DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics

HEALTHCARE INSPECTION | REPORT #18-04633-254 | AUGUST 14, 2018

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Executive Summary

The VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection after an OIG Comprehensive Healthcare Inspection Program (CHIP) review identified several significant environment of care (EOC) deficiencies at the McComb Community Based Outpatient Clinic (CBOC) on May 23, 2018. The purpose of the inspection was to assess EOC conditions at the remaining six contract CBOCs under the auspices of the G.V. (Sonny) Montgomery VA Medical Center (Facility) in Jackson, Mississippi.

On May 30, three OIG teams conducted unannounced inspections at the Columbus, Greenville, Hattiesburg, Kosciusko, Meridian, and Natchez, Mississippi CBOCs. OIG inspectors did not identify deficiencies related to general privacy requirements or the availability of medical equipment and supplies. The OIG inspectors found general safety, medication safety and security, infection prevention and environmental cleanliness, and information technology deficiencies. While OIG inspectors did not find that those conditions placed patients or staff at risk, corrective actions were needed to ensure a clean, healthy, and safe environment for patients and staff.

In addition, the OIG team found inconsistencies between the requirements for Veterans Health Administration oversight as described in the respective CBOC contracts, the Contracting Officer's Representative (COR) expectations, and Facility managers' approach to CBOC site visits. Specifically, the contracts require audits pertaining to access, quality improvement, documentation, safety and performance measures be submitted to the COR on a monthly basis. However, the Facility's CBOC Coordinator, who is also the COR, told the OIG team that the audit reports should be sent quarterly.

With the exception of Kosciusko, the contracts also state that "VA shall inspect the Contractor's facility" and that a list of any deficiencies identified during inspection will be provided to the Contractor along with a required date for correction of the deficiencies. Reportedly, Facility staff try to visit each of the CBOCs quarterly as another method by which the Facility oversees the CBOCs. However, Facility managers conducting these visits did not consistently keep written records of what was reviewed, deficiencies found, or required dates for correction. Therefore, it was unclear to the OIG team the extent to which these visits contributed to the official oversight functions required by contract.

The OIG team briefed Facility leaders on the results of the inspection findings on June 7, 2018. The OIG made two recommendations to improve the conditions noted:

1. The Facility Director requires a team of subject matter experts to complete comprehensive reviews of the CBOCs' compliance with environment of care and other contract requirements, and initiate corrective action plans, as needed.

2. The Facility Director ensures that responsible managers and team members provide consistent oversight of CBOC operations in accordance with contract requirements.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans. (See Appendixes A and B, pages 8–10 for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
EOC	environment of care
FY	fiscal year
GS	general safety
IP	infection prevention
IT	information technology
MSS	medication safety and security
OIG	Office of Inspector General
TJC	The Joint Commission
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection after an OIG Comprehensive Healthcare Inspection Program (CHIP) review identified substantial environment of care (EOC) deficiencies at the McComb Community Based Outpatient Clinic (CBOC) on May 23, 2018. The purpose of the inspection was to assess EOC conditions at the remaining six contract CBOCs under the auspices of the G.V. (Sonny) Montgomery VA Medical Center (Facility) in Jackson, Mississippi.[1]

Background

The Facility provides primary, secondary and tertiary medical, surgical, neurological, and psychiatric inpatient care. In addition to the main hospital, the Facility provides care at seven contracted CBOCs located in Columbus, Greenville, Hattiesburg, Kosciusko, McComb, Meridian, and Natchez, Mississippi. The Facility contracts with two non-VA healthcare companies to staff and provide care to veterans at the CBOCs. The Hattiesburg CBOC is contracted with one company; the six remaining CBOCs are contracted with the second company. The Facility is part of Veterans Integrated Service Network (VISN) 16, also located in Jackson, Mississippi. A map of the CBOCs in relation to the Facility is in Figure 1.

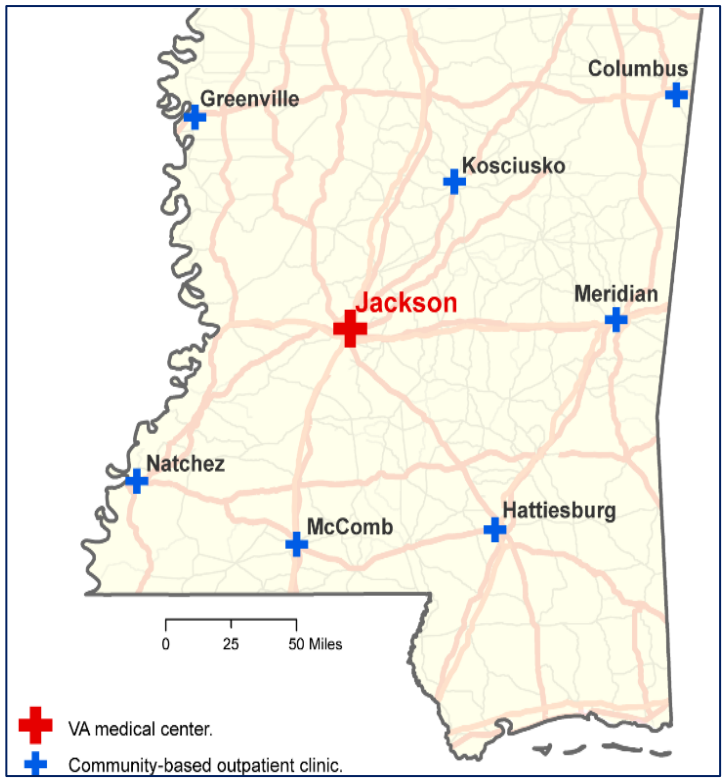

Figure 1. Mississippi VA-Contracted CBOCs
(Source: CBOC locations extracted from VHA Site Tracking (VAST))

[1] Findings related to the McComb CBOC will be published in the CHIP report.

Prior OIG Reports

In 2015, an OIG CHIP team evaluated selected aspects of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi Community Based Outpatient Clinics and Other Outpatient Clinics.[2] The Columbus Community Based Outpatient Clinic was randomly selected as a representative site for an EOC review on June 17, 2015. No deficiencies were found.

OIG reports involving the Facility from January 1, 2015, through June 5, 2018, can be accessed at www.va.gov/oig.

Concerns

On May 23, 2018, an OIG team conducted an unannounced inspection at the McComb CBOC as part of a routine CHIP review. OIG team members identified a variety of safety, security, general cleanliness, and infection control concerns. Facility leaders acted promptly to close the McComb CBOC and to evaluate the situation.[3] However, as the conditions at the McComb CBOC potentially placed patients and staff at risk, and because five additional CBOCs were run by the same non-VA contractor, the OIG decided to evaluate EOC and related conditions at all six of the Facility's remaining contracted CBOCs.

Scope and Methodology

The OIG initiated the inspection of the remaining CBOCs on May 24, 2018, and conducted unannounced site visits on May 30. For consistency, the OIG team evaluated areas similar to those reviewed by the CHIP team members during the McComb CBOC inspection. During and after the site visits, the OIG inspectors interviewed several employees and managers, and reviewed selected aspects of the contracts for the six CBOCs.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

[2] VA Office of Inspector General. *Review of Community Based Outpatient Clinics and Other Outpatient Clinics of G.V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi*, (Report No. 15-00152-481, August 19, 2015).

[3] The McComb CBOC was closed from 8:00 a.m. Thursday, May 24 until 2:00 p.m. Tuesday, May 29, 2018, for a total of approximately 2.5 business days due to the weekend and holiday.

Inspection Results

Issue 1: Environment of Care

While the OIG teams identified a range of EOC deficiencies during the unannounced inspections, the OIG team members did not find that those conditions placed patients or staff at risk. Nevertheless, corrective actions were needed to ensure a clean, healthy, and safe environment for patients and staff.

Any medical clinic, 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.[4]

All the Facility's CBOCs were managed by contract companies. The OIG team found the following requirement outlined in five of the six contracts: "Services and documentation of care provided under the resultant contract shall be subject to quality management and safety standards as established by VA, consistent with the standards published by TJC [The Joint Commission] or equivalent."

The OIG team inspected six CBOCs and did not identify deficiencies related to general privacy requirements or the availability of medical equipment and supplies. The OIG teams found deficiencies in four areas:

- General safety (GS), including requirements related to automated external defibrillators, panic alarms, fire extinguishers, building egress, and medical equipment preventive maintenance
- Medication safety and security (MSS), including medication security and disposition of expired medications
- Infection prevention and environment of care (IP/EOC), including requirements related to sharps containers, biohazardous waste storage, and maintenance of patient care areas, furnishings, and equipment
- Information technology (IT) security, including access to IT network rooms

OIG team members toured each CBOC with members of the CBOC staff and provided immediate feedback about deficient conditions at the time they were identified. In several instances, OIG team members suggested remediation of potentially unsafe conditions such as an

[4] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

expired medication and a fire door that was propped open. Table 1 below reflects deficiencies, by category, found by the OIG teams.

Table 1. OIG CBOC Deficiency Findings

CBOC Location	GS	MSS	IP/EOC	IT
Columbus	4	1	4	1
Greenville	3	1	2	0
Kosciusko	0	0	2	1
Meridian	7	2	5	0
Natchez	1	0	1	1
Hattiesburg	1	0	0	1

Source: VA OIG site visit findings

On June 7, the OIG team provided Facility leaders with a detailed written list of findings and a verbal briefing of the six CBOCs' inspection findings. Below are examples of the deficient conditions:

General Safety

The National Fire Protection Association (NFPA) requires that fire extinguishers be conspicuously located, and where visual obstructions cannot be completely avoided, there are signs identifying the location of the fire extinguisher.[5] TJC requires means of egress to be clear of obstructions.[6] This allows patients and staff to escape from fire and other emergencies without delay. The OIG teams noted inadequate signage of fire extinguishers at three CBOCs and one of those CBOCs had blocked egress (supply cart in a back hallway).

Medication Safety and Security

TJC requires medications to be secured from unauthorized access and that multi-dose medication vials are not expired.[7] The OIG team found two unsecured epinephrine autoinjectors (EpiPens®) at one CBOC, an unsecured vial of lidocaine at a second CBOC, and an open expired multi-dose vial at a third CBOC.

[5] NFPA 10 (2013 Edition), 6.1.3.1 and NFPA 10 (2013 Edition), 6.1.3.3.2.

[6] TJC E-dition, July 1, 2017, Hospital JC (EC.02.03.01, EP4) and JC (LS.03.01.20 EP8, EP15).

[7] TJC E-dition, July 1, 2017, Hospital JC (MM.03.01.01, EP 4) and JC (MM.03.01.01, EP 8).

Infection Prevention and Environmental Cleanliness

TJC requires hospitals to continually monitor environmental conditions in order to identify opportunities to resolve environmental safety and infection prevention issues.[8] This ensures a clean and safe health care environment and minimizes the spread of infection and reduces or eliminates potential safety hazards. Three of six CBOCs inspected had soiled carpeting or damaged or soiled furnishings in patient care areas; two of the three also had dirty and/or dusty floors in patient care areas.

VHA IT Network Rooms

VHA requires that IT network rooms only be accessible to authorized staff, and that logbooks including name, signature, date, and purpose of visit, among other elements, be maintained.[9] OIG team members found an unsecured IT network room at one CBOC; logbooks at two other CBOCs did not contain all the required elements. At a fourth CBOC, the logbook was maintained on a different floor of the building.[10] OIG determined that because of these deficiencies, managers could not be assured that only authorized staff were accessing the IT network rooms for appropriate purposes.

Issue 2: Contract Oversight

The OIG team found inconsistencies between the requirements for VHA oversight as described in the respective CBOC contracts, the expectations of the Contracting Officer's Representative (COR),[11] and Facility managers' approach to CBOC site visits.

The contracts state that the Contractor "shall conduct audits pertaining to access, quality improvement, documentation, safety and performance measures. These reports shall be submitted to the COR on a monthly basis…" When the OIG requested EOC and clinical quality improvement data related to the CBOCs for the previous year, the Facility's Interim Associate Director responded that the Facility CBOC Coordinator (who is also the COR) had received some of the audit reports, but that the CBOC Coordinator did not have an expectation that the respective CBOC contractors send the documents regularly. The Facility CBOC Coordinator told the OIG team, however, that the audit reports should be sent quarterly. There did not appear to be

[8] TJC E-dition, July 1, 2017, Hospital JC (EC.02.01.01 EP1 and EP3), JC (EC.02.06.01, EP 20) and JC (EC.02.06.01, EP 26).

[9] VA Handbook 6500**,** *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program,* March 10, 2015, Appendixes F-115 (2) PE-2: Physical Access Authorizations (P1); F-119 (8) PE-8: Visitor Access Records (P3).

[10] The keys did not work at a fifth CBOC and staff were unable to access the IT network room during the OIG team's visit.

[11] Contracting Officers may designate CORs to ensure compliance with the terms of the contract.

a consistent expectation or method to collect the CBOCs' audit reports monthly per contract requirements.

With the exception of Kosciusko, the contracts also state that "VA shall inspect the Contractor's facility" and that a list of any deficiencies identified during inspection will be provided to the Contractor along with a required date for correction of the deficiencies. The Facility CBOC Coordinator/COR told the OIG that in addition to daily contacts and a weekly Thursday meeting with all the CBOC contractors to discuss performance measures and other issues, she and other Facility staff try to visit each of the CBOCs quarterly. The quarterly staff visits were described as another method by which the Facility oversees the CBOCs. All six CBOCs included in this review were visited between February 6 and May 15, 2018. However, a standardized inspection format was not used during three of those visits, and the results noted were vague; for example, "[t]he clinic was neat and clean." Facility managers conducting these quarterly visits did not appear to consistently keep written records of what was reviewed, deficiencies found, or required dates for correction. Several Facility leaders reported they provided verbal reports back to the CBOCs, and that the CBOC administrators verbally confirmed corrective actions during the daily or weekly meetings. Therefore, it was unclear to the OIG team the extent to which these visits contributed to the official oversight functions required by contract. Overall, the OIG team concluded that CBOC oversight processes could be improved.

Conclusion

OIG inspectors found general safety, medication safety and security, infection prevention and environmental cleanliness, and information technology deficiencies during unannounced inspections on May 30, 2018. While OIG inspectors did not find that those conditions placed patients or staff at risk, corrective actions were needed to ensure a clean, healthy, and safe environment for patients and staff.

In addition, the OIG team found inconsistencies between the requirements for VHA oversight as described in the respective CBOC contracts, the COR's expectations, and Facility managers' approach to CBOC site visits. These inconsistencies led OIG to conclude that the Facility's oversight processes needed enhancement.

The OIG team briefed Facility leaders on the results of the inspection findings on June 7, 2018. The OIG made two recommendations to improve the conditions noted.

Recommendations 1–2

1. The Facility Director requires a team of subject matter experts to complete comprehensive reviews of the CBOCs' compliance with environment of care and other contract requirements, and initiate corrective action plans, as needed.

2. The Facility Director ensures that responsible managers and team members provide consistent oversight of CBOC operations in accordance with contract requirements.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 11, 2018

From: Director, South Central VA Health Care Network (VISN 16)

Subj: Healthcare Inspection— Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics

To: Director, Office of Healthcare Inspections Rapid Response Team (54RR)

Director, Management Review Service (VHA 10E1D MRS Action)

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the findings, recommendations and action plans submitted by the G. V. (Sonny) Montgomery VA Medical Center, Jackson, MS, in response to the OIG Draft Report.
2. Please contact Tom Drago, VISN CMO at 601-206-7027 if you have any questions.

(Original signed by:)

Skye McDougall, PhD
Director, South Central VA Health Care Network (10N16)

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 11, 2018

From: Director, G.V. (Sonny) Montgomery VAMC (586/00)

Subj: Healthcare Inspection— Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics

To: Director, South Central VA Health Care Network (VISN 16)

1. Attached is the G. V. (Sonny) Montgomery's response to the Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics.
2. I concur with the Office of Inspector General (OIG) recommendations.
3. Please contact me at 601-364-1435 if you have any questions regarding our responses.

(Original signed by:)

David M. Walker, MD, MBA, DFAPA
Medical Center Director

Comments to OIG's Report

Recommendation 1

1. The Facility Director requires a team of subject matter experts to complete comprehensive reviews of the community based outpatient clinics' compliance with environment of care and other contract requirements, and initiate corrective action plans, as needed.

Concur.

Target date for completion: September 30, 2018

Director Comments

An interdisciplinary team of subject matter experts will perform unannounced visits to all seven community based outpatient clinics (CBOC) to assess environment of care and other contract requirements. Identified deficiencies and/or concerns will be provided to the Contractor along with a required date of correction. Deficiencies will be recorded in Performance Logic and tracked in the Environment of Care Committee.

Recommendation 2

2. The Facility Director ensures that responsible managers and team members provide consistent oversight of community based outpatient clinics operations in accordance with contract requirements.

Concur.

Target date for completion: September 30, 2018

Director Comments

The seven community based outpatient clinics (CBOC) will be incorporated into the Environment of Care Assessment and Compliance Tool Rounding schedule for FY 2019. All CBOCs will be assessed by the Environmental Rounding Team twice per fiscal year. Identified deficiencies and/or concerns will be provided to the Contractor along with a required date of correction. Deficiencies will be recorded in Performance Logic and tracked in the Environment of Care Committee. The CBOC Coordinator will ensure that the contractor provides the required audits pertaining to access, quality improvement, documentation, safety and performance measures as required by individual contract.

OIG Contact and Staff Acknowledgments

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