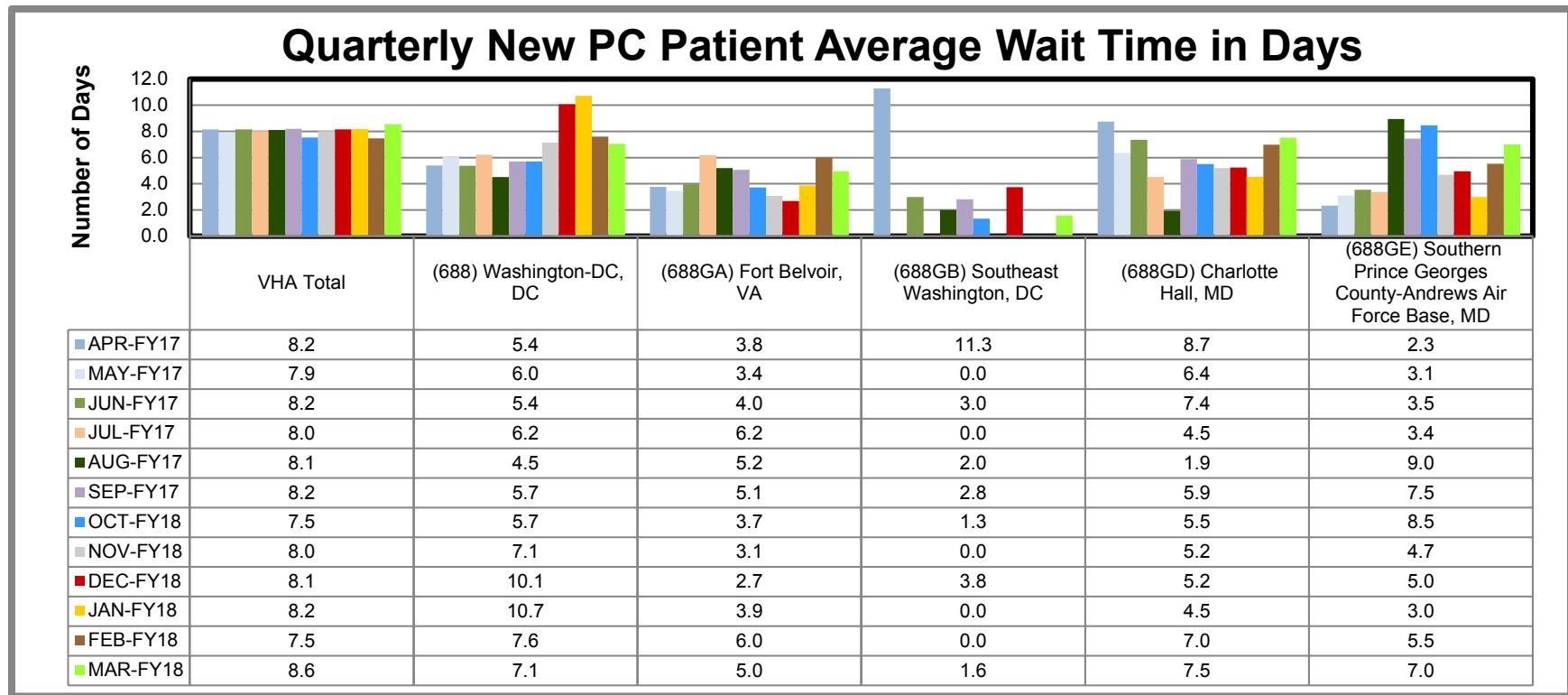
Location	Station No.	PC Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹²⁷ Provided	Diagnostic Services ¹²⁸ Provided	Ancillary Services ¹²⁹ Provided
Charlotte Hall, MD	688GD	9,298	3,342	Cardiology Dermatology Endocrinology Hematology/ Oncology Poly-Trauma Rehab Physician	n/a	Pharmacy Prosthetics Social Work Nutrition
Camp Springs, MD	688GE	10,741	4,971	Cardiology Dermatology Gastroenterology	EKG	Weight Management Dental Nutrition
Washington, DC	688QA	1,082	249	n/a	n/a	n/a

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix D: Patient Aligned Care Team Compass Metrics¹³⁰



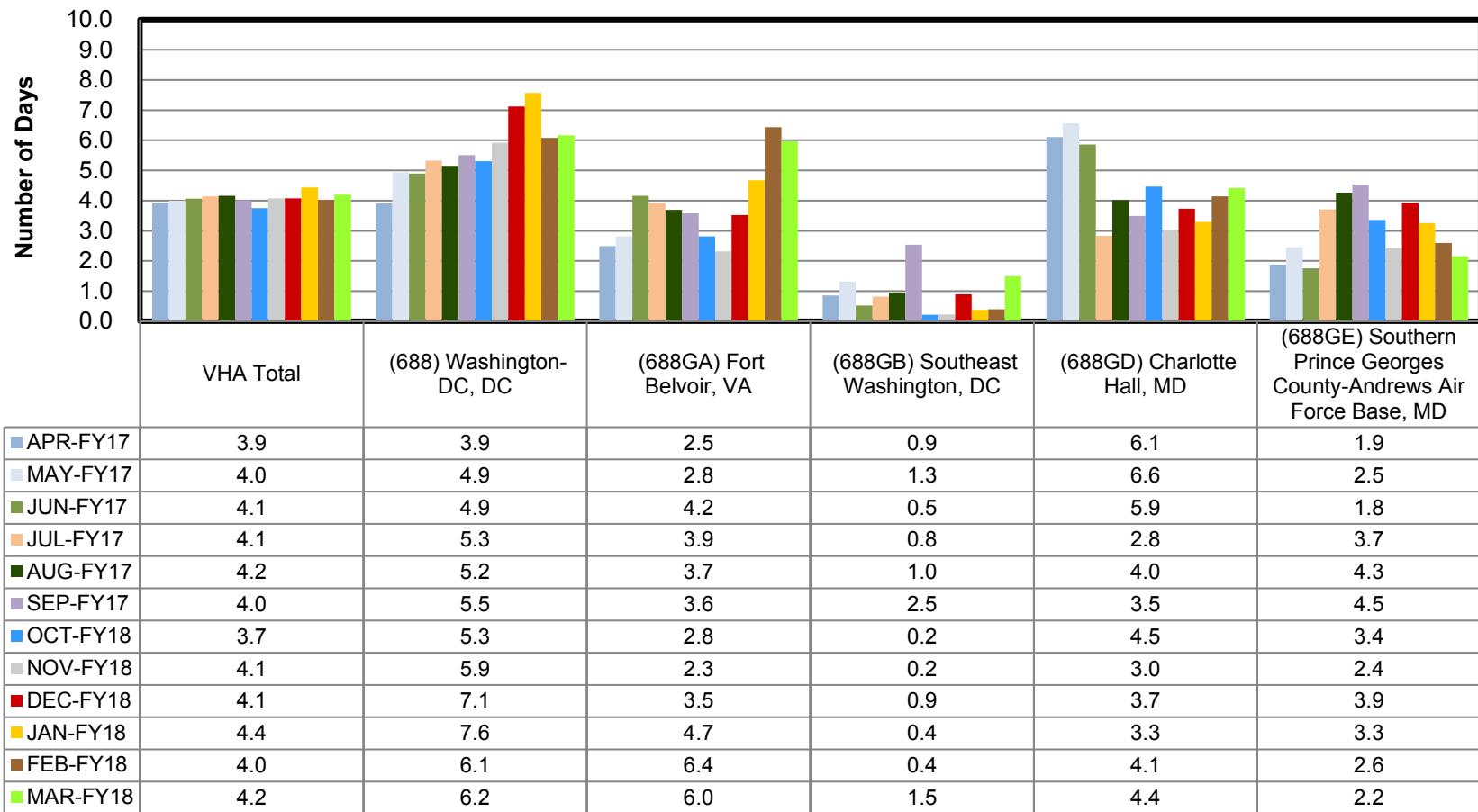
Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Franklin Street VA Clinic, DC (688QA), as no data was reported.

Data Definition: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY 2015, this metric was calculated using the earliest possible create date.

¹³⁰ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

Quarterly Established PC Patient Average Wait Time in Days

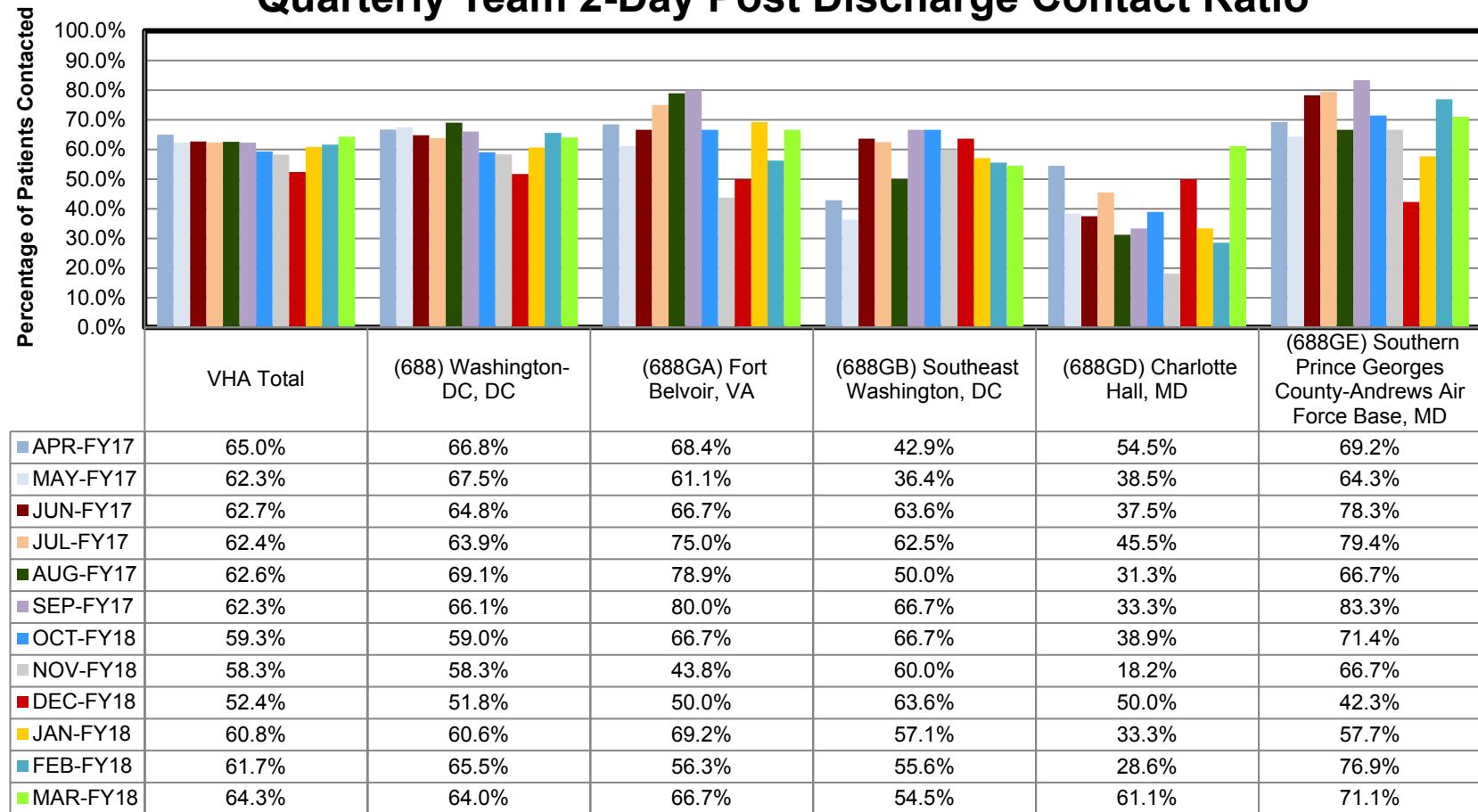


Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Franklin Street VA Clinic, DC (688QA), as no data was reported.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.

Quarterly Team 2-Day Post Discharge Contact Ratio

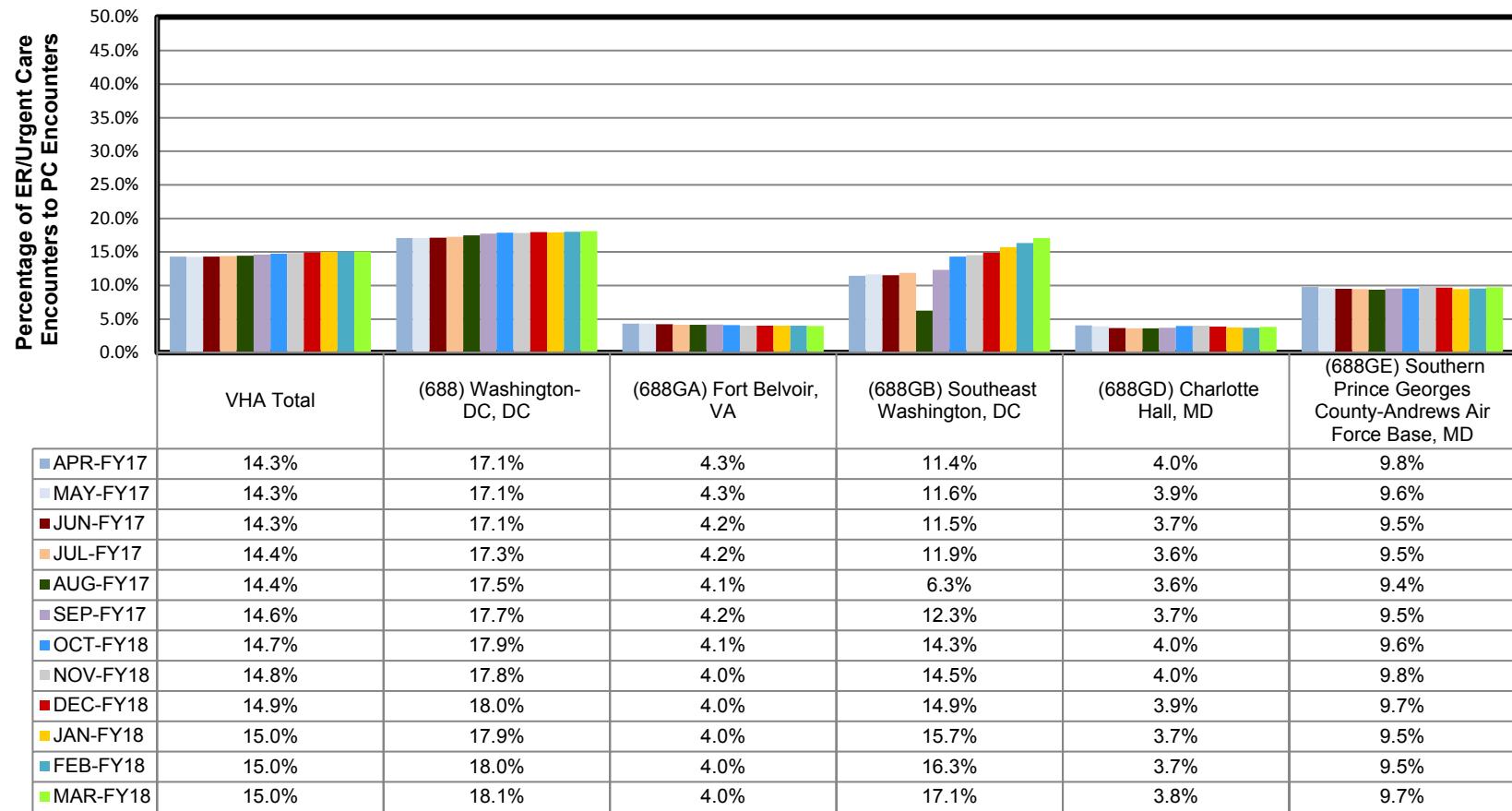


Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Franklin Street VA Clinic, DC (688QA), as no data was reported.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within two business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within two business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17".

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)



Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Franklin Street VA Clinic, DC (688QA), as no data was reported.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a LIP divided by the number of PC Team Encounters WOT with an LIP plus the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹³¹

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value

¹³¹ VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
HC Assoc Infections	Healthcare associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix F: Acting VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 7, 2018

From: Acting Director, VA Capitol Health Care Network (10N5)

Subj: CHIP Review of the Washington DC VA Medical Center

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center in Washington D.C. Further, I have reviewed and concur with the Washington DC VAMC Medical Center Director's response.
2. Thank you for this opportunity to focus on continuous performance improvement. If you have any questions, please contact the VISN 5.

(Original signed by:)

Raymond Chung, M.D.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix G: Acting Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 7, 2018

From: Acting Director, Washington DC VA Medical Center (688/00)

Subj: CHIP Review of the Washington DC VA Medical Center

To: Acting Director, VA Capitol Health Care Network (10N5)

1. Thank you to the CHIP Healthcare Inspection Team for the professional review of the organization that was completed. I have reviewed the draft report and concur with the findings and recommendations.
2. Attached are the facility responses to the eighteen (18) recommendations, including actions that are in progress to correct the identified opportunities for improvement.

(Original signed by:)

Michael S. Heimall

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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