DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021

CHIP REPORT | REPORT #22-00811-07 | OCTOBER 20, 2022

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Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
OIG	Office of Inspector General
VHA	Veterans Health Administration

Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected requirements in the management of disruptive and violent behavior.

The OIG initiated unannounced inspections at 45 VHA medical facilities from November 30, 2020, through August 23, 2021. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[1]

Inspection Results

The OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with required members' attendance at disruptive behavior committee or board meetings, patient notification of Orders of Behavioral Restriction, and completion of required training.

Conclusion

The OIG conducted detailed inspections at 45 VHA facilities to ensure staff implemented selected requirements in the management of disruptive and violent behavior. The OIG subsequently issued three recommendations for improvement to the Under Secretary for Health in conjunction with Veterans Integrated Service Network directors and facility senior leaders. VHA leaders should use the results in this report to improve operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

[1] Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

VA Comments

The Under Secretary for Health concurred with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix C, page 11, and the responses within the body of the report for the full text of the executive's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and evaluates specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' high-risk processes is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.[1] These leaders are directly accountable for program integration and communication within their level of responsibility.

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[2] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[3] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[4]

[1] Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, § 505 (2010).

[2] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

[3] VHA Directive 2012-026.

[4] An employee threat assessment team is "a facility-level, interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s), that are disruptive or that undermine a culture of safety." VHA Directive 2012-026.

- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[5]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[6]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[7]

VHA requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[8] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[9] The OIG assessed staff compliance with the completion of required training.

The OIG initiated unannounced inspections at 45 VHA medical facilities from November 30, 2020, through August 23, 2021. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections.[10] The findings may help VHA leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

[5] VHA defines a disruptive behavior committee as "a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior." VHA Directive 2012-026. VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, requires specific membership for facility-level disruptive behavior committees.

[6] VA requires each medical facility's disruptive behavior committee "to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and to document notification of a patient when an OBR is issued." VHA Deputy Under Secretary for Health for Operations and Management (DUSHOM) memo, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

[7] The Workplace Behavioral Risk Assessment "is a data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace." VHA DUSHOM memo, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012.

[8] VHA DUSHOM memo, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

[9] VHA DUSHOM memo, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

[10] Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

Methodology

The OIG evaluated compliance with selected processes for the management of disruptive and violent behavior through comprehensive healthcare inspections and randomly selected six Veterans Integrated Service Networks (VISNs) for review during fiscal year 2021. All facilities assigned to these VISNs were then inspected virtually. These 45 VHA medical facilities represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks.

To determine whether VHA facilities implemented and incorporated OIG-identified key processes for the management of disruptive and violent behavior, the inspection teams examined relevant documents and training records and interviewed key managers and staff.

The OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow up until VHA leaders complete corrective actions. The comments and action plans submitted by the Under Secretary for Health in response to the report recommendations appear within the report. The OIG accepted the action plans that the Under Secretary for Health developed based on the reasons for noncompliance.

In the absence of current VA 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).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[11] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[11] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

The OIG found general compliance with many of the selected requirements. However, across the facilities inspected in fiscal year 2021, the OIG identified weaknesses with required members' attendance at disruptive behavior committee or board meetings, patient notification of Orders of Behavioral Restriction, and completion of required training.

VHA requires facility chiefs of staff and associate directors for patient care services to be responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; clerical and administrative support staff; a patient advocate; and representatives from the Prevention Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[12] The OIG found inconsistent attendance by representatives from the Prevention Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, a patient advocate, and clerical and administrative support staff. This could result in a lack of knowledge and expertise when assessing patients' disruptive behavior. Reasons for noncompliance included staff vacancies and competing priorities.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that chiefs of staff and associate directors for patient care services ensure all required members attend disruptive behavior committee or board meetings.

[12] VHA Directive 2012-026; VHA Directive 2010-053.

VHA concurred.

Target date for completion: September 2023

Under Secretary for Health response: VHA Directive 1160.08(1) identifies the required members of the Disruptive Behavior Committee (DBC). The VHA Office of Mental Health and Suicide Prevention's Workplace Violence Prevention Program (WVPP), in collaboration with the Assistant Under Secretary for Health (AUSH) for Patient Care Services / Chief Nursing Officer, will develop and issue guidance via an AUSH for Clinical Service (CS) notification and/or memorandum. The notification/memorandum will outline the responsibilities of the facility and VISN, including the responsibilities of the medical center director, associate director for patient care services and chief of staff, and require VISNs to monitor the attendance of each required position to DBC meetings at each medical facility within their respective network. A facility will achieve attendance monitoring compliance through 2 consecutive quarterly attestations by the VISN to the WVPP that each required position attended at least 90% of the facility's DBC meetings. VISNs must be able to provide, upon request, documentation of DBC meeting attendance rates for required positions at each facility. Facilities not achieving the 2 consecutive quarters of a 90% or better attendance rate for each required position must submit a corrective action plan to WVPP through their respective VISN. VHA will consider this recommendation closed when 90% of VA medical facilities achieve compliance.

VHA requires the disruptive behavior committee or board to document patient notification of Orders of Behavioral Restriction in the Disruptive Behavior Reporting System.[13] The OIG determined that 7 of the 44 facilities' committees or boards (16 percent) that issued Orders of Behavioral Restriction did not consistently document patient notification of the order in the Disruptive Behavior Reporting System. This calls to question whether patients were notified of their restriction orders and could have resulted in the committee or board's inability to collect, communicate, and manage disruptive event information. Reasons for noncompliance included lack of oversight and human error.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that chiefs of staff ensure disruptive behavior committees or boards document patient notification of Orders of Behavioral Restriction in the Disruptive Behavior Reporting System.

[13] VHA DUSHOM memo, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

VHA concurred.

Target date for completion: September 2023

Under Secretary for Health response: The WVPP will develop guidance issued via an AUSH for CS notification and/or memorandum requiring each VA medical facility chief of staff's designee, the DBC, to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and patient notification of the OBR that includes the request for review process. DBRS documentation of OBR placement and patient notification compliance monitoring for a facility will be achieved by 2 consecutive quarterly attestations by the VISN to the WVPP that 90% of the facility's OBRs and patient notifications are documented in DBRS. VISNs must be able to provide, upon request, documentation that deficiencies in using DBRS to document OBR placement and patient notification are corrected by the facility. Facilities not meeting the required 2 consecutive quarters of 90% or better of OBR placement and patient notification documentation in DBRS must submit a corrective action plan to WVPP through their respective VISN. VHA will consider this recommendation closed when 90% of VA medical facilities achieve compliance.

VHA requires that staff complete prevention and management of disruptive behavior training based on the risk level assigned to their work area.[14] The OIG found 514 of 1,346 selected staff (38 percent) had not completed the required trainings. This could result in lack of awareness, preparedness, and precautions needed when responding to disruptive behavior. Reasons for noncompliance included facilities halting face-to-face training during the COVID-19 pandemic.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that medical center directors ensure staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.

[14] VHA DUSHOM memo, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*.

VHA concurred.

Target date for completion: September 2023

Under Secretary for Health response: The WVPP will develop guidance issued via an AUSH for CS notification and/or memorandum requiring each VA medical center director ensures staff complete all required Prevention and Management of Disruptive Behavior (PMDB) training as determined by annual Workplace Behavioral Risk Assessment data by completing the following:

1) Identify the number of PMDB classes needed at the facility for initial PMDB training (the indicated combination of Part 1, Part 2 Low, Part 2 Mod/High, and/or Part 3) to meet 100% of all PMDB mandatory training needs by September 30, 2024 (i.e., the end of Fiscal Year 2024).
2) Schedule the number of PMDB classes needed each quarter to meet the identified need for PMDB mandatory training as identified in sub-paragraph 1 above. Note: PMDB classes may only be conducted by a minimum of two certified and calibrated PMDB trainers who are provided with protected time.
3) Ensure a minimum of 90% of all PMDB classes scheduled each quarter achieve a minimum attendance rate of 75% of class capacity (i.e., at least 12 participants).

PMDB training compliance monitoring for a facility will be achieved by 2 consecutive quarterly attestations by the VISN to the WVPP that 90% or better of the facility's required PMDB training (as specified in sub-paragraphs 1, 2, and 3 above) was completed. VISNs must be able to provide, upon request, documentation of PMDB training needs (sub-paragraph 1 above), schedule of PMDB training courses required each quarter to meet the facility's PMDB training needs (sub-paragraph 2 above), and course attendance rates for each facility (sub-paragraph 3 above). Facilities not meeting the required 2 consecutive quarters of 90% or more quarterly PMDB training completion rate for all staff must submit a corrective action plan to WVPP through their respective VISN. VHA will consider this recommendation closed when 90% of VA medical facilities achieve compliance.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The intent is for these leaders to use the recommendations to guide improvements in operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• Disruptive behavior committees or boards document patient notification of Orders of Behavioral Restriction in the Disruptive Behavior Reporting System. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.	• All required members attend disruptive behavior committee or board meetings.

Appendix B: Parent Facilities Inspected

Table B.1. Parent Facilities Inspected)
(October 1, 2020, through September 30, 2021)

Names	City
Bay Pines VA Healthcare System	Bay Pines, FL
Beckley VA Medical Center	Beckley, WV
Charles George VA Medical Center	Asheville, NC
Cheyenne VA Medical Center	Cheyenne, WY
Durham VA Health Care System	Durham, NC
Eastern Oklahoma VA Health Care System	Muskogee, OK
Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA
Fayetteville VA Coastal Health Care System	Fayetteville, NC
Hampton VA Medical Center	Hampton, VA
Hershel "Woody" Williams VA Medical Center	Huntington, WV
Hunter Holmes McGuire VA Medical Center	Richmond, VA
James A. Haley Veterans' Hospital	Tampa, FL
James J. Peters VA Medical Center	Bronx, NY
Louis A. Johnson VA Medical Center	Clarksburg, WV
Manchester VA Medical Center	Manchester, NH
Martinsburg VA Medical Center	Martinsburg, WV
Miami VA Healthcare System	Miami, FL
Montana VA Health Care System	Fort Harrison, MT
North Florida/South Georgia Veterans Health System	Gainesville, FL
Northport VA Medical Center	Northport, NY
Oklahoma City VA Health Care System	Oklahoma City, OK
Orlando VA Healthcare System	Orlando, FL
Providence VA Medical Center	Providence, RI
Salem VA Medical Center	Salem, VA
Samuel S. Stratton VA Medical Center	Albany, NY
Sheridan VA Medical Center	Sheridan, WY
Syracuse VA Medical Center	Syracuse, NY
VA Boston Healthcare System	Jamaica Plain, MA
VA Caribbean Healthcare System	San Juan, PR

Names	City
VA Central Western Massachusetts Healthcare System	Leeds, MA
VA Connecticut Healthcare System	West Haven, CT
VA Eastern Colorado Health Care System	Aurora, CO
VA Finger Lakes Healthcare System	Bath, NY
VA Hudson Valley Health Care System	Montrose, NY
VA Maine Healthcare System	Augusta, ME
VA Maryland Health Care System	Baltimore, MD
VA New Jersey Health Care System	East Orange, NJ
VA New York Harbor Healthcare System	New York, NY
VA Salt Lake City Health Care System	Salt Lake City, UT
VA Western Colorado Health Care System	Grand Junction, CO
VA Western New York Healthcare System	Buffalo, NY
W.G. (Bill) Hefner VA Medical Center	Salisbury, NC
Washington DC VA Medical Center	Washington, DC
West Palm Beach VA Medical Center	West Palm Beach, FL
White River Junction VA Medical Center	White River Junction, VT

Source: VA OIG.

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: September 30, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021 (2022-00811-HI-1229) (VIEWS 08451442)

To: Office of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021. The Veterans Health Administration concurs with the recommendations and provides an action plan in the attachment.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal, M.D., MBA

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